VOLUNTARY ASSISTED DYING BILL 2019

Consideration in Detail

Resumed from 4 September.

Debate was adjourned after clause 10 had been agreed to.

Clause 11: Voluntary assisted dying not suicide —

Mr Z.R.F. KIRKUP: The term that is being defined in this clause is that voluntary assisted dying is not suicide. Obviously there is some contention, especially in relation to a self-administrative decision, and the perspective that might be. Can the minister provide some insight into why the government has decided to define voluntary assisted dying as not suicide?

Mr R.H. COOK: This clause provides that, for the purposes of the law in Western Australia, a death that results from the administration of a prescribed voluntary assisted dying substance is not considered to be a death resulting from a person committing suicide. This clause reflects the tenor of the bill, and the views of the government, that voluntary assisted dying is not suicide. Suicide occurs when a person takes their own life in circumstances outside those permitted by this bill. Voluntary assisted dying must be viewed as completely separate to and distinct from suicide. Suicide connotes a loss of life of a person who is typically not dying, and in circumstances that are often tragic, and a person feels socially or emotionally isolated. Voluntary assisted dying, however, involves a person's choice about their mode of death, when they are already dying—a process that is requested and led entirely by the person, in which they are given the support and care they require in the end-of-life stage.

Concern was raised in the committee's minority report that there is an artificial distinction between assisted dying and suicide generally. Whether one construes such a distinction as artificial is a matter that depends solely on a person's opinion, based on personal views, including political and religious beliefs on the ethics, morality and psychology behind the choice to take one's own life. The bill reflects the views of a significant proportion of people in Western Australia, and addresses a genuine choice. This is one of the provisions that brings into sharp focus the philosophical issues within the bill. It is what it is. As the member can see, it is a fairly simple, straightforward clause, and it may be that we simply will not be able to provide comfort for folk who have a philosophical opposition to this.

Mr Z.R.F. KIRKUP: I am assuming, as well, that this clause has some relationship with the death certificate. Because we are defining, at this point, that voluntary assisted dying is not suicide, obviously that will not be reflected on the death certificate either. Can the minister confirm that?

Mr R.H. COOK: That is correct. There are obviously a range of reasons of clarity for having this clause included in this bill, but it is certainly our intention that the death certificate would not include voluntary assisted dying or suicide in its outcomes.

Mr Z.R.F. KIRKUP: Given the lack of language in relation to the word "suicide" throughout the rest of the bill, why was it considered necessary to include this definition? Why was it considered necessary to insert this clause into the bill if it was not referenced anywhere else?

Mr R.H. COOK: Because it reflects the policy intent of the bill, it is therefore an important clause to clarify.

Mr Z.R.F. KIRKUP: The policy intent is that someone can access voluntary assisted dying. Is that what the suggestion is?

Mr R.H. COOK: We want to make it absolutely clear to those perusing the legislation, and also to the general community, that this is not a question of advising suicide. This is a very distinct act, and to provide clarity in the bill is an appropriate way to go.

Dr D.J. HONEY: I am absolutely perplexed by this clause. It is a clause saying that in this bill, we say black is white, or orange is pink, because we do not like the colour black or the colour orange, and we do not want people to think. I see a theme going through this bill; clearly, the ministerial committee and the people who wrote this bill are strident advocates for euthanasia. We saw that in the briefings. When I went along to the briefings, any discussion from the expert panel that suggested anything other than this bill was appropriate was, I will not say attacked, but vigorously put down. The tenor of the bill is that anything considered uncomfortable or irksome is defined away, hidden or redefined. We do not talk about a "poison"; we talk about a "voluntary assisted dying substance". We do not want to use the word "poison" because the community does not like it, so we hide it and use another phrase to describe it.

If a person takes their own life, it is suicide. I am dumbfounded. I am not a hardline zealot on this issue, but I do have considerable concerns about the protections in this bill—or the lack of protections in this bill. I am extremely concerned why the government, if it is so certain that this is the right thing to do, is trying to hide anything that has negative connotations or is irksome. It is perverse. The idea that someone is not committing suicide because

they are going to die anyway is a nonsense. We are all going to die. To be really frank, the minister has no idea whatsoever and a doctor has no idea whatsoever when a person is going to die. They are making an estimate about it; they are making a guess about it. They say that voluntary assisted dying is different because it is a considered process assisted by someone else. Many suicides—I would say nearly all suicides—are a considered process, and many suicides are assisted by another person. If someone takes it upon themselves to commit suicide and they are assisted by another person, it is clearly a considered process. Do we say that is not a suicide?

To say that this is a philosophical issue is really dumbfounding. This is not a philosophical issue; this is a simple matter of a common English definition. It does a disservice to this bill that the government continues to try to hide or obfuscate anything that could put this legislation in a bad light. It gives me great concern about the motives behind the bill. It is not an open discussion or an attempt to have an open discussion; it is an attempt to hide the facts behind it. I do not know why this provision needs to be in the legislation. This goes further, because when we talk about the death certificate, it will not recognise that a person has gone through this formalised process at all. Again, the fact that this has occurred at all is hidden. I do not know why that has to be; there is no shame in a person accessing this process. I disagree with this bill, but I understand there are people who want access to voluntary assisted dying and there are people who support it. Again, we see this constant thread through this bill of trying to hide any single thing that could have any negative connotation whatsoever. In this case, it is trying to fundamentally redefine a term that is well understood and well accepted in the English language.

Dr M.D. NAHAN: I assume that this clause means that there are accepted definitions of "suicide" in the various acts. Could the minister provide me with some accepted definitions of "suicide" in the various acts relevant to this legislation?

Mr R.H. COOK: I am advised that there are references to the concept of suicide in the Criminal Code, but we are not sure whether it is actually defined in the legislation. Certainly, we could check that for the member. We are going to be in consideration detail on this bill for some time, as the member knows, so we can provide that feedback to him in due course. I am happy to provide that information.

As I said in my earlier remarks, I understand that members find this particularly confronting, because people feel strongly about this issue. From that perspective, it is important that members take care when they are making remarks about this particular clause. At the moment, in some instances, as members would be aware, a patient's death can be hastened under a clinical environment. As a rule, we do not describe that as suicide, and we certainly do not describe it as taking one's life. What we are doing here is legislating for particular activities around someone's end-of-life experience. We are doing this from a legislative point of view rather than it simply taking place in the community unregulated, unobserved and unmonitored. It means that we need to proceed carefully and make sure that we are accurate in both the intent and the structure in the drafting of the bill.

I reject the member for Cottesloe's contention that doctors are guessing—they are not. They are trained, paid, and under the great history and regulation of their occupation. On behalf of all the community, they provide calculated and scientific judgements, which are exercised every day. To say that doctors are guessing is, quite frankly, a little sad. This clause provides clarity in relation to the intent of the bill. It has not been put in through some ideological perspective, which the member for Cottesloe might be suggesting. The clause is there to make sure that we have competent and appropriate legislation.

Mr A. KRSTICEVIC: In the minister's answer, he indicated that there are other procedures or processes that are akin to suicide that are currently undertaken. I beg to differ on that point, because those procedures are not about suicide; they are about pain relief and management. Someone may pass away as a result of those procedures, but the purpose is not to take a person's life. Obviously, looking at the definition of "suicide"—it does not matter where one looks—we see that it is the act of someone intentionally taking his or her own life. In regard to this clause, which states that voluntary assisted dying is not suicide, how is that concept—that idea—going to get prominence to be understood in Western Australia, Australia and internationally? I am sure if a person were to google it and look at all the international research, they would see that the definition of "suicide" would not change just because clause 11 of this bill states that suicide is no longer a person intentionally taking his or her life if it comes under VAD legislation. Apart from the suggestion in clause 11, what will this mean to people? Is the government going to have a major advertising campaign to tell people that VAD is not suicide? Is the government going to change the definition of "suicide"? When I google "suicide" it is very clearly defined, and this bill will allow what is currently defined as suicide. I want to know the minister's thinking in that realm.

Mr R.H. COOK: With regard to the member's earlier remarks, I certainly never used language like "it is akin", so please do not verbal me. The member's following remarks lay bare just how complex this issue is and the fine line we tread. I thank the member for his support. The government is trying to clarify the issue to make sure that the intent and approach of this bill is clear in the public's mind. I do not have any further remarks to add beyond

those that I made to the member for Dawesville, except to say that I appreciate that this might go to the heart of a lot of the philosophical differences on this bill, but it is an appropriate clause to have in the context of the intent and approach of the bill.

Mr Z.R.F. KIRKUP: Is there a need to reiterate that voluntary assisted dying is not suicide for the purpose of trying to ensure that we are not caught under the commonwealth communications act on the use of a carriage service to incite suicide? Is that a reason to reiterate why this is not?

Mr R.H. COOK: As the member knows, the issues with the commonwealth act have been a fairly contemporary or recent development. This clause predates those considerations. As he knows, we have cited this clause as being material to that issue.

Mr P.A. KATSAMBANIS: This clause particularly troubles me. It troubles me philosophically, but it also troubles me legally. As I understand this clause—this has not really been canvassed so far in the debate that I have heard; I missed the opening parts of it, so the minister can correct me if I am wrong and it has been canvassed—it has nothing to do with the person whose life is being ended. This is really a protection. A clause such as this is necessary to protect those people involved in the process from the application of the parts of the Criminal Code that relate to aiding and abetting and assisting suicide. At the genesis of it, a clause such as this that provides protection for those people would make eminent sense if we were to embark on this sort of regime. However, it could be achieved in other ways that do not try to tell the public of Western Australia that black is white, which is what this is attempting to do.

