

Dr David Honey; Mr John McGrath; Mr Roger Cook; Mr Peter Katsambanis; Ms Margaret Quirk; Mrs Liza Harvey; Mrs Alyssa Hayden; Dr Mike Nahan; Mr Zak Kirkup; Mr Sean L'Estrange; Dr Tony Buti; Mrs Michelle Roberts; Mr Tony Krsticevic; Mr Bill Johnston

VOLUNTARY ASSISTED DYING BILL 2019

Consideration in Detail

Resumed from an earlier stage of the sitting.

Clause 6: Decision-making capacity —

Debate was interrupted after the clause had been partly considered.

Dr D.J. HONEY: I want to follow up on a matter that was raised by the member for Riverton in relation to whether a person will have decision-making capacity. I raised this issue in my second reading contribution. I have a real concern, and I know it is shared by others, that a person who has just been given a prognosis of imminent death from an illness or disease may not be in the correct frame of mind to make a decision. A doctor may have just announced to the person, "I'm sorry. You've got an illness, and you're going to be dead within a matter of days." We have heard examples of people who have been given that prognosis, and in fact it turned out to be completely wrong. We have also heard from a number of members, and we will have a chance to talk about this later as well, that especially for action-oriented people, there is a real risk that they will make the instantaneous decision that, "That's it. I want to have control. I'm not going to let the disease take control. I'm going to terminate my life."

In the examples, fortunately, very loving and caring people who deeply cared about those people and who knew them well prevailed upon them to not do that. There was the example of an individual who was told with certainty that they had months to live, but then lived for 17 years; and there were other examples in which people lived for several years afterwards. My concern is that when someone receives a prognosis, I am not sure that they are in a fit state of mind to make a decision to end their life. In fact, based on the examples—we were given real examples from people in this house—if people had made that decision, they would have robbed themselves of years of fulfilled living, for not just them but also their family. I am not sure whether the committee considered this, but would it not be prudent in that particular case—I am not saying in every case; we can talk about the waiting period later on—to seek advice on some sort of minimum waiting period before a person can make a decision to enter that final nine-day countdown? I say that because I am not sure it is possible for anyone who has just received such a prognosis to be in the right state of mind. To a degree I anticipate the response will be, "Well, medical practitioners can assess that." But we have heard in the debate on this bill that a medical practitioner will not need to know that person at all. They do not have to be a loving caring person who knows the person well; they can be a complete stranger, and may very well be a complete stranger. I imagine a lot of people's family doctors will not want to be involved in this. Some people, particularly action-oriented people, can be very convincing and state that this is what they want to do and this is their purpose. I will come back to that question.

I wonder, minister, whether it is not prudent to investigate some specified waiting period. I do not presuppose what that should be. I think that is something that the experts in this area would be able to determine, but it certainly seems that at least a week or weeks should be required to allow a person to be in the right frame of mind to make a properly informed decision—not a decision that is influenced by the shock and trauma of having just received a diagnosis. Quite often it is a surprise; many people know that. Quite often it is a complete surprise. Someone who has been feeling a little unwell may go to the doctor, have some tests done and all of a sudden they are being told that they have days, weeks or months to live.

Mr J.E. McGRATH: I think my colleague the member for Cottesloe is losing sight of what happens in people's lives. I agree that a lot of people when they get what is called the death sentence or are told by a doctor that they have only six months to live, they will be quite shocked. For some people it will be very difficult to cope with. But a lot of those people will be in shock for a few days and think, "Well, I reckon I can still beat this," because people want to live. We forget that people want to live. I did not talk in my second reading contribution about what happened to my father-in-law, because my wife's family were fairly private. They were racing people. When my father-in-law got cancer, his wife did not even want our kids to see him in hospital. He was in a pretty bad way and died a fairly private death. He was given six months to live. The doctor said, "We will put you on a course of chemo." I used to drive him from the stables at Ascot to St John of God in Subiaco for his chemotherapy. One day after a course of chemo he came out to the car and said, "I want you to take me to Royal Perth Hospital." I said, "What for?" He said, "I want to find that bastard who gave me the death penalty." They had told him that day that the chemo had worked and he was on the road to recovery. Within six months he was dead. But he wanted to live. I think that is what we are losing sight of here. The member says that when people get a prediction from their specialist that they have only six months to live they are going to walk out straightaway and say, "I want to end it now." I do not think many people will do that. We all want to live and we all value life. I think the one thing that we on the committee all learnt was that people will always want to live rather than die.

It will only be when they get to a certain stage that they cannot put up with it anymore.

Extract from Hansard

[ASSEMBLY — Wednesday, 4 September 2019]

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Dr David Honey; Mr John McGrath; Mr Roger Cook; Mr Peter Katsambanis; Ms Margaret Quirk; Mrs Liza Harvey; Mrs Alyssa Hayden; Dr Mike Nahan; Mr Zak Kirkup; Mr Sean L'Estrange; Dr Tony Buti; Mrs Michelle Roberts; Mr Tony Krsticevic; Mr Bill Johnston

I know the point the member is making, but we have to trust the general practitioners and the people who know. If a guy went to his GP and said, "I have been given six months by the specialists; I want to end it now", I am sure the GP who had been his GP for a long time would say, "Hang on a minute, let's think about it. There are things we can do and you can still get treatment." I do not see that that will happen. I think people will want to cling to life for every hour that they can. It will only be when they get to the stage that life is unbearable and they do not have quality of life. A person can be given six months to live and still live a reasonable life, but the prognosis is that they will not be around for much longer. They may have six months and they will gradually get worse, but in a lot of cases, they will still be able to live a reasonable life. They may still be under medical treatment such as chemotherapy and stuff like that. I would like to think that under this assisted dying legislation, those people would be given support and that support would come. If they decided that they want to end it, I would like to think that the specialists or the GP would say, "Hang on; if you want to do that, you have to go through a process, and there might be other things you can do first." That is what I believe of this legislation. I understand what the member is saying, but I will be interested to hear what the minister says.

Mr R.H. COOK: I thank the member for South Perth for his observations. I think that is right. This is not a thought that springs to mind. The checks and balances in the bill, the 102 safeguards, are around the issues of not allowing that situation to occur. A person who would have been given a diagnosis that would in any way make them eligible under this bill would have an advanced and terminal disease. We are not talking about someone who suddenly discovered that they have something wrong with them. This is a process that is significantly advanced. The decision that that person would have to make has to be enduring, as set out in clause 15, and in addition to that, the request will have to be overseen by two medical practitioners. I understand the member's anxiety, but he can be assured through the processes that will be in place that the scenario he described quite simply would not be possible.

Dr D.J. HONEY: I do not wish to drag this point out for a long time but I have to specifically disagree with the point that the member for South Perth made and that the minister reinforced. We have heard actual examples in this house of people who have had such a prognosis and said straightaway, "I want to terminate my life." Let us take that a little further. If someone in that position said, "Actually, I have thought about this, and I don't", this does not apply. The member and the minister may well be right—most people will not want to access this; I know that. I am not concerned about those people. This will never affect them because they do not want to access it. I am worried about someone who will make that snap decision to access this on the cusp of being given a terrible prognosis. I am not talking about them never being able to access it. I asked the minister two questions. I asked whether the panel looked at this point and came to an idea around when a person would be in this position. I do not think it is feasible for a person to be in this position when they have just been told or within a few days of being told, but I am not a medical expert. Obviously, the minister and others have been talking to medical experts. Was this discussed and would it be prudent in that specific circumstance? It is not about someone who has had a disease for some time or who has known about it for some time; it is about someone who has just had that prognosis and makes that snap, but certain, decision. As I say, action-oriented people will be more likely to do that. The other thing is that there does not have to be any reference to their GP at all. If they decide, "I'm going to do this. I don't even want my family to know", and they go to a practice that has been set up to specialise in this area, no-one else has to know—not even the family has to know and they then cannot talk the person out of it.

Mr R.H. COOK: I appreciate the member's anxieties, but it is simply not a realistic scenario. The checks and balances in place would simply not allow for that. Under this clause, the person has to demonstrate that they have decision-making capacity and they would have to be knowledgeable about what is happening. In subsequent clauses we will learn that if they are to be eligible in the first place, the condition has to be advanced and the prognosis has to be on the balance of probabilities that that person will pass away within six months. Their decision has to be enduring, not simply made on the spur of the moment or an act of inspiration, and they have to be suffering. I can assure the member that the scenario he painted could not take place. A medical practitioner would have to consider all the conditions and issues that confront that patient. Simply suffering from the shock of the news would not provide them with the opportunity to be considered eligible for voluntary assisted dying.

Mr P.A. KATSAMBANIS: Decision-making capacity is something that I spoke about for some length in my second reading contribution. As I have indicated, I have had significant professional experience in this area, but obviously in a different context of wills, estates, powers of attorney and decisions around medical treatment. I must say that I welcome the fact that there is a test of sorts codified in this legislation. I note that it is similar—I will not say identical—to the test that applies in wills, estates and medical decisions. I do not necessarily think that is a bad thing, because, again, we need some sort of guidance. I know it is a slightly different decision, but we need some sort of guidance, so I welcome that. My first query is about subclause (3), which says —

For the purposes of this Act, a patient is presumed to have decision-making capacity in relation to voluntary assisted dying unless the patient is shown not to have that capacity.

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I know there is some consternation in some quarters that it is a presumption that capacity exists, but, again, based on legal precedent in similar areas, I do not have a problem with that. I would like to know what the test to be applied is to show that a person does not have capacity. What is the standard of proof in relation to that test and who is to apply that test at first instance?

Mr R.H. COOK: The test is in front of the person and, obviously, it would be on the balance of probabilities.

Mr P.A. KATSAMBANIS: Who would determine that capacity is not there at first instance?

Mr R.H. COOK: It would be two people—the trained coordinating medical practitioner and the trained consulting medical practitioner—who both have to come to the decision and the conclusions independently of each other.

Mr P.A. KATSAMBANIS: What specific qualifications would those people have to make the determination around capacity and to apply that test? Where else in their professional capability are they entrusted with this sort of framework for making this sort of decision and what sort of experience would they be able to apply in this area?

Mr R.H. COOK: This is territory that we have spent some time on. The medical practitioner would be a trained medical practitioner as defined under the Health Practitioner Regulation National Law (WA) Act. In addition, they would have to have undertaken the mandatory training, which we have discussed. In addition, if there is any doubt in the coordinating practitioner's or the consulting practitioner's mind about the person's decision-making capacity, they are required to refer to a specialist who can provide them with further advice. That may be a geriatrician, a psychiatrist or someone of that nature.

Mr P.A. KATSAMBANIS: Why was the Chief Psychiatrist's recommendation made to the Joint Standing Committee on End of Life Choices to include compulsory psychiatrist screening in this assessment not accepted in the framing of this bill?

Mr R.H. COOK: I am advised that to suggest that only a psychiatrist can assess decision-making capacity mischaracterises the role of psychiatrists. A psychiatrist treats mental illness. They are not general experts on decision-making capacity. During consultation with registered health practitioners, including the Office of the Chief Psychiatrist, it was made clear that it would not be appropriate nor necessary for every patient who requested voluntary assisted dying to undergo a psychiatric assessment. Furthermore, the Royal Australian and New Zealand College of Psychiatrists made clear that although the practitioner assessing capacity needs relevant expertise, they do not need to be a specialist and the capacity assessment is not solely in the domain of psychiatrists. Psychiatrists are rarely the most appropriate clinicians to do capacity assessments. As the member would be familiar, general practitioners and medical practitioners of all persuasions make decisions regularly about a patient's capacity to make a decision, whether it is about refusing treatment or the type of treatment they want to receive. These are part and parcel of the skills and the training that a medical practitioner receives as a medical student, and, in addition, they would be subject to the mandatory training that is part of this bill.

Ms M.M. QUIRK: The minister will appreciate that the bar shifts in determining capacity depending on the nature of the decision. A low-level executive decision is less of a concern than if it is the ultimate decision—that is, to end life early. As I said before the break, someone can be a GP for many years and certainly miss that there is a comorbidity with dementia. Perhaps the minister can spell out for us the nature of the test for capacity and how long it lasts. In the case of aged care, we are talking about people who at medical school probably did two weeks on gerontology. As Alzheimer's Western Australia says, the average time for diagnosis of dementia is two to three years. I hope it is more than asking who the current Prime Minister is. I know that for a while they stopped asking that question because there was such a turnover in Prime Ministers! It is not clear in this legislation. I was advised in one of the very useful briefings—we will get to this soon—that it was likely to be a six-hour module online, and that would include testing for capacity. Frankly, the community is littered with people who realise they have dementia only when they do not pass their driving test, and suddenly the families who live with them every day go, "Oh, maybe mum or dad has dementia." It is like the frog in the cold water. We do not necessarily know. A 20-minute conversation with a person who is ostensibly lucid is frankly not enough.

Mr R.H. COOK: The criteria around that test is before the member in clause 6(2), paragraphs (a) through to (e). In addition, as I have reported to the house, it will be subject to training as part of the voluntary assisted dying process. The assessment of capacity in a clinical setting cannot be tick a box, but will involve a robust, international assessment as well as consideration of the specific criteria. The test has to be undertaken twice with two medical practitioners coming to the same conclusion independent of each other and the decision has to be enduring.

Dr D.J. Honey: Which clause was that?

Mr R.H. COOK: Clause 6(2).

Dr D.J. Honey: I saw that but the words that you mentioned —

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Mr R.H. COOK: I am reading from advice. It is not part of the bill.

The two medical practitioners have to be able to continue to hold that the person has decision-making capacity right through the process. The patient has to make two requests verbally and a request in writing and ultimately has to undergo a final review. As the member will appreciate, the safeguards in relation to the decision-making capacity are quite robust.

Mr P.A. KATSAMBANIS: The test contained in clause 6(2) is not limited to only a voluntary assisted dying decision but applies generally in relation to the voluntary assisted dying process. As I understand it—the minister will correct me if I am wrong—initially two medical practitioners have to make an assessment on capacity. But in a case in which someone chooses to have the assisted dying substance administered by a practitioner, they can in certain circumstances have a nurse practitioner administer the substance. I understand that at the point the substance is administered, a decision has to be made as to decision-making capacity. What sort of training would a nurse practitioner have to determine decision-making capacity in those circumstances?

Mr R.H. COOK: That is in part 4 of the bill, so we will come to that later. It will require the same level of mandatory training.

Mr P.A. KATSAMBANIS: We will discuss that there, and I will be interested to see what the case will be. But ordinarily in what other circumstances would a nurse practitioner, outside the assisted dying framework contained in the bill, have to make that sort of determination in the framework contained in the bill?

Mr R.H. COOK: As the member would be familiar, the nurse practitioner is a highly qualified position involving significant periods as a clinician as well as undertaking subsequent post-graduate studies. It involves diagnosis and prescription within the scope of the nurse practitioner field. They would be very familiar and very adept in relation to these sorts of decisions.

Ms M.M. QUIRK: The minister mentioned the two independent assessments of a person's capacity by the medical practitioners. Where is the word "independent" used?

Mr R.H. COOK: Member, it is not part of clause 6.

Ms M.M. QUIRK: Is it used somewhere else in the bill? Rather than take up time now, I am happy to receive that advice later. It is in the explanatory memorandum in various places, but I cannot actually find the word anywhere in the bill. Since the minister mentioned it then, I thought I would check.

The other thing I wanted to raise is that clause 6(2) mirrors the Victorian legislation except in one material respect. In Victoria, not only does a person need to understand information and matters involved in a voluntary assisted dying decision, understand the effect and weigh up the factors referred to for the purposes of making a voluntary assisted dying decision, but also the test in Victoria requires a person to retain that information. If there is a comorbidity of a terminal disease and dementia, for example, that is a real challenge. I want to know why the word "retain" was removed. As the minister will be aware, if he were to ask someone with dementia what happened in 1963, they would be able to tell him, but if he were to ask them what they had for lunch, they would probably have no idea.

Mr R.H. COOK: I am advised that our clause is consistent with other decision-making capacity frameworks that we use in the health system, including the mental health system. Under our processes, the patient has to understand the information, they have to understand the matters involved and they have to understand the effect. Those requirements provide a framework for retention. From that point of view, it was not considered necessary to include the Victorian approach. As I said, this is consistent with other decision-making frameworks that are used in Western Australia.

Ms M.M. QUIRK: Someone made a conscious decision to take out that phrase, "Retain that information to the extent necessary to make the decision". How did that occur and what instructions were given?

Mr R.H. COOK: It was not taken out. We are using the Western Australian framework, which is consistent across the medical field in Western Australia, including in the Mental Health Act.

Mrs L.M. HARVEY: In determining capacity, I draw the minister's attention to clause 6(2), to give context, which states —

For the purposes of this Act, a patient has *decision-making capacity* in relation to voluntary assisted dying if the patient has the capacity to —

...

(e) communicate a voluntary assisted dying decision in some way.

Could the minister please clarify that a little more clearly? I note that one of the requirements in clause 14 to access voluntary assisted dying is that "the person has made a written declaration". It would seem to me that an individual

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can be determined to have capacity if they can in some way communicate that they want to access voluntary assisted dying, but that individual may not necessarily have the capacity to fill in a written declaration. I want to know how clause 6(2)(e) intersects with clause 14.

Mr R.H. COOK: It is anticipated that a person in the last six months of their life and suffering intolerably may be incapacitated in their ability to speak or write. Clause 6(2)(e) requires them to be able to make a clear and unambiguous communication of their decision. For instance, they may not be able to write, so someone else might be able to write the declaration for them and they can make a mark. They might not be able to speak, so at that point they might be using an iPad, for instance, to communicate with their carers and things of that nature. This legislation contemplates that people will have differing capacity to communicate in the usual ways that we understand. However, this bill requires them to communicate in a clear and unambiguous way, even if it is not necessarily verbally or in their own handwriting.

Mrs L.M. HARVEY: The minister has made that clear. It raises some more questions concerning the person making a written declaration. I will deal with that when we get to clause 14.

Mrs A.K. HAYDEN: I would like to expand on the Leader of the Opposition's question about clause 6(2)(e). It is a somewhat loose expression. Can the minister explain what will constitute an acceptable form of communication?

