

Mr Zak Kirkup; Mr Roger Cook; Dr David Honey; Mrs Alyssa Hayden; Mr Vincent Catania; Mr Terry Redman; Mrs Liza Harvey; Ms Margaret Quirk; Amber-Jade Sanderson; Mr Peter Katsambanis; Dr Mike Nahan; Mr John McGrath; Mr Bill Marmion; Mr Sean L'Estrange; Mr Donald Punch; Mr Tony Krsticevic; Deputy Speaker; Mr Shane Love

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## VOLUNTARY ASSISTED DYING BILL 2019

### *Consideration in Detail*

Resumed from 3 September.

Debate was adjourned after clause 4 had been agreed to.

#### **Clause 5: Terms used —**

**Mr Z.R.F. KIRKUP:** We are dealing with the terms used in the legislation. I am sure there are a number of questions from members about a range of the terms used. I was keen to get more clarity on one of the terms if I could. I am conscious of the principles that we have discussed and the minister's second reading speech. Page 4, line 28 of the bill states —

*contact details*, in relation to a person, includes the address, telephone number and email address of the person;

In a remote or regional context Aboriginal people might not have a fixed address, email address or anything like that. Can the minister provide some insight into how that might work when an individual might not have a fixed address? I am aware that throughout the legislation there is a requirement for contact details of the patient to be provided to the Voluntary Assisted Dying Board throughout the process. What happens in the event that they do not have contact details? Does that interrupt their ability to access voluntary assisted dying should they choose to do so? What does that look like?

**Mr R.H. COOK:** Member, I am advised that this is a standard approach. However, we would be including this information on contact details, but one would anticipate that there would be other information about the ongoing therapeutic relationship with the patient involved, which will be included in that process consistent with the circumstances of that patient.

**Mr Z.R.F. KIRKUP:** If I could get some confirmation or satisfaction about this. By way of example, I am going to keep using an Aboriginal person in a remote setting who may not have a contact address. Does that interrupt their ability to access VAD?

**Mr R.H. COOK:** No, member.

**Mr Z.R.F. KIRKUP:** In a similar situation, and being conscious of the minister's earlier comments, there is obviously the ability for more details to be provided to the board through the form. For clarification, is the minister suggesting that it is likely that more information will be garnered or is this just the basic and bare minimum?

**Mr R.H. COOK:** I could not put it better myself, member. Yes.

**Dr D.J. HONEY:** I cannot see in the definition section a definition of the assisted dying substance. One of my concerns with this bill is that it appears to have been constructed so as to avoid any possible controversy, if you like, or anything that could trigger some criticism of it. We had an extensive discussion yesterday on the short title. Throughout the bill, reference is made to the assisted dying substance. It is obviously the key part of the process; that is the thing that kills the person. Why is there not a definition of the assisted dying substance in the definition section?

**Mr R.H. COOK:** "Voluntary assisted dying substance" is defined under clause 7 and on page 8, line 10, and "prescribed substance" is defined on page 6, starting at line 28.

**Dr D.J. HONEY:** Why would that not be put in the definition section so people do not have to search for it in the bill? It is a key part of it. I am not sure why things are put in that definition section otherwise. That would appear to be a critical definition for interpreting this bill.

**Mr R.H. COOK:** I draw the member's attention to the definition section on page 6, line 28, and page 8, line 10, where both of those specific items are clarified. The member can also refer to clause 7, which provides further clarity on a voluntary assisted dying substance.

**Mr Z.R.F. KIRKUP:** On page 6, line 1, the definition of "medical practitioner", as it stands, is —

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

Can the minister provide us with some examples as to which practitioners might be captured within that? I have looked at the Health Practitioner Regulation National Law (WA) Act —

**Mr R.H. Cook:** That's a laugh.

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**Mr Z.R.F. KIRKUP:** Yes, it is a good fun read. It is very general in what it provides. Can the minister provide some insight as to the professions that would be covered by that provision?

**Mr R.H. COOK:** I draw the member's attention to clause 16 on page 13, which sets out the specific details of what a medical practitioner is. For further clarity on that, we make the distinction between a medical practitioner and a health practitioner, which is a broader definition.

**Mrs A.K. HAYDEN:** I want to follow the line of questioning by the member for Cottesloe about the definition of "substance". Can the minister explain to me why the word "substance" is the choice of terminology?

**Mr R.H. COOK:** I am advised that it is to create consistency with the Medicines and Poisons Act 2014.

**Mrs A.K. HAYDEN:** Why are we not simply outlining it as it is outlined under the poisons act, and under clause 7 as the minister alluded to earlier, that a substance means a schedule 4 or schedule 8 poison approved by the CEO under the Voluntary Assisted Dying Bill in order to cause a person's death? The terms "schedule 4 poison" and "schedule 8 poison" are defined in section 3 of the Medicines and Poisons Act. Why are we not simply calling it a poison?

**Mr R.H. COOK:** As I pointed out in both of my contributions to the second reading debate, one of the strengths of our legislation is that it borrows all the regulatory robustness of the Medicines and Poisons Act. Under the Medicines and Poisons Act, "substance" includes a compound, preparation, mixture or plant. The member would understand that in that context it is absolutely appropriate to use the same language in the Voluntary Assisted Dying Bill.

**Mrs A.K. HAYDEN:** On that line of questioning, it is going to be more than just a poison. It could be a plant or an abstract—anything. Is the minister able to advise what will be in that substance? There is a definition for substance, there is a meaning for substance, but we do not know what the substance is.

**Mr R.H. COOK:** As the member would have seen mentioned in several aspects of the debate, but also in terms of the bill, it is anticipated that it will be either a schedule 4 or schedule 8 drug as defined under the Medicines and process would take care of under the guidance of the clinical oversight committee.

**Mrs A.K. HAYDEN:** The minister just said it will be a schedule 4 or schedule 8 drug. It is actually a poison, so let us get the terminology right. A schedule 4 drug is a poison; a schedule 8 drug is a poison. As I outlined in my speech in the second reading debate, and as I outlined last night, the terminology and language that has been chosen to be used throughout this legislation is, in my opinion, a little soft. It disguises what it actually is. The minister just referred to a schedule 4 drug; it is a schedule 4 poison.

**Ms A. Sanderson:** Morphine is a poison under what you are saying. That is the logic you are putting to the chamber.

**Mrs A.K. HAYDEN:** What I am trying to say is that this legislation refers to a schedule 4 poison and a schedule 8 poison; the legislation uses the terms "schedule 4 drug" and "schedule 8 drug". We need to make sure that the language used in this bill is easy for people to understand and follow. If it looks like a duck and sounds like a duck, it is a duck.

**Mr R.H. COOK:** I recall a number of aspects of the member's speech, so I will reflect on those as I provide this answer. Essentially, all poisons are a substance, but not all substances are a poison. As was mentioned in my previous response, we have nominated a schedule 4 or schedule 8 poison, having their meaning as given in section 3 of the Medicines and Poisons Act 2014 and contained within the national Standard for the Uniform Scheduling of Medicines and Poisons. Schedule 4 drugs are prescription-only medicines or a prescription animal remedy. They are substances the use or supply of which should be by or on the order of persons permitted under the act to prescribe, and should be available from a pharmacist on prescription. Schedule 8 drugs are controlled drugs. They are substances that should be available for use, but require restriction on manufacture, supply, distribution, possession and use to reduce abuse or misuse or physical or psychological dependence.

I recall that the member asked in her speech in the second reading debate for us to clearly set out what particular drugs would be used. Respectfully, we will not do that, and there are a number of reasons for that. Obviously, information in relation to those drugs is sensitive for the public health and the good of the community. Also, we do not want to create a situation whereby we are essentially nominating a drug in the legislation and throwing up flags for the particular company, whichever it may be, to say, "Great—if they all have to use my drug, guess what happens to the price of the drug?" I recall that the member spoke at length in the second reading debate about the issue of affordability. Obviously, that comes very much into sharp focus if we nominate the specific drug. I am reminded that that is essentially what happened in Hawaii when its legislation pointed to a specific drug in use—ultimately, the price of that drug skyrocketed.