I will put it in context. If somebody chooses to end their life by taking a cocktail of drugs outside of the operation of this regime, that is suicide. If someone chooses another, more fatalistic, method—jumps off a bridge, hangs themselves or slashes their wrists—that is suicide. If someone undertakes a process whereby they access a medication that is approved by the state to end their life, the outcome will be absolutely no different. The outcome is that they will take their life by ingesting a poison. That is suicide. Whether or not it is deemed to be suicide under this legislation, it is—in the ordinary use and the well understood meaning of the word. If there are other participants in that process, they need to be protected from the application of the Criminal Code, as I said. A different formulation for this clause that would not incite the concerns that this clause incites would exempt those people who are involved in the process of the ending of a life in accordance with this legislation from the operation of those sections of the Criminal Code. Why was that formulation not considered? Why was it deemed necessary to essentially put in a clause that tries to convince the public that the deliberate taking of one's life is not suicide, despite thousands of years of understanding that that is exactly what it is? From a legal point of view, I understand why a clause such as this ought to be in this legislation for the purposes of the law of this state, but it could have been formulated in a much better and much more appropriate manner than this ham-fisted way that turns our language upside down.

Mr J.E. McGRATH: Mr Acting Speaker.

Mr P.A. Katsambanis: I would like a response.

Mr R.H. Cook: I am happy for the member to speak, but I will address the member's issues.

Mr J.E. McGRATH: I have concerns with the way this is going. I will tell members what suicide is. I knew a young fellow at Brightwater who was almost totally incapacitated. He was in a wheelchair. His father was killed in a plane crash in the Congo. His stepmother loved him dearly. He could come and go at the facility, and one day he got a cab to take him to the Garratt Road jetty. He had a bottle of Jim Beam and a ghetto-blaster. He drank the bottle of Jim Beam and then wheeled himself off the jetty and committed suicide. That is committing suicide. If he wanted to avail himself of this legislation—I do not think he would have because he was not near death—and if he met the conditions of the legislation that we are trying to put through this place, he would have had to go through a process. Going through those hoops is completely different from someone just saying, "I've had enough", and a family member coming home and finding them hanging in the garage, with all the distress that that causes to the people who arrive at the scene first, such as paramedics and police. That is suicide. This is not suicide.

My worry is that a lot of people who do not want this in the legislation are the same people who want this bill to be called the voluntary suicide bill. I think there is an ulterior motive here and we have to be very careful. I am not sure, and I will be guided by the minister, but does the Victorian legislation spell out that it is not suicide? I need to know. I understand that there is a problem with the commonwealth legislation. We have to spell out everything for all those people members have been talking about who are disadvantaged and who might not understand the legislation. It has to be spelt out that if a person's life has become unbearable, they are in such pain that it cannot be managed and they want to go through that process, what they are doing is not committing suicide; they are deciding that they want to take a different path, and make a different choice, at the end of their life. They might

want to do that surrounded by family and friends, not in a lonely way on their own in a garden shed, by driving their car into a tree or jumping off a boat in the middle of the ocean. We have to support this. It is very important that this clause is in the legislation.

Mr R.H. COOK: I thank members for their commentary. This is an important aspect of the bill. To answer the member for South Perth's question, it is not in the Victorian legislation, but it was a clear message that came through in all the consultation by the Ministerial Expert Panel on Voluntary Assisted Dying, and I have Mr McCusker sitting next to me and providing me with this feedback. In all the community consultation, people were very clear: "Do not call this suicide; this is not suicide." They wanted us to make that distinction within the legislation, because they are saying that this is not suicide; this is the relief of suffering at one's own hand.

The ministerial expert panel said —

> Suicides are potentially avoidable; 'every effort should be made to prevent these deaths' and there is a 'range of critical work being undertaken to prevent suicide'. By contrast, the people 'who are the focus of voluntary assisted dying face an inevitable death as a result of an incurable disease, illness or medical condition. It would not be appropriate to use the same terminology to describe' their choice about the circumstances of their impending death. For these reasons, the Panel agreed the word 'suicide' should not be used in relation to voluntary assisted dying. It is wrong to confuse these two very different kinds of deaths.

From that perspective, the very clear call from the community—we all know that the community wants this legislation, that it is widely supported and that in the community's mind this is not suicide—is that this is an important addition to the legislation. I reiterate that this was not put in for ideological reasons; it was put in to make sure we have clear and competent legislation, and it was put in before the issues with the commonwealth were raised. I made this comment before the member for Hillarys came into the chamber: I do not expect to be able to convince him of this because it goes to the deep, fundamental and philosophical issues inherent in the bill. I know many members, both in front and behind me, find that difficult, but we do have to grasp the moral nettle to take this on.

The member for Cottesloe said that it is like saying that the sky is pink when he believes it is blue; the member for Hillarys said that it is like calling something black when we all know it is white. I am not sure I can convince those members about this. I do not mean that disrespectfully and I do not say that the arguments are not pronounced; however, this goes to the deep philosophical aspects of the bill. It is an important clause to create clarity in both the minds of lawmakers and the community that we are doing something that is very distinct from suicide. We are prescribing very carefully the circumstances in which voluntary assisted dying will take place to create that distinction that, as the clause says, "For the purposes of the law", it is not suicide. For that reason, it is important to make that distinction. If a death takes place outside the framework of this law, it will become subject to the Criminal Code and it is suicide. We are providing absolute clarity around what the community's intent is on this—this was screamed from the rafters in the community consultation process—and the legal aspects of it; that is, to make very clear the intent and scope of it in the minds of people who are observing this law.

Mr S.K. L'ESTRANGE: I want to pick up on some of the minister's remarks. I am still keen to understand why we need to ignore what is a fundamental definition. An equivalent to clause 11 is not contained in the Victorian Voluntary Assisted Dying Act 2017. Before I go on, can the minister explain why it has been deemed necessary to include such a clause in this bill when it was not deemed necessary in the Victorian bill?

Mr R.H. COOK: I think Oregon probably looks at the Victorian legislation and thinks, "Wow! We wish we'd included some of the elements they have in their bill." I think that Victoria might be looking at our bill and saying, "Wow! I wish we had that insight before we drafted ours." Each time a jurisdiction legislates for these issues, we modernise and make more contemporary, sound legislation. Before the member for Churchlands joined us, I provided a lengthy explanation to the member for Dawesville about the background and thinking on this. I do not want to go into those arguments again, but it is there for reasons of clarity and to assure people in the future what the intent of the legislation is. It is not an ideological flight of fancy; it is about creating modern, competent and appropriate legislation.

Mr S.K. L'ESTRANGE: I have some further questions. If suicide is not recorded on a death certificate, what will be recorded? A lot of researchers and universities undertake research into the causes of death to track the health of our society over time. That certainly is being done at the University of Western Australia where researchers are going through all the coroner's reports to look for markers on the cause of youth suicide. It is quite a big study that is going on at the University of Western Australia that will take some time. Going back through all the documentation on a person's death to understand exactly how and why they died can be very informative and helpful for our society in the future because it results in better health outcomes. I am very interested to know how that information will be captured, if suicide will not be recorded as the cause of death for people who take their lives prematurely

through the Voluntary Assisted Dying Act, and how will we as a society be able to assess in time how many people have taken this option? I think it is important to know that.

I now turn to the comments the minister made when he referred to the ministerial expert panel. I understand an assumption was made in the Ministerial Expert Panel on Voluntary Assisted Dying discussion paper that suicide involves the tragic loss of life of a person who is otherwise not dying. The premise of that is straight-up wrong. The committee's report states that it was provided data from the State Coroner that demonstrated that as many as 10 per cent of suicides in Western Australia each year are carried out by people who are suffering from terminal, chronic or neurological conditions; that is, people who are dying are committing suicide. In the government's own committee report, the minister's statement that suicide is not about people who are dying has been found not to be true. The need to remove the word "suicide" from voluntary assisted dying does not make a lot of sense to many of us, and the minister has heard why. Fundamentally, it comes back to the definition of the term, which is the action of killing oneself intentionally. That is what it is. It is not pleasant. It is not something that any of us want to have to see a member of our families go through. It is tragic. We are simply denying that fact.

Last night we heard in debate on, I think, clause 10, how people will receive advice from a doctor. An amendment moved by the member for Armadale was seeking to include a clause in the bill to make it illegal for a doctor to initiate a conversation around voluntary assisted dying—essentially, a conversation about ending life early, which is suicide by definition. We cannot mince words here. We have to be honest about what we are dealing with and the whole premise of society. If society is saying, as the minister points out, that it is in favour of the bill, that is fine. But that does not negate a responsibility for the legislation to accurately reflect what is happening by using correct definitions.

Mr P.A. KATSAMBANIS: I am sure the minister will address that. I listened to the minister's explanation, in which he suggested that this was a moral divide. The point I made in my contribution, which the minister has not answered, and I understand that we will be poles apart on this, is that it was unnecessary to frame this clause in a way that creates that moral divide. This is not a clause that I believe has been included in this bill for some sort of moral purpose or to define the relative morality that has been balanced here. It ought to have been a very simple legal protection clause, and it could have been drafted in a way that it was. Unfortunately, as we discovered last night with the very good new clause moved by the member for Armadale, it is quite clear to me that the minister and the government are simply not prepared to consider any suggestion made in good faith to make this legislation better and safer. I will not continue on that path, but I would like to interrogate the operation of this clause, because it will be critically important for people who are participating in this space. Obviously, I am not a supporter of this type of regime, but there are people out there who are and who will be engaged in this, either as medical practitioners, other health practitioners, pharmacists, nurse practitioners and the like. This clause says —

> For the purposes of the law of the State, —

Just for the state, not for the commonwealth —

> a person who dies as the result of the administration of a prescribed substance in accordance with this Act does not commit suicide.