Mr R.H. COOK: It will be a clear and unambiguous one.

Mrs A.K. HAYDEN: Great. Fantastic! What is that? Two blinks for yes and one blink for no? I think we need to have a bit more of an explanation about that. If someone had been born with a speech impediment, they would know how to communicate without the ability to speak, but if someone has lost their voice due to illness, this will be a whole new area for them. I think we need a bit more of an explanation of what will be acceptable as a form of communication. If someone has lost their way to express their desires, opinions and thoughts, and this legislation will allow them to access voluntary assisted dying, we need to have some form of acceptable communication.

Mr R.H. COOK: That is why under clause 6(2)(e), they have to be able to communicate a voluntary assisted dying decision in some way. It has to be communicated in a clear and unambiguous way. They may be signing or they may have other ways to communicate with their carers. We need to be satisfied that they have that capacity.

Mrs A.K. HAYDEN: Just to be clear, if it is a choice of one blink for no or two blinks for yes, would that be acceptable?

Mr R.H. COOK: It would depend upon the patient.

Mr P.A. KATSAMBANIS: I have a question about this issue. Again, I have some professional experience in this area. As I said about the test contained in subclause (2), I welcome that a clause such as 6(2)(e)—communicate a voluntary assisted dying decision in some way—is in the legislation. That is all well and good because some people may not be able to communicate verbally, and others may not be able to communicate in writing, as the case may be. However, I also have some experience in legislative interpretation. That is why processes such as the one we are going through right now, consideration in detail, are really critical for people who will interpret this legislation in the future, judicial officers in particular, to try to work out the legislative intent. Again, I speak from considerable professional experience. I am occasionally alerted to the fact that justices in Victoria quote my parliamentary speeches in Victoria when interpreting wills and administration legislation in gleaning legislative intent. I hope that actually provides them with some guidance. That is why I would have expected that when the member is asked to clarify in some way what the term means, he would have come here prepared by his most senior advisers to put on the record some examples to provide guidance in the future from the most senior of authorities—the minister sponsoring the legislation. In that way, judicial officers and others—perhaps medical, legal and nurse practitioners—could have at the outset some sort of guidance to perhaps even get to the point at which we could avoid judicial oversight and interpretation in this area. So, in the spirit of cooperation, I seek that from the minister. The minister knows I am uncomfortable with the legislation, but I still want it to be as good as possible when it leaves this place and goes out there into practice. The minister is the minister; can he at least utilise this process to put on the record some examples of what would be considered in some way, and perhaps some examples that might fall short of meeting the test? I think that would be valuable for the general public and actually add some significant betterment, if you like, to the legislation as it is currently drafted in this ambiguous way.

Mr R.H. COOK: Examples of how a patient might communicate would include such devices as a voice modulator, which the member will be familiar with the late Professor Hawking having used; someone might use an iPad to type out a message; someone might write things down; and people might utilise braille. These are the sorts of ways in which people might communicate, but the medical practitioner, with the required training, will be required to be satisfied that the patient is capable of communicating a voluntary assisted dying decision in some way.

Mr P.A. KATSAMBANIS: I think everyone understands a written request, whether it is written on a piece of paper or typed out on an iPad. Everyone understands communication of a message through a voice box. Those are

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the really simple ways—the ones that are unambiguous, if you like. What happens when we get into the more ambiguous decisions? For instance, would a nod, a wink or a squeeze of the hand suffice in response to a message that is communicated on behalf of the person by an assistant, be they a child, a friend or someone else they have taken along to the doctor? If, for example, someone presents to a medical practitioner with a friend, a child or a partner, and the person accompanying says, “Prior to losing their voice, my partner said they were in favour of this legislation and they can confirm that”, and the partner nods, would that be sufficient to satisfy this particular test?

Mr R.H. COOK: Member, I am not going to be able to satisfy your curiosity to explore all the ways in which someone might communicate. The decision-making capacity has to be clear. They have to be able to make a clear and unambiguous decision and communicate that decision. There are a range of ways of doing so. The member asked me to provide him with some examples, and I did so. I cannot satisfy the member any further than to provide him with that information. The coordinating medical practitioner and the consulting medical practitioner, who are both medical practitioners with years of clinical experience, plus the mandatory training that comes with this bill, would be required to make that decision.

Mr P.A. KATSAMBANIS: There is no point in debating this. I have made my point that this is a highly ambiguous area. The simple “write it down on a piece of paper, type it out on an iPad, communicate it through an artificial voice box that is still utilising the person’s own function”, as Professor Hawking and the like used, I think they are non-controversial. It is those areas that I raised. I understand that the minister might not want to give an answer, but it is that area that people who ordinarily may want to support this legislation have some issues about. I think they are legitimate issues. Sadly, they will need to be interpreted at some point by a court and unfortunately in many cases they are going to be post a terminal event and so the interpretation would be academic at best. I think that is why the requirement in the Victorian legislation, which has been removed from this provision, would have been extremely helpful in requiring the practitioner in this particular case to retain the information. I join with the member for Girrawheen in highlighting that there is an issue with this clause.

Mr P. Papalia: It is not a second reading debate.

The ACTING SPEAKER: Minister!

Mr P.A. KATSAMBANIS: I actually do not think these interjections are helpful. I am trying to highlight really important issues. I am almost at the conclusion and the peanut gallery comes in and starts throwing barbs that detract from a fair examination and simply try to make political points. I am not making a political point here. I have made my political point in the second reading debate. The minister has handled my queries here with great respect, and I was going to say aplomb as well. I commend him for that. I do not necessarily think those other interjections are helpful, especially when they are an attempt to derail my train of thought in a complex area that will be litigated. They will need to be examined even by practitioners before litigation. The majority of what we have in the bill before us is really good. I am not a supporter of the principle of the legislation, but I want the legislation to work in practice. What has been done here is really good. I have said that consistently as we have gone through this clause. Because of this difficulty in articulating all of the ways that a decision could be communicated “in some way”—I use those three words in quotation marks—the added protections in the Victorian legislation would have been preferable to what we have here.

Dr M.D. NAHAN: Clause 6(3) may need some clarification. It states —

... a patient is presumed to have decision-making capacity in relation to voluntary assisted dying unless the patient is shown not to have that capacity.

I want the minister’s assurance that in all cases, a test will be made by two practitioners to assess that.

Mr R.H. COOK: Yes, member, that would be part of the assessment process.

Dr D.J. HONEY: I appreciate that this is dealt with later in the bill, but it appears that we are going down the path of whether the person should have a psychiatric assessment, so we might as well exhaust it now. I know of a reasonably personal story of a person in Sir Charles Gairdner Hospital who was dying and all they wanted to do was go home and die in their own house. A doctor carried out an assessment of their capacity to make a decision, which consisted of five perfunctory, rapid-fire questions, and then that person was deemed not to have any capacity and was trapped in the hospital until they died. That person used to get up every day, get dressed and pack their case so that they could go home and die in their house. It is certainly the view of other doctors that although that person was dying, they had plenty of capacity and, in fact, had the capacity to make that decision for themselves and not be literally trapped as a prisoner in the hospital. That brings me to the concern about how the assessment will be done and whether the people will be qualified. It may be right or wrong, but it was the clear view of other respected medical practitioners that that doctor had made a fundamentally wrong decision in a rush.

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That brings me to how this assessment will be carried out and whether a psychiatrist is needed. The words in the bill are vague. It says that they will assess whether they have decision-making capacity, and we are going to rely on the fact that a doctor will do that. I will be very frank with the minister. I think we see the normal range of abilities in doctors that we see in people in any other profession. Some doctors are outstanding in every regard and some doctors, to be frank, should not be practising. They are not competent and quite often they are not found out. That is not to criticise doctors; doctors are like humans in every other walk of life. Some people are exceptional and outstanding; some are not. How they got through their exams is a mystery to everyone. What I am getting to is not a general discussion. The minister used some specific words. He had some advice that the test has to be world standard et cetera. How will that manifest itself in the application of the bill? The words that the minister used—I cannot remember them verbatim—sounded reassuring to me. There was going to be some rigour and detail in the standard of that test. How will that manifest itself in the bill? Is there any reason that that could not be included in the bill if it is not going to be guaranteed in some other way? As I say, I was reassured by that form of words, but I just do not see it reflected in the bill.

Mr R.H. COOK: The words I used were in the submission from the Chief Psychiatrist to the Joint Select Committee on End of Life Choices. From that perspective, I think the member understands the gravitas that that has and what would be brought to bear. As I said in answer to a number of questions, if the medical practitioners have any inkling that the person does not have decision-making capacity, they must refer on to a specialist who can then provide them with assistance in making that assessment. That person might be a specialist in a particular field of medicine. They might be a geriatrician or a psychiatrist if there are particular mental health issues and so on. The assessment of decision-making capacity goes on all the time in medicine, and the member has just described a very good example. These sorts of cases, in which a GP or a medical practitioner of some form has made a call about a patient's capacity to make a decision, come before the State Administrative Tribunal regularly. It happens all the time. I am sorry if the member feels that there is too great a variation in the skills and qualities of the medical workforce. We have one of the best medical workforces in the world, but I accept that sometimes good decisions are made and sometimes bad decisions, or decisions that would otherwise be reflected on, are made. In health, they are made all the time.

Dr D.J. HONEY: I do not want to drag this out, but is there any reason that we could not include that form of words in the bill? That is an explicit form of words; it defines a standard. Otherwise, we will just be leaving it up to that individual medical practitioner. There is a diversity of skills, and a diversity of inclinations, might I say, in the medical profession. Is there any reason why we could not use that form of words to specify how the assessment would be done? That would make it unequivocal. It would not give us absolute certainty, but it would give us much greater clarity about how the assessment would be done. This is probably one of the more important aspects of the whole bill—how do we assess that the person has capacity to make that final decision?

Mr R.H. COOK: Member, you and I would not come across this stuff very often, because we do not often delve into the world of medical practitioners and assessments of decision-making capacity. As I stated to the member for Girrawheen, the criteria that we have used are in common usage across the health system in Western Australia, including as part of our Mental Health Act. What I described is the clinical standard. From that point of view, I have provided that as a way of assurance to the member that these things will be dealt with in the appropriate way.

Ms M.M. QUIRK: Minister, I have put on the notice paper an amendment that relates to the insertion of a new subclause (aa). I therefore move —

Page 8, after line 24 — to insert —

(aa) retain the information or advice to the extent necessary to make the decision; and

I have already articulated that the reason for that proposed amendment is that it is in the Victorian bill. It will provide an additional test to ensure that the person whose capacity is being assessed can, if you like, reiterate what has been put to them, and their understanding of the procedures around voluntary assisted dying. The idea of testing retention is not novel. We do it in all forms of life. A footy coach might say to a player, "I want you to take out the full back. Did you get that? Do you know what you have to do?" We might say to kids, "We would like you to go to the shop and get X, Y and Z. Now, what are you going to get for me?" It will not be a major impost on practitioners. I would have thought it would give practitioners a lot more confidence about their assessment. As I have said, certainly in cases of dementia, retention is one of the first things that goes. It is a threshold question that needs to be addressed. I know the minister has told us that the Western Australian framework is different. I am trying to ascertain why those words were removed. I seek the minister's response to the proposed amendment.

Mr R.H. COOK: The definition in the bill of "decision-making capacity" is consistent with the provisions of the WA Mental Health Act 2014. Medical practitioners are already comfortable with the definition of decision-making capacity in the WA Mental Health Act. The reference to "retain the information" is a reference to Victorian

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legislation and is not reflective of Western Australian legislation. As I assured the member earlier, those words were not removed; they were never there. This is the way in which we have described decision-making capacity in the context of the WA Mental Health Act.

Mr P.A. KATSAMBANIS: I think I have made my point on the amendment moved by the member for Girrawheen. I definitely think it will improve the test for decision-making capacity in the bill. I have not heard any explanation of why Western Australia is so different from Victoria that this proposed amendment is unnecessary. I think it is a necessary part of the protection framework for people who may or may not be on that threshold where their capacity can be questioned. I think it is a well understood test and, as the member for Girrawheen has pointed out, with respect, it improves what is already a relatively robust test. I do not know why there is such opposition to improving something in the bill. It certainly does not add any harm, nor does it weaken the provisions. It does not change the provisions in any way; it is just one more step to make things even better.

Mr S.K. L'Estrange: Safer.

Mr P.A. KATSAMBANIS: Ultimately, as the member for Churchlands points out, the whole idea here is to make things safer and to assuage the concerns of people who might be a little worried about how this test is going to be applied in practice. To me this seems like the sort of good and harmless amendment that ought to be accepted in good faith to indicate that the government is prepared to listen and is prepared to actually make things safer and better. With that, I will sit down; I cannot continue to make the same point.

Ms M.M. QUIRK: I want to ask the minister quickly: he has indicated to this chamber that this test is done routinely. I know that every individual case is different, and we are not yet at the training section so I cannot cloak our discussion in relation to training. On average, how long does the minister think it will take to do a test of capacity by working through these criteria? Can we get some sort of medical advice on how long that will take?

Mr R.H. COOK: It will really depend upon the patient, their capacity to communicate, the way that they communicate and the comorbidities that they are suffering from. In some respects, the answer is: how long is a piece of string? The assessment will take place over a period of time in a clinical setting as part of a therapeutic relationship.

Dr M.D. NAHAN: I want to make a quick statement. We are looking at issues in which there is a great deal of variability in people's mental and physical state and their ability to communicate and think. One key thing is that people have good days and bad days. They can be in and out of comas, in and out of consciousness, and have good feelings and not so good feelings, so it is physical and mental. It seems to me that when people are making an assessment about whether a person can consciously make a decision about their life earlier—not real early, but earlier—we should make sure that there is enough time between asking the question and going through the process to make sure that it has sunk in and that it is their final decision.

I recognise that this has to be done twice by two medical practitioners, but it seems as though retention is an important point. I add that a large number of supporters of voluntary assisted dying in the community want it to apply to people with dementia. That is the reality. They hope that having a living will allows them to do this, but we are not doing that here. However, there is no doubt that many of them—the public—think right now that this will apply to them if they get dementia. This is a real process that we will have to deal with. Therefore, I think that a statement of retention, as the member for Girrawheen has proposed in the amendment, is a sensible approach to addressing this very important issue.

Mr R.H. COOK: As I said, this is part of the provisions of the Mental Health Act. In some respects, when there is already best practice, we stick with it. It is widely understood by the medical community and, as a result, we think it is absolutely adequate. To pick up on one of the member's points, the decision-making capacity will have to be demonstrated not twice but three times, in assessments carried out by authorised medical practitioners. However, the authorised prescriber needs to be satisfied, and if the person seeks an administering practitioner, they have to be satisfied that they have decision-making capacity as well. As the member said, they might have a bad day. In this process, they have to demonstrate that decision-making capacity throughout the process. In that sense, it is a very robust framework and in that context I am sure it should provide satisfaction to the members for Riverton and Hillarys, given their concerns and anxieties around that.

Mr Z.R.F. KIRKUP: Just to clarify the amendment moved by the member for Girrawheen, is there already adequate capacity in the decision-making capacity clauses? Is the minister suggesting that there is no need to ensure that someone can retain the information that has been provided to them?

Mr R.H. COOK: That is right. There are essentially two arguments. Firstly, the person has to understand the information, the matters involved and the effect of the decision, which is essentially the definition of retention; they have to retain the information. As I mentioned to the member's colleagues, these are also consistent with the provisions of the Mental Health Act, so they are widely understood by the medical fraternity.

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Mr Z.R.F. KIRKUP: I appreciate that response, minister, which went to the first question I asked on this clause about trying to demonstrate that the patient has understood the information. This clause would not necessarily change the ability for a practitioner to ascertain whether someone understands the information. As the minister said, there are already a number of points at which it has to be demonstrated that the patient understands. It is important, though, to make sure that a patient fully absorbs the consequences of the decisions that they will undertake. Would the insertion of an amendment such as this help to strengthen that at all? I appreciate the consistency with the Mental Health Act, but this goes beyond that.

Mr R.H. COOK: I do not believe so. Essentially, this is about the person understanding that they will die if they enter the voluntary assisted dying process and that they understand the consequences of that decision. From that perspective, I think we have captured it.

Division

Amendment put and a division taken, the Acting Speaker (Ms J.M. Freeman) casting her vote with the noes, with the following result —

Ayes (15)

Mr I.C. Blayney	Mr Z.R.F. Kirkup	Mr W.R. Marmion	Ms M.M. Quirk
Mrs L.M. Harvey	Mr A. Krsticevic	Ms L. Mettam	Mrs M.H. Roberts
Dr D.J. Honey	Mr S.K. L'Estrange	Dr M.D. Nahan	Mrs A.K. Hayden (<i>Teller</i>)
Mr P.A. Katsambanis	Mr R.S. Love	Mr D.C. Nalder	

Noes (38)

Ms L.L. Baker	Mr M. Hughes	Mr M.P. Murray	Mrs J.M.C. Stojkovski
Dr A.D. Buti	Mr D.J. Kelly	Mrs L.M. O'Malley	Mr C.J. Tallentire
Mr J.N. Carey	Mr F.M. Logan	Mr P. Papalia	Mr D.A. Templeman
Mrs R.M.J. Clarke	Mr M. McGowan	Mr S.J. Price	Mr P.C. Tinley
Mr R.H. Cook	Mr J.E. McGrath	Mr D.T. Punch	Mr R.R. Whitby
Ms M.J. Davies	Ms S.F. McGurk	Mr J.R. Quigley	Ms S.E. Winton
Ms J. Farrer	Mr D.R. Michael	Mr D.T. Redman	Mr B.S. Wyatt
Mr M.J. Folkard	Mr K.J.J. Michel	Ms C.M. Rowe	Ms A. Sanderson (<i>Teller</i>)
Ms J.M. Freeman	Mr S.A. Millman	Ms R. Saffioti	
Ms E.L. Hamilton	Mr Y. Mubarakai	Ms J.J. Shaw	

Amendment thus negatived.