**Extract from Hansard**

[ASSEMBLY — Wednesday, 4 September 2019]

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The member would have heard from interjections in the chamber that it is the nature of medicines that some are poisonous and used in a therapeutic way to produce particular health outcomes. It is simply part and parcel of the medical profession's tools of trade.

**Mrs A.K. HAYDEN:** I thank the minister very much for his response. I really appreciate the manner in which he is doing this. I understand that the minister is trying to keep costs down. At the end of the day, the state government will have to foot the bill. The minister said that he would not release information on what the substance will be made up of, but will the minister be advised confidentially of what the decided substance will be? Will someone be advised of that? There has to be some oversight. I do not mean an elected board or certain CEOs; I mean at a parliamentary level.

**Mr R.H. COOK:** I would not be ordinarily; it is one of the requirements, or duties, that is specified under the legislation for the chief executive officer, which, of course, in ordinary language, means the director general. I understand the director general will also be advised by a clinical panel that will provide advice on what schedule 4 and schedule 8 drugs could be included in the voluntary assisted dying substance.

**Mrs A.K. HAYDEN:** On that note, what will happen if something does go wrong? How could a government step in and say, "What are you using? There's something going wrong"? What will be the avenues for government to find out what substance is being used to make sure that nothing adverse is going on and there are no unintended consequences? We have to remember that we are legislating for the worst-case scenario, not the best-case scenario. If the minister or the government of the day is unaware of the substance and what makes up that substance, at what point could the government intervene? At what point would the government have the knowledge and the ability to ensure that the legislation it created and put in place was able to deliver on its intent and question what was being used? As we all know, once the deal is done, if those people have suffered any pain, they will not be coming back to tell us.

**Mr R.H. COOK:** As everyone in this place would be aware, the health system is under acute surveillance at any point in time—I refer members to the member for Dawesville. In addition to that, obviously, there will be patient records, prescriptions and any death that is inconsistent with this act will be referred to the State Coroner. There are critical incident reports that take place in any health setting, be it in a hospital, aged-care setting and so on. There is critical oversight of all these things by the director general as the system manager. The member would be aware of a range of forums that take place in which we examine root cause analysis and other forums in which we look at any adverse medical outcome.

**Mr V.A. CATANIA:** Staying on page 6 and clause 5, I refer to the definition of "nurse practitioner". Can the minister outline to members the role nurse practitioners would play under this legislation and his thoughts on the role of nurse practitioners?

**Mr R.H. COOK:** The member would be familiar that the ministerial expert panel, which our friend here, Malcolm McCusker, chaired, recommended that nurse practitioners should be a consulting practitioner in relation to the voluntary assisted dying process. We thought that we should take a more cautious approach, but we did foresee a role for nurse practitioners as potentially an administering practitioner. The member would be familiar with nurse practitioners and the rigorous nature of their training for postgraduate qualification. In that context, we envisage the nurse practitioner playing only a single role—that is, as potentially the administering practitioner.

**Mr V.A. CATANIA:** Can the minister elaborate on the role of nurse practitioners as an administering practitioner? Would they play a role as part of the panel, as well as another doctor or nurse practitioner? Would they be able to sign off, for want of a better word, to enable a person to progress along the voluntary assisted dying pathway?

**Mr R.H. COOK:** I am advised that the answer is no. The nurse practitioner cannot play the role of either the coordinating or the consulting practitioner. Although we do foresee a situation in which potentially a nurse practitioner could be the administering practitioner, which is a role delegated from the coordinating practitioner to create the role of the administering practitioner.

**Mr V.A. CATANIA:** In terms of any consultation that has occurred with, say, doctors—that is, the Australian Medical Association or the Department of Health—have concerns been raised about any role that nurse practitioners may play in this process? The minister said that it is only an administering role—that is, obviously administering the substance. Has any consultation been done with doctors around that issue?

**Mr R.H. COOK:** I have received advice from both Malcolm McCusker and the departmental officials to say that the AMA was of the view that doctors should not be involved in any part of the process and certainly did not want nurse practitioners to be either the coordinating or the consulting practitioner. It did foresee a situation in which the nurse practitioners could be an administering practitioner. My understanding is that the nurse practitioner

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representatives are keen for them to be involved in as much of the process as possible. We have defined it around that single role.

**Mr D.T. REDMAN:** We are debating clause 5. We have definitions in legislation to give clarity to the exact scope of the words used. My question is not directed to a particular word in the definitions clause but one that is not. Although it will be considered in due course, I refer to clause 15(1)(c)(iii), which in reference to a diagnosis states —

is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable;

Why is there no definition of suffering in the legislation? I ask that because the word “suffering” when used in the natural sense refers to pain. If someone is in pain, they have an issue and we have to try to relieve that pain. Suffering can have a much wider scope to include emotional and spiritual pain. It has been put to me that the word “suffering” in this context is being used in its widest scope. I would have thought that suffering might have been defined so that there is no ambiguity around the intent of the legislation in respect to a person who is suffering and whether the full scope of the word should be used or considered in the assessment of the nature of a person’s suffering. Why is suffering not defined in the legislation to clarify its use?

**Mr R.H. COOK:** I thank the member for raising the issue. Suffering is not defined because it is entirely subjective. I think the member for Kalgoorlie spoke quite a lot about one person’s suffering being another person’s niggle. From that perspective, it is to resolve issues of suffering as felt by the person involved. The Joint Select Committee on End of Life Choices and the ministerial expert panel formed the view that a patient’s suffering was an intensely personal experience and may take a variety of forms, such as physical, mental, emotional, social, spiritual or existential.

**Mrs L.M. HARVEY:** I want to go back to the definition of substances to pick up on something the minister said in his response. All the way through this debate the minister has been saying that he expects a small number of people to access voluntary assisted dying, so it does not make sense to me that by naming a substance in Hawaii, the price escalated rapidly. I would like the minister to explain a little more about why that happened, because if we do not have thousands of people wanting to access the drug, why would the price escalate?

**Mr R.H. COOK:** The circumstance in Hawaii was that the specific drug that had to be involved was named. Regardless of how much it was used, the price reflected the monopoly market that was created as a result. The member is right; this will apply to a smaller number of people than perhaps many people would like. I think the member for Moore spoke about that in his second reading contribution. A lot of people will be disappointed by this. The member is absolutely correct to characterise it as a small number of people. These substances are obviously very important to the process and to the public health issues that are involved as well. I have been subsequently advised that in Hawaii the price went from \$70 to several thousands of dollars. We know what drug companies are capable of, so from that perspective I think we have moved in a prudent manner.

**Mrs L.M. HARVEY:** Thank you for explaining that; that actually makes a lot more sense, because it did not make sense to me why, if a small number of people are accessing a drug, the price of the drug would go up. I understand that there is some sensitivity around this. We do not really want to be advertising the drugs that people can use to end their lives, but it is well known that we have problems with fentanyl overdoses. We know that morphine is administered as a form of palliative sedation, and for people with respiratory difficulties, that hastens their death, unfortunately. It is a balance that the medical fraternity manages at the moment. We know that sodium barbital is involved in palliative sedation. Are these the sorts of drugs that are likely to be used and prescribed by the CEO, or are there other drugs that we are not aware of? I accept that the minister is not going to want to name a specific drug that might give a particular company a market advantage, but we are just trying to get an idea of whether these are readily available substances that are currently prescribed or whether a new drug is likely to be used for this purpose.