I emphasise "in accordance with this act". What if there is a death under this legislation that is committed by the self-administration of a substance that would, in the ordinary course of language, not under this bill, be considered suicide, and it is later found that some of the requirements of the legislation were not complied with—a form was not filled out, a step was not taken, perhaps a capacity decision was wrong? All those individuals exposed in the chain would then be exposed to the operations of the Criminal Code, would they not, minister?

Mr R.H. COOK: I thank the member. I will go back to a number of those issues that the member for Churchlands raised. I think he described what would be on the death certificate. Again, I already answered that question from the member for Dawesville earlier in the day, but for that purpose, that is covered later in clause 51. I am happy to discuss that when we get there.

In relation to the other comments the member made about the reports and the oversights and so forth, that is covered in the clauses dealing with the Voluntary Assisted Dying Board. The board will be required to prepare an annual report, and within that annual report it will address issues to do with its oversight of the legislation. That report will obviously be a public report, and will provide clarity and information on the functioning of the legislation.

I come to the point that the member for Hillarys raised around the issues of morality. As I said before, this clause provides clarity and signals clear intent in relation to the law from that perspective. The member might think that it uses confronting language, but from that perspective, this clause does both those things and provides important insights.

In terms of the second part of the member's question, there are offences under the bill. Some of those offences may be considered at the minor end of the process, and some at the very extreme end of the process. That is why the penalties under the bill range from fines of up to $10 000 to life imprisonment. We are dealing with difficult and serious issues here, and that is why there are 184 clauses in this bill to ensure that we have safeguards in place to ensure that this takes place. In its oversight, the Voluntary Assisted Dying Board will be able to have reference to the coroner, the Australian Health Practitioner Regulation Agency, the police and the chief executive officer, and from that perspective we will have every opportunity to examine whether the law is not working. But as the member can see, in every aspect of this bill there is a capacity to review to make sure that we have safeguards in place. From that perspective, and on the point the member for Churchlands made, the annual reports of the Voluntary Assisted Dying Board will show this at a forensic level and we will be able to understand what is going on.

Mr P.A. KATSAMBANIS: I do not find that answer satisfactory, and I put on record right now that anyone involved in this regime should be fully aware that if, after the event, it is found that there was a failure of process to comply with all aspects of this legislation, they may be liable to penalties under the Criminal Code. This clause does not say "in substantial compliance with the act" or "in accordance with the really important parts of the act rather than the less important parts of the act, or the less critical parts of the act"; it says "in accordance with this act". If a pharmacist prescribed a substance to an individual who then took it and ended their life, and it was found that further up the chain one of the practitioners had not complied with every step along the way, that pharmacist would not have the protections that this clause purports to deliver. They would then be liable for penalties under the Criminal Code for assisting suicide. If a delivery person delivered the substance, the same thing would apply. If an intermediary were involved, it may apply to them. In actual fact, if the second of the two medical practitioners signing off did things in good faith but the coordinating practitioner did something wrong, perhaps they might be liable under this sort of framework. Despite the language used, I believe this clause is drafted to provide protection in good faith; I just think it fails that test and is unsafe for the practitioners involved and for all the parties involved along the chain. If we took off our ideology blinkers and treated this as legislation that can be improved, then I think the minister would be providing better protection for those people he wants to empower with this legislation. This is not me standing up and saying, "I have a philosophical objection to this bill", which I have; this is me standing up and saying, "You're not actually achieving what you ought to be achieving with this clause." It is a flawed clause; the minister can do better. If he wants to let it go through, let it go through, but he cannot say he was not warned.

Mr R.H. COOK: This clause is informed by advice that we have received within government from the Solicitor-General, the Department of Justice, the Director of Public Prosecutions and the State Solicitor's Office. The member has made a number of remarks and comments in this debate. Most of them are very insightful and helpful; this is not one of them.

Mr V.A. CATANIA: I carry on under clause 11. At the start of consideration in detail I spoke to the minister about his conversations or his department's conversations with the commonwealth Attorney-General and the Attorney-General's Department. If my memory serves me correctly, the minister said that he would provide me with some information on that correspondence. I think the member for Hillarys has a point about section 474.29A and 474.29B of the commonwealth Criminal Code Act. Has the minister sought clarification from the federal Attorney-General? The minister said that the Western Australian Attorney General wrote to his federal counterpart seeking clarification. When was clarification sought by the Attorney General? It is my understanding that the state Attorney General sought advice from the federal Attorney-General on this very matter as little as seven days ago. The member for Hillarys asked a very important question—one that members of the chamber need to ask: has the commonwealth Attorney-General's Department corresponded with the minister, his department or the Attorney General to give confidence that this does not go against the commonwealth Criminal Code Act 1995 in any way? This is a very important point if we are to move forward with the legislation. Perhaps the minister can table the correspondence that the Western Australian Attorney General sent to the federal Attorney-General and any advice that the minister has sought through the State Solicitor, the minister's department or any other means to clarify this point. Potentially, people may breach the commonwealth Criminal Code Act. I do not think anyone wants that to happen. We are questioning the legislation in good faith. Members may or may not agree with the legislation, but we will hit a brick wall in furthering this legislation if we cannot clarify the situation or the minister does not table the correspondence to show exactly how this provision will not breach the commonwealth Criminal Code Act. The minister said at the start of consideration in detail that he would provide that evidence.

Mr R.H. COOK: I cannot table the letter because it is a letter between the Attorney General and the commonwealth Attorney-General and, from that perspective, it would be inappropriate to make that correspondence public. I can confirm that this issue was first brought to our attention on 26 June after it was raised in the media and public discussions. Conversations have been ongoing since that time. I can confirm that the Attorney General wrote a letter to the commonwealth Attorney-General dated 28 August in response to the conversations that were taking

place between the state Department of Health and the commonwealth Attorney-General's Department. It is not an impediment to the bill. But certainly as I confirmed privately to the member for North West Central, and I am sure I have talked about it in the chamber in the course of the debate, this is material to the issues associated with the commonwealth act. The drafting of the legislation did not come subsequent to the discovery of the issue. The drafting is there for our own purposes, although it is material to that discussion. What it means, as the member knows, is that it comes down to the issue about a carriage service—I think that is the expression—such as telecommunications, the internet and so forth in relation to the provisions of the Voluntary Assisted Dying Bill 2019. We are very confident that there is no conflict between the commonwealth act and this legislation. If we have to get around it because that is not the case, we will get around it. In the context of the member's constituents, that will mean that we will have to get out on the ground. That will be more expensive and more difficult, but it is the right of the member's constituents to receive that service.

Mr V.A. CATANIA: I sort of accept the minister's explanation. However, the government found out about this in June and the Attorney General wrote to the federal Attorney-General only on 28 August. There is quite a time between first finding out about the issue and writing a letter. The minister may not want to disclose the letter but I think that either he or the Attorney General should disclose it to members in the chamber because that will give us clarity about what the Attorney General asked. Did he ask for advice about whether this clause breaches the commonwealth Criminal Code Act? Did the letter that the Attorney General sent to the federal Attorney-General ask for clarification about whether clause 11 will breach the provisions of the commonwealth Criminal Code Act? That is a very important question. Alternatively, did the Attorney General write to the federal Attorney-General to say, "There's nothing to see here. Our advice says it's okay"? They are two very distinct and different questions. It is important that the minister table the Attorney General's letter to provide clarity and remove any uncertainty that someone may commit a crime.

It does not matter whether members think this bill is right or wrong. As I said, I support this legislation but we want to make sure that it is as tight as possible so that no-one breaks the law. Will the minister table the advice sought on this matter about whether the bill breaches the provisions of the commonwealth Criminal Code Act? Did the Attorney General seek advice on whether that is the case or did he provide advice to the federal Attorney-General on this issue? They are two very different but very important questions. If the Attorney General wrote to the federal Attorney-General and said, "Look, we believe that we are right. Our advice says that we are right", that is not asking the federal Attorney-General whether this will breach the commonwealth Criminal Code Act. Given that the Attorney General wrote the letter on 28 August—we are now seven days or so down the line—and we are debating this clause today, has the minister picked up the phone and spoken to the federal Attorney-General and said, "We really need your advice on this matter urgently to ensure confidence in the chambers of the Parliament of Western Australia that no-one is going to break the Criminal Code Act"? That is a fair question. There is urgency in this matter. The Attorney General sent a letter several months after the government found out that this clause could potentially breach the commonwealth Criminal Code Act. I do not think that is good enough. There should have been a phone call to, or a meeting with, the federal Attorney-General, who happens to be from Western Australia, to determine whether this clause is in breach of the commonwealth Criminal Code Act. Minister, I have asked two questions. Is the minister able to clarify what was in the letter if he is not prepared to table it? It is important that we receive the advice that the minister received to give peace of mind to not only those members who support the legislation, but also those who do not support it but are working to ensure that it is workable and watertight so that people who go down this path will not break any commonwealth laws.

Mr R.H. COOK: The member will appreciate that we will not waive privilege. There has been communication between the Department of Health and the commonwealth Attorney-General's Department. The government is consulting with the commonwealth to ascertain its position with a view to seeking an undertaking that the commonwealth will not prosecute or that it will take steps to amend the Criminal Code Act 1995 to make it clear that the provisions do not apply to voluntary assisted dying. There has been a lot of activity within the department. We do not seek advice from the commonwealth. We seek advice from the Solicitor-General and other counsel within government. That process takes time and there has been a lot of discussion around that. That clarifies the two points the member made.