Mr Z.R.F. KIRKUP: I refer to clause 6(3), which states —

For the purposes of this Act, a patient is presumed to have decision-making capacity in relation to voluntary assisted dying unless the patient is shown not to have that capacity.

If I am reading that right, the onus is to prove that a patient does not have capacity.

Mr J.E. McGrath: I cannot hear, Chair.

Mr Z.R.F. KIRKUP: I am sorry; can the member not hear me? I am sorry, I do not know what is happening. Just to clarify for the member for South Perth, I just want to understand that subclause (3) shows that the onus is not reversed, but on the practitioner to assume that the person has capacity unless otherwise proven. Is that correct?

Mr R.H. COOK: Yes, that is a WA standard. As I think I have explained to the chamber before, the definition acknowledges that a person is presumed to have decision-making capacity unless there is evidence they do not. In Western Australian law, there is a presumption that a person has capacity to make decisions about their own life. This is reflected in the presumption in the legislation.

Mr Z.R.F. KIRKUP: The way that a practitioner assesses that is against all the other parts of that clause as well as the eligibility and things like that, as defined in the legislation. Is that right? That is how the practitioner would practically come to any conclusion one way or the other. Is that basically right?

Mr R.H. COOK: As the member knows, there is a range of tests. The person has to be eligible to start with, and we will go into some detail on that in the first place, but this is obviously the test by which the assessment would be made that the person has the capacity to make the decision.

Dr D.J. HONEY: The minister knows that I have a concern about undue influence and coercion. I wonder whether it would not be prudent to specifically mention that in this clause. I am not suggesting an amendment, but I am asking the minister perhaps to consider a form of words—for example, that the patient is not subject to any undue influence or coercion. The reason for highlighting it is to make sure that that is specific consideration by the

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practitioner. I appreciate that there are references later in the legislation, but the reason to include it in this clause is to especially highlight that because that is one of the particular risks in this legislation.

Mr R.H. COOK: That is a different test or requirement of the act. It comes later in the act. In particular, I draw the member's attention to clauses 99 and 100, which deal with the offences committed under the bill. This clause is specifically related to decision-making capacity.

Dr D.J. HONEY: I am not trying to drag this out or frustrate the progress of this legislation in any sense. My concern is that if someone is subject to coercion or undue influence, they do not necessarily have the capacity to make an informed decision.

Mr R.H. COOK: If someone has decision-making capacity, they can understand the decision that they are making and the consequences of that decision. But if that decision is considered to be taken in the context of coercion, they would not be eligible for voluntary assisted dying.

Mrs A.K. HAYDEN: In case I have missed it, is there an obligation for the doctor to seek the medical history of a patient when determining the decision-making capacity of that individual?

Mr R.H. COOK: It is not a subject of this clause, but it is obviously a significant part of a medical practitioner's clinical and legal obligations as a clinician.

Mrs A.K. HAYDEN: Before we move on from that, can we ask this question in another part of the legislation? Is the minister prepared to answer that now or does he want us to come back to it? I do not want to move on from this clause if it cannot be discussed later.

Mr R.H. COOK: It is not part of the bill. It is part of good clinical practice and, of course, the obligations that medical practitioners are required to practise under, in relation to the law and registration with the Medical Board of Australia.

Mrs A.K. HAYDEN: So that I have it right—I do not want to misquote the minister—under the decision-making capacity provision in clause 6, the doctor is not obliged to seek the medical history of a patient to determine whether they have the capacity to make that decision. I want to clear that up.

Mr R.H. COOK: A medical practitioner is required to draw upon their medical practitioner training, experience and skills to make that assessment. Obviously, they would take the full range of information available to them, including the medical records of the patient.

Mrs A.K. HAYDEN: I have one last question because I know the member for Cottesloe wants to ask something on this clause as well. Is it in the Victorian legislation?

Mr R.H. COOK: I am advised that it is not.

Dr D.J. HONEY: I want to clarify that, because I was not reassured by those words. We have these general words that it would be good practice, but the question that was very specifically asked is whether there is an obligation under this act for them to do that. We have heard the member for Girrawheen talk about a patient with dementia or some other degenerative illness that may not be readily apparent to someone, even a medical practitioner, when talking to or meeting that patient for the first time. It is all right saying that it is good practice or it is good clinical practice but, specifically, is there an obligation under this bill for a doctor to do that? I guess a corollary of that is—I will not draw this out into 20 questions—how would anyone know whether they had done that? The very specific question is not, "Is it good practice?" but "Is there an obligation under this bill, and how would anyone know whether they had done that?"

Mr R.H. COOK: As the member knows, we rely upon medical practitioners to make decisions and conduct themselves in specific ways as a matter of Australian law under the conditions associated with their Australian Health Practitioner Regulation Agency registration. They have ethical, legal, professional and moral obligations to undertake all these practices. It is not prescribed in this legislation but it is implicit in the use of a medical practitioner in this role and it is explicit in the national health professions law.

Dr D.J. HONEY: To complete the second part of the question, how would anyone know whether that had been done?

Mr R.H. COOK: In the same way that we can be assured that anyone receiving clinical care receives that care within the appropriate legal framework.

Dr D.J. HONEY: I do not wish to verbal the minister at all but that response was general and generic. We either have a mechanism to know that that has been done or we do not. I do not think we can ever say that we know because we assume it would be done as best practice. I take it from the minister's answer that we do not have any way of knowing whether that has been done. We can only assume that it was done.

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Mr R.H. COOK: A medical practitioner will have to make declarations on the authorised forms throughout the voluntary assisted dying process. They might lie on those forms.

Dr D.J. Honey: I'm not worried about lying.

Mr R.H. COOK: That is right. All those declarations and authorisations on the authorised form will obviously take into account that they have discharged their duties and there would have to be a declaration around that. That is how we would know, and obviously the Voluntary Assisted Dying Board will see those as part of the voluntary assisted dying processes. Yes, there will be declarations and certifications and they will be part of the assessment process.

Mrs A.K. HAYDEN: I apologise that we keep asking the same question. I know that it can get a bit frustrating but this decision-making capacity will enable an individual to access voluntary assisted dying. This is one of the most critical clauses in the legislation. Having heard that there is no obligation for a doctor to seek the medical history of a certain patient, red flags are going up at 100 miles an hour. If a person's capacity deteriorates over time, is there a test for that capacity? Are there existing legal tests or things such as estate management decisions about medical treatment and so forth? The minister just said that there will be no obligation to check a person's history if their capacity deteriorates over time. What about going forward? Is there a test or anything in place to counteract a person's capacity changing over time?

Mr R.H. COOK: Yes, there are multiple assessments throughout the process, as I explained to the member for Riverton in my answer just a short while ago. There are multiple assessments throughout the process based upon the written requests, the final review, the prescribing and the handover; and, if the patient uses an administering practitioner, at that stage as well. If someone of standing is of the view that that process is incorrect, they can appeal to the State Administrative Tribunal. As the member can see, I think all members share the concerns that this process is robust and is enduring throughout the process, and that is why we have these measures in place.

Clause put and passed.

Clause 7: Voluntary assisted dying substance —

Mr P.A. KATSAMBANIS: Clause 7 provides —

- (1) The CEO may, in writing, approve a Schedule 4 poison or Schedule 8 poison ... for use under this Act for the purpose of causing a patient's death.

It goes on to define the approved poison as a "voluntary assisted dying substance". I would like to know, firstly, why was the decision made that the CEO would do this in writing, rather than have this prescribed in regulations, as would ordinarily be the case? Secondly, what process will the CEO follow in making this approval? Thirdly, once the approval is made in writing, to whom will it be communicated? Will it be a publicly available document; and, if so, under what process?

Mr R.H. COOK: The answer to the member's first and third questions is no, it will not be in regulations, because we do not want it to be public. The answer to the third question is no, it will not be public. To answer the member's second question, the choice of lethal medication will be a clinical decision made by the coordinating practitioner from the approved list of schedule 4 or 8 poisons that the CEO of the Department of Health approves or authorises. As part of the implementation of the bill, it is intended that a clinical panel will be convened to determine the schedule 4 and schedule 8 medication protocols suitable for voluntary assisted dying in Western Australia. The clinical panel will also inform the operational requirements for the supply, dispensing and safe management of these medications. It is expected that the clinical panel will include appropriate representation from pharmacy, medical and nursing experts from both a Department of Health and clinical perspective. The recommendations of the clinical panel will inform the CEO's approval under clause 7.

Mr P.A. KATSAMBANIS: This will not be communicated to the public; I think the minister has alluded to that in previous discussion in consideration in detail. The CEO will make a determination in writing. Who will the CEO communicate that decision to? Who are the people or the groups of people who will find out what this determination is? Clearly, the public is not going to know.

Mr R.H. COOK: Obviously, the trained medical practitioners will be informed, because they are the people who will undertake the prescribing, and the chief executive officer will be informed by the clinical panel. From that perspective, it is essentially a closed loop to make sure that the public is not made aware of what those substances are, the make-up of those substances or the way that they are combined, because that would be very dangerous information to have out in the public domain.

Mr P.A. KATSAMBANIS: I understand that we do not want a circumstance in which a formula might become publicly available and people start making the stuff at home, even if it is from a well-meaning perspective. But

Extract from Hansard

[ASSEMBLY — Wednesday, 4 September 2019]

p6458b-6492a

Dr David Honey; Mr John McGrath; Mr Roger Cook; Mr Peter Katsambanis; Ms Margaret Quirk; Mrs Liza Harvey; Mrs Alyssa Hayden; Dr Mike Nahan; Mr Zak Kirkup; Mr Sean L'Estrange; Dr Tony Buti; Mrs Michelle Roberts; Mr Tony Krsticevic; Mr Bill Johnston

I assume that at some point the substance considered to be the voluntary assisted dying substance will need either to be purchased from the manufacturer in its entirety or otherwise to be compounded by a compounding pharmacist. I assume the list of people who will eventually find out the formula will go beyond those whom the minister has articulated in his answer. I would ask the minister to reflect again and give me a fuller answer as to the range of people who will find out what this substance or range of substances will be.

Mr R.H. COOK: I apologise. I misunderstood the member's question. I thought he was talking about oversight. The clinical panel will have oversight, and only those medical practitioners that have had the training for voluntary assisted dying will have access to that information. The authorised supplier, which will be a pharmacist, will have access to that information as well because they will receive the prescriptions. To pre-empt a potential question the member might have, that prescription will not be handed over. It will be communicated directly from the medical practitioner to the pharmacist so that the person for whom the prescription is made available, or their representative, will not find out what the substance is.

Mr P.A. KATSAMBANIS: I have a range of questions about that. Will the pharmacist be a pharmacist in private practice or a pharmacist in the Department of Health system in Western Australia? I ask because in Victoria the substance is compounded in one place. I hesitate to name it because I am not sure whether it is publicly known, but I know where it is. It is a public facility, and I will leave it at that. If the minister understands that it is publicly known where the Victorian facility is, I will leave it for him to name it. At this stage, I will not. That is how I understand it works in Victoria, but how will it work in Western Australia? Will the health system purchase the voluntary assisted dying substance from a pharmacist in private practice or will it be compounded in the public system?

Mr R.H. COOK: It will not necessarily be compounded. That will depend on the substance itself. A proposed central pharmacy service will have governance over the training requirements and certification of any authorised suppliers—for instance, pharmacists at regional hub pharmacies who are involved in the supply of voluntary assisted dying medications. It is not anticipated that that will be pharmacists in a commercial setting.

Mr P.A. KATSAMBANIS: Can the minister clarify that last bit? Did he say that it is not anticipated that it will be pharmacists in the commercial framework?

Mr R.H. Cook: No. That is correct.

Mr P.A. KATSAMBANIS: It will be somehow contained within the Department of Health. Will the government at some point create a series of guidelines for how the substance will be delivered to the far-flung parts of the state that it must be transmitted to? In that case, who will create the guidelines? Will it be the CEO, the central pharmacy authority or the minister? Will that be prescribed in the regulations? How will that work?

Mr R.H. COOK: That will be subject to the implementation phase. It will certainly be the CEO, who is responsible for everything that goes on in the Department of Health. The CEO will have to authorise the process. The member will understand that, consistent with my previous answer, the proposed central pharmacy service will be responsible for the training and auspicing of the process and advising the CEO of the appropriate ways that the substance can be efficiently delivered to the patient.

Mr P.A. KATSAMBANIS: I have further questions about this. It is important that we get into the minutiae of this. I want to cover a number of areas. The first is confidentiality. The minister has clearly articulated that it will be important to maintain confidentiality to control the manufacture of the substance. I think it was mentioned earlier that it will also help control the price. I accept that that might be a factor that needs to be taken into account. A range of people will become aware of the formula of the substance and will have some knowledge of what comprises the voluntary assisted dying substance. What confidentiality requirements would they be under; where in the bill are they contained; and what are the penalties for breach of any of those confidentiality requirements right across the chain, from the trained doctors to the central pharmacy authority to all the other distributed parts of the network that may end up receiving knowledge of this substance?

Mr R.H. COOK: Clause 102 creates a specific prohibition with regard to the advertising of a schedule 4 or schedule 8 poison as a voluntary assisted dying substance. The penalty is imprisonment for three years and a fine of \$36 000. That is under clause 102.

Mr P.A. KATSAMBANIS: That relates to advertising, and I can understand that we do not want anyone putting up their shingle and saying, "Come and buy the medicine from me", but that does not cover disclosure. It does not cover someone who has received information that the minister and the people who are putting this bill together clearly want to be kept confidential. It does not in any way cover disclosure, whether it is disclosure done for malfeasance or simply inadvertent disclosure. That is why I ask again: what is the protection against disclosure; where is it contained; and what are the penalties for breach of any of those confidentiality requirements?

Mr R.H. COOK: It is clause 105, under "Recording, use or disclosure of information".

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Mr P.A. KATSAMBANIS: I will just have a look.

Mr R.H. Cook: Perhaps I can take a question from some others while you are doing that.

Mr P.A. KATSAMBANIS: I have another area that I want to canvass on the same clause, whilst the advisers might look at that.

Mr R.H. Cook: No, you're looking at that, and I'll take another question from perhaps the member for Cottesloe while you familiarise yourself with that clause. That was my suggestion.

Mr P.A. KATSAMBANIS: No. I just wanted to go through those provisions. I am okay to go through that. The minister referred to clause 105. I am happy to deal with that when we get to that clause, but I have another question on clause 7 that just fits in.

I do not want to sound like I am getting into the minutiae, but as the minister understands, this is actually important and I am sure he will grab this straightaway. When dealing with schedule 8 poisons, we know that there are medical practitioners out there who have had their right to prescribe schedule 8 poisons restricted or removed by medical boards for various reasons, which we do not need to get into. We know that happens on not infrequent occasions. What happens, both legally and practically, in a circumstance in which a practitioner who otherwise fits all the requirements of this legislation is willing to participate in the scheme provided for under the legislation but is prohibited from prescribing a schedule 8 poison? I think the minister understands that I am not dealing with a hypothetical here; I am dealing with a circumstance that would exist out there right now in Western Australia, on more than one occasion.

Mr R.H. COOK: There are severe penalties under the Medicines and Poisons Act in relation to the abuse of schedule 8 drugs by either someone who is not a medical practitioner, or a medical practitioner who is seeking to prescribe them. In that sense, there are very harsh penalties associated with that. Under section 14 of the Medicines and Poisons Act, a person who manufactures a schedule 4 or 8 poison, including a voluntary assisted dying substance, will commit an offence, unless that person does so under, and in accordance with, an appropriate licence or a professional authority in accordance with that act.

Mr P.A. KATSAMBANIS: Sure. But it does not cover off the question that I asked. It is not in relation to the manufacturing of drugs. We have a medical practitioner who has gone through this process. They are ready to go; they are ready to write out the prescription and the patient has asked them to do so. However, at that stage, having covered all that, the medical practitioner is not able, through a prohibition placed on them by the medical board or others, to fill out that prescription because it contains a schedule 8 poison. In that circumstance, what happens? Do they refer them to another practitioner simply for the prescribing? Does that practitioner then have to undertake all the other tests and checks and balances that are contained in this bill? What happens in that circumstance?

Mr R.H. COOK: If the medical practitioner is not eligible, under their qualifications, to manage a schedule 8 poison or medication, they would not therefore be eligible to be a coordinating or consulting practitioner and so would not be involved in the process. They have to have the capacity to participate under the Voluntary Assisted Dying Bill—or act, if it passes—in order to play those roles. If they are not able to play those roles, they would not be eligible to be either a coordinating or a consulting practitioner.

The ACTING SPEAKER (Ms J.M. Freeman): Member for Girrawheen.

Mr P.A. Katsambanis: I just wanted to finish on this.

Ms M.M. QUIRK: Good. I will let the member do that then.

The ACTING SPEAKER: Member for Hillarys, finishing on this!

Mr P.A. KATSAMBANIS: I have two questions on this. The first one is just to follow up on that. Is the system robust enough to eliminate a person who has already been qualified through the system to be a practitioner in this space and has subsequently lost their right to prescribe schedule 8 poisons? That is the first question: is our system here in Western Australia robust enough to quickly pick that up and remove them from the list of eligible practitioners?

Mr R.H. COOK: The answer to the member's first question is yes, the system is robust in the first instance. If they are not qualified, they would not be able to register. In the second, if they lost that registration, they would not be eligible to continue to be a coordinating or a consulting practitioner.

The ACTING SPEAKER: Do you want to do it by way of interjection, member for Hillarys?

Mr P.A. Katsambanis: No, not at all.

Mr R.H. COOK: Let us take it to an extreme scenario. Maybe they are halfway through the process or they have just about completed the process under voluntary assisted dying; they could delegate that function to a medical practitioner who was qualified to do it, but, clearly, they would come off the register thereafter.

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Mr P.A. KATSAMBANIS: That was the sort of answer I was looking for. My final question on this clause is: What will the prescription look like? When a medical practitioner writes out a prescription, does he or she write out the actual substance that is approved in writing, or do they write out a prescription that simply says, "Please prescribe this patient an approved voluntary assisted dying substance"? Is the practitioner actually writing a script for a generic term or for an actual pharmaceutical or brand-name product?