**Mr R.H. COOK:** I am advised that, ultimately, the drugs involved in this process will be oversighted by a clinical panel, so I would not want to pre-empt the decision that it will make. The drugs would also have to be appropriate for the individual and their circumstances. The member would understand that a person who cannot absorb drugs orally would require a different form of voluntary assisted dying substance. It is also specifically for the Western Australian setting, where some communities may be more isolated than others. The member is quite right to nominate the issue of the abuse of prescription drugs. Many drugs that can do great harm to the community are already out there, so it is important that we proceed with these things very carefully.

**Mr Z.R.F. KIRKUP:** I refer to the definition of “prepare” at line 21 on page 6. I note that the word is used a number of times—in the administration decision, the administering practitioner, and a number of different iterations throughout the bill. There is obviously a need for the patient or the administering practitioner to prepare the substance in some way, shape or form. I note that a definition of “prepare” has been provided in this case. Is it

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required that the substance be prepared? Are we anticipating a substance that needs to be prepared in order to be self-administered in that instance? In that case, we would have some comfort, therefore, that it is not just a singular pill, but there would be a step involved in the process, given that it is stated a number of times in the legislation that the patient must prepare the substance.

**Mr R.H. COOK:** I am advised that a combination of drugs may be involved. It may also be a combination, to give a typical example, of an active ingredient or medication that may be very bitter and a substance to make it more palatable. In this context, it provides the authority to make that preparation.

**Mr Z.R.F. KIRKUP:** I appreciate the minister's response. I am concerned because part (b) is a bit of a chemistry summary—decant, dissolve, reconstitute. This puts a lot of onus on the patient, particularly if they come from a disadvantaged background and may not be able to undertake such a task. It is obviously not prescriptive; it just gives the option for that to occur. Why was the flavouring and colouring, in particular, included as part of the preparation definition?

**Mr R.H. COOK:** I am advised that it is consistent with common practice under the Medicines and Poisons Act 2014. I cannot provide the member with a technical description of the role that colour might play in that process, but clearly in that world, all these things need to be considered.

**Ms M.M. QUIRK:** I refer to the absence of the term “palliative care” amongst the definitions provided in clause 5. I drafted an amendment that referred to the definition in the Guardianship and Administration Act, and the minister indicated that that was too narrow and outmoded. Overnight, in my spare time, I have drafted another amendment that I think better reflects the minister's view of current palliative care practice. I move —

Page 6, after line 10 — to insert —

*palliative care and treatment* includes a medical, surgical or nursing procedure or other treatment or service that is directed at identifying or relieving the pain, discomfort or distress of a person who has been diagnosed with at least 1 disease, illness or medical condition that is advanced, progressive and incurable and will cause death;

The minister will see that the word “incurable” is included. It was used elsewhere in the legislation, but it is in the same form as the Victorian legislation. This definition was partially based on the definition on page 18 of the “WA End-of-Life and Palliative Care Strategy 2018–2028”.

**Mr R.H. COOK:** I thank the member for her amendment. As I confirmed to the house last night, palliative care is not defined in the bill, as the contemporary common meaning will apply and is associated fundamentally with the principles or values which underscore it. In the context of this bill, the term “palliative care” is used in three provisions in which it does not need defining. First, it is used to set out the principle that a person has the right to be supported in making informed decisions about the person's medical treatment and should be given, in a manner that the person understands, information about the medical treatment options, including comfort and palliative care. The second one requires the coordinating practitioner, if satisfied that the person meets all the eligibility criteria, to inform the person about the palliative care options available to the person and the likely outcomes of that care. The third provision requires the consulting practitioner, if satisfied that the person meets all the eligibility criteria, to inform the person about the palliative care options available to the person and the likely outcomes of that care. I respectfully submit that we do not need to have a definition of “palliative care” to meet the needs of the bill. Ultimately, I would have some difficulty with the wording that the member used. Without going to the substance of the actual definition, I come back to the key point that a definition around palliative care is not needed.

**Ms A. SANDERSON:** I am also of the view that this is not an appropriate amendment. It is not appropriate to be defining medical treatments in legislation. Medical treatments evolve over time and develop with new technology and new treatments. It would be inappropriate to actually define what those treatments are. Palliative care is different according to different palliative care specialists. One person's idea of palliative care is different from another person's idea of palliative care, so defining it is virtually impossible and would be incredibly restrictive under the legislation. I will not be supporting the amendment. If a person goes to one hospice to seek palliative care treatment, they will get one set of treatments; if they went to another palliative care specialist, they would get another set of treatments. Some palliative care specialists believe in the mind-body-soul treatment of palliative care. Other palliative care specialists believe in the treatment of pain and that patients are able to resolve their own spiritual issues at the end of life. It is a very broad area of medicine. I think it is very dangerous and unhelpful to start defining medical terms and treatments in legislation. We are not doctors. Essentially, if this amendment were passed, it would be in place for many, many years to come.

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**Ms M.M. QUIRK:** The member for Morley has actually hit it on the head. I do not know whether she has a copy of the amendment in front of her, but this amendment uses the word “includes”. The member also mentioned that palliative care means different things to different people. We are going on trust in terms of clause 26, for example, under which a medico will be placed under an obligation to advise a patient of the availability of palliative care. He could be in legal jeopardy if he does not do so, yet we do not know what he will be telling his patients. I know that some form of words may be developed by the CEO, but I make the point that this amendment—and I accept that it is not perfect—is inclusive of other broader definitions, as the member for Morley talked about, because it uses the word “includes” and refers to relieving pain, discomfort or distress. That covers psychosocial issues as well as pain management and spiritual issues. It is a broad definition for that reason. If anything, when I sent the amendment to parliamentary counsel, I did not have something about the timing of palliative care, but for the convenience of drafting, I have omitted that. I am just perplexed, because the term is used throughout the bill and obligations are placed on doctors to advise patients of the availability and prognosis of palliative care, but nowhere is the term defined.

**Mr P.A. KATSAMBANIS:** I thank the member for Girrawheen for bringing this amendment to the house. This is an issue that we identified last night in consideration in detail when we were going through earlier clauses. It is obvious that the term “palliative care and treatment” is not defined in the legislation, although it is used extensively. As I pointed out last night, or early this morning, this term is defined in the Victorian legislation. Perhaps the Victorians are lucky that they have an existing legislative framework that includes a definition of the term “palliative care”. In the only other Australian jurisdiction that has live legislation in this very complex area, it was clearly considered vital that the term “palliative care” be defined in the legislation. As we discussed last night with the minister—I think the minister was quite accepting of the general concept—these sorts of definitions ought to be inclusive rather than exclusive. We were not talking about palliative care at that time; we were talking about the concept of abuse.