Mr V.A. CATANIA: It is interesting that the minister says that this letter is privileged. If he wants to claim privilege on this letter, perhaps he may look at ways in which members on the other side have foregone privilege of the house in other parts of Parliament when it comes to emails of members of Parliament. This is about people who want to end their life because they are terminally ill. The minister is now saying that he is hiding behind privilege on a letter that the Attorney General has sent to the federal Attorney-General. Minister, is the letter asking for advice and clarity on the issue or is the Attorney General telling the federal Attorney-General that there is nothing to see here? I think it is a pretty honest approach to try to make sure that we flush out these things. If the

minister is hiding behind privilege for a letter about something that is so important, that tells me he has something to hide. He is not being forthcoming with the members in this place who are trying to ensure—I keep repeating myself, because I think this is important enough to repeat myself—that this legislation is watertight, and that no-one will breach the commonwealth Criminal Code. I think it is important for members to know. This debate has been conducted in good faith, to make sure that we uphold the standards that the community expects of us as members of Parliament in debating this extremely important legislation, probably one of the most important bills that we will ever debate. People out there expect us to do our job—to scrutinise and make sure that we cover every possibility. We have to dot our i's and cross our t's. I am sure that all members of Parliament, whether they support the legislation or not, want to ensure that no-one is breaching the commonwealth Criminal Code.

In order to move on from this clause, it is important that the minister provides the evidence to show that anyone who goes down this path will not breach the commonwealth Criminal Code. That is all we are asking. Provide us with the knowledge and safety that the work has been done to ensure that no law is being broken. I cannot see how that letter is privileged. I have been passed a letter—where did that come from? Anyway, I cannot see how this letter is privileged, given the debates that are occurring in this place on other matters that are considered not to be privileged. This is about dealing with people's lives. This is about ensuring that no-one goes to jail for doing something that this state says is right but the commonwealth says could be wrong. That is the important thing. Will the minister table the Attorney General's letter? As I said, I want clarity on whether the Attorney General has said, "There is nothing to see here! We are right. Our advice says that we are right." We would like to see that advice. Alternatively, has the minister sought advice from the federal Attorney-General on whether the commonwealth Criminal Code will potentially be breached? Those are two very important questions because there are two very different answers.

Mr R.H. COOK: If the member sits down, I can clarify.

Ms A. Sanderson: Sit down, member!

Mr V.A. CATANIA: Hang on. Member, do not be like that! We are being open and honest, and having a debate in this house to ensure that no-one is breaking the law. Yes, we are, member, so do not be pushy. I will keep standing on this clause until we get the answer, because I think we deserve to have the answer to the questions I have raised.

Mr R.H. COOK: Thank you, member. I have been receiving subsequent advice while the member was on his feet—confirmation that it is okay to table the letter, but also confirmation that the member has actually been provided a copy of the letter. I do not have a copy here. I see that there was an exchange of documents between the member for North West Central and the member for Warren–Blackwood. I think the member for Warren–Blackwood has a copy of that letter.

Mr V.A. CATANIA: The minister should still table it so that we all have a copy. I did not have it while I was speaking.

Mr R.H. COOK: I understand that letter has been with members for some time. I hope we can move on now. I do not have a copy of the letter. Obviously, I have seen the letter. It is not mine to table, but if the member can hand it to me, I can table it. I appreciate the member's spirited speech. It was a classic Catania, and from that perspective, I am happy to assist the member. If he gives me the letter, I am happy to table it for members. Perhaps the member could tell us, given that he now holds a copy of that letter, what it does. Obviously, he can see what it does.

Member, this is not something about which the Victorians are worried. They think they can work with it. They do not believe it is suicide, but from the perspective of clarity, they are getting on with the job, as would we. We do not believe it is suicide either and do not think it contravenes the commonwealth Criminal Code, so we will continue to move forward.

As the member said, this legislation is about important issues to do with life and death. It does not go to the nub of the issue of voluntary assisted dying; it goes to the issue of how we implement the act. We are determined to implement the act. The member is right: this particular issue relates to how we do that, but it will not stop us from doing it. I appreciate the spirit that the member brought to his contribution this morning, but this is not about whether we move forward. We are moving forward. This is about how we move forward.

Mr Acting Speaker, with your indulgence, I table the correspondence.

[See paper 2693.]

Dr M.D. NAHAN: If someone goes through the process, takes the substance and ends their life, and under this clause it is not defined as suicide, what is it? I know that we will deal with the coroner and the death certificate later. We can deal with that; that is a formal process. But what is it? We are prematurely ending life—maybe not very early, but potentially a year early in the case of somebody with an autoimmune disease. That is the purpose of this legislation. I am not questioning the purpose of the taking of the substance, but experience shows that if someone has a terminal disease, they do not necessarily die from that disease. They can often die from something else, such as a complication from the disease or the failure of another organ, or it might be something completely

extraneous. I have personal experience on this one. If someone took the substance, that would be the cause of death. In the absence of the substance, if the person has a terminal illness or autoimmune disease, that might not be the cause of death. What is the cause of death in this case? Will the death certificate indicate that they went through the voluntary assisted dying process? Therefore, it is open to question. What is it?

Mr R.H. COOK: Member, again, the notification on the death notice is dealt with substantially under clause 81, so we will come to that in due course. That is the specific. In general, this legislation is about voluntary assisted dying. If someone dies, the underlying cause of that death is put on the death certificate. For instance, if a patient's feeding tube was removed as they slipped away, the death certificate would not record that they died of starvation. If, as takes place in palliative care settings at the moment, people are encouraged in their departure—I had a very close relative who recently left us last week and this was the case—terminal sedation is not recorded. The underlying cause of the death is recorded. We will come to that issue under clause 81, but that is the general approach.

Dr D.J. HONEY: I think we have explored this issue pretty thoroughly and there are other important matters to consider, but I want to touch on a couple of topics that have been raised in the debate. Firstly, I thank the minister for pulling me up on the use of "guess". My only excuse is tiredness. It is an estimate. That was a fair comment. It is an estimate that is made. My concern is, and there are many examples, when those estimates are wildly inaccurate. We will debate that later on. In reference to a couple of the comments that the member for South Perth made, I suspect that everyone in this place has had some contact with suicide, as the minister clearly has. There is no shame in suicide. There is sadness, sorrow and heartbreak. It is not something that anyone should be ashamed of. As for defining suicide as a violent death, I have a close relative who committed suicide—someone I dearly loved—and their death was a gentle and considered death. It was not violent.

For my contribution and, I am certain, the contributions of my colleagues, this is not a contrivance for some other purpose. This is the most important bill that I have had to deal with in Parliament and probably the most important bill any member has had to deal with. This bill requires great consideration. We are not debating a concept. I know that some members are very keen on the concept and want this bill to go through now. They would be happy to vote on it now and for it to go through Parliament. We are debating a bill that has clauses in it. Our job is to make sure that there are not unintended consequences. We are respecting the process and we are respecting the Parliament in doing that. There is not some contrivance to change the title of this bill. For my part, and, I am certain, the part of everyone I have heard speak this morning, there is genuine concern about issues they have with the bill.

Ms M.M. QUIRK: I apologise if I am engaging in tedious repetition, but I have been paired this morning so there are a couple of things that I want to clarify about this clause. The minister has probably already told our colleagues this, but can the minister confirm whether the phrase "for the purposes of the law of the state" has any specific meaning or is it included to avoid unintended conflict with commonwealth laws?

Mr R.H. COOK: I am advised that for this legislation it is "for the purposes of the law of the state" because we cannot make laws for other states or extend that jurisdiction.

Ms M.M. QUIRK: That is a given, so I am a bit perplexed about why it needs to be there. If we proceed, the letter from the Attorney General dated 28 August this year to federal Attorney-General, Christian Porter, has kindly been distributed. Although, on its face value, the letter seems to suggest that people will not fall foul of sections 474.29A and 474.29B of the commonwealth Criminal Code, in the ultimate paragraph, Attorney General Quigley states —

> Officers from my Office, the Department of Justice, and the Department of Health would welcome discussions with officers from the Commonwealth … to explain the clauses in the Bill that deal with any potential interaction with the … Criminal Code.

I have two questions. Firstly, have any discussions taken place; and, secondly, has federal Attorney-General Porter responded to the letter?

Mr R.H. COOK: As I have already reported to the chamber, conversations have been going on between departmental officials since 26 June. I am not aware that the federal Attorney-General has responded, but that is, obviously, with the state Attorney General.

Ms M.M. QUIRK: The state Attorney General has written that he has —

> … taken advice at the highest level and it is my view that communications about voluntary assisted dying by a carriage service do not contravene the Cth Criminal Code.

He says that is his view. Was it the view of the people who gave him the advice, and who were those people?

Mr R.H. COOK: I am advised that our view was informed by the Solicitor-General, and the Director of Public Prosecutions in conjunction with the State Solicitor's Office and the Department of Justice.

Ms M.M. QUIRK: Is it possible for legal professional privilege to be waived and that advice to be tabled?

Mr R.H. COOK: The member will appreciate that it is not.

Ms M.M. QUIRK: What is the reason it would not be?

Mr R.H. COOK: Because we do not waive privilege in these circumstances. We are monitoring the situation very closely.