Mr R.H. COOK: It is anticipated that the prescription will be communicated through a secure means, probably through a portal of some form. Obviously, that would include information about the medical protocol that is required for the specific patient and the limited range of substances.

Mr P.A. Katsambanis: So it would be the substance; it would not be a generic?

Mr R.H. COOK: That is correct. It would obviously be a very specific request, but also it would not be on a piece of paper that someone could wander down the street with. It will never get into the patient's hands; it will be communicated by secure communication.

Ms M.M. QUIRK: I have two fairly prosaic inquiries about clause 7. Clause 7(1) says that the CEO may, in writing, approve a schedule 4 poison. Should that not say "must"? If he is approving a drug, surely he should commit that approval to writing?

Mr R.H. COOK: Again, this is a drafting convention. The reason that the expression "may" is used is that it authorises the CEO to do so in the event that the CEO undertakes these actions consistent with clause 7.

Ms M.M. QUIRK: Does that not give the CEO carte blanche to approve a schedule 4 poison without doing so in writing?

Mr R.H. COOK: The concept of the term "the CEO may" is attached to the concept of the term "approve a schedule 4 poison or schedule 8 poison". The term "in writing" describes the means by which the CEO would create that authority.

Ms M.M. QUIRK: Would we not then get into problems about whether there is a record of whether approval was made, when it was made and so on? How do we get over that?

Mr R.H. COOK: If the CEO makes an approval, it will be in writing, and that is what that clause expresses.

Ms M.M. QUIRK: Clause 7(1) confers the CEO with power to approve a schedule 4 poison. Can that power be delegated to another person under the Interpretation Act or is that power limited solely to the CEO?

Mr R.H. COOK: I am advised that it can be delegated and would likely be delegated to the Chief Pharmacist.

Ms M.M. QUIRK: Is it likely that it will be delegated to any other individuals or will there be a list of positions that will be permitted to be so delegated? Will that delegation occur only when the CEO is on leave or away?

Mr R.H. COOK: My understanding of the way that this will operate is that the CEO will create a schedule. The Chief Pharmacist has agency in relation to the provisions of the Medicines and Poisons Act, so in that context may have a role to play. This is another example of the interplay between this bill and the Medicines and Poisons Act.

Ms M.M. QUIRK: This is my last question, minister. Will there be some formal instrument of delegation under the Medicines and Poisons Act?

Mr R.H. COOK: Yes.

Ms M.M. QUIRK: Thank you.

Dr D.J. HONEY: Some of this was touched on in yesterday's debate. I refer to clause 7(2). I will not labour it, but could the minister please explain why there was seen to be a need to create the term "voluntary assisted dying substance" and not simply continue to use the word "poison"? This states clearly that one is the other. Why is there a necessity to use another form of words for that?

Mr R.H. COOK: In the same way that in another context we have something called pain medication, this is simply a way in which we can describe the substance in the context of the bill. We have a voluntary assisted dying decision, and, in this context, we have a voluntary assisted dying substance.

Mr Z.R.F. KIRKUP: I am conscious of the question that I asked the minister previously. I appreciate the comments that the minister provided to the member for Cottesloe, or it might have been the member for Hillarys, about correspondence about CEO decisions. If the CEO were to write to the minister or write some sort of executive order, is it possible that that would be captured under freedom of information? I imagine that it would be.

Mr R.H. COOK: No, I do not believe it would. Let me take specific advice, but, obviously, the intent is that the information will not become public. The answer is no.

Mr Z.R.F. KIRKUP: I agree with all the sentiments of the bill. We would not want details about the use of a schedule 4 or schedule 8 drug to be published. The minister might need to clarify, when we get to the implementation

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phase, what that will look like. However, given my previous life and my knowledge of the FOI act, I am concerned. As I read the legislation as it stands, I do not think there is any clause under which that information could be exempted from being provided, unless there was some commercial-in-confidence information, or it was, perhaps, covered by cabinet confidentiality. I am conscious that although the intent of the bill is to ensure that that information is not made public, it might be possible to access that information through FOI.

Mr R.H. COOK: We will come back to that.

Clause put and passed.

Clause 8: When request and assessment process completed —

Dr D.J. HONEY: What capacity will there be for a third party to raise concerns at the stage at which the request and assessment process has been completed? Let us imagine that, for whatever reason, a passionate euthanasia advocate has gone around the process in some clever way and is pushing ahead, and a third party becomes aware of that. Could a third party intervene in the process at that stage to raise a concern and in fact stop the process from going forward?

Mr R.H. COOK: I am advised that if someone had a special interest in the context of the operations of the State Administrative Tribunal, they might be able to intervene, and the State Administrative Tribunal would determine whether they had a special interest in the context of that request to appeal to SAT.

Dr D.J. HONEY: I take it that a person will have to approach the State Administrative Tribunal. If that were the case, would the State Administrative Tribunal be able to consider anything outside the principles outlined in clause 4 of the bill and the administrative steps? We will come back to this point a number of times, but if there is coercion or undue influence, for example, would the SAT be limited to consider the principles—we were told that the court would look at this as part of the sequence of administrative steps—or would that be initiated on other grounds?

Mr R.H. COOK: My understanding of these things, which is not extensive, is that we are not in a position to tell the SAT what it can and cannot do. We can lend from its framework in the context of its normal jurisdiction, but ultimately it will test whether someone can appeal to the SAT and the grounds upon which they can appeal. For the sake of completeness, the Supreme Court also has *parens patriae* over the provisions of the bill so, ultimately, the SAT can have oversight of any aspect of the person's interest.

Dr D.J. HONEY: Thank you, minister. That was very clear. As I outlined in my second reading contribution, going to the SAT is daunting and going to the Supreme Court is only for the well-heeled and well-informed. Would it be possible for a person to raise a concern with the board or, in fact, is the only available mechanism through the SAT or going to the Supreme Court?

Mr R.H. COOK: I am advised that there is capacity for a member of the public to draw a matter to the attention of the CEO, who has powers under the Health Act and this bill to undertake investigations. I accept the point the member is making about the Supreme Court. That is why there is the administrative tribunal system.

Mr P.A. KATSAMBANIS: I understand the genesis of why this clause has been included. Effectively, we are dealing with a process whereby the coordinating practitioner will self-assess whether the request and assessment process has been completed. If other actions took place after that stage was reached without that stage being completed, what will be the remedy and what penalty will the coordinating practitioner who breached this section be liable for?

Mr R.H. COOK: It would ultimately depend upon the nature of the shortfall, for want of a better description, in terms of their assessment and review of the process. In general terms, I refer the member to part 6 of the bill, which refers to offences under the act. Ultimately, it would depend upon the nature of the transgression in that context.

Mrs A.K. HAYDEN: This clause states the request and assessment process will be complete if the coordinating practitioner for the patient has completed and certified the final review. Why was it decided that a medical practitioner would determine this process?

Mr R.H. COOK: They will have the central responsibility from the beginning of the process through to the end of the process. They are the clinician in this case—that is, the coordinating practitioner.

Mrs A.K. HAYDEN: Is there any reason the board will not get involved at this level?

Mr R.H. COOK: The board will be involved at every stage of the process. At each of the points that the person goes through to access voluntary assisted dying, it will be the responsibility of either the coordinating or consulting practitioner to lodge authorised forms with the Voluntary Assisted Dying Board throughout the process.

Mrs A.K. HAYDEN: Just to clarify, clause 8(b) states that the coordinating practitioner “has certified in the final review”. Will that certification of the final review get ticked off by the board?

Mr R.H. COOK: It certainly will be sent to the board straightaway, yes.

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Mrs A.K. HAYDEN: It will be sent to the board. Will it be up to the board to review that finding, or is it just a tick and flick that gets filed away? Will the board go over the information sent, or is it just a self-review by the medical practitioner with no real oversight? Is there an obligation for the final review to be sent or for the board to review the decision and the process?

Mr R.H. COOK: It is the responsibility of the board to make sure that all those assessments have taken place. It is not the responsibility of the board to second-guess the accuracy of the assessments, but it needs to be satisfied that each of the assessment processes have been followed.

Mrs A.K. HAYDEN: Obviously, this line of questioning is about safeguards. If it is not up to the board to assess whether the review has been done and the final report has been ticked off by the coordinating practitioner—again, I am not condemning the majority of coordinating practitioners by any means, but we are here to legislate for the element of doubt—how do we know whether a practitioner is not maybe doing it to the board's expectations of the intent of this legislation? How would that be picked up? What is the safeguard for that?

Mr R.H. COOK: The assessment process will take place between the coordinating and consulting practitioners; they will both have come to their decisions and undertaken the assessment process. They are required to lodge authorised forms throughout the process as the patient undertakes their journey. The board itself can authorise police, the chief executive officer of the Department of Health or other investigating authorities to make inquiries into that. There is oversight through checks and balances around the assessment process, and the VAD board will be responsible for overseeing the whole process.

Clause put and passed.

Clause 9: Registered health practitioner may refuse to participate in voluntary assisted dying —

Dr D.J. HONEY: I want to explore this clause generally, because I have concerns about it. The title of this clause is “Registered health practitioner may refuse to participate in voluntary assisted dying”. My concern is that a registered health practitioner does not have any option to refuse to participate, at least in part, in the voluntary assisted dying process. I am happy for the minister to correct me, and I have read the clauses, but it is my understanding that if a person says to a medical practitioner that they wish to participate in the voluntary assisted dying process, that medical practitioner is then formally required to respond and will be required to submit a report to the CEO within 48 hours. Let us assume that the medical practitioner, as many do, has a fundamental conscientious objection to voluntary euthanasia and wants nothing to do with the process whatsoever. They will still be required to submit a report to the CEO within 48 hours outlining the details of the patient and why they are refusing to participate. Furthermore, they will be required to give the person information provided by the CEO. We do not know what the information is at this stage, but we assume it is information that will direct the patient to another source to assess them for voluntary assisted dying. Does the registered practitioner have the right to completely refuse to participate in the process and say they do not wish to be involved at all, and that is the end of it, or is the registered practitioner forced to go through the process I outlined?

Mr R.H. COOK: I think the member is referring to clauses 19, 21 and 30. I am happy to discuss those issues when they come up. This simply sets out the voluntary nature of the voluntary assisted dying process. It is voluntary for the medical practitioner as well.

Dr D.J. HONEY: I am happy to explore this in more detail on debate on those clauses. I just want to be clear because the statement at the top of the clause is that a registered health practitioner may refuse to participate in voluntary assisted dying, which to me would imply not having to participate in that process at all, but when we go further on, it seems they have to at least go to the extent of providing information to a person, and if they do not, they potentially could be fined \$10 000.

Mr R.H. COOK: I apologise for my earlier statement. I used the words “medical practitioner”. This clause applies to a health practitioner, so it casts the net much wider. This clause states in general terms that a health practitioner is not required to participate in the voluntary assisted dying process. There are obligations set out later about the specific requirements of a medical practitioner when confronted with the initial request, but this clause states in general terms, for the purposes of this bill, that health practitioners are not required to participate in the voluntary assisted dying process. I apologise for my earlier answer.

Dr D.J. HONEY: This is the problem with having extended sitting sequentially: we get tired. If we want to do this properly —

Dr A.D. Buti interjected.

The ACTING SPEAKER (Ms S.E. Winton): Thank you!

Dr David Honey; Mr John McGrath; Mr Roger Cook; Mr Peter Katsambanis; Ms Margaret Quirk; Mrs Liza Harvey; Mrs Alyssa Hayden; Dr Mike Nahan; Mr Zak Kirkup; Mr Sean L'Estrange; Dr Tony Buti; Mrs Michelle Roberts; Mr Tony Krsticevic; Mr Bill Johnston

Dr D.J. HONEY: Let me tell the member that I take this deadly seriously. Anyone who has been to hospital would know that there is a strict hierarchy of medical professionals and specialists who walk around in a godlike manner and general practitioners are loath to do anything that would upset a specialist. Equally, many of the other medical staff in the hospital, such as nursing staff, are very loath to do anything to deny the request of a more senior doctor. In a hospital setting, all the staff will be employed by the hospital, so it is not an employer–employee relationship. However, a doctor who is more senior to, for example, a nurse, may say to a nurse, “I want you to come and help me with this.” Does the minister think there is a realistic chance that in some cases someone may feel compelled to be involved in the voluntary assisted dying process even when they have an objection to the process?

Mr R.H. COOK: I do, member. Obviously, I am the Minister for Health so I have to at least have faith in the capacities and the lines of command in the health system. Further to the member’s point and to provide the member with some comfort, I draw his attention to clause 10, which provides further protections for a health practitioner who does not wish to participate in the voluntary assisted dying processes.

Dr D.J. HONEY: I believe I understand clause 10, minister, but again people may not feel as though they can complain as they may feel that it could affect them professionally. I have some indirect experience of the hospital environment. A little bit like law firms, hospitals are anachronistic in the sense that they are strictly hierarchical, unlike most other workplaces I know of. The specialists are treated in a godlike fashion, as are the senior doctors in the hospital. The junior medical staff do not wish to disobey a request that they are given and they may feel compelled to be involved. I guess to that end, is there another reassurance in reinforcing that with staff? I imagine that this could potentially affect any health professional. The bill refers to a registered health practitioner and a medical practitioner. It can affect any of those and it can be in any hospital or hospice setting. Particularly in remote communities, there may be only two professionals—one a medical practitioner and the other a health practitioner. I wondered what other protection there is to make it clear to all those parties that this is purely consensual and there is a clear right not to participate.

Mr R.H. COOK: I do not think we can get more explicit than to have an explicit clause that is backed up by the following clause, which is also explicit! It is explicitly voluntary. To contravene the act in relation to this issue is explicitly considered an act of professional misconduct or unprofessional conduct for the purposes of the Health Practitioner Regulation National Law. I think the member should take some comfort from that. I also assure the member that the 18-month implementation period will require an awareness-raising exercise right across the health system about what everyone’s obligations may or may not be under this legislation. Obviously, we will make it very clear to everyone that voluntary assisted dying is just that—a voluntary process.

Dr D.J. HONEY: I guess we are taking it on face value that that will cover that. I appreciate the minister’s genuine intent. I am not questioning his sincerity in any sense whatsoever. I do not think I need a response, but the trouble is that I see clause 10 applying when there is an overt act. It is effectively bullying if someone says, “You do this or else.” That is very rarely the case. More often than not it is simply that the other person does not feel that they have the ability to object because they think it will subsequently affect their career or there is a strict hierarchy in hospitals, which, as I have said, is usual, in my vicarious experience. It does not exist in other workplaces but it seems to be a very strong characteristic in many hospitals. I will not labour the point anymore.

Mr P.A. KATSAMBANIS: I note that the term “registered health practitioner” is defined in clause 5 by reference to “a person registered under the Health Practitioner Regulation National Law (Western Australia)”. I seek some clarification. What types of health practitioners are covered under that specific national law? Does the list include doctors, nurses, pharmacists and pharmacy assistants? Who is included in the national law, so that we are all on the same page?

Mr R.H. COOK: I am advised that this definition of “registered health practitioner” means —

... a person registered under the *Health Practitioner Regulation National Law (Western Australia)* to practise a health profession (other than as a student);

Those covered by the national law include—I refer to the list taken from the Australian Health Practitioner Regulation Agency website—Aboriginal and/or Torres Strait Islander health practitioners; Chinese medicine practitioners, including acupuncturists, Chinese herbal medicine practitioners and Chinese herbal dispensers; chiropractors; dental practitioners, including dentists, dental hygienists, dental prosthetists, dental therapists and oral health therapists; medical practitioners; medical radiation practitioners, including diagnostic radiographers, radiation therapists and nuclear medicine technologists; nurses and midwives; occupational therapists; optometrists; opticians; osteopaths; paramedics; pharmacists and pharmaceutical chemists; physiotherapists; physical therapists; podiatrists; chiropodists; and psychologists. The list only goes up to “p”!

Extract from Hansard

[ASSEMBLY — Wednesday, 4 September 2019]

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Dr David Honey; Mr John McGrath; Mr Roger Cook; Mr Peter Katsambanis; Ms Margaret Quirk; Mrs Liza Harvey; Mrs Alyssa Hayden; Dr Mike Nahan; Mr Zak Kirkup; Mr Sean L'Estrange; Dr Tony Buti; Mrs Michelle Roberts; Mr Tony Krsticevic; Mr Bill Johnston

Mr P.A. KATSAMBANIS: That is pretty comprehensive. Given that it includes medical practitioners, clause 9 effectively creates an absolute right to conscientious objection. Subclause (1) reads —

A registered health practitioner who has a conscientious objection to voluntary assisted dying has the right to refuse to do any of the following —

I am interested in paragraph (a) —

participate in the request and assessment process;

It is an absolute right. Clause 9(2) indicates that there is no intention that subsection (1) limits the circumstances in which that right can be exercised. In relation to medical practitioners, is that not a direct and inherent contradiction to the obligations that medical practitioners have, if they have a conscientious objection, to inform the board and provide a form to the patient in the form that is approved by the CEO, which, in actual effect, requires them to participate in the request and assessment process in some way as articulated in clause 19? Why is there this inherent contradiction and which of the two clauses would apply?

Mr R.H. COOK: As the list suggests, medical practitioners are health practitioners but not all health practitioners are medical practitioners. “Health practitioners” casts the net more widely. I explained this to the member for Cottesloe a short moment ago. This goes to the issue in general terms about the rights of a health practitioner not to participate in a voluntary assisted dying process. Later in the bill, it goes to the specific way in which a medical practitioner must respond in order to make sure that they can exercise this right. The member for Hillarys is a lawyer; I am not. My understanding is that it is widely accepted that the general gives way to the specific; therefore, in this context, a medical practitioner has a general right not to participate in the voluntary assisted dying process. Clause 19 prescribes the way that they exercise that right; however, as a medical practitioner, I guess there are parameters or frameworks to the way they do that.