However, irrespective of the word or term that is being defined, because of advances in medical science, because of changes in theory or concept around treatment, and simply because some people have a different definition from others, it is better to have an inclusive rather than an exclusive definition when defining these sorts of terms. But we do need a starting point—a baseline—of what an important term such as “palliative care” ought to be in relation to this legislation. That is magnified when we then consider the debate more broadly around funding for palliative care and the need to ensure that palliative care is available where it is needed and when it is needed, so that it is one of the genuine, realistic options available to a patient and that it is not just simply an option to which we pay lip-service but cannot provide in reality, whether it is in the metropolitan area, the suburbs, regional towns and cities or more remote areas of Western Australia. It presents challenges. I recognise that it presents challenges to provide palliative care in any setting, let alone a setting such as our state with its extraordinary geographic reach and far-flung population. Many members of our population live in small groupings—one would not call them more than villages, really—in extraordinarily inaccessible locations. If we are to live up to and achieve the lofty principles that are outlined at the start of this bill and the principles in clause 4, which we debated so well last night, including the principle that a person is entitled to genuine choices about the person’s care, treatment and end of life, irrespective of where the person lives in Western Australia, and having regard to the person’s culture and language, a starting point would be to know what we are talking about. A definition of “palliative care” would be critical to that. I think everyone accepts that palliative care ought to be one of those genuine choices. Given the similarity, in many respects, of our legislation to the Victorian legislation, including —

**Dr M.D. NAHAN:** I would like to hear further from the member for Hillarys.

**The ACTING SPEAKER:** Member for Hillarys, carry on.

**Mr P.A. KATSAMBANIS:** Given the close proximity of the wording of the principles in the Victorian legislation and the proposed Western Australian legislation, given the extraordinarily critical importance of the availability of palliative care in relation to giving people legitimate, genuine choices about their care and treatment at the end of life, and given that the Victorians chose to provide a definition, I think it is axiomatic that this legislation have that very same definition. It is an inclusive definition, rather than an exclusive or exhaustive one. However, it gives us a starting point for what palliative care may entail so that we can then fund that care in order to provide those genuine choices. Without a definition, we will constantly debate whether new money is going to palliative care. The member for Girrawheen, who made a substantive and excellent contribution to the second reading debate, highlighted, by the table that she provided, the question marks about what may or may not be palliative care funding. There is genuine concern in the community that legislation such as this may actively encourage governments—perhaps not this government or the next government, but governments in the future—to treat the provisions in this bill as the primary way of dealing with people at end of life. In my contribution to the second reading debate, I described that as a humanitarian tragedy of the highest order, and it would be. I know that is not the intention of

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this minister; I know that is not the intention of the Premier. They have both indicated that they want to provide greater funding for palliative care. However, at the moment, all we can do is take them at their word. We have not seen that additional funding. We hope it is provided, and we hope it is provided in the context of the debate on this bill. However, without even a definition in the bill, and in the act if this bill eventually becomes an act, we will not even have a starting point.

The member for Girrawheen indicated in her contribution that she would be happy to consider alternatives. I do not want to speak for other members, but if the definition provided by the honourable member for Girrawheen is not acceptable to the minister, I also will be happy to consider alternatives. It would be a fundamental flaw if this definition were not included in the legislation. The reason it would be a fundamental flaw is that palliative care ought to be a primary and genuine choice. I will leave it to the minister. We know how the weight of numbers in this place is used from time to time. This proposed amendment has not been brought into this place out of malice or spite. It has been brought simply to make this legislation better. I think it would make it better. As I have said, it would be a travesty if we allowed a disagreement about the wording to stop us from providing an appropriate definition in the bill.

**Mr J.E. McGRATH:** I, too, will not be supporting the amendment. I was a member of the joint standing committee, which looked at this subject over 12 months, and went with a palliative care nurse to hospitals at which palliative care was provided. I know that palliative care is a wideranging health service that people can avail themselves of. We all agree that palliative care is an essential element of our health system for people who are dying. I want to raise an interesting point. In 2008, the then government made an amendment to the Criminal Code to protect doctors who administer palliative care. That amendment did not include a definition of palliative care. Therefore, if I am to believe what members are saying now, what went wrong back then? I think the reason that no definition was provided is that palliative care is such a wideranging medical service that it is very hard to define. That is my view.

**Mrs A.K. HAYDEN:** I congratulate the member for Girrawheen for this proposed amendment. The minister referred to the Victorian legislation as a come-back to some of the questions that have been asked by members on all sides about why things are the way they are in the legislation. The minister said it is in the Victorian legislation and that is why we are doing it. This proposed definition is in the Victorian legislation, yet the minister has chosen not to include it in this legislation. The minister has said that this legislation is benchmarked on the Victorian legislation. The minister cannot use that to support one argument and not another. I struggle with why the minister is not willing to include that definition in this legislation. I understand the argument that has been put against this proposed amendment—namely, that palliative care is very broad. However, I honestly believe that is encapsulated in this proposed amendment. I will read the amendment, in case members have not read it —

*palliative care and treatment* includes a medical, surgical or nursing procedure or other treatment or service that is directed at identifying or relieving the pain, discomfort or distress of a person who has been diagnosed with at least 1 disease, illness or medical condition that is advanced, progressive and incurable and will cause death;

That is as broad as we can make it. Palliative care is broad. It is also a major step in this legislation that an individual must go through, and should go through, before they can access voluntary assisted dying. However, that major step in this assisted dying process has not been defined in this clause. We are talking about a simple request to include this proposed definition as a safeguard, and as a way of appeasing people who have concerns about this legislation. Just about every member in this chamber, no matter what their position is on this legislation, raised palliative care as a major concern. Palliative care is a concern in our community. The fact is that over 80 per cent of people who need to access palliative care are not able to access it. The fact is also that many people are unaware of palliative care. We need to make it clear that we are not just saying, “Hey, go ahead with assisted suicide or assisted dying”, or whatever we want to call it. We are saying, “Hey, here is some help. Here is some relief and some assistance.” This needs to happen before people make the final decision. This is a simple request from the floor of the chamber that this definition be included in the bill as a safeguard to ensure that people understand. I think this is an extremely reasonable request. It is not in the best interests of the government to not support this proposed amendment. We expect Western Australians to be aware of palliative care. This will be another step that will enable that to occur. I fully support this amendment.

**Mr W.R. MARMION:** I will not go over the reasons that have already been given in support of the proposed amendment. I think the member for Girrawheen has put a legitimate argument. I have some questions that I would like the minister to answer. What would be the impact on the bill if we did include a definition of palliative care? Would it take away anything from the bill? I do not know the meaning of a lot of big words, so when I look at

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a bill, I always look to the definitions clause to find the meaning of the words that are used. When I read this bill, I looked at all the definitions of what people will have to do as they go through the process. The logic I go through is that if I see a word I do not know, I go to the definitions clause. I think a compelling case has been put for the proposed definition. I would like the minister to put the case for why he would not include this proposed definition. I do not think it is valid to say that because it is general and if we cannot define it, we will not put it in. I think we should have a crack at it. Young people—they might be at university or in primary school—could read the bill and want to look up what “palliative care” means and they would find a definition at the front of the bill. I would like the minister to outline the negative impact on the bill if we included that definition.

**Mr S.K. L'ESTRANGE:** I join a number of people in this chamber who have argued why a definition of palliative care should be included in the bill. The member for Morley outlined that it is too difficult because it can be too broad, or words to that effect. I notice that on page 7 of the bill —

**Ms A. Sanderson:** Don't verbal me, member.

**Mr S.K. L'ESTRANGE:** I am happy for the member for Morley to interject and let me know what she said.

**Ms A. Sanderson:** I said it was inappropriate to legislate for medical definitions—inappropriate.

**Mr S.K. L'ESTRANGE:** In this instance, there is a definition on page 7 of the bill for “professional care services”, which frames what professional care services are. Somebody has gone to a fair bit of trouble to work out how to frame what professional care services are. What all those people who have stood so far to argue in favour of this amendment have said is that we should make sure that people understand what palliative care is. If we were to go down Hay Street Mall today and grab 30 people off the street and ask them their understanding of palliative care, I think that they would be like I was a year or two ago and would say, “Well, it's when you are within hours of death and you are being supervised on a bed and you are being cared for in the final hours of life.” They might not say what the professionals at the palliative care unit at Bethesda Hospital told me, which is that palliative care can last for five years or longer, and that when a person is diagnosed with a chronic or terminal illness, they will receive counselling, support services, family and medical support, and an ongoing point of contact with people who care for and look after them on that journey.

I think it is pretty important that we help the community, and the media who report on these things, to understand how we as a Parliament are framing what palliative care means. We are about to sign-off on a pretty important and serious bill, which a number of us in this chamber are really concerned about. I do not think this need be a binary thing. It does not need to be an “us versus them”—a win-lose. This is simply a definition—that is all it is—so that people can better understand what palliative care means, as part of a care program, in this bill.