Ms M.M. QUIRK: This probably has been repeated by other people, but the minister will excuse me if I repeat myself. Is clause 11 purely to obviate the issues that have arisen in Victoria that conflict with the commonwealth Criminal Code?

Mr R.H. COOK: I have spoken to this already. It is not. The drafting of this legislation predates the issues that have come up. This is about the clarity and intent of the law.

Ms M.M. QUIRK: One of the regimes that is heralded as being successful is the one in Oregon, where I think it is referred to as patient assisted suicide. I am trying to get some clarity about why there is the issue with suicide here. Is it a question of the stigma or are there some broader issues?

Mr R.H. COOK: I cannot provide insight about the lawmakers of Oregon. I know that no jurisdiction legislating in this area since 2009 has used the word "suicide".

Division

Clause put and a division taken, the Acting Speaker (Mr R.S. Love) casting his vote with the ayes, with the following result —

Ayes (45)

Ms L.L. Baker	Mrs L.M. Harvey	Mr D.R. Michael	Ms J.J. Shaw
Mr I.C. Blayney	Mr T.J. Healy	Mr K.J.J. Michel	Mrs J.M.C. Stojkovski
Dr A.D. Buti	Mr M. Hughes	Mr S.A. Millman	Mr C.J. Tallentire
Mr J.N. Carey	Mr D.J. Kelly	Mr Y. Mubarakai	Mr D.A. Templeman
Mr V.A. Catania	Mr Z.R.F. Kirkup	Mrs L.M. O'Malley	Mr P.C. Tinley
Mrs R.M.J. Clarke	Mr F.M. Logan	Mr P. Papalia	Mr R.R. Whitby
Mr R.H. Cook	Mr R.S. Love	Mr S.J. Price	Ms S.E. Winton
Ms M.J. Davies	Mr W.R. Marmion	Mr D.T. Punch	Mr B.S. Wyatt
Ms J. Farrer	Mr M. McGowan	Mr J.R. Quigley	Ms A. Sanderson *(Teller)*
Mr M.J. Folkard	Mr J.E. McGrath	Mr D.T. Redman	
Ms J.M. Freeman	Ms S.F. McGurk	Ms C.M. Rowe	
Ms E.L. Hamilton	Ms L. Mettam	Ms R. Saffioti	

Noes (7)

Dr D.J. Honey	Mr A. Krsticevic	Dr M.D. Nahan	Mrs A.K. Hayden *(Teller)*
Mr P.A. Katsambanis	Mr S.K. L'Estrange	Ms M.M. Quirk	

Clause thus passed.

Clause 12: Inherent jurisdiction of Supreme Court not affected —

Mr P.A. KATSAMBANIS: I note that the Premier is the minister at the table at the moment; welcome, Premier. Clause 12 states —

> Nothing in this Act affects the inherent jurisdiction of the Supreme Court.

Why do we need this clause? We are dealing with the inherent jurisdiction of the Supreme Court. If it is inherent, this bill would not necessarily do anything to that inherent jurisdiction. I do not have a problem with it being there, but why do we need it?

Mr M. McGOWAN: The advice of my learned colleagues is that it is to make it clear that the jurisdiction of the Supreme Court is not impacted in any way. This has often been raised as an issue for matters related to assisted dying, so an express provision will avoid all doubt. The Supreme Court may, in the exercise of its parens patriae jurisdiction, make orders for the protection of vulnerable people such as children, the mentally ill and the elderly. The parens patriae jurisdiction may be invoked in respect of persons who have mental capacity but whose autonomy has been compromised because they are under constraint or subject to coercion or undue influence. It provides an additional protection, if you like, which I thought members would support.

Clause put and passed.

Clause 13: Relationship with *Medicines and Poisons Act 2014* and *Misuse of Drugs Act 1981* —

Mr P.A. KATSAMBANIS: This clause deals with conflicts or inconsistencies between the provisions of this bill and provisions of either the Medicines and Poisons Act 2014 or the Misuse of Drugs Act 1981. It states clearly that when there is any conflict or inconsistency, this legislation will prevail to the extent of the conflict or inconsistency. Clearly, that is important and, clearly, it is drafted on the understanding that conflicts or inconsistencies may be present. Some practitioners will grapple with this issue. For the avoidance of any doubt and for further clarity, can the Premier put on the record examples of the sorts of conflicts and inconsistencies that have already been determined between this legislation and those two other acts and, therefore, highlight to people the things from which they will be protected by this clause?

Mr M. McGOWAN: This clause provides that if there is a conflict or inconsistency between this legislation and the other acts, this legislation will prevail to the extent of any conflict. The Medicines and Poisons Act applies to poisons, including a voluntary assisted dying substance, and regulates and controls the manufacture and supply of medicines and poisons. It also contains offences related to the manufacture, supply, prescription and possession of schedule 4 and schedule 8 poisons, and poisons more generally. For example, there are provisions relating to unlawfully obtaining poison by wholesale; fraudulent behaviour to obtain supply of poison; storage, handling, transport and disposal of poisons; and record keeping and reporting. The voluntary assisted dying legislation will prevail over the Medicines and Poisons Act in the event of a conflict or inconsistency. The Misuse of Drugs Act applies to schedule 8 poisons and some schedule 4 poisons and also contains offences relating to the manufacture, sale, supply or possession of prohibited drugs and drug paraphernalia. The voluntary assisted dying legislation will prevail. I think this is to ensure—maybe I will be corrected—that there is not a provision under those other acts that prevents this legislation from operating. Obviously, under the voluntary assisted dying legislation there will be substances that people will need to consume, as awful as that is, in order to access voluntary assisted dying. If there is an inconsistency, this legislation will prevail in order to allow the intent of the legislation to operate.

Mr P.A. KATSAMBANIS: I take it from the last part of that answer that this clause is really about covering off in case, at some point in time, there is a question about the processes undertaken in the compounding, sourcing and supply of the poisonous substance. It is in case the multiple operations of the provisions come up with a conflict or inconsistency rather than having identified a specific conflict or inconsistency between those two acts and this legislation. In the ordinary course of events, I imagine that a practitioner, be it a medical practitioner or a pharmacist, would not be in contravention of either the Medicines and Poisons Act or the Misuse of Drugs Act if they were following the provisions of this legislation.

Mr M. McGOWAN: My understanding is that there are consequential clauses further on in the bill, which will be dealt with later, that narrow the scope of who can prescribe the schedule 8 poisons for the purposes of voluntary assisted dying. In effect, this clause is saying that this bill narrows the way in which those substances will be prescribed, supplied and used, and that if there is a difference between this legislation and the other acts, what that might be for. When it is for therapeutic purposes, this legislation will prevail.

Mr P.A. KATSAMBANIS: That last answer is very helpful because it tends to indicate that this legislation will provide a narrower regime for these particular drugs than may otherwise be deemed through those other acts. Was any consideration given to the necessity to make direct amendments to those acts in drafting this bill, or was it considered better to simply put in this clause and deal with it that way rather than directly amend those acts?

Mr M. McGOWAN: As I understand it, the member is correct. Further amendments in part 11 of the bill amend those acts in the way the member is suggesting.

Clause put and passed.

Clause 14: When person can access voluntary assisted dying —

The ACTING SPEAKER (Ms S.E. Winton): Thank you, Premier. You were a great bench man.

Dr D.J. HONEY: I congratulate the Premier on the speedy progress of the clauses.

Mr R.H. Cook: Member for Cottesloe, we will be having words later.

Dr D.J. HONEY: Clearly, the elder statesman of the house.

The ACTING SPEAKER: Member for Cottesloe, I am hoping to get some more clauses done while I am in the chair.

Dr D.J. HONEY: As has happened before, I am not sure whether this is the correct spot to discuss this. I am happy to have the minister's guidance, but I thought this would be a chance to debate this point so we can perhaps avoid debating it earlier—later on, I should say. We could go back to the future! Clause 14(a) states —

> the person has made a first request; …

I am interested in the form of that request. Obviously, there are overt requests when someone articulates that they wish to do this and engage the doctor as a coordinating practitioner. Some may not be able to speak, but they are able to write, so they write down that request. It is quite clear, and the legislation goes through all the other checks in that process. I wonder whether a scenario that has been put to me would also constitute a request. Imagine a mother has previously told her daughter, "When I get to this point, I no longer wish to live. I wish to end my life." Then the mother gets to the point at which she cannot communicate—she cannot talk and she cannot write—so the daughter articulates the request. The practitioner, who may be the coordinating practitioner, says to the mother, who can hear perfectly well, "Your daughter has indicated this. Is this your request?" The mother nods or makes some other indication in agreement. Would that also constitute a first request? I am not going to labour this point, but then obviously in the other stages of the process, would that same process constitute compliance with the legislation?

Mr R.H. COOK: The member is right; it is dealt with in detail later in the bill in clause 17. The request must be clear and unambiguous. The first request is verbal, not written, but it could be communicated by a gesture. The member outlined a scenario in which the daughter says that mum wants this, the doctor turns to mum and asks her whether it is something she wants, and mum says yes with a wave of her hand or whatever. I do not think a medical practitioner would say that scenario was clear and unambiguous. The principle here is that the request must be clear and it must come from the person. We do contemplate a situation in which someone cannot speak; the doctor in that scenario would have to have a very direct exchange with the mother. It could not be augmented, if you like, by the daughter beginning the process and mum just waving her hand to say she is going along with this. Under clause 17(2)(a), the request must be "clear and unambiguous". It is an important step; obviously, the medical practitioner would want to satisfy themselves absolutely that it is not just someone going along for the ride.