Mr P.A. KATSAMBANIS: I am not sure that proposition is tested under this legislation. I think it is a general proposition. I am prepared to accept it and move on. Of course, it highlights that the conscientious objection rights under this legislation for registered health practitioners who are not medical practitioners are broader, better and stronger than the rights of a medical practitioner, because, for other registered practitioners, those rights are not limited by the limitations contained in subsequent clauses, including clause 19. I can ask the question here or I can ask it at clause 19: why has the decision been made to limit the conscientious objection rights for medical practitioners in a way that they are not limited for other registered health practitioners?

Mr R.H. COOK: Because, as the member is aware, medical practitioners have a specific role within this legislation, particularly when playing the role of a coordinating, consulting or administering practitioner. From that perspective, it is obviously important that we describe their rights and interests and, indeed, their obligations. By virtue of the seniority of their position in the medical field, medical practitioners have extra obligations that set them apart from other health practitioners, which is perhaps the hierarchy that the member for Cottesloe described. In that context, it is important that we clearly enunciate the way a medical practitioner would discharge their duties under this bill.

Mr P.A. KATSAMBANIS: I understand that is the minister’s position; let us just accept that there is a philosophical difference between the minister and me on this. I have to say, I do not think that someone’s conscientious objection right should be limited in the way that it is in this bill. I highlight that under this bill some health practitioners have greater rights than others in relation to conscientious objections. That is obviously a direct policy decision of the government and the minister who is responsible for the bill. As I pointed out in my second reading contribution, I think that is a significant failure of the bill. Obviously, it is a failure that is drawn from that direct policy choice, and I will leave it at that.

Mr S.K. L’ESTRANGE: Following up the questions by the member for Hillarys, I, too, was interested in this clause, particularly how it relates to clause 19(4)(b). This is where I seek clarification. Clause 9 states, in part —

(1) A registered health practitioner who has a conscientious objection to voluntary assisted dying has the right to refuse to do any of the following —

(a) participate in the request and assessment process;

Clause 19(4)(b) states that the medical practitioner must —

give the patient the information approved by the CEO for the purposes of this section.

I know the minister has more or less addressed that with the member for Hillarys. The member for Hillarys and I think there is a problem in that the medical practitioner has to provide information approved by the CEO. My question is: what information approved by the CEO do they have to give?

Mr R.H. COOK: That is set out very clearly in clause 19 itself. It is detailed under subclause (4)(b).

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Mr S.K. L'ESTRANGE: The minister says it is detailed under clause 19(4)(b). I am asking the question about clause 19(4)(b); that is my question. Clause 19(4)(b) states —

give the patient the information approved by the CEO for the purposes of this section.

I am asking what type of information approved by the CEO must the medical practitioner give the patient?

Mr R.H. COOK: It would be standardised information regarding the voluntary assisted dying process, eligibility criteria, access points, supports, and that a patient's request for assisted dying may be withdrawn at any time. It is important that they communicate with the Voluntary Assisted Dying Board to make sure that the patient's rights have been observed.

Mr S.K. L'ESTRANGE: Based on that answer, does that not contradict clause 9(1)(a), which states they have the "right to refuse to do any of the following". Doctors may say that they are a conscientious objector and will not give a patient any further information about voluntary assisted dying, but under clause 19(4)(b), they will be obliged to do so.

Mr R.H. COOK: This is the same answer I gave the members for Cottesloe and Hillarys: it is not a contradiction. In drafting, the general gives way to the specific. This clause specifies how a medical practitioner will discharge their rights under clause 9.

Mrs A.K. HAYDEN: I wish to follow on from the line of questioning raised by my colleagues. I believe that Victoria has the extra safeguard of health practitioners having the right to refuse to give out information about voluntary assisted dying. We have talked about this a couple of times. The government has followed a lot of the guidelines from the Victorian legislation. Can the minister explain why that right was removed and the government did not choose to have that additional safeguard?

Mr R.H. COOK: We are striking a balance between the rights of the patient and the obligations of the medical practitioner. This clause reflects the position that a medical practitioner is professionally obliged not to unduly delay a person's access to voluntary assisted dying. They should make a decision and inform the patient as quickly as possible.

Mr Z.R.F. KIRKUP: As part of the request and assessment process, a medical practitioner might have a conscientious objection. I appreciate that we have explored that quite thoroughly.

The ACTING SPEAKER (Ms S.E. Winton): I think we have too. I am looking forward to a new question.

Mr Z.R.F. KIRKUP: I am underlining that. Thank you for your endorsement, Madam Acting Speaker.

What will happen if a medical practitioner does not believe a patient has the cognitive capacity to make the first request or assessment? I imagine the practitioner would form a conscientious objection to proceeding with the rest of the process. How would that occur? What is the mechanism by which they would inform the patient that the process would not continue? Will the board be informed of that?

Mr R.H. COOK: There are a number of ways a medical practitioner may not participate in the process. Conscientious objection is one that we are particularly focusing on. They may not be registered as a coordinating practitioner or done the training and all that goes with it. They just might not be eligible. Upon receiving a request from a patient to access voluntary existing dying, there are specific clauses. Clause 21 specifically states what that practitioner must do. That includes saying to the patient within a specific period of time, "Sorry, I'm not your dude" or "I'm not your dudette". Then a very specific set of information is required to be handed on to the Voluntary Assisted Dying Board. That medical practitioner will then have discharged their obligations.

Mr Z.R.F. KIRKUP: In that case, the practitioner would not form a conscientious objection to refuse to participate based on their view of the patient's inability to access it. If they believe the patient is ineligible to continue with the process, will they go through the requirements that are spelt out in the legislation?

Mr R.H. Cook: Yes.

Mr Z.R.F. KIRKUP: That is, inform them in two business days and the rest of it. Will they inform the board? I want to clarify whether the board will be informed.

Mr R.H. Cook: Yes.

Mr Z.R.F. KIRKUP: I realise that this might be covered in the implementation, but I am getting to this because it is a refusal to participate in some way, shape or form. Is there a way for the board to track that refusal to stop the patient going a number of times to a number of different practitioners to try to find a practitioner who does not choose to refuse?

Extract from Hansard

[ASSEMBLY — Wednesday, 4 September 2019]

p6458b-6492a

Dr David Honey; Mr John McGrath; Mr Roger Cook; Mr Peter Katsambanis; Ms Margaret Quirk; Mrs Liza Harvey; Mrs Alyssa Hayden; Dr Mike Nahan; Mr Zak Kirkup; Mr Sean L'Estrange; Dr Tony Buti; Mrs Michelle Roberts; Mr Tony Krsticevic; Mr Bill Johnston

Mr R.H. COOK: There is no prohibition on doctor shopping or on seeking second or third opinions; that is an inherent part of our system. Obviously, the board would see that as an emerging pattern taking place and would then be able to inform the Department of Health, the hospital or whoever else is responsible for providing the service, be it palliative care or whatever, about what is going on. It would say, “We see this pattern; clearly something’s not working here. What do we need to do to respond to it?”

Dr M.D. NAHAN: This relates to the medical practitioner, but what about the institution within which the practitioner potentially works—the hospital? The practitioners are employees of the hospital and the hospital might be a Catholic hospital, for instance, and might want to be a conscientious objector to voluntary assisted dying. Is there a facility for the institution to be a conscientious objector, or does it go right down to the individual employee, the medical officer?

Mr R.H. COOK: No; faith-based hospitals are able to object to participating in the voluntary assisted dying process for any reason, including, but not limited to, conscientious objection. The bill seeks to balance the provision of more comprehensive end-of-life choices for a person with the choice of individuals and organisations who do not wish to participate. A person seeking to access voluntary assisted dying may be required to transfer to a participating hospital or care facility.

Dr M.D. NAHAN: If someone is in a hospital that has decided to be a conscientious objector, is there a requirement on employees of the hospital to inform the board, as there is for medical practitioners? In other words, if a doctor is a conscientious objector, the request is passed on and facilitated by the board. Is there something else in place if it relates to an institution?

Mr R.H. COOK: The medical practitioner might be working at—let us call a spade a spade—St John of God, and a patient says to them, “I wish to access voluntary assisted dying and I make my first request.” The onus is on that medical practitioner to then inform the Voluntary Assisted Dying Board. There is no obligation on the organisation.

Dr D.J. HONEY: Just to follow up on that line of questioning, although the minister says that the institution is not required to participate, if a person comes to that hospital to make that request, would that medical practitioner not still be required to hand the information to the person? In fact, that is making provision for the distribution of information to access voluntary assisted dying within an institution that is fundamentally opposed to voluntary assisted dying.

Mr R.H. COOK: Yes, that would be duty of care to the patient.

Dr D.J. HONEY: Where would that information be kept? Would the hospital have to keep that information in the hospital to make it available for practitioners to distribute? Would the medical practitioner have to have the information? The minister can see where I am going with this. It is a fundamental concern. I know there are people who think that this is something that should be everyday, but there are individuals, institutions and medical and health practitioners who are utterly opposed to it and want nothing to do with it whatsoever. But it seems as though even an institution that is fundamentally opposed to voluntary assisted dying is still going to have to carry information that promotes it.

Mr R.H. COOK: The member would see that ordinarily there would not be stands around the corridors of a St John of God hospital displaying standardised information. One could imagine that the standardised information would be a printout from a website and that the medical practitioner would say, “No, not only can I not help you but you’re in the wrong place. Why did you come to St John of God if you wanted to access voluntary assisted dying?” In that instance they would say, “No, I can’t help you. Under the act, I’m required to provide you with some information.” Print: “Here’s the information and I will inform the board of your request. Have a great day.”

Dr M.D. NAHAN: What about Midland hospital that is operated as a public hospital by St John of God?

Mr R.H. COOK: Yes, that issue! As the member knows, there are a range of things that St John of God Midland Public Hospital does not provide, and this is another one. We cannot compel St John of God to do something that it, in good faith, cannot carry out.

Dr M.D. NAHAN: We are picking on a certain institution in St John of God, but I think it might apply to aged-care homes and others where these types of activities would take place. Some of them are religious based, and I assume have the same concerns.

Mr R.H. COOK: I am not using St John of God to be judgemental; it is just by way of example. I know of other organisations involved in palliative care that are not mad keen on this stuff either.

Mr Z.R.F. KIRKUP: As part of the ability for a registered health practitioner to choose not to participate or to be a conscientious objector in any step of the process at clause 9(1)(a), (b) or (c), is it envisaged that as part of the first request stage a practitioner might have to inform the patient up-front, “I’m happy to proceed with the first

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request and the first assessment, I'm happy to agree to be your coordinating practitioner, but I won't be your administrating practitioner"? Is there an obligation on them to inform them at that stage or will they have to get to the end of the stage where they come to the administration decision before the patient is informed by the practitioner about how they wish to proceed, if the patient opted for an administration practitioner to provide the substance?

Mr R.H. COOK: There is a bit of a misunderstanding about what the member is asking, so I will get him to clarify that in just a second. The member used the language, in the first instance, of "health practitioner". A health practitioner would not be required to do so; a health practitioner who is also a medical practitioner has obligations under this bill. A health practitioner obviously does not need to worry about this aspect of it. Could the member ask again what he is looking for so that we can be completely clear?

Mr Z.R.F. KIRKUP: I appreciate that; thank you, minister. I am trying to assess whether a health practitioner has the right to refuse to do any of the following. Firstly, clause 9(1)(c) states —

be present at the time of the administration of a voluntary assisted dying substance.

If they choose to be a conscientious objector to that part of the process, are they obliged to inform the patient at the earliest possible opportunity? Is there any requirement on the practitioner to inform the patient or do they get through the entire process and then say at that point, "I'm not going to participate here"? Is there a requirement on them to state, if they have already formed the view, for example, that they will not be there when the administration decision is made?

Mr R.H. COOK: It would be at the first request stage.

Clause put and passed.

New clause 9A —

Dr A.D. BUTI: I move —

Page 10, after line 5 — To insert —

9A. Registered health practitioner not to initiate discussion about voluntary assisted dying

- (1) A registered health practitioner who provides health services or professional care services to a person must not, in the course of providing those services to the person —
 - (a) initiate discussion with the person that is in substance about voluntary assisted dying; or
 - (b) in substance, suggest voluntary assisted dying to the person.
- (2) Nothing in subsection (1) prevents a registered health practitioner from providing information about voluntary assisted dying to a person at the person's request.

My proposed amendment follows, in the main, section 8 of the Victorian legislation. The amendment that I am seeking to insert in this bill does not have subsection (3) of the Victorian legislation, which states —

A contravention of subsection (1) is to be regarded as unprofessional conduct within the meaning and for the purposes of the Health Practitioner Regulation National Law.

The reason it is not included is that clause 10 of the Western Australian bill already includes that offence. No new offence would be generated by the insertion of this new clause, but any contravention of the new clause would be covered under clause 10 of the bill, which relates to the contravention of the legislation by a registered health practitioner.

The proposed new clause refers to a person and states —

A registered health practitioner who provides health services or professional care services to a person ...

The term "person" is deliberately used rather than "patient", because a patient for the purposes of our bill means someone who has made a request for access to voluntary assisted dying. The new clause refers to the situation prior to requesting information about voluntary assisted dying, so that is why "person" is used rather than "patient".

The new clause refers to a registered health practitioner who provides health services or professional care services. In a previous answer to a question from the member for Hillarys, the minister went through what a health practitioner is and read out a long list of people, such as dentists, nurses, optometrists, pharmacists, chiropractors and physiotherapists. In his response to the second reading debate, he said that he did not agree with the new clause I flagged as he did not want to interfere in the doctor-patient relationship. The fact is that it may not be a doctor. A lot of people with disability have longstanding relationships with physiotherapists, chiropractors, occupational therapists et cetera. By not accepting this new clause, the minister is saying that a chiropractor or physiotherapist who may have a long-term relationship with a patient could initiate discussion on voluntary assisted dying with that patient. It is not necessarily a medical practitioner-patient relationship; it could be a wider relationship with another health professional.

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The minister mentioned that he does not want to interfere with the medical practitioner–patient relationship. Why should that necessarily be sacrosanct when we are trying to prevent the possible abuse of the vulnerable? As the Premier has rightly said, the government is looking at introducing legislation to break the confessional seal between a priest and a confessor—I do not know what the person would be called—and I agree with that. Sometimes we need to look at reasons why we may need to break the autonomy or independence of that relationship. In any case, the new clause goes to not just medical doctors but also health professionals. As the minister said, there is a long list of people. If we do not include this new clause, which is in the Victorian legislation, we will be saying that there will be no protection from a situation in which any health professional forms a close relationship with a patient who may easily be swayed by what they say.

Dr D.J. HONEY: I would like to hear more from the member.

Dr A.D. BUTI: The Joint Select Committee on End of Life Choices, chaired by the member for Morley, looked at this issue in its report “My Life, My Choice”. At paragraphs 6.78 and 6.79 on pages 199 and 200 of its report, the committee said that it looked at it but did not agree that the section in the Victorian legislation should be included. Paragraph 6.79 states —

To that end, the prohibition contained in the Victorian legislation should not be a feature of Western Australia’s legislation. Assisted dying should be considered as one of many clinical options available to patients for responding to terminal illness.

I do not disagree that it should be considered as one of the clinical options—I am in favour of the bill—but it is not a normal clinical option. It is quite a significant clinical option. If someone gets it wrong, there is no reversal. It is not like recommending paracetamol. It is quite an important clinical option that may need to be treated differently. Surely for most clinical options, we do not have 102 safeguards. The reason we have 102 safeguards is that the government, and, I presume, this Parliament, recognises that this is an incredibly important issue and we need to get it right.

The Ministerial Expert Panel on Voluntary Assisted Dying also considered this issue. It states at page 29 of its final report —

Victoria is the only jurisdiction that prohibits health practitioners from starting a conversation about voluntary assisted dying.

Many health practitioners are reluctant to discuss end-of-life care with people. It is also known that up to 60% of Australians have low levels of individual health literacy.

That may be so. However, members continue to quote in this Parliament, and I may have mentioned it in my second reading debate speech, that 88 per cent of Western Australians support voluntary assisted dying. If we say that most Western Australians support VAD, that means they must know about it. It has been said that people will not know about VAD after we pass this bill—I think we will pass it—and it will allow the doctor to initiate the discussion. I do not agree with this. It has been put to me that of course educated people will know about it, but people who are not well educated will not know about it. I do not know that that is true. I do not want to stereotype Armadale, but I can assure members that a lot of people in Armadale know about this legislation. It is stereotyping to say that people in Western Australia who are not well educated will not know about VAD.

People from all over Australia are listening to this debate. This morning, I received an email from Professor Lindy Willmott, professor of law at Queensland University of Technology, who I quoted during the second reading debate. I make full disclosure: she does not agree with the amendment that I have moved. She included in her email two papers, one written by Professor Willmott and various colleagues, and another paper, “Discussing Voluntary Assisted Dying”, by Carolyn Johnston and James Cameron. The “Discussing Voluntary Assisted Dying” paper refers to other jurisdictions, in particular Oregon, and to the likely implications of the prohibition that I am seeking to have included in the bill. Victoria is the only jurisdiction that has the prohibition. Oregon does not have it.

Dr D.J. HONEY: I would like to hear more from the member.

Dr A.D. BUTI: This paper states, in part —

The limitation in Victoria on health practitioners initiating discussions is likely to further limit access for those with limited literacy.

It also states —

Data showing a lower use of assisted dying among low socioeconomic status groups might reflect unequal access rather than a less of a preference among these groups.

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As I have said, Oregon does not have this prohibition. Therefore, we cannot say that this prohibition will prevent people from low socioeconomic groups from accessing voluntary assisted dying. There may be other reasons that those people do not access voluntary assisted dying. The government may need to look at providing a better education program, and I will get to that.

It was put to me when I flagged this proposed amendment that the government has looked at the Victorian legislation, and that is why the government will not agree with this prohibition.

That could not have been done on the basis of the Victorian legislation because it has just become operative. Both the report of the Joint Select Committee on End of Life Choices and the final report of the Ministerial Expert Panel on Voluntary Assisted Dying were tabled prior to the Victorian legislation coming into operation. It was not on the basis of any empirical evidence that it was determined that section 8 of the Victorian legislation had been causing a problem. I have also been told that section 8 of the Victorian legislation was introduced because of a compromise. That is not true either. I refer members to the Victorian “Ministerial Advisory Panel on Voluntary Assisted Dying: Final Report”. At page 87 is the heading “Initiating a request for voluntary assisted dying”. Then on page 89 it states —

During the consultations a range of stakeholders raised concerns that people may seek access to voluntary assisted dying because they feel like a burden. The most common reason for accessing voluntary assisted dying in Oregon is loss of autonomy, with 91.4% of people reporting this as a reason.