The minister will recall that towards the end of last night, when we were looking at clause 4, “Principles”, I highlighted subclause (1)(c). The final part of that paragraph states —

... including comfort, palliative care and treatment;

It is important that when a fundamental principle that underpins this bill refers to the need for people to be advised on palliative care, that term should be included in the definitions. We should at least let them know what palliative care means. I do not think we need to take this as being about winning or losing, a binary thing, or about losing a vote on the floor. Do not think like that. It is purely about making sure that people understand what palliative care is. That is it. I am sure we can craft something that can achieve that outcome.

**Mrs L.M. HARVEY:** I want to respond to the member for Morley's interjection. She said that it is inappropriate to describe a medical service. I draw members' attention to the bottom of page 5, which states —

*health service* has the meaning given in the *Health Services Act 2016* section 7;

Section 7 of the Health Services Act states —

**Meaning of health service and public health service**

- (1) A *health service* is a service for maintaining, improving, restoring or managing people's physical and mental health and wellbeing.
- (2) Without limiting subsection (1), a health service includes —
  - (a) a service mentioned in subsection (1) that is provided to a person at a hospital or any other place;
  - (b) a service dealing with public health, including a programme or activity for —
    - (i) the prevention and control of disease or sickness; or
    - (ii) the prevention of injury; or

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- (iii) the protection and promotion of health;
- (c) a support service for a service mentioned in subsection (1);
- (d) the provision of goods for a service mentioned in subsection (1).

The amendment that the member for Girrawheen has moved provides a definition for “palliative care and treatment”. In looking up the definition of “palliative care”, we find that it is care for the terminally ill and their families especially that provided by an organised health service. It is suitably broad. The term medical, which is also used in this amendment, is defined as of or relating to the science or practice of medicine. The term surgical pertains to or involves surgery or surgeons. Nursing procedure is defined as a course of action intended to achieve a result in the delivery of health care. The word palliative in and of itself is defined as relating to a medicine or medical care that is involved in relieving pain but without dealing with the cause of the condition.

We are trying to achieve some consistency in these definitions. The words palliative care are used consistently throughout the legislation. There are definitions in the bill for terms as innocuous as department, disability, medicine and nurse practitioner. Numerous medical definitions are described aptly in the definitions clause of this legislation. All we seek from the minister is that the bill be consistent with the Victorian legislation and have a definition of “palliative care and treatment”. The proposed definition is suitably broad. It covers off on a wide range of services and treatment options—a range of aspects in the delivery of palliative care. I hope that when I sit down, the minister will explain how putting in a definition of palliative care and treatment has an adverse impact on the legislation, as I fail to understand it. How can having a definition like this in the bill be detrimental to the purpose of the legislation, given that palliative care is actually mentioned as part of the purpose of this legislation—that an individual should have access to palliative care? I seek the minister’s explanation of why we cannot have this definition in here when nearly every other term used in the legislation is defined.

Several members interjected.

**The SPEAKER:** Hold on! The minister has a right to reply before everyone jumps up.

**Mr R.H. Cook:** I do not mind hearing all the arguments first, Mr Speaker. What would you like?

**The SPEAKER:** Whatever suits you, minister. I am very easy.

**Mr D.T. PUNCH:** I wish to speak against this amendment. Putting a definition of palliative care into the legislation will put an artificial constraint on what palliative care could and should be. In my second reading contribution I spoke extensively about palliative care. It is not a trade-off between assisted dying and palliative care; it is about putting the patient central to a range of options that the patient, in discussion with their family and medical practitioner, can make some choices about. I think the amendment would put a constraint on the notion of what palliative care is, because we principally see palliative care as a medical response to end of life with some social components. A lot of evidence is coming out overseas and emerging in Australia that says that end of life is about the quality of life and social environment, with some medical aspects. I am concerned that this debate is shaping the response to palliative care to be in a medical context, which would see more and more Australians dying in hospitals, which is not their preferred situation. We need a much broader view of community-based palliative care within a medical context that supports pain and symptom management, but puts the patient first in their community and with their family. That is why I am speaking against this amendment. We need a much broader vision for the future. I certainly think there can be a debate about palliative care, but it needs to be separate from the bill that we are debating today, which puts the patient at the heart of a decision about whether they want to end their life voluntarily in light of intolerable suffering and a life-limiting disease.

**Mrs L.M. HARVEY:** I have to get up and rebut what the member for Bunbury has just said. The Health Services Act 2016, from which I earlier read out a definition, refers to “health service”. Section 5 of the Health Practitioner Regulation National Law (WA) Act 2010 states, in part —

*health service* includes the following services, whether provided as public or private services —

- (a) services provided by registered health practitioners;
- (b) hospital services;
- (c) mental health services;
- (d) pharmaceutical services;
- (e) ambulance services;
- (f) community health services;
- (g) health education services;
- (h) welfare services necessary to implement any services referred to in paragraphs (a) to (g);

**Extract from Hansard**

[ASSEMBLY — Wednesday, 4 September 2019]

p6398e-6413a

Mr Zak Kirkup; Mr Roger Cook; Dr David Honey; Mrs Alyssa Hayden; Mr Vincent Catania; Mr Terry Redman; Mrs Liza Harvey; Ms Margaret Quirk; Amber-Jade Sanderson; Mr Peter Katsambanis; Dr Mike Nahan; Mr John McGrath; Mr Bill Marmion; Mr Sean L'Estrange; Mr Donald Punch; Mr Tony Krsticevic; Deputy Speaker; Mr Shane Love

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- (i) services provided by dieticians, masseurs, naturopaths, social workers, speech pathologists, audiologists or audiometrists;
- (j) pathology services;

This is in the context of “health profession” being defined in the same section as —

... the following professions, and includes a recognised specialty in any of the following professions —

- (a) Aboriginal and Torres Strait Islander health practice;
- (b) Chinese medicine;
- (c) chiropractic;
- (d) dental (including the profession of a dentist, dental therapist, dental hygienist, dental prosthetist and oral health therapist);

That is probably not relevant —

- (e) medical;
- (f) medical radiation practice;
- (g) midwifery;
- (ga) nursing;
- (h) occupational therapy;
- (i) optometry;
- (j) osteopathy;
- (ja) paramedicine;
- (k) pharmacy;
- (l) physiotherapy;
- (m) podiatry;
- (n) psychology;

The act lists a range of health professionals and health services. I challenge anybody in this place to come up with a health service that could be provided by way of palliative care service that would not be included those definitions that are clearly referred to in the legislation. I know, having been through a palliative care program, that we had reflexology, a range of massage therapies and all sorts of things available to us to help with chemotherapy and other palliative therapies. Every one of those therapies that were accessed was more than adequately covered by existing definitions. The only healthcare service that is not actually described by way of definition is the palliative care service that is essential and intrinsic to the issue that we are debating. People will not access voluntary assisted dying unless they are in the same group of people who are accessing palliative care should it be available. To have a definition of “palliative care” in this legislation is worthwhile and necessary. Clearly, the Victorian Parliament thought that it was needed and essential because it forms part of its legislation.

We would really appreciate it if the minister got to his feet and explained to us how this will have any manifestly detrimental outcome for the operations of the legislation. I cannot see that it could, given that there are so many other definitions in the bill. The definition of palliative care and treatment is very broad. Including this definition would increase the significance and prominence of our focus on palliative care going forward. As a society, we need to focus on this area; we are all aware of that. The Joint Select Committee on End of Life Choices made numerous recommendations on the provision of palliative care services. I see the inclusion in the bill of a definition of palliative care as key and essential. It would make the bill stronger. I would like the minister to get to his feet and explain why he is not considering it.