Dr D.J. HONEY: It is clear in the minister's mind that the request has to come directly from that person. Thank you, minister.

Mrs L.M. HARVEY: I seek clarification that a person needs to meet all the criteria to access voluntary assisted dying.

Mr R.H. Cook: Yes, member.

Mrs L.M. HARVEY: I draw the minister's attention to clause 14(c) —

> the person has made a written declaration; …

I seek a bit of information around that paragraph. Obviously, some people are incapacitated—they might have paralysis or whatever it might be—and would not be able to make a written declaration. This might also be problematic for individuals who cannot speak. Can the minister cover off on how those circumstances can be managed to satisfy the criteria for a written declaration? If the person's language is other than English, can the written declaration be made in Italian, Greek, Arabic or whatever language it might be or does it need to be a written declaration in English?

Mr R.H. COOK: I am advised that in the event that someone makes a written declaration, protocols will already be in place about the way that that person communicates. It might be by way of iPad or something like that. They would obviously be at the end of a long journey and there would be clear protocols with their clinician about the way that they communicate their wishes, so it would take advantage of that. Division 5 of part 3 deals with how someone can make a declaration. Legally, a person can make a written declaration without putting pen to paper. It provides avenues and ways that that can be undertaken.

On the question of the language, the role of the interpreter is made clear in clause 41(6), so we can come to that in due course—hopefully sooner rather than later. The Department of Health stands by the language services policy, including using a language other than English. Yes, it would be okay for that person to make a declaration in a language other than English, but clearly the medical practitioner would need to be satisfied that they have an appropriate translation of it.

Mrs L.M. HARVEY: Drawing on my experience as a former Minister for Police, we started to tape in various different Indigenous languages the information that people need to receive when they come into the custody of police so that individuals understand exactly what is going on. Could an illiterate person who wants to access voluntary assisted dying have a voice-to-text arrangement or a recording of their wishes? Would that be acceptable in lieu of a written declaration for somebody who is illiterate?

Mr R.H. COOK: Ultimately, there has to be transcription, and there are ways that someone can transcribe what the other person has verbally communicated and then make a written declaration in that instance. The member raised the issue of the language barriers in Aboriginal communities. I think she is absolutely right to raise that as an issue. I know the Attorney General has been working on its interaction with the justice system. We are looking

at a range of ways that we can engage people from an appropriate cultural background to translate not so much for VAD, because that will come with the implementation, but certainly around palliative care.

Mr Z.R.F. KIRKUP: Clause 14(b) refers to the coordinating practitioner and the consulting practitioner. I note and entirely accept the definitions of both those terms. I think this has come up a number of times and certainly the Australian Medical Association has stated its position on the level of commerciality that might exist between the coordinating practitioner and the consulting practitioner. I note that there is nothing in the requirements for people to access voluntary assisted dying to stop the level of commerciality that might exist between the coordinating practitioner and the consulting practitioner. Can I get some understanding from the minister about whether the ministerial expert panel or the minister looked at that? If my reading of the legislation is correct and there is an allowable level of commerciality—that is, two practitioners from the same practice—why was that included and not specifically ruled out?

Mr R.H. COOK: As I stated in my response to the second reading debate, the issue around commerciality is not considered to be a material risk. I think in the Netherlands, where this is much more prominent, it is around four per cent and the experience in Oregon is that it is around 0.4 per cent. We are really looking at a very small cohort of patients. Ultimately, there would be slim pickings if someone decided this was going to be their core business.

Mr Z.R.F. KIRKUP: I appreciate that. The sheer volume of people who will access voluntary assisted dying, by design of the legislation, is obviously meant to be a very small number. That is the intent with which everyone has approached this. This is just my own concern. I still have a level of reservation about the ability of someone to set up a dedicated clinic in the sense that there could be a deliberately designed facility at which people might access a coordinating practitioner, witnesses and a consulting practitioner without there being an existing relationship with their own practitioner. I would be quite concerned about a dedicated facility such as that. That is probably not the intent of the legislation. I think the intent of the legislation is to ensure that there is a deliberate and good faith interaction between patients and practitioners. If a commercial arrangement such as that were set up, I would feel quite uncomfortable about it, and I suspect most people in this chamber would feel uncomfortable about it. Although I realise the market force might not be there, some people—practitioners in particular—might be quite intent on establishing a clinic such as that. I appreciate that there is a two-year review, but is there any mechanism by which the CEO, the minister or the board might be able to get involved and stop that from occurring? I genuinely think that is a real and present concern.

Mr R.H. COOK: The member is absolutely right to identify those mechanisms. The board obviously would take a view on it. The board would refer that to the CEO, who is responsible for the management of it. Ultimately, the member is right; after some experience, we might want to put some sanctions around these things, but, as I said, it is not considered a material risk and can be managed within the administration of the legislation. As the member knows, the coordinating and consulting practitioners must make declarations. They are very solemn declarations that they, regardless of their corporate entity, are personally responsible for. We all know that most doctors in Western Australia went to school with each other—it is a small community—but they have to come to an independent view about the eligibility of the patient.

Mr Z.R.F. KIRKUP: Noting that the practitioners have to come to an independent view, would the minister believe that a clinic set up for the sole purpose of providing access to voluntary assisted dying would be in breach of the level of independence required by the two practitioners?

Mr R.H. COOK: Not necessarily. Again, the consulting practitioner cannot look at the work that the coordinating practitioner has done and say, "Oh, yes, that looks about right." They have to come to their own independent view on that. Again, as the member knows, medical practitioners specialise from time to time and maybe that would increase the quality of the work they do under that. We are talking about such a small cohort that I do not think there is material risk in how the process might work in that context.

Mr Z.R.F. KIRKUP: I appreciate that, minister. I might just leave it on this point: obviously, this is something that we should be aware of. I appreciate that the minister will likely have custody of this, at least during the implementation phase, so there is the possibility for the department and the minister to be aware of the issue. I note that the AMA provided information that reveals 82 per cent of doctors surveyed said that they believed a commercial contract should not exist between two practitioners. All of us are aware of that issue. It is difficult to specifically state how that could be prohibited because, of course, it would be very easy for a commercial relationship to exist between two subcontracting clinicians operating within the same facility, which occurs now in our hospitals. I appreciate that it will be very difficult to adhere to that and to legislate accordingly. However, I would appreciate the minister making an undertaking about that. The clinical expert panel also would have been aware of that as part of the implementation.

I put to the minister one challenge I see in the situation he described. If a clinic is set up in which Dr Smith and Dr Johnson, for example, are the practitioners and all patients go to Dr Smith first, then Dr Johnson will know that his role is to receive all patients from Dr Smith. It will be assumed, for example, that patients will have gone through the appropriate process of appointing a coordinating practitioner. Dr Johnson's role will be as consulting practitioner and although the relationship, or the commerciality, is not explicit, each of them will understand the role that the other plays. My best read of the legislation is that it is possible that a consulting practitioner will have a conversation with the patient about who their coordinating practitioner is. There is nothing that will rule that out. Any practitioner could assume, for example, that if a patient has gone to a coordinating practitioner—that is, Mr Smith—their role is as consulting practitioner. I appreciate that they will have to follow the provisions of the act and that these mechanisms will be in place. I just think we should be aware of that. I would appreciate some assurance from the minister that that is something we would be alive to and would be looked at as part of the implementation of the bill.

Mr R.H. COOK: The member is right. It is an issue that the board would be alive to. Obviously, it will be informed about every step of the process for every person who goes through this process. The board would very quickly pick up on what is going on and the CEO would investigate it.

Ms M.M. QUIRK: I have two questions. The first is: the minister reiterated that doctors must be independent from one another; I am not sure that I can find that in the legislation.

Mr R.H. COOK: Member, there is no express reference in the bill to the first and second assessments being independent; however, it is implicit. First, each coordinating consulting practitioner must assess whether a patient is eligible for access to voluntary assisted dying, which is contained in clauses 23 and 34. Second, the second assessment cannot take place until the patient has been assessed and is eligible for access to voluntary assisted dying by the coordinating practitioner and a referral is made to the consulting practitioner, which is contained in clause 29. Thirdly, a patient cannot be assessed as eligible for access to voluntary assisted dying by a coordinating or consulting practitioner unless the practitioner is satisfied that the patient meets all the eligibility criteria and understands the information required to be given to them, which is contained in clauses 27 and 39.

Ms M.M. QUIRK: Why is it "explicit"? It says "explicit" in the explanatory memorandum, but, ironically enough, it does not say that in the legislation.

Mr R.H. COOK: The explanatory memorandum reflects the intent and interpretation of the bill.

Ms M.M. QUIRK: The explanatory memorandum is a secondary aid when the legislation is ambiguous. It seems to me that it would have been more satisfactory to have put it in the legislation, but I know it was prepared in haste.

The second matter I want to talk about is clause 14(b), which refers to persons being assessed as eligible for access. I presume that is in the following clause, which is about the eligibility criteria. In particular I ask: will that assessment be subjective and will subjective factors be taken into account in relation to the person making the request, as opposed to an objective assessment?

Mr M. McGOWAN: The criteria and how they will be assessed are contained within clause 15.

Clause put and passed.

Clause 15: Eligibility criteria —

Dr D.J. HONEY: I would like to understand the thinking behind the age that has been chosen in this clause. I am particularly concerned about this age. I am sure other members will want to comment on this. One issue that affects a person when making such a decision is their experience of life. When I was 18 years old, I was quite fatalistic. As I recounted to another member, I grew up in the bush. I used to have a little Mini and I used to drive that car as fast as it would go on the gravel roads, oblivious of the concerns of the world, and it was only due to God's good grace that I am here now. My concern is that someone at the age of 18 years may be predisposed to make a decision, for example, to end their life but not understand the decision they are taking and what they are giving up. I appreciate this is in the context of an estimate of imminence of death, but we have heard a number of times that, although there will be some reasonable accuracy, there are many examples in which it is highly inaccurate. Was an older age considered? Why was this age chosen?