It talks about that and then it states —

The Panel is of the view that the additional safeguards —

That is, the additional safeguard of the prohibition, which is what I seek to introduce —

it has recommended will ensure decisions in relation to voluntary assisted dying are voluntary.

That is key. That is why I am a big supporter of this bill: it is voluntary and we should ensure that it is voluntary. It continues —

These safeguards and the assessment process also provide a further opportunity to identify potential abuse; even if a person does not meet the eligibility criteria for voluntary assisted dying, the assessment process will still provide an opportunity to alert health practitioners and services to the situation so they can address any abuse. The Panel notes that while legitimate concerns about elder abuse and coercion must be taken into account in assessing requests for access to voluntary assisted dying, most people who are dying have loving and supportive families and it is important that these relationships are maintained throughout the request and assessment process.

The report then refers to elder abuse and abuse of people with disabilities. Before I go into that, I will read what it says at page 91. It states —

In 2016, a Victorian Parliamentary Committee Inquiry into abuse in disability services identified widespread abuse and neglect of people with a disability in disability services in Victoria. Concerns about a lack of respect for people with a disability or different treatment of people with a disability were also raised during consultations. The Panel recognised the importance of addressing these concerns when considering its recommendations.

The Panel supports the Government’s ‘zero tolerance of abuse of people with a disability’ and notes the measures taken by the Government in response to the Inquiry, including strengthening oversight of disability services. This includes the creation of a new code of conduct for disability workers and greater support and training to identify and respond to abuse of people with a disability. Recent steps to clarify the roles of Victoria Police and the Disability Services Commissioner will also assist in responding to instances of abuse effectively.

Dr D.J. HONEY: I would very much like to hear more from the member.

Dr A.D. BUTI: The report continues —

The framework recommended by the Panel does not allow people to make judgments about the lives of others. The framework allows people who are already at the end of their life to make a choice about how they will die. This decision must always be made by the person themselves. The Panel is confident that the process recommended will identify any coercion or undue influence, and ensure that this is dealt with appropriately.

Ministerial Advisory Panel Recommendation 7

Dr David Honey; Mr John McGrath; Mr Roger Cook; Mr Peter Katsambanis; Ms Margaret Quirk; Mrs Liza Harvey; Mrs Alyssa Hayden; Dr Mike Nahan; Mr Zak Kirkup; Mr Sean L'Estrange; Dr Tony Buti; Mrs Michelle Roberts; Mr Tony Krsticevic; Mr Bill Johnston

That a request for access to voluntary assisted dying, or for information about voluntary assisted dying, can only be initiated by the person. Requests cannot be initiated by others, including family and carers.

Then I come to recommendation 8 of the Victorian ministerial advisory panel, which is the one that I am seeking to follow. It states —

That a health practitioner cannot initiate a discussion about voluntary assisted dying with a person with whom they have a therapeutic relationship.

Policy intent

To ensure a person is not coerced or unduly influenced into accessing voluntary assisted dying and to demonstrate the request for voluntary assisted dying is the person's own voluntary decision.

I have just referred to the issue of the abuse of people with disabilities. I must say that in the minister's response to the second reading—I will stand corrected because I have not read that speech—I did not hear him once mention disability. He may have, but I did not hear disability mentioned by the minister once. When one is looking at the history of euthanasia, the concerns of the disabled are very important. We are, of course, not seeking to engage in eugenics et cetera, but once upon a time we did. The minister can understand how people with disabilities may be fearful of that. My drive for this prohibition is not just for people with disabilities; it could also be for older people or anyone, in fact, because it is understood under law that there is a presumed undue-influence relationship between a doctor and a patient. That is one of the presumed relationships of undue influence. We do not have to prove actual undue influence; we start off from a presumption of undue influence.

The responses that I have received since I wrote my op-ed are interesting. Some people approached me and asked why I want to do this, because I will be affecting people's ability to access VAD or I will prevent a doctor from giving all the clinical options. That may be so, but what about the protection of the vulnerable? Surely that is also very important. One reason I am a member of the Labor Party is that I want to protect people who are vulnerable. We always seem in this place to forget the people who have disabilities. We very rarely talk about people with disabilities in this chamber. It is interesting that when I became a member of Parliament in 2010, we very rarely talked about domestic violence. I will take some responsibility for this, because I think as a result of me pushing that in 2010, we now have a fantastic Minister for Prevention of Family and Domestic Violence. I hope that we might improve the profile of people with disability. It is interesting that in a debate on VAD, with the history of people with disabilities, it has not been mentioned in this debate, or if it has, very rarely. It is also interesting that I mentioned my daughter, and some people have made an assessment that my daughter would not have the mental capacity to make this decision. I do not know how people made that assessment, because they do not know my daughter. I can tell the minister that a person with an intellectual disability can still have the capacity to make a decision. If we look at the decision-making capacity under clause 6, I can tell members one thing: my daughter can understand information. She can process information and she can make a decision, but what I am fearful of is that she wants to please. After I made my contribution to the second reading debate, a constituent contacted me.

Dr D.J. HONEY: I would like to hear more from the member for Armadale.

Dr A.D. BUTI: She wrote me an email. This is, in part, what she said —

When I think of my own daughter, I get emotional. When I read Hansard the other day, I think you feel similarly about Alkira ...

Who is my daughter. She then mentioned her daughter's name, which I will not mention. She continues —

... has a communication disorder (among other things) and trusts people implicitly. Consequently, she is very easily led and that makes her vulnerable in all sorts of ways. Right now, my husband and I are here to care for her, but that won't always be the case. If this law is enacted, then I have to trust future, unknown politicians to make laws that are safe for my daughter.

I cannot emphasise enough that this is a major concern for people with disabilities. Malcolm McCusker contacted me after my op-ed and we had a very civil discussion, as you would with Malcolm. He mentioned that there was a person on the expert panel who represents people for disabilities. That might be the case; that was one person. I am not sure, but Samantha may have a disability. Does she have a physical disability?

Mrs L.M. Harvey: Not an intellectual disability, a physical disability.

Dr A.D. BUTI: Okay, a physical disability. I looked back at the people who were consulted. I think four or five organisations that deal with people with disabilities were contacted, but I wondered what sort of consultation that was. I wonder whether there was consultation with people who live with disabilities, like my daughter. This is not only about my daughter; this is also about that constituent who emailed me. This is about my daughter's best friend, who would be very competent, but has an intellectual disability. People with Down syndrome can have normal

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intelligence. I am on the board of the Armadale special education centre, and I reckon 50 to 60 per cent of those kids would have mental competence under this legislation to make a decision. As I said in my contribution to the second reading debate, I do not want to deny people with disabilities the right to be involved in VAD, but I want to ensure that they have not been coerced at all. I am very fearful about that. I use my daughter as an example. She wants to please, and I know, because I have manipulated her a lot of times as a parent! If I ask her something or say X, she will want to do it. It has been said that the reason this amendment will not be accepted is that it will prohibit the doctor from giving a full range of clinical options, but it will not once the person initiates the discussion. It might be said that people from lower socioeconomic backgrounds may not know about this, but the Victorian Voluntary Assisted Dying Ministerial Advisory Panel talked about setting up a ministerial task force to educate the public. If we pass VAD, I think we have the responsibility as a government and a Parliament to provide information to the public about it. In his response to the question about conscientious objectors the minister mentioned that the doctor would have to give a pamphlet. If the doctor has to give a pamphlet and that does not mean they are engaged in the process, there could be a pamphlet at a doctor's surgery. We cannot have it both ways. We cannot say that a doctor has to give a pamphlet but it does not mean they are engaged in the process, but if there is a pamphlet at the doctor's surgery, the doctor has initiated the discussion about VAD. That could be done. People could go to the doctor's surgery and they would know about it. I find it hard to believe, with all the attention we have had for a long time on VAD, that most Western Australians would not know about it. We have a role as the government to educate them—not to tell them they should do it, but to educate them that it is legal. I am very, very disappointed that the objection to my raising of this issue is that —

Dr D.J. HONEY: I would like to hear more from the member for Armadale.

Dr A.D. BUTI: — it is going to affect the ability of a doctor to give the full range of clinical options. It will not once the patient raises the issue. Is that more important than protecting people who are vulnerable to abuse or engaging in something that they would not have engaged in? Under this legislation, somebody could go to a doctor with a terminal illness—I gather with six months to live on the balance of probabilities—and not even be thinking about VAD. If they are easily led by a medical practitioner, within two weeks they could be dead. I think that is something we should try to prevent. We are reviewing this legislation in, I think, three years. If we find that it is causing such a limitation on the doctor's ability to provide information to a patient, we can review it, but just to blankly disregard this new clause is a failure. I am very supportive of this bill, but I will be even more supportive if we include this new clause.

Mrs L.M. HARVEY: I rise to support this new clause. I had a similar amendment drafted, but the member for Armadale pipped me at the post in putting it on the notice paper. I concur with everything he has so eloquently put about protections for vulnerable people. He talked about people with disabilities, who are one category of vulnerable people. The other category of vulnerable people I am particularly concerned about is our seniors and the elderly. I know from dealing with elderly people in my constituency and also elderly grandparents who are sadly no longer with us that they absolutely revere the medical profession and will do whatever medical practitioners tell them. I can recall one story of an elderly lady who was nearing 90 years of age. Her GP put pressure on her for two years to have a knee replacement because once she got over 90 years of age, she would not be able to have it for free. She followed the doctor's advice, against family advice at the time, went in and had the knee replacement. She ended up with a massive infection and was in hospital for six months. The titanium knee had to come out, so she had no knee for another year. She had to go back in and have further surgery once she got on top of the infection, and, sadly, it shortened her life. These are the sorts of decisions that people can be talked into. She thought that she was getting a bargain because her GP wanted her to have that free medical treatment and said to her that she would not be able to get it later because of her age. That is the vulnerability of some elderly people in the community; a power imbalance exists in the relationship between vulnerable people and their GP.

I believe that most doctors are great, but doctors are representative of our community and we find doctors who do the wrong thing. We will find doctors who will approach voluntary assisted dying with an air of zealotry. There might be only one, but if we have one, it is one too many. I will use some examples of when doctors do the wrong thing so that members can understand where I am coming from. I am not saying that the broad suite of GPs and medical professionals in Western Australia are like the examples I will mention. However, I will mention these examples because I think it is important that we consider that some individuals in the medical profession do not act in the best interests of their patients.

I have one case here of a French doctor charged with killing nine patients by poisoning them during surgery. The article reads —

An anaesthetist in the French city of Besancon is suspected of poisoning patients during surgery to trigger heart failures and then heroically bring them back from the brink of death.

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Investigating magistrates have found evidence linking Frederic Pechier to 24 out of 66 suspicious incidents that happened during surgical proceedings at the clinic where he practiced, according to Besancon prosecutor Etienne Manteaux.

Several members interjected.

Ms S.F. McGurk: What's this got to do with anything?

Mrs L.M. HARVEY: I am trying to illustrate that some doctors lose their way and become obsessed with issues. I have another story here from the universities. The article is titled "US doctor charged with murdering 25 patients using fentanyl overdoses" and states —

A US doctor has been charged with the murders of 25 hospital patients who Ohio authorities said were killed with deliberate overdoses of painkillers, many of them administered by other medical workers on his orders.

Several members interjected.

Mrs L.M. HARVEY: Just wait. Everybody has an opportunity to put their opinion in this place. It continues —

... Dr William Husel was accused of ordering excessive doses of the powerful painkiller fentanyl.

Mrs A.K. HAYDEN: I would like to hear more from the member.

Mrs L.M. HARVEY: This is where it is pertinent and this is why I raise it. It continues —

Many of the patients who died were on ventilators and receiving palliative care.

The deaths occurred between 2015 and 2018.

These two doctors completely lost their way. Two individuals—49 lives. I put to members in this place that without a protection to prevent doctors from initiating a conversation with a patient about going down the pathway of voluntary assisted dying, there is a real risk that one of these doctors may be a psychopath—I do not know; I am not a clinical psych to make the diagnosis. We might get that one doctor who is a psychopath, and if they decide that they want to initiate conversations with terminally ill people in palliative care to encourage them down the voluntary assisted dying pathway, they will be able to do it without that protection.

Mr F.M. Logan: They have done it without it.

The SPEAKER: Members, this is a very important debate. You might have an opinion but the member is on her feet and her opinion counts at the moment.

Mrs L.M. HARVEY: I agree with the member for Armadale that this is a very important protection for vulnerable people, people who can be easily influenced. They may not necessarily always be influenced but when they are talking to their doctor, what their doctor says is right. We all know who those people are. Members will have people in their lives, like I do, who have a suite of medical options available to them but unless they go to the doctor and get a prescription for some pills, they do not think that they are going to get better. They rely on the doctor's information and if that doctor says, "You are looking at a couple of pathways here. You're looking at a world of hurt. Your health is deteriorating and your cognitive function might deteriorate. You had better access voluntary assisted dying now", people may take that course without necessarily having contemplated it. If their doctor suggests it, they might do it. I do not in any way, shape or form say that every doctor is going to do this. I do not believe that to be the case. There are other checks and balances with the reporting requirement et cetera to catch doctors who behave in that way. However, there is an element of risk. We are debating legislation in this place, which, in the minister's own words, will cater for a very small number of people who will want to access it—a very small number of people who will fit the criteria and whose circumstances are so dreadful that they will want to access voluntary assisted dying—and that is the choice that this legislation will provide them. But in introducing this legislation, we do not want to open it up to a very small or potentially large number of people who may be guided into voluntary assisted dying without necessarily initiating it themselves because that will then not be their choice. That choice will be influenced by somebody else whom they trust, somebody whom they hold on a pedestal and think is smarter than them, knows more than them, has more experience than them and understands what is best for them. For those individuals, we cannot take the risk. This amendment has a precedent because it is in the Victorian legislation. I do not believe that it will fundamentally affect access to voluntary assisted dying for the people who want to access it for the various reasons that they do. I think it will be a small number of people. But even if one vulnerable person is talked into voluntary assisted dying after a doctor initiates that conversation, we in this place will have failed. If members think about the conversations about the death penalty, they are all predicated on the one innocent person who was put to death and subsequently found to be not guilty. We need to view this legislation and this amendment through the prism of the one individual, the one vulnerable person who may be influenced by a doctor, even if that doctor thinks that they are doing the best thing for their patient.

Mrs A.K. HAYDEN: I would like to hear more from the member.

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Mrs L.M. HARVEY: They may influence vulnerable people into a choice not of their initiative—a choice that they would not contemplate until the person they trust tells them that it is their best option. We cannot allow that to happen. It is one amendment. I one hundred per cent support it. I thank the member for Armadale for putting it on the notice paper.

Dr A.D. BUTI: After speaking to my friend the member for Kimberley, I forgot to add one part to my presentation, which I do not want to miss—that is, the issue of Aboriginal people. The Ministerial Expert Panel on Voluntary Assisted Dying heard mixed views about doctors initiating the conversation. Page 30 of its report states —

Discussions that took place in the Kimberley raised issues in relation to self-harm and suicide and noted that even discussing palliative care with patients can be challenging in this context. There may be complexities surrounding concepts such as blame or ‘pay back’ in Aboriginal communities and potential implications if the family has a negative perception of the practitioner or health service because of involvement in voluntary assisted dying.

I refer to a quote from Kimberley Palliative Care Service at the consultation stakeholder meeting, which states —

High turnover of staff and GPs is a huge issue. For people to establish a relationship with their GP to even have a discussion about voluntary assisted dying is hard.

The report continues —

The complexity of medical terminology and the balance of power between health practitioner and patient was also identified as potentially challenging and would require thorough consideration during any implementation planning (including being part of practitioner education and training).

There is then an excerpt from a submission of the Aboriginal Health Council of Western Australia —

‘Clinicians often use complex medical terminology when discussing treatment options with Aboriginal people ... This results in the real risk that Aboriginal people may consent to something they don’t fully understand. There is also the issue of the disparity of power between a doctor and Aboriginal people; Aboriginal people will often agree with a doctor’s advice even if they are not happy with it as they can feel overpowered in the doctor–patient relationship’.

Mr Speaker, when I was working at the Aboriginal Legal Service, it was during the time that Marshall Perron introduced the Northern Territory legislation. I remember reading that and speaking to Aboriginal clients. They were so fearful of voluntary assisted dying, or euthanasia, whatever one wants to call it, because they thought that the state was coming after them. They said, “We always have to do what people tell us to do”, and they were very fearful. The state is not coming after Indigenous people, but one can understand that in some remote communities, the relationship between the only doctor in the community and Aboriginal people is a very strong relationship, and there is a power imbalance. I think Aboriginal people should be able to access VAD if they want to, but we should guard against the possibility that they would not have done so but for the initiation by the medical practitioner.

I believe that there is no evidence at this stage that this section in the Victorian legislation is causing any prohibition. I went to Melbourne about two months ago and spoke to people in the Minister for Health’s office and other people. There was no concern from what I gathered, and I was surprised it was not in our bill. Even in the articles that Professor Willmott sent me there is no evidence. It is saying that it may inhibit. Yes, it may, but I am more concerned with protecting the vulnerable. I do not believe that the VAD legislation that we are debating in this Parliament, which is a very good piece of legislation, will be detrimentally affected by the inclusion of this clause. If anything, it will protect it. Surely, in the Labor Party, our number one commitment is to protect those who are vulnerable; that is much more important than maybe one or two doctors who may have a hard time in dispensing some information to a patient. I do not understand why there is this hesitancy to introduce this. There is no evidence anywhere that it has affected the ability of the VAD legislation to operate.