**Mr R.H. COOK:** I do not think I had got to my feet yet, but I am very happy to do so now. The member for Hillarys observed that the concept of palliative care is used extensively throughout this bill. It is not. As I explained in my contribution earlier, it is referred to twice in the broadest possible way. One is in the principles and the second is in the context of the coordinating practitioner and the consulting practitioner. The concept of palliative care is not material to this bill. The member for Darling Range observed that palliative care is intrinsic to this bill. This bill is about voluntary assisted dying. People may access voluntary assisted dying without necessarily accessing palliative care. I know that some people here find that concept offensive, and very much in their minds

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the issue of palliative care and voluntary assisted dying are conflated. Indeed, in some contexts it is seen as either/or, and from that perspective it is true that the government has a very different approach from that.

It is not appropriate to define palliative care in the context of this bill because this bill is about voluntary assisted dying. In that sense, it is not appropriate for us to try to insert “palliative care” definitions in this bill because, quite frankly, that is not what this bill is about. The joint select committee made a range of observations on palliative care. One of those is that it is a very evolving and misunderstood area, but in its broadest definition, it can mean a range of things. I notice that Palliative Care WA states —

Palliative care identifies and treats symptoms which may be physical, emotional, spiritual or social. Because palliative care is based on individual needs, the services offered will differ but may include:

- Relief of pain and other symptoms e.g. vomiting, shortness of breath
- Resources such as equipment needed to aid care at home
- Assistance for families to come together to talk about sensitive issues
- Links to other services such as home help and financial support
- Support for people to meet cultural obligations
- Support for emotional, social and spiritual concerns
- Counselling and grief support
- Referrals to respite care services

Palliative care is a family-centred model of care, meaning that family and carers can receive practical and emotional support.

I take the point that the member for Bunbury made. The concept of palliative care is an emerging one, and although we often picture palliative care taking place in a hospital or hospice setting, it goes beyond those simple definitions. As I said, this is not about palliative care versus voluntary assisted dying. It is not material to this bill. In the broadest possible term—that is, the generic concepts of palliative care—it is referred to in the principles, but it is not material to this bill. It does not give effect to aspects of this bill. From that perspective, I understand what members are saying in terms of it would be nice to have it in the legislation, but that is not appropriate because this bill is about voluntary assisted dying. I know from a range of speeches given by members that people are keen to conflate the two issues and I understand that, and a bunch of work on palliative care is going on, which is also an exercise or an activity of government.

Members should be very clear about what we are doing here. We are describing and prescribing a process around voluntary assisted dying. It is not appropriate to seek to craft a definition or that a definition sits in the context of this bill.

**Mr S.K. L'ESTRANGE:** I found the minister's answer unusual to say the least.

**Mr R.H. Cook:** You usually do, member.

**Mr S.K. L'ESTRANGE:** No, I do not. The minister knows that is not true. He is saying that it is not part of the bill, but it is. It is a part of the bill.

**Mr R.H. Cook:** I said it is not material to the bill.

**Mr S.K. L'ESTRANGE:** I think it is material to the bill.

**Mr R.H. Cook:** I understand that.

**Mr S.K. L'ESTRANGE:** Clause 26, “Information to be provided if patient assessed as meeting eligibility criteria”, is a key part of the bill and states —

- (1) If the coordinating practitioner is satisfied that the patient meets all of the eligibility criteria, the coordinating practitioner must inform the patient about the following matters —

...

- (c) the palliative care and treatment options available to the patient and the likely outcomes of that care and treatment;

If a coordinating practitioner reads that bill, goes to the definitions and says, “Okay, according to this legislation, I must inform them”, and then cannot find a definition of what they need to inform, where do they go?

**Mr W.R. Marmion:** The Oxford dictionary!

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**Mr S.K. L'ESTRANGE:** Great! They could go to the Wikipedia definition. Is that going to fulfil clause 26? The problem is that it might not. This is not about being binary, or us versus them. As I said before, it is fundamental to the bill that information is to be provided to a patient who is assessed as meeting eligibility criteria for voluntary euthanasia. This is about the patient being eligible to go ahead and take on a premature death. The clause states that the practitioner must inform the patient of the palliative care and treatment options, and the minister is telling us now that palliative care is not a part of his bill. It is, minister! It is in clause 26. If it is not defined in the definitions, then it is left to these practitioners to make up their own definition. When legislating on such a serious matter, I think that is leaving way too much to chance.

**Mr R.H. COOK:** I thank the member and appreciate that this is an important issue. If the member refers to clause 26, it states —

... the coordinating practitioner must inform the patient about the following matters —

There is no obligation for that patient to actually be taking palliative care; it is simply to say that the issues and the treatment options, including palliative care, are made available. This is about the patient, not about the doctor. From that perspective, we could chase ourselves down a hole trying to define all the issues that come within that eligibility criteria. This is something that is simply part of the conversation that takes place between the practitioner and the patient.

On the use of the term “palliative care”, Palliative Care WA, as I said, defines it in the very broadest terms, and the Department of Health and palliative care providers already refer to that policy statement. It is not necessary to define it, because it is not going to determine whether a patient is eligible or not. That is the crucial aspect here in clause 26. It does not determine it, and it does not say that palliative care is determined in a particular way, therefore the patient is eligible; it is simply that it is part of the conversation, and the practitioner must be satisfied that the patient has been made aware of other care pathways. But it is not for the practitioner to decide whether that person is appropriately captured within it. This is about the patient, not the practitioner.

**Mr S.K. L'ESTRANGE:** I have a follow-on question. Can the minister then explain to this chamber what he thinks palliative care is, so that we have an understanding? This is the government's bill and it is not defined within it. Can the minister at least tell us what he thinks palliative care is?

**Mr R.H. COOK:** Member, as I stated a very, very short time ago, I am informed by the Palliative Care WA policy statement, which includes those features that I put in *Hansard* in my previous remarks.

**Mr A. KRSTICEVIC:** Obviously, I am listening to what everyone is saying about this. Palliative care is critical. The fact that the minister cannot give us a definition, or is not prepared to put a definition into this bill, concerns me greatly. Supposedly, over the next four years, the government is putting \$206 million into palliative care. The question is: where is that going and what is it being spent on? We do not know what palliative care is. Nobody wants to put a definition to it, or give us an explanation, or, at least, the minister cannot, and he refuses to put it in the bill. Will that money be spent on capital expenditure, on buildings and infrastructure, as it has been in Carnarvon; or will the money go into people and pain relief and services? It is very concerning from that perspective.

When I listen to other members argue that palliative care should not be included because the definition of medical services should not be included, I assume those same members will be moving amendments to take a number of definitions out of this legislation where those services are defined, to rationalise the arguments that they have made here today.

Another part that concerns me is that point (i) of the definition of “professional care services” outlines a whole range of things such as bathing, showering, personal hygiene, toileting, dressing, undressing or meals, but it does not say anything about fluids, or about helping people to drink. Fluids are the most important aspect, and nowhere are they included in professional care services. Again, that definition and explanation is flawed, based on the rationale I am hearing today in this discussion. I will get back to that point later on with that amendment—whether or not meals includes fluids, and whether there is another definition somewhere else.

Again, palliative care is critical. I know the minister says that they are not linked, and I know people talk about listening to the community. An article by Nathan Hondros that appeared in yesterday's *WAtoday* states “Polling reveals country voters want palliative care fixed before euthanasia legalised”. Some 2 000 people were surveyed, and 73 per cent said, “No, you've got to fix up palliative care first.” Of course, according to the minister, this bill has nothing to do with palliative care. Palliative care is not part of euthanasia—sorry, voluntary assisted dying. Palliative care is nothing to do with it. It is mentioned three times; by the way, we are putting \$206 million into palliative care, but we do not want to define it. Even though this definition is very broad, and the minister cannot give us a definition, he refuses to accept it, and he refuses to put it in there because it has nothing to do with the bill.