Mr M. McGOWAN: The age of 18 years is obviously the age of adulthood in our society, and has been for decades. At age 18 a person is eligible to go to war, which is the often-used example. A person can join the Army or other service and potentially go to war for the country, which has significant risk attached to it. The 18-year-old criteria was a recommendation of the joint select committee and the ministerial expert panel. It is contained within the Victorian legislation and is consistent with what occurs overseas. There was no other consideration of any other age.

Mr D.T. REDMAN: I want to ask a question which is further to a question I asked earlier. I refer to clause 15(1)(c), which states —

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

…

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

When we debated the definitions clause, I sought the minister's advice on whether he would consider including in the definitions a definition of "suffering". The simplistic one-dimensional approach to suffering simply says it is a physical suffering—it is pain—and everyone understands that. But the definition of suffering that the minister put to me was the full breadth of suffering, including mental suffering, spiritual suffering and emotional suffering. There is a whole range of suffering. I have the view that the full breadth of suffering in a very personal and subjective sense should be explicit in the bill. I seek clarification about where in the bill the word suffering is treated in the full context of suffering and not limited to physical suffering, which is perhaps the one-dimensional thinking that the broader community understands it to be.

Mr M. McGOWAN: I thank the member for the question. Whether a disease, illness or medical condition causes suffering to a patient that cannot be relieved in a manner that the patient considers tolerable, is a subjective element to be determined by the patient. This is consistent with the person-centred approach of the bill to voluntary assisted dying. Both the joint select committee 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, or, probably a mix of all, to be frank. It is up to the individual to determine the level or standard of suffering and how much they can withstand. It really is up to the individual to make that decision. I suspect in most, if not all, cases, the person in question will have gone through considerable suffering over an extensive time prior to making the decision to access voluntary assisted dying. Even then, it would be a decision they would make after some further consideration. By necessity, a person's pain and suffering is subjective and the decision is on their advice. I do not know whether it is physically possible to determine it objectively.

Mr D.T. REDMAN: The concern for me is not one of trying to constrain the bill. In this regard, it is to strengthen the full breadth of it. Nothing that I read in here gives us guidance that explicitly says that suffering is considered in the full context. I am concerned that it is an eligibility criteria for access to voluntary assisted dying. A practitioner could hold a view that physical pain is easy to define—if someone is groaning in agony, it is not difficult to understand what is occurring. If it is emotional or indeed spiritual pain, it is a very different beast. A practising practitioner will have been through training and whatever else in order to take on those particular roles. A person could present to them with spiritual suffering, and that might be something deep in their spiritual beliefs causing them significant concern. I understand it is a subjective issue, but I would be very concerned if that practitioner chose not to put the person into the eligible category because they defined suffering in a narrow sense, and therefore the person was not able to access the opportunities that this bill provides. I recognise there is a long way to get to that point, such as having an advanced progressive illness that will cause death in six or 12 months. I recognise that, but it concerns me that the last hurdle is a doctor or practitioner making judgement, and because it is an eligibility criteria, if it does not meet that threshold, they are not in the game. We need to be explicit about the breadth of that. I think a practitioner should be given a bit more scope and direction in the assessment of someone meeting a threshold of suffering, in the full breadth of that sense.

Mr M. McGOWAN: I agree with the member and that is why the explanatory memorandum is very clear that it is a subjective decision based on the patient's consideration of their suffering. If the member has a look at clause 15(c)(iii), it is qualified by the words "that the person considers tolerable". In effect, that explains that it is a subjective test by the person.

Mr D.T. REDMAN: Just for a little guidance, the Premier referenced the explanatory memorandum. If these matters come up as a challenge, in a legal sense, is the explanatory memorandum relevant in giving clarity to legislative intent?

Mr M. McGOWAN: My recollection of statutory interpretation is somewhat rusty, but under the Interpretation Act, the explanatory memorandum is used by courts in determining what the bill means.

Dr M.D. NAHAN: This a very important area and I think there is a lack of clarity in the community. I might ask some questions, and the purpose is to explore this a bit on behalf of the public. Under clause 15(1)(c), I accept paragraphs (i) and (ii). The issue I want to explore and get a response from the Premier about is building on the discussion he just had with the member for Warren–Blackwood. I want to clarify that pain has many dimensions. Indeed the evidence overseas, particularly in Canada, is that the majority of people taking up VAD are not necessarily suffering physical pain, but have what they call "existential trauma". They get a death notice and they respond to it. There might be an amalgam of dimensions of pain, I am not arguing that, but the perception out there is that this act will be restricted to people who have a terminal illness, as defined in the bill within a certain period, and when palliative care is not working any longer or is not working to address the pain the VAD will overwhelmingly be used in that restrictive sense. That might be the case. As I think the minister made particularly clear, the desire

to live is profound. I expect that to be the overwhelming case. However, people have asked me whether it will be restricted to people with just physical pain, and I want to get clarification for people who meet the criteria otherwise. For those who simply do not want to avoid the imminent painful death that has been the prognosis, will they be able to act pre-emptively on the basis of existential pain?

Mr M. McGOWAN: As I think I indicated before, suffering does not necessarily mean physical pain, when someone is writhing in agony; it can be other forms of pain as well. As I said before, I outlined a range of suffering, including physical, mental, emotional, social, spiritual or existential, or a combination of all of them. Some people do not want to go through palliative care. They might have seen it, they might have a religious objection, they might have a conscientious objection to taking drugs or something of that nature. It is all qualified under section 15(1)(c)(iii), which states —

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

The person makes the decision based on their own circumstances.

Dr M.D. NAHAN: I am not an expert in this, but the restrictions are, "cause death within a period of six months". My experience is that doctors usually give people an expectation and a range. How is that six months determined? Let us say a doctor gives someone a prognosis of six to 12 months? Does that fit? The doctor does not necessarily give a median or a mean, or a single quote, because there is a lot of uncertainty in it. What is the cut off?

Mr M. McGOWAN: It is six months or less, except in the circumstances of a neurodegenerative illness.

Dr D.J. HONEY: This is obviously a key clause of the bill, because it is trying to define that this will only be enacted given the imminence of death. My concern is around the impreciseness of that. I bothered to look at the scientific literature on this and some review papers. Having read those papers, I understand why it uses the phrase "balance of probability", because if doctors are estimating the period that someone is likely to live, that is the estimate that is most often accurate. If a doctor is asked how long someone will live, typically those estimates are quite inaccurate. But if a doctor is asked about the probability of a person living for six months, 12 months or two years, those estimates are much more accurate. However, as the Premier is well aware, our job in this place is to look at where this could go wrong. What really concerns me is that we heard from a relatively small group of people about a number of loved ones whose life estimates were not just a little bit inaccurate—they were wildly inaccurate. The member for Midland told us the harrowing story of Batong Pham, who was given a life estimate of days or hours, but, in fact, he completely recovered and has gone on to live a long and fulfilling life. He was unconscious so he would not have been able to access voluntary assisted dying, but his friends, relatives and loved ones were told that he was completely brain dead. I am recounting the member for Midland's story because I am not personally aware of it. However, after the suggestion of an ex-member of Parliament, whom many members here know very well, there was a change to his medication and he regained consciousness quite rapidly. Nevertheless, his relatives were told that he should be taken off life support and be allowed to die. He recovered and is living a long, happy and productive life.

The member for Carine gave us a similar example in which someone was told that they had only months to live but they went on to live for another 17 years. The member for Scarborough gave an extremely moving contribution about the circumstances of her husband, Hal. I will not go through that. My concern is that although we are talking about the balance of probabilities, it is imprecise. I appreciate that this bill will go through this place. What guidance will be given to this provision? What efforts will be made to improve it? These are hard lines in the sand, if you like. The bill refers to the balance of probabilities. The example given by the member for Riverton was of someone being given a balance of six or 12 months and the Premier answered appropriately that in the bill, it is six months and 12 months. My great concern is that someone will terminate their life based on that life estimate even though the estimate could be fundamentally wrong. People may want to end their life because the imminence of death is so disturbing and distressing. I would appreciate understanding how this will be improved. What guidance will be given to practitioners to make sure that we are not simply relying on their native talent?

Mr M. McGOWAN: Just to be clear, if a practitioner is unsure, clauses 25 and 36 provide that they must refer the patient for further advice. That is a safeguard. With the example of a person on a life support machine, so that members are aware, an individual on life support would not be able to access voluntary assisted dying. However, as we all know, life support machines are turned off every day by family members in conjunction with medical professionals. It is probably happening in our hospitals right now as we speak. Individuals in those circumstances will not be able to access voluntary assisted dying. The member referred to a miraculous recovery. That person would not have been eligible for voluntary assisted dying.