Mr R.H. COOK: I would like to acknowledge the member for Armadale on this amendment. We heard from him in the second reading debate. This is clearly a matter and a subject about which he is greatly passionate, and I think it is important that we as a chamber acknowledge that. However, I do not support the amendment that the member has proposed. There is no prohibition in the Western Australian bill. This is different from the Victorian act, which expressly prohibits registered practitioners from initiating a discussion with the patient about voluntary assisted dying. Victoria’s prohibition was not supported by the Joint Select Committee on End of Life Choices or by the Western Australian Ministerial Expert Panel on Voluntary Assisted Dying. The reason for this is there should not be an attempt to censor the conversation health practitioners have with their patients. They should be able to raise and discuss voluntary assisted dying in the same way as other serious health medical decisions and care options, so that the patient is making fully informed decisions, particularly at the end of life. I think the scenario the member for Armadale described of the special relationship between a health practitioner and patient in this particular instance

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would amount to coercion, in the way he characterised and described it, which, of course, is expressly prohibited under the bill.

Victoria is the only jurisdiction in the world that prohibits health practitioners from starting a conversation about voluntary assisted dying. I am drawn to comments made by Dr Linda Sheahan, who is an Australian palliative care physician and a Churchill Fellow, in her report dated 30 May 2013. She stated —

... it is highly reassuring to review the data and find no evidence of increased risk to vulnerable groups ...

Further, a submission that People with Disabilities WA and the Australian Federation of Disability Organisations made to the Joint Select Committee on End of Life Choices in 2018 stated —

There is no evidence to suggest, from either Oregon or the Netherlands data, that people with disabilities are at heightened risk of assisted dying. Vulnerable groups generally including women, ethnic minorities, people from lower socio-economic circumstances, children, people with a psychiatric disability or dementia were not found to be at any heightened risk of assisted dying. People with psychiatric disability ... constituted 20% of referrals to the Netherlands assisted dying process, but none progressed.

In Western Australia, a registered health practitioner may commence a discussion related to voluntary assisted dying with a person to whom they are providing health services or professional care services. This may include the provision of written information by the practitioner to the person. That the patient's decision is well informed is fundamental to the proposed model of voluntary assisted dying in Western Australia. Indeed, I believe there is an obligation on medical practitioners, in dispensing their professional obligations, to inform patients of all their treatment options. In order to allay concerns about a health practitioner coercing or inadvertently encouraging a patient to seek access to voluntary assisted dying, at least two medical practitioners, the coordinating and consulting practitioners, must independently assess the patient. If an assessing medical practitioner is unable to determine whether the person's condition meets the eligibility criteria, whether they have decision-making capacity or whether their decision is voluntary and without coercion, they must refer them for further assessment. Furthermore, if the patient wishes to proceed, they are required to make a written declaration of their request to access voluntary assisted dying. That must be witnessed by two adults. The witnesses must not be members of the person's family or stand to benefit financially or otherwise from the person's death, nor can the coordinating or consulting practitioner be a witness. If the person has completed a written declaration and makes a further final request, the coordinating practitioner must undertake a final review.

Mr J.E. McGRATH: I would like to hear more from the minister, Mr Speaker.

Mr R.H. COOK: In the final review, the coordinating practitioner must confirm that the process has been undertaken in accordance with the requirements of the act and that the patient has decision-making capacity to request voluntary assisted dying, that they are acting voluntarily and without coercion and that their request is enduring.

I believe the process by which someone will access voluntary assisted dying has ample safeguards. Evidence from overseas and other jurisdictions suggests that vulnerable patients are no more at risk under voluntary assisted dying legislation than any other medical process. It is important that we get the proper balance between the rights of the patient and the need to protect and provide safeguards. That is what we have done. We are not saying that the issue of voluntary assisted dying should not be raised with a patient. It is the patient's right to be fully informed of all the treatment options that are available to them.

Mrs L.M. Harvey: It is not a treatment! Death is a treatment option?

The SPEAKER: Excuse me, members, I will hear this in silence.

Mr R.H. COOK: Options at the end of life.

The cases that the member for Scarborough outlined in her speech were, quite frankly, extreme and inflammatory. Several members interjected.

The SPEAKER: Members!

Mr R.H. COOK: She essentially described overtly criminal activity, which is not the way to enter this debate and characterise the relationship between medical practitioners and their patients. It is important that we understand, in respect of what the member for Scarborough described, that nothing in this bill will protect patients from someone who has decided to become a serial murderer—nothing—so to try to provide protection by way of explanation or defence of the member for Armadale's amendment is absurd.

I respect the member for Armadale; I think he comes to this debate with a very considered position—one that, as we all witnessed, was born of his own personal circumstances—and he has our utmost respect. I think this place is the better for him having raised those issues, and we really appreciate it. He is right; we had a member from the

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disability sector on the Ministerial Expert Panel on Voluntary Assisted Dying, Samantha Jenkinson, who considered the issues along with the other members of the ministerial expert panel. The panel stated, in its final report —

The Panel carefully weighed the outcomes of the consultation and knowledge of other jurisdictions, with the unique cultural circumstances of Western Australia in its deliberations on this matter.

The Panel believes that health practitioners have a professional obligation to ensure that their patients are fully informed about their choices at end of life, including voluntary assisted dying.

The Panel acknowledges the position of the Joint Select Committee and agrees that health practitioners should not be restricted in their ability to have comprehensive end of life discussions with patients, including that there be no prohibition on health practitioners appropriately raising the subject of voluntary assisted dying.

I greatly respect the member for Armadale and the issues that he brings to this place on not only this occasion but also other occasions. But on this particular point, I respectfully disagree with him that we should restrict health practitioners from raising this as one of the many issues that will confront someone at the end of life. There is no evidence from overseas to suggest that their having the capacity to do so will create an extra level of vulnerability for patients.

Mr S.K. L'ESTRANGE: I think this is an eminently sensible amendment to make because it is there to give the medical profession and our society the capacity to protect the weak, the sick, the ageing and the demoralised when they front a professional about their illness. When they are sitting in that room, discussing their illness and discussing a way forward, there cannot be a presumption that they want to die early. It must be up to the patient to decide whether they want to have a conversation around that topic. If they are, in good faith, in front of a medical professional seeking the advice of that professional to help them deal with an illness, to have them actually being told that an early death brought on by a substance is an option for them would go against all the principles that I understand the Hippocratic oath to encompass. I would be amazed if the medical fraternity at large would agree with what the minister has just said. The minister has spoken about his expert panel. Let us be frank: the panel was put together to help the minister write the bill. The medical fraternity at large has opposing views to the bill; the Australian Medical Association has said that.

Several members interjected.

The SPEAKER: Members, please. Just let him speak.

Mr S.K. L'ESTRANGE: This is not political banter; this is a serious matter that the member for Armadale has raised in the context of personal lived experience. The minister may not like what he is hearing from me, but he should show some respect to one of his own who has moved this amendment.

We have a duty to protect the weak, the sick, the ageing and the demoralised who are standing in front of a medical professional to seek advice. We have a duty in this bill to protect them. We have a duty to control whether coercion occurred. Coercion can be very overt or it can be very subtle. Outside of a doctor's room with him or her and their patient there is absolutely no way of knowing whether coercion has taken place. There is no way of knowing that unless the patient comes out and says it. If they say nothing, there is no way of knowing that. To suggest that coercion can or cannot be controlled is irrelevant, because it can occur. We know that. That is a risk. I find it most unusual, to be polite, to actually consider euthanasia as a treatment in the context of health care: "Doctor, I've got an illness. What can you do to support me with my illness?" "Here's a treatment. You can have voluntary euthanasia, which is essentially voluntary suicide assisted by a physician. There's a treatment." How is that possibly medical treatment? It is not. When the minister said that he thinks it is a medical treatment, he cannot have his cake and eat it too. He has said in this context that it is a medical treatment, but earlier when we asked why do we not put "palliative care" into the definitions part of the bill, the minister said, "No, because that is separate from this." He is trying to shape his argument around a very sensible amendment. The minister's argument will not stack up. To coin that classic old phrase, it simply would not pass the pub test.

Dr D.J. Honey: Mr Speaker.

The SPEAKER: Had you finished, member for Churchlands?

Mr S.K. L'Estrange: No.

Dr D.J. HONEY: I would like to hear some more from the member.

Mr S.K. L'ESTRANGE: That explanation given by the minister would not pass the pub test. That is straight up. This is not a treatment. This is absolutely an option for a patient, if the patient wants to explore that option. That is what this bill should be about. What all the people in this chamber are saying we are most concerned about is if the patient did not go in to seek that type of information, they should not be presented with it. That is all—nothing

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more than that. I would be very interested to know what the Australian Medical Association of Western Australia would have to say, given this is Western Australian legislation, about the comments the minister made tonight on the proposed amendment. I really would like to know what it would have to say on this.

Dr D.J. HONEY: Someone said the Premier would be answering questions. I am extremely disappointed in the minister's response to this proposed amendment. This is a crucial amendment to make this bill the proper and reasonable bill that the government and the minister are presenting. I wish to dwell on a point. I am not a lawyer, but I am aware of the doctrine of presumed undue influence. To explain to members what the doctrine of presumed undue influence is, the doctrine presumes that if a doctor gains any benefit from a patient, it is presumed that there was undue influence. In fact, there is a considerable burden of proof required for that medical practitioner to prove that they did not influence that decision. That is profound. If a doctor gains some benefit, it is presumed that there was undue influence because of the imbalance of power. I am not going to rearticulate the excellent speech made by the member for Armadale on this matter. It is presumed that there is undue influence. This is not about someone doing some extreme thing. This is not about someone who is doing this out of any malice or for any other purpose. It may well be that a doctor has a particularly strong view about things. As we have discussed, some doctors are vehemently opposed to voluntary euthanasia—it makes them feel sick. Some medical practitioners are absolute advocates of voluntary euthanasia and, in fact, think that this bill is weak and does not go far enough. That is just because doctors reflect the breadth of views in this room and in the broader community. It may be that a doctor does not have any particular view. However, if the doctor said, "Maybe you could leave the house to me", and the person left the house to them, the presumption under law would be that that was undue influence, because the law has recognised for a long time that doctors have special power in a relationship.

Let us equate voluntary euthanasia with a commercial benefit to the doctor. If a patient who has no thought of this and is not considering terminating their life comes in to see a doctor and the doctor looks at the patient and believes that the patient's case is hopeless and they ask the patient, "Have you considered the range of options? We can give you the treatment but, by the way, you can also access voluntary euthanasia", the law would say that the doctor has undue influence per se. The doctor would have to presume that they had not unduly influenced that decision. In this case, the minister is saying, "No, I don't presume that." It is in complete contradiction to a principle in law that has existed for some considerable time. I am astounded that Malcolm McCusker has not raised this as a concern, because every lawyer I have spoken to about this topic has raised this. That is true. I know of many lawyers, both personally and otherwise. It is true, members. I do not know why members are pulling faces and laughing about this matter. Every lawyer I have spoken to has expressed this concern; that is, the imbalance of power between a doctor and a patient is such that if a doctor were to simply discuss this with a patient, that could unduly influence the patient to take this decision—a decision that they would not otherwise take.

Mrs A.K. HAYDEN: I would like to hear more from the member.

Dr D.J. HONEY: I see this in a number of bills that are brought before this place and I heard it in the discussion today; that is, we assume that in the best possible circumstances, everyone is of goodwill, everyone will do things in the best possible way, everyone will receive the information in the best possible way and we will have the best possible outcome. Members, we know that that is simply not true. Again, the member for Armadale outlined very eloquently the simple reality. It is in not just remote Aboriginal communities but also country communities. In country towns, the doctor is an esteemed and revered figure. Doctors have enormous influence in country towns. Members who represent regional areas will know that in many communities, the doctor is not just a leader in the medical field, but a civic leader. When the doctor raises an issue or a concern or suggests something, per se the community takes that to be an important matter and something that it should consider and do. Members know that for many patients, a doctor is a revered figure. It is absolutely certain that if a doctor suggests to a patient that they consider voluntary assisted dying, some patients—members can debate how many patients until the cows come home, but that is speculation—will go through that process, and nothing will pick that up. How will that possibly be picked up? We hear about these checks and balances, but nothing will pick that up. There is not a specified question. There is not a deemed provision in this legislation that says that one of the questions that must go onto the checklist is: did the doctor suggest this before you asked? Nothing in this legislation will pick that up.

I want to dwell on one point. The minister used the example of Oregon a few times to say there is no evidence that vulnerable people access voluntary euthanasia more than other people do. Of course they do not in Oregon. I can tell the minister that most vulnerable people are poor. In fact, it goes exactly the other way. Poor people are less likely to access voluntary euthanasia. That is because in Oregon, if people do not have insurance, it costs a heap of dough. The minister has not given us one skerrick of evidence that doctors will not influence a person who is in that position. I am not talking about a person who is mischievous or criminal. I am talking about a doctor who is well meaning and believes this is an option that the person should consider. The minister has not told us anything that proves that will not be the case. In fact, all the evidence indicates that doctors have a special position and

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a special power, and that, simply by discussing something, doctors can unduly influence a person to make a decision that they otherwise would not make. I know that there seems to be some sort of dogmatic position that not one skerrick of this bill will be changed. The minister may say I am saying this because of politics, religious belief, or extremist belief, but I strongly urge every member to support this amendment. This amendment is absolutely crucial to make this the proper, reasonable, fair and balanced bill that I know the minister intends. I will finish on that. I strongly urge members in this house to support the outstandingly ideal amendment put forward by the member for Armadale.

Mr R.H. COOK: I want to clarify a couple of points. Member for Churchlands, I did use the word “treatment”, but I then corrected myself in my comments. It is end-of-life options.

Several members interjected.

Mr R.H. COOK: A number of members drew it to my attention, and I said options at end of life.

Mr S.K. L'Estrange: You are correcting it now, of course.

Mr R.H. COOK: Indeed.

Mr S.K. L'Estrange: If I may make an interjection —

The SPEAKER: No interjections, please. You had your chance to talk.

Mr R.H. COOK: I said that people should be familiar with all the end-of-life options.

Mr P.A. Katsambanis: It was a flourish. It was a slip of the tongue. I accept that.

Mr R.H. COOK: I want to go to the issue that everything a doctor says, a patient does. That is simply not the case. In fact, doctors are already entrusted with a range of life and death medical decisions that are made without the safeguards that are contained in the Voluntary Assisted Dying Bill. For example, death may occur as a consequence of a decision to remove assisted ventilation, cease medical hydration and nutrition, or cease renal dialysis. Such decisions are routinely made by doctors, in collaboration with patients and their families, whether they come from high socioeconomic backgrounds or, as the member for Cottesloe described, are vulnerable people because they come from low socioeconomic backgrounds. We are all, from time to time, confronted with having to work with our doctor to make these sorts of decisions. These decisions are routinely made, in collaboration with patients and their families, and are also open to the possibility of coercion and abuse, yet we trust that process, because medical practitioners have a trusted role within our medical framework. They make these decisions all the time, in conjunction with patients and patients' families. We recognise, as a number of members have commented, that this is a particularly important decision. That is why these added safeguards are baked into the Voluntary Assisted Dying Bill. From that perspective, we believe we have achieved the best balance between the right of patients to be informed about all their end-of-life options, and the safeguards that are needed to protect vulnerable patients who might be coerced, by either someone within the medical or health fraternity or someone in the community, such as a friend or relative. That is why we have put these safeguards in the bill.

Mr P.A. KATSAMBANIS: I rise tonight to congratulate and commend the member for Armadale for the contribution he has made to this debate. I do not say the following words lightly at all. I was first elected to Parliament in 1996 and have been around parliamentary chambers a long time. I have heard a lot of debate. The amazing contribution I heard tonight is almost certainly the one contribution that has profoundly moved me as a legislator—hearing the comments of the member for Armadale tonight and hearing how he spoke lucidly and knowledgeably, with a great amount of research and a lot of personal lived experience. He incorporated that into his contribution because he fundamentally cares about the rights of vulnerable people. He also fundamentally supports the principles and provisions of the bill before us. It was an astounding contribution from a learned individual who truly and utterly believes that what he is proposing will make a better bill, in particular, because it provides protections for the most vulnerable in our society. Through his own lived experience, he highlighted how some sections of the community might be particularly vulnerable to suggestion because they want to please or because of cultural backgrounds—for instance, in Aboriginal communities.

In my contribution to the second reading debate, I spoke about the vulnerability of some people to suggestion from medical practitioners because of their cultural background. I can tell members that in many culturally and linguistically diverse and non-English speaking communities, the doctor, the medical practitioner, is revered. They are held up to a higher standard. Their word is taken almost as gospel. If you want, members should come to my parent's church group, which comprises almost totally elderly first-generation migrants from southern Europe, most of them from Greece. The mere suggestion by a medical practitioner about almost everything, from direct health to broader health, including diet, to perhaps ways that they might communicate with their children or

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grandchildren, is elevated to a status well beyond what it would have if it was a suggestion from another person—perhaps a child, a grandchild or a sibling.

In that way, when we talk about that power imbalance—as the member for Armadale rightly put it, that power imbalance between a medical practitioner and a client is rarely recognised—it may be something that is not obvious to the medical practitioner. It may not be obvious at all. A medical practitioner may not deliberately act in a wrong way or in a pernicious way. They may even not have a clear understanding of the unusual and coercive impact that their words have on that individual, particularly if they do not have an overly longstanding relationship with them.

Mrs A.K. HAYDEN: Can I hear more from the member?

Mr P.A. KATSAMBANIS: It covers a lot of cultural groups, a lot of vulnerable groups in the community. That is why it is important to provide the strongest possible protections for vulnerable people. I want to pick up on the commentary of the Leader of the Opposition, who rightly said that an objection to capital punishment is often couched by many people, including myself, on that one rare case—that is, the one rare case that you want to avoid. The one wrongful death must be avoided. That is how we should view this provision that I believe would rarely come into play. The heartfelt plea from the member for Armadale gives voice to the voiceless. It gives voice to the vulnerable and it ought to be heard by all of us here tonight. It ought to be heeded and it ought to be enacted, because if we do not do it, we are condemning the most vulnerable in our society to a risk that is not worth imposing upon them. It is not fair to impose that risk upon them. I do not think there was a person in this chamber or anyone listening to this debate who was not moved by the personal story that the member for Armadale related. But I also think not too many people cannot extrapolate that personal story out to circumstances that they are aware of through their interaction with their family members, other community members or, in the case of us as legislators, our constituents. We know it is the case. This new clause will not obliterate the provisions of the bill, it will not be a victory for opponents of the bill and it will not even bring into question the learnedness of the body of people who have spent time putting this bill together. It will simply add one more protection, one more safeguard, which is why I implore members to support it.