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However, it is a key part of the process. Palliative care is critical to people's decision-making and the end-point they get to at the end of this process.

We have heard from experts who say that palliative care works in 99.9 per cent of cases, if it is carried out and funded properly. Even for the percentage for whom it does not work, I think experts responded back to the inquiry to say that in those cases, they have a solution that works. From the medical perspective or the palliative care perspective, they can deal with 100 per cent of cases, if they have the right funding and resources. I am not an expert in that field; I do not think any of us are. But if that is what they say—the 15 people in that field in this whole state—they are the people we should be asking: What is palliative care? Should it be defined? Should it be in this legislation? We should not be asking people who have no idea about the specifics of all that palliative care entails. I think it is a major shortcoming and a major flaw not to include the definition of palliative care.

Another part that concerns me, minister, is when we get to the more serious areas of concern where the community needs to be scared of this legislation, where there is the possibility of coercion or of people ending their lives without getting fair and proper advice, and a whole number of other aspects that are concerning, it makes me wonder what chance we have to fix that up, when we cannot do something as simple as a definition that I am pretty sure most people agree with. Apart from the minister, the arguments I am hearing from everybody else are focused on whether those definitions should or should not be in the bill. I am interested to know what the minister thinks about that, and whether some of these other definitions need to be taken out, based on the arguments put by members.

**The DEPUTY SPEAKER:** Members, before we have any other conversations on this subject, I have been listening to the debate, and I have heard the minister respond to this question quite a few times. It is entirely up to the minister what he does and how he responds. I would urge members to remember that this is not a repetitive debate; it is to try to bring new issues to the table. Could members please think about that when they respond.

**Mr R.H. COOK:** I hope the member does not mind if I respectfully stick to responding to the point that he is making, which is consistent with the amendment that has been moved. As I said, a definition of palliative care is not needed because it is not material to this bill. Professional care services are referred to in relation to other aspects of the bill and do have a material effect on it. That is essentially that. If the member wants to dig a little bit further on the definition of professional care services, I think we need to do that separately from the member for Girrawheen's amendment.

**Mr R.S. LOVE:** I want to make some comments on this proposed amendment. The amendment that I have read seems to closely follow in some aspects the definition of "eligibility criteria" for a person to access voluntary assisted dying in clause 15(1)(c), which states —

the person is diagnosed with at least 1 disease, illness or medical condition that —

- (i) is advanced, progressive and will cause death ...

This definition of when palliative care is applicable seems to closely follow what is in the voluntary assisted dying legislation, which I think is somewhat at odds with my understanding of when palliative care should be sought. Finding 12 of the report of the Joint Select Committee on End of Life Choices states —

Access to specialist palliative care in the early stages of a diagnosis might improve remaining quality of life, mood, resilience, symptom management and allow for death in the patient's preferred location.

Although I am not opposed to the principle of inserting a definition of "palliative care" in the bill, I do not think I would accept this definition for palliative care because it is clearly aimed at the end stage of a person's disease when progressing towards death. As the committee found, it is better if palliative care treatment is undergone sooner. I do not agree with the definition, but I agree with there being one.

**The DEPUTY SPEAKER:** Member for Cottesloe.

**Mr R.S. Love:** I was hoping to get a comment from the minister.

**The DEPUTY SPEAKER:** I think the minister wants to respond, member for Cottesloe.

**Mr R.H. COOK:** Thank you, member for Cottesloe.

I agree with the member for Moore. I, too, have problems with the definition. Palliative care is also for the treatment of pain and suffering, not necessarily at the end of life. However, I differ from the member on the need to have a definition in the legislation. Palliative care is referenced, as would be expected, but it is not material to the bill.

**Dr D.J. Honey:** Deputy Speaker.

Mr Zak Kirkup; Mr Roger Cook; Dr David Honey; Mrs Alyssa Hayden; Mr Vincent Catania; Mr Terry Redman; Mrs Liza Harvey; Ms Margaret Quirk; Amber-Jade Sanderson; Mr Peter Katsambanis; Dr Mike Nahan; Mr John McGrath; Mr Bill Marmion; Mr Sean L'Estrange; Mr Donald Punch; Mr Tony Krsticevic; Deputy Speaker; Mr Shane Love

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**The DEPUTY SPEAKER:** The member for Girrawheen was on her feet. We will come back to that. We have a day to do this.

**Ms M.M. QUIRK:** I am sorry. I will try to bring the debate back on track.

The Victorian legislation, which ours closely mirrors, has a definition of “palliative care”. That references the definition in the Victorian Medical Treatment Planning and Decisions Act 2016, in which it is defined as including —

- (a) the provision of reasonable medical treatment for the relief of pain, suffering and discomfort;
- (b) the reasonable provision of food and water;

I would probably say that is too narrow, given the comments of people such as the member for Moore, but what is it about Western Australia that makes it different from Victoria? Victoria seems to have no issue about including a definition. That is the crux of the matter.

**Mr R.H. COOK:** I am advised that it is essentially a drafting convention in Victoria and it is not imperative. As I have already mentioned, it is not material to our bill.

**Dr D.J. HONEY:** I was concerned that the minister was worried that people were trying to conflate the issues of palliative care and the Voluntary Assisted Dying Bill. In fact, that is one of the very specific concerns that people who are opposed to this bill have; that is, that the inadequacy of palliative care in the state and the inadequacy of the training of practitioners in palliative care will, in fact, lead people to access voluntary assisted dying and will be causative of it. I think it is entirely appropriate that we include a definition. I echo the comments of the member for Girrawheen. The truth is that the Victorian bill is not an idle bill, as the minister knows. Victorian legislators went to enormous effort to put the definition in there. They saw it as very important and we do as well.

I note that the minister’s intent with this bill is genuine and comes from the right place, but when we look at any bill, we are not here to look at the best of possible circumstances; we are to look at the worst of possible circumstances. One of my concerns about this bill is that if we do not specifically recognise palliative care and treatment in the bill, over time, voluntary assisted dying will become the default and the alternative to adequate palliative care in the state. I think that was reflected in the debate today. Over time, we will see drift. It is important that we recognise palliative care. Adequate palliative care to the end of life should be the primary focus of all governments. It is the contention of members across this parliament that voluntary assisted dying should be another alternative at the end of life. I do not think it is in any sense conflation to include this definition in the bill. It is critical that we recognise palliative care and that inadequacies in palliative care could, in fact, lead more people to access voluntary assisted dying that otherwise would be the case.

**Mr R.H. COOK:** I think the member has summarised well some of the concerns that were voiced in the second reading debate, but I do not accept his premise. I certainly do not accept his premise that there is a problem with palliative care in Western Australia and I reference our record investment in it. I also challenge the other premise of the member’s argument—that is, to discuss voluntary assisted dying is to somehow diminish or move away from palliative care. I do not see the two as being played off, one against the other. In fact, the evidence from overseas is that investment in palliative care across countries is growing at the same rate in those that already have voluntary assisted dying legislation as those that do not. The fact of the matter is that voluntary assisted dying invites the conversation and provides a greater policy focus for palliative care. I simply reject the premise of the member’s argument.

**Ms M.M. QUIRK:** I know when I am flogging a dead horse, but I have two questions. The first is about clause 26, which we will deal with later. But in the context of a conversation having to take place between a medical practitioner and the person, the person needs to be alerted to the existence of palliative care treatment. Will that be in a form drafted by the CEO so that there are standard words?

**Ms A. Sanderson:** I can’t see what that has to do with the definition.

**Ms M.M. QUIRK:** It has something to do with the definition because if there is a standard form of words, member for Morley, there is less possibility of there being a misunderstanding. At least we will be able to satisfy ourselves that a consistent approach will be taken. The second matter I wanted to raise, subject to what the member for Morley wants to say, is that the minister has said that it is a drafting issue. I am not quite sure what that means. Could the minister please expand on that?