When I heard the minister's response, initially I was shocked that he mentioned that assisted dying was a treatment option. However, as I sat here before he got up to set the record straight, I thought: "Long time, long night. The minister is there in the chair on his own with a lot of us talking to him. It was a bit of rhetorical flourish, he got a bit carried away and I think he meant it is an available option—it is a choice at the end of life if this bill becomes law." I am glad that I did not have to broach it with him directly and that he got up and put on the record that that is the case, because it never should be considered a treatment option. If it comes into law, voluntary assisted dying will be an available option, but it is certainly not treatment. I digress from the main point of the amendment before us. Again, member for Armadale, congratulations from the bottom of my heart. It will take an extraordinary contribution in whatever time is left for me in parliamentary life into the future for his contribution to be topped. He deserves the plaudits, but in particular the people he is voicing concern for today deserve support for his amendment, and I intend to give that support.

Dr A.D. BUTI: I thank everyone who has contributed to this motion that I put forward. Although I am disappointed with the minister's response, I appreciate him giving me a full hearing. I would like to bring it to a vote, to divide. I move that the vote be put.

Point of Order

Mrs M.H. ROBERTS: My point of order is that that member is not able to move the vote be put, because he has already spoken.

The SPEAKER: We just realised that.

Debate Resumed

Mrs M.H. ROBERTS: I would like to speak on this new clause put forward by the member for Armadale. I have been in the chamber for part of the time and the rest of the time I have listened to the debate on this clause. I think the amendment moved by the member for Armadale is excellent. I am very keen that someone in his own party supports him on his amendment in this chamber, because it is a very good and appropriate amendment. It is not asking the world; it is part of the legislation in Victoria. It is an additional safeguard for people who are vulnerable—the disabled, Aboriginals. I have no idea why it is being opposed in this chamber. I am quite confident that this amendment will get up in the other house. We have wasted a lot of time tonight debating an amendment that will no doubt succeed in the upper house, and, on that basis alone, it should probably have been accepted here so we could move on. There is a big differential between a professional medical doctor and an ordinary person. So many of my constituents are quite intimidated by doctors. They have enormous respect for doctors. There is a huge power imbalance, and members here have reflected on the imbalance between the doctor and an individual, but

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particularly a vulnerable individual such as an Aboriginal. The Attorney General has taken up the cause for Aboriginal people in remote communities, and I have seen in my portfolio Aboriginal people pleading guilty to crimes that they did not commit. They can be very open to suggestion. On that basis alone, I think if people just reflected on that, they would see this new clause is probably more important in Western Australia than in any other state.

I do not want to delay the house. I have spoken for about two minutes. The member for Armadale has my full support with this amendment and I hope it is successful in the upper house. I have no doubt it will be brought back to this house again.

Mr A. KRSTICEVIC: I would very quickly like to pass on my congratulations to the member for Armadale for moving this amendment, because I spoke about this issue in my contribution to the second reading debate. I also spoke about the possibility, especially for people with non-English speaking backgrounds, whose son or daughter could —

Withdrawal of Remark

Mrs A.K. HAYDEN: Point of order, Mr Speaker. I would like you to apologise to me, without me having to say why, for what you just did.

The SPEAKER: It is a good point of order, but you were continually having a go at me. I gave one of your own members the point. I just asked your Whip to go and explain to you.

Mrs A.K. HAYDEN: Point of order, Mr Speaker. I am asking you to apologise without me having to tell the chamber —

The SPEAKER: No. I am not. I was talking.

Mrs A.K. HAYDEN: Point of order, Mr Speaker. I take offence at you putting one certain finger up to your face.

Mr D.A. TEMPLEMAN: Point of order!

Mrs A.K. HAYDEN: I am on my feet with a point of order.

The SPEAKER: I have already made my ruling.

Mrs A.K. HAYDEN: I am offended by the way that your —

The SPEAKER: I am speaking to your Whip. I have made my decision; sit down!

Mrs A.K. HAYDEN: I will now say it in public that you put the finger up to me while in the chair.

The SPEAKER: I beg your pardon?

Mrs A.K. HAYDEN: You know what you did.

The SPEAKER: Now you withdraw that or I will name you.

Mrs A.K. HAYDEN: I will not withdraw. If you are denying that you did that to me —

The SPEAKER: I deny that. I was talking to your Whip.

Mr P.A. Katsambanis: Manager of opposition business.

Mrs A.K. HAYDEN: I am the Whip.

The SPEAKER: Manager of opposition business—sorry. You withdraw that remark.

Mrs A.K. HAYDEN: I will not withdraw, because you know what you did, because you tried to hush me doing it.

The SPEAKER: I call you to order for the first time.

Mrs A.K. HAYDEN: I will withdraw for the rules, but I am very disappointed.

The SPEAKER: No. I call you to order for the second time. It is not about you; it is about the person on their feet.

Debate Resumed

Mr A. KRSTICEVIC: I again reinforce importance of this amendment. I concur with the member for Midland. I think the rational heads in the Legislative Council will listen to the debate in this house and understand that a number of members have some valid concerns and amendments, which for whatever reason are not being accepted in this place. I have no doubt that we will be debating this legislation again in this chamber. The member for Armadale's amendment is very critical because, as I said, when people from non-English speaking backgrounds go to the doctor, they sometimes take their son or daughter with them to discuss things. I used to do that with my late father. I would go to the doctor, interpret for him and talk him through what the doctor was suggesting. Nothing

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would stop a son or a daughter from encouraging the doctor to raise the topic and to discuss it with the father. Again, the son or daughter may well be supportive of the doctor's view and encourage a vulnerable parent who holds the doctor in high regard to go down the path of voluntary assisted dying when they otherwise would not have considered it. This could occur in many circumstances. This area could become a problem.

I do not see anything wrong with the patient raising this as an issue. At the end of the day, we are talking about someone terminating their life and it is probably something they should decide to raise themselves. I do not think they necessarily need someone else to look at them and say, "Hey, have you thought about ending your life as a good idea?" I am sure people who want to go down that path would think of it themselves and raise it with the doctor. I note that some people in this chamber are not listening to rational and intelligent suggestions from the member for Armadale, but I think most people are, and I think it is fair to say that we should give them serious consideration. If this amendment is not passed in this place, I implore the other house to do its best to try to get this amendment through.

Mrs A.K. HAYDEN: I rise to thank the member for Armadale for his bravery in putting forward this amendment. I also thank the member for Midland for her bravery for standing up and speaking to this amendment. I know how difficult it is to stand and talk to an amendment against one's own government. Minister, this is exactly what everybody has raised. I raised this issue in my second reading contribution. If one vulnerable person is not treated respectfully and slips through the cracks, that means this legislation is not worth it.

I simply do not understand. We have had all the debate and I do not need to go through it all again. I do not understand why the minister is so adamant about not including this additional safeguard for the most vulnerable people in our community. I do not understand. It has been put in the Victorian legislation for a reason. I do not understand why the minister is so adamantly opposed to it. I would like an explanation from the minister of why he is so adamant not to insert this new clause. If the government were to put in this new clause, what adverse effect would it have on the legislation? The only effect I can see this amendment having is to assist and put in another safeguard for our vulnerable and the people in our community who need it the most. I would really like an explanation of why the minister so adamantly does not want to put it in the legislation. What adverse effect would it have on the legislation?

Mr R.H. COOK: I think I have made my position very clear and I have explained all the issues, but I thank the member for her contribution.

Dr D.J. HONEY: I wish the minister to correct something he said earlier. My understanding is that the minister said that I referred to people from lower socioeconomic groups. I certainly did not refer to those. I referred to people from Aboriginal communities and then I said that the concerns for those communities were the same concerns I had for other isolated communities where a doctor is an esteemed figure in the town. I believe the minister should reflect that I did not refer to lower socioeconomic groups.

Mr R.H. COOK: I apologise if I misrepresented the member's position. I referred to the comments the member made about Oregon and low socioeconomic and therefore vulnerable groups there. If I mischaracterised those comments, I apologise. It is true that doctors have a lot of power, and the member raised that issue. Doctors already make suggestions around a range of end-of-life decisions such as whether to continue to ventilate or keep someone on life support or whether a patient should withdraw from chemotherapy or dialysis. The logical extension of what the member is suggesting is that they should not have those discussions either. Everyone in this place would agree that doctors need to have the full range of these discussions. I thank everyone for their contributions this evening and, once again, I thank the member for Armadale. It has been a good ventilation of the issues and from that perspective, Mr Speaker, I think we should move forward.

Question to be Put

Dr A.D. BUTI: I thank everyone for their contribution. After checking with the Clerk, I move —

That the question be now put.

Question put and passed.

Division

New clause put and a division taken with the following result —

Dr David Honey; Mr John McGrath; Mr Roger Cook; Mr Peter Katsambanis; Ms Margaret Quirk; Mrs Liza Harvey; Mrs Alyssa Hayden; Dr Mike Nahan; Mr Zak Kirkup; Mr Sean L'Estrange; Dr Tony Buti; Mrs Michelle Roberts; Mr Tony Krsticevic; Mr Bill Johnston

Ayes (17)

Dr A.D. Buti	Mr P.A. Katsambanis	Mr W.R. Marmion	Mrs M.H. Roberts
Ms J. Farrer	Mr Z.R.F. Kirkup	Ms L. Mettam	Mrs A.K. Hayden (<i>Teller</i>)
Mrs L.M. Harvey	Mr A. Krsticevic	Dr M.D. Nahan	
Dr D.J. Honey	Mr S.K. L'Estrange	Mr D.C. Nalder	
Mr W.J. Johnston	Mr R.S. Love	Ms M.M. Quirk	

Noes (34)

Ms L.L. Baker	Mr D.J. Kelly	Mrs L.M. O'Malley	Mr C.J. Tallentire
Mr J.N. Carey	Mr F.M. Logan	Mr P. Papalia	Mr D.A. Templeman
Mrs R.M.J. Clarke	Mr M. McGowan	Mr S.J. Price	Mr P.C. Tinley
Mr R.H. Cook	Mr J.E. McGrath	Mr D.T. Punch	Mr R.R. Whitby
Ms M.J. Davies	Ms S.F. McGurk	Mr J.R. Quigley	Ms S.E. Winton
Mr M.J. Folkard	Mr D.R. Michael	Mr D.T. Redman	Mr B.S. Wyatt
Ms J.M. Freeman	Mr K.J.J. Michel	Ms C.M. Rowe	Mrs A. Sanderson (<i>Teller</i>)
Ms E.L. Hamilton	Mr S.A. Millman	Ms J.J. Shaw	
Mr M. Hughes	Mr Y. Mubarakai	Mrs J.M.C. Stojkovski	

New clause thus negated.

Clause 10: Contravention of Act by registered health practitioner —

Mr Z.R.F. KIRKUP: Clause 10 states —

- (1) A contravention of a provision of this Act by a registered health practitioner is capable of constituting professional misconduct or unprofessional conduct for the purposes of the *Health Practitioner Regulation National Law (Western Australia)*.

Does that restrict any other criminal charges that might apply, or anything like that? Does it restrict any other criminal matters?

Mr R.H. COOK: No, it does not.

Mrs L.M. HARVEY: Could the minister please advise what the penalty for professional misconduct or unprofessional conduct would be?

Mr R.H. COOK: There are a range of penalties under the Australian national law. It may come down to sanctions from the professional body associated with it. Ultimately, it may come to essentially forming a view that that person is no longer fit to remain in that profession. As the member will understand, the regime that the Australian Health Practitioner Regulation Agency works under is extensive. We could come back to a range of contraventions that could typically be contemplated, and how they are typically dealt with under that law, but, as I said, each of them is dealt with under their own professional bodies.

Mrs L.M. HARVEY: Clause 10(2) states —

Subsection (1) applies whether or not the contravention constitutes an offence under this Act.

Can the minister explain that clause?

Mr R.H. COOK: This clause provides that where a registered health practitioner contravenes a provision of the act, that contravention, as one would expect, is capable of also constituting a professional misconduct or unprofessional conduct. Professional misconduct or unprofessional conduct will be ascertained pursuant to the Health Practitioner Regulation National Law (WA) Act. A contravention may be an act or an omission of an act, but even where the act or omission is found not to be a criminal offence—that is, it does not trigger those offence provisions under this act in terms of criminality—the act or omission may still be considered professional misconduct or unprofessional conduct. It may not trigger the criminal sanctions associated with this act; however, ultimately, it may still trigger regulatory framework for the medical profession.

Mr Z.R.F. KIRKUP: I am keen to understand: With the contravention of any provision, who would assess that a contravention has been made? Under the existing practices of the Health Practitioner Regulation National Law (WA) Act, is it the practices as they stand? How would a contravention be assessed and a conclusion arrived at?

Mr R.H. COOK: I am advised that AHPRA would be the responsible enforcement agency. AHPRA's attention may be drawn to it by either the CEO or potentially the Voluntary Assisted Dying Board.

Mr W.J. JOHNSTON: I said to the minister that I would ask a couple of questions to get matters on the record. I just want to confirm, if we look at clause 10(1), we see that an example of a contravention might be a failure by a medical practitioner to provide the information required by clause 19(5)(b). Clause 19(5)(b) directs the medical

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practitioner to give the patient the information referred to in clause 19(4)(b), that being the information approved by the CEO. If a doctor fails to give the information prescribed there, is that an example of something that would be in contravention of the provision and could be capable of constituting professional misconduct?

Mr R.H. COOK: Yes.

Mr P.A. KATSAMBANIS: I seek a little clarification. In the absence of this provision, would a contravention of this bill not be capable of constituting professional misconduct or unprofessional conduct for the purposes of the national law? My understanding is that it would be unaffected because this bill will not amend the national law. I do not have any objection to this provision being in the legislation. I think it is good for completeness. But does the minister have any advice about what the ill would be if this clause did not exist?

Mr R.H. COOK: The member is right. It is to provide clarity.

Dr D.J. HONEY: I have a question following on from the Minister for Mines and Petroleum. If a medical practitioner who has a profound objection to voluntary euthanasia refuses to pass on information to a person so that they can access voluntary euthanasia, could they be charged with professional misconduct or unprofessional conduct?

Mr R.H. COOK: As the member said and the member for Cannington observed, that potentially could be found to constitute professional misconduct or unprofessional conduct. Whether there would be sanctions or any implications of that is entirely the purview of the Australian Health Practitioner Regulation Agency.

Dr D.J. HONEY: I know this might sound obvious, but if a medical practitioner refused to participate by submitting a form to the CEO rejecting being involved in the process, would that apply as well?

Mr R.H. COOK: It could. I think the member means that the form had been sent to the Voluntary Assisted Dying Board, but it could. It would not automatically trigger that process. Whether there is a sanction is entirely up to the national law.

Mr S.K. L'ESTRANGE: Picking up on the contravention of the act, if a mistake is made, what remedies would be available to a patient or, in the worst-case scenario, a family that is left, after a malpractice has occurred with wrong advice or whatever?

Mr R.H. COOK: The remedies under this bill, as the member would be aware of, are detailed in the relevant clauses. The remedies, as the member has said, under the national health practitioner law would, essentially, relate to the way that AHPRA views the severity of the offence.

Mr S.K. L'ESTRANGE: Is the minister intending to establish some sort of redress scheme attributed to any contraventions of the legislation?

Mr R.H. COOK: No.

Ms M.M. QUIRK: I am curious about how this contravention or allegation of misconduct gets to the various medical boards. Is it referred by the board? I am not quite sure about the process and who investigates it.

Mr R.H. COOK: There is a range of ways that the Australian Health Practitioner Regulation Agency might be made aware of the issue, including through its own observation of circumstances. An individual could refer to AHPRA an accusation of misconduct or otherwise by a medical practitioner. Ordinarily, one would expect the chief executive officer or the Voluntary Assisted Dying Board to refer to AHPRA, and of course the Health and Disability Services Complaints Office would be another such entity. Once they have undertaken their own investigations, they would refer their evidence on to AHPRA.

Ms M.M. QUIRK: What are the procedures for referring it to one of those bodies? For example, is material disclosed to the practitioner before the findings? It is not clear from here whether it is a different process from what is normally adopted for medical negligence or misconduct.

Mr R.H. COOK: What is referred to AHPRA in that particular instance is the conduct of the medical practitioner, so that would not ordinarily require disclosure in relation to the actual patient. AHPRA, of course, has authority to undertake its own investigations, make findings as a result of those investigations, and provide sanctions and penalties commensurate with its legislation.

Ms M.M. QUIRK: By way of interjection, this is expanding the nature of conduct that can be regarded as being professional misconduct; is that correct?

The SPEAKER: Can the member talk up a bit, or get a bit closer to the microphone?

Extract from *Hansard*

[ASSEMBLY — Wednesday, 4 September 2019]

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Dr David Honey; Mr John McGrath; Mr Roger Cook; Mr Peter Katsambanis; Ms Margaret Quirk; Mrs Liza Harvey; Mrs Alyssa Hayden; Dr Mike Nahan; Mr Zak Kirkup; Mr Sean L'Estrange; Dr Tony Buti; Mrs Michelle Roberts; Mr Tony Krsticevic; Mr Bill Johnston

Ms M.M. QUIRK: I will stand up, then. This clause is effectively expanding the categories of conduct that may well lead to charges and adjudication or allegations that there has been professional misconduct or unprofessional conduct.

Mr R.H. COOK: Technically, yes, but ultimately it simply draws a ring around the full range of clinical practices that a medical practitioner undertakes and, in any sort of clinical setting, the rules and regulations of their profession that they are obliged to follow.

Clause put and passed.

Debate adjourned, on motion by **Mr D.A. Templeman (Leader of the House)**.