**Mr P.A. Katsambanis** interjected.

**Mr R.H. COOK:** I think I should do the mover of the motion the courtesy of responding, member for Hillarys.

I hope the member for Girrawheen will forgive me if I do not go into details about clause 26 now. I will be very happy to do so when we arrive at that clause. Suffice it to say, as I mentioned earlier, there are a range of issues

Mr Zak Kirkup; Mr Roger Cook; Dr David Honey; Mrs Alyssa Hayden; Mr Vincent Catania; Mr Terry Redman; Mrs Liza Harvey; Ms Margaret Quirk; Amber-Jade Sanderson; Mr Peter Katsambanis; Dr Mike Nahan; Mr John McGrath; Mr Bill Marmion; Mr Sean L'Estrange; Mr Donald Punch; Mr Tony Krsticevic; Deputy Speaker; Mr Shane Love

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around which, in the context of the therapeutic relationship between a practitioner and patient, we would ordinarily expect for there to be a conversation. One of those will be the range of treatment options available to the patient, including palliative care. That does not, in and of itself, make palliative care a material aspect of this bill. As I said in my earlier remarks, it is not material. I refer to the Victorian legislation. I am advised that it is a drafting convention. Not being a drafter of legislation, I do not necessarily appreciate the full drivers of that, but as the member knows, laws have particular styles and approaches. That is simply the approach that was adopted in Victoria. I am not here to advise the Victorian government whether its legislation is competently drafted; I certainly know that ours is.

**Mr P.A. Katsambanis:** Deputy Speaker.

**The DEPUTY SPEAKER:** Is this a new issue?

**Mr P.A. Katsambanis:** It is just on this issue.

**The DEPUTY SPEAKER:** Do not ask the same question again, please, member.

**Mr P.A. KATSAMBANIS:** I will not. I have to say that I welcome the minister's refreshing honesty when he said that a definition of palliative care is not material to this legislation. I think that is a fear and concern of everyone who has read this legislation. Palliative care is used in a number of contexts. It is used several times in the principles in clause 4 —

**Ms A. Sanderson:** I have a point of order.

**The DEPUTY SPEAKER:** That is fine, member. You do not need to make a point of order. Member for Hillarys, I think the minister has addressed this. Minister, do you wish to address this question again?

**Mr P.A. KATSAMBANIS:** I am allowed to comment. It is consideration in detail.

**The DEPUTY SPEAKER:** You absolutely are. I am just encouraging you not to repeat issues that the minister has already addressed.

**Ms A. Sanderson:** It is tedious repetition.

**Mr P.A. KATSAMBANIS:** I am not repeating it. I have not made this point.

**The DEPUTY SPEAKER:** Would you make the point, please.

**Mr P.A. KATSAMBANIS:** Would you like me to start again?

**The DEPUTY SPEAKER:** No. I would like you to make the point.

**Mr P.A. KATSAMBANIS:** If I was not interrupted, perhaps I would not need to start again.

**The DEPUTY SPEAKER:** I am doing it to try to get us through this, member.

**Mr P.A. KATSAMBANIS:** The issue here is that lip-service has been paid to palliative care in the introduction of this bill. The minister's position is clear—he is not accepting —

*Point of Order*

**Ms A. SANDERSON:** Standing order 97 states —

A member who persists in irrelevance or tedious repetition, either of the member's own arguments or of the arguments used by other members, may be directed by the Speaker to discontinue the speech.

I would argue that this is tedious repetition of other arguments that have been put several times on this clause.

Several members interjected.

**The DEPUTY SPEAKER:** Members, I tend to think that the member for Morley has a point. Can we please move on.

*Debate Resumed*

**Mr P.A. KATSAMBANIS:** I will move on. The point I was making before I was rudely interrupted was that, unfortunately, despite all of the motherhood statements we have heard, lip-service is being paid to palliative care. It is really immaterial to this bill and that is really, really seriously disappointing. It is even more disappointing that when it is raised in this house, other members want to shut down debate. That is disgraceful.

*Division*

Amendment put and a division called for.

Mr Zak Kirkup; Mr Roger Cook; Dr David Honey; Mrs Alyssa Hayden; Mr Vincent Catania; Mr Terry Redman; Mrs Liza Harvey; Ms Margaret Quirk; Amber-Jade Sanderson; Mr Peter Katsambanis; Dr Mike Nahan; Mr John McGrath; Mr Bill Marmion; Mr Sean L'Estrange; Mr Donald Punch; Mr Tony Krsticevic; Deputy Speaker; Mr Shane Love

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Bells rung and the house divided.

**Mr V.A. Catania:** Point of order, Deputy Speaker. There are five members who are not sitting down.

**The DEPUTY SPEAKER:** Could members please be seated to be counted.

The division resulted as follows, the Deputy Speaker casting her vote with the noes —

Ayes (13)

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

Noes (39)

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

**Amendment thus negated.**

**Mrs L.M. HARVEY:** On page 5, line 16 of the bill, there is a definition of “family member”. The definition states —

*family member*, of a person, means the person’s spouse, de facto partner, parent, sibling, child or grandchild;

This is particularly pertinent to clause 42 of the legislation, which is on page 27. Clause 42 identifies people who are inappropriate to witness the signing of a written declaration of a person wanting to access voluntary assisted dying. Clause 42(2) states —

For the purposes of subsection (1)(b), a person is an ineligible witness if the person —

...

(b) is a family member of the patient making the declaration; or

Given that in modern times there are various kinds of family arrangements—blended families—I want to understand whether step-parents, stepchildren, half-siblings and foster-children are included in this definition; and, if not, why they would not be listed. When we get to the issue of inheritance from patients, it is often at its worst when there is a blended family with a sick family member, with competing members from two different families potentially applying pressure, if you like, or competing for that inheritance. Could the minister please explain whether stepfamilies are included in these definitions, or whether it might be prudent for us to amend this so that they are included?

**Mr R.H. COOK:** I am advised that the term “family member” is narrowly defined in the bill because it is primarily applied to limit who is eligible to witness a patient’s written declaration, to act as an interpreter or to witness the administration of the prescribed substance via an administering practitioner.

Several members interjected.

**The DEPUTY SPEAKER:** Members, can you please be quiet so we can hear the speaker.

**Mr R.H. COOK:** There are, however, materiality provisions that exclude a person from being a witness if they may obtain a material benefit from the patient’s death. The term “family member” does not include a step-parent, stepchildren or extended family member; however, the materiality provision will serve to exclude a wider range of persons from taking advantage of a patient making the declaration.

**Mr P.A. KATSAMBANIS:** The definition of “medical practitioner” at the top of page 6 states —

*medical practitioner* means a person registered under the *Health Practitioner Regulation National Law (Western Australia)* in the medical profession (other than as a student);

That definition mirrors definitions used across a range Western Australian legislation for the purposes of defining a medical practitioner, save for this concept at the end, “(other than as a student)”. I seek clarification from the

**Extract from *Hansard***

[ASSEMBLY — Wednesday, 4 September 2019]

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Mr Zak Kirkup; Mr Roger Cook; Dr David Honey; Mrs Alyssa Hayden; Mr Vincent Catania; Mr Terry Redman; Mrs Liza Harvey; Ms Margaret Quirk; Amber-Jade Sanderson; Mr Peter Katsambanis; Dr Mike Nahan; Mr John McGrath; Mr Bill Marmion; Mr Sean L'Estrange; Mr Donald Punch; Mr Tony Krsticevic; Deputy Speaker; Mr Shane Love

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minister of why that has been included and why it is necessary to include “other than a student” in this legislation when it is not included in any other Western Australian legislation that defines a medical practitioner.

Debate interrupted, pursuant to standing orders.

[Continued on page 6425.]