In relation to the balance of probabilities, a medical practitioner will be required to make a clinical judgement that a disease, illness or medical condition will cause death within six months or 12 months if the condition is

neurodegenerative. Only medically qualified professionals will be able to make that determination. The probabilities test will be used as agreed to by the Ministerial Expert Panel on Voluntary Assisted Dying in discussions with the department. The test is easily understood and has case law to support it. When considering whether a disease, illness or medical condition is expected to cause death within six months or 12 months if the condition is neurodegenerative, the medical practitioner will have regard for the treatment decisions made by the patient. This includes a situation in which the patient chooses not to undergo or continue treatment that may prolong their life. For example, if a person has advanced and progressive cancer that will cause their death but they refuse life-prolonging or other measures, the result of that decision is reduced life expectancy. Their time of death may be six months instead of 18 months with treatment. This person will still be able to access voluntary assisted dying as long as they meet the eligibility criteria. In any event, their disease, illness or medical condition is still terminal and they should not be restricted because they choose not to partake in treatment options that they find unacceptable. Patients should not be forced into treatment options to buy time. The bill sets out a robust assessment process that ensures that an accurate assessment will be made of a person's disease, illness or medical condition. Only qualified and suitably experienced medical practitioners may assess a patient's eligibility. Independent assessments must be conducted by two medical practitioners, who must each be separately satisfied that the patient meets all the eligibility criteria. Both medical practitioners will be able to refer any part of the assessment to a suitably qualified professional with specialised skills or training if they are unsure.

People refuse medication every day. In fact, I am familiar with someone who is presently in the position of not wanting medication. That is their choice. Some people think medication will make their situation worse. Some people have seen family members go through chemotherapy and decide that they do not want to go through it themselves and choose to live for a few months without chemotherapy than live a few extra months because of chemotherapy. That is a valid choice that people make every day.

Dr D.J. HONEY: Thanks, Premier. I am aware that a person whose situation is similar to that of the person in the first example will not be able to access voluntary assisted dying. I referred to it more as an example of the ability of doctors to estimate life expectancy, not as an example of a person in that situation having access to voluntary assisted dying. I appreciate the Premier's comments.

I come back to the accuracy of the estimate and coordinating and assessing practitioners. My understanding is that there is no requirement in this bill for either of the two practitioners to have any expertise whatsoever in the terminal condition from which the patient is suffering. I have heard this concern expressed by medical practitioners. A general practitioner may have a high level of confidence that they know—this is not uncommon with some general practitioners—but specialists in the area will have a far greater understanding of the illness and the probability of when that person may succumb to their illness. Is it correct that neither of the two medical practitioners will be required to have any specialist knowledge of the disease that will kill a person?

Mr M. McGOWAN: There is a requirement that the practitioners have at least 10 years' experience in the profession, and if the practitioner has any doubt, they are required under the act to refer to a further practitioner for that patient. In practice, the patient will have an illness, disease or medical condition that is advanced, progressive, and will cause their death, and in the vast majority of cases will have had consultation with a specialist and have been informed about treatment options. In all cases, an assessing medical practitioner will need to be satisfied that the diagnosis meets the eligibility criteria. Where available, the assessing medical practitioners would utilise results and reports from the relevant specialist in making that determination. If there is uncertainty regarding any of the eligibility criteria, then the practitioner is required to refer for further assessment, thereby linking the patient with a specialist in their disease who would inform the patient about treatment options. In addition, the bill would require assessing medical practitioners to provide the patient with a suite of information, including treatment and palliative care options. It should be noted that an adult patient of sound mind may refuse medical treatment, even if that refusal would lead to their death. The bill does not require the patient to undergo treatment that will prolong their life or might cure them, because to do so would cut across the fundamental principle of patient autonomy. Obviously, if we include a requirement that there needs to be a certain specialist involved, then in Western Australia—the largest state in the world—there are large areas in which people will not be able to access the provisions of this legislation.

Dr D.J. HONEY: I think the Premier gets the gist of my concern here. My understanding is that, in fact, the prognosis for the probability of death can be given by two medical practitioners who have no expertise at all in the disease that is going to kill the person. We have "may" and "can", but there is no requirement for them to seek any specialist advice. I have great respect for medical practitioners. I have a daughter and a brother who are doctors; I have two pending son-in-laws who are doctors. I have a few doctors in my own family, and I regard all of those people very highly. However, we should never look at legislation through the lens of the best possible outcome. That is great, if everything works out well. If everything worked out in the best possible way, I suspect your senior adviser would have had a much less illustrious legal career. Obviously, things do not go right. People do not do

things in the best possible way. The member for Dawesville raised the concern about, for example, the setting up of practices that specialise in this area. It may be that two doctors consider themselves experts in everything. It would give me much greater confidence in this bill if there were a requirement that at least one of either the coordinating or the assessing practitioner did have some specialist knowledge. I appreciate the difficulties that may cause in some circumstances; equally, I think it is very important that we do not have a situation of misdiagnosis that adds to the distress of an individual. In fact, that could be the distress that causes a patient to take their life much earlier than would have been the case if they had not had been so diagnosed. Certainly, we were given examples of patients who may have missed out on years of their life if they had been able to access voluntary assisted dying. I am not sure what answer the Premier can give me on this, but I express this view strongly: I believe that at least one of the practitioners should have some expertise in the particular disease. We should not rely on the fact that a general practitioner is an expert in everything.

Mr M. McGOWAN: As the member knows, the requirement is that there are two practitioners—the coordinating and consulting practitioner—both of whom are required to have at least 10 years' practical experience. The requirement by law is that if either of them is of the view that they are unable to make an assessment of eligibility—that is, the six months rule—then they are required to refer. That is mandatorily required. If there is any lack of clarity, or if they are unsure, they are required to refer. I have a lot of faith in doctors. I think that two doctors with 10 years' experience each who would in all likelihood have a range of medical reports before them would be able to make that assessment quite clearly, but if there were any doubt, then they would be required to refer.

Mr J.E. McGRATH: I need to make a comment about this. I could not imagine in any circumstance that if I went to my local general practitioner or any GP and said, "I have been given six months to live, I've got cancer", the GP would say, "Okay, you've got six months, fair enough", and then just write it down. He or she will want some evidence about who the patient has been going to, whether they have been on chemotherapy, and what is their specialist's name. We have My Health Record information now. They are not going to just tick it off without making some investigation into the patient's medical background and the treatment that they have been under. I understand the member for Cottesloe's concern about this, but I have a lot of faith in GPs and the medical system. I would not think that any self-respecting GP would just tick off on something like that. If I went to my GP with something like a skin complaint, in the old days, he would just burn it off or put something on it. Now, he would send me to a specialist. They do not take any chances, because they are worried about litigation. I think this process will be well run, and I think the GPs will make sure that a person cannot just knock on the door and say, "The specialist guy down the road has given me six months to live, I want to end it all." It is going to be a bigger process than that, and that is why I am supporting it.

Ms M.M. QUIRK: Clause 15 is titled, "Eligibility criteria". I note that clause 15(1)(a) states that the person must have reached 18 years of age. The question of language and how it is used has been an issue throughout this debate. I note that, for example, in clause 15(1)(a), "the person has reached 18 years of age" comes under the heading of "Eligibility criteria"; however, it is also described under the 102 listed safeguards. I would like some clarification: is it an eligibility criteria or is it a safeguard?

Mr M. McGOWAN: I would say it is both. It is a criteria—obviously, the person must be at least 18 years of age—and it is a safeguard that we do not have people under that age accessing voluntary assisted dying.

Ms M.M. QUIRK: The second issue that I want to raise is something that I foreshadowed when we were debating the last clause. I refer to clause 15(1)(c)(iii), which states that the medical condition "is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable." We have heard that that is a subjective test; it is a person-centred test. We look at the individual making the request to make the assessment. This is an issue that I raised at the consultation forum at Fiona Stanley Hospital. The circumstances of the individual making the request will be looked at. If someone is indigent, does not have many family members or other social networks, has a history of drug or alcohol addiction, or possibly has a disability, it could be said that they do not have much to live for. The response we got at that forum from Dr Towler was that a person in those circumstances would more likely be assessed as being an appropriate person than someone who had family supports or the personal resilience to persist. In those cases, it seems to me that a subjective test may well be creating a situation in which the vulnerable are vulnerable.

Mr M. McGOWAN: As I said earlier about suffering, it is a subjective test of what the individual involved can tolerate. That is contained within the clause. It will be up to the individual to determine what amount of suffering they can withstand. I think individual circumstances will be different depending upon the individual involved, but that is just one of the many eligibility criteria.

Dr D.J. HONEY: I want to explore two other subclauses, but I will do them sequentially. I refer to clause 15(1)(d), which states —

the person has decision-making capacity in relation to voluntary assisted dying;

Does the Premier have any details of how that decision-making capacity will be confirmed? I hear that there will be a process. My understanding is that the Victorian legislation requires a psychiatric report to make sure that it is in fact an informed decision that is not impacted by any psychiatric or mental condition and the person has the capacity to make an informed decision. There are two parts to it: How will this process ensure that the decision-making capacity is assessed properly? Why is there not a requirement to have a separate psychiatric assessment to test this? This goes to the heart of whether the person has the capacity to make an informed decision.

Mr M. McGOWAN: I think clause 6, which deals with decision-making capacity, may have been dealt with at length earlier. It may have been dealt with last night or the night before. The minister outlined all the criteria for a patient having decision-making capacity. That is where the definition of a decision-making capacity used in this clause is contained.

Dr D.J. HONEY: I appreciate that, Premier. I have not had any understanding of why we do not require a separate psychiatric assessment. I do not believe that was clearly answered before.

Mr M. McGOWAN: The advice I have is that a psychiatric report is not mandatory in Victoria. It is required only when there is doubt about the person's capacity to make a decision. The conditions about the requirement for a psychiatric referral is contained in clause 25.

Dr D.J. HONEY: I have a question on clause 15(1)(e). We covered this a little bit before. I am not going to go into a detailed description of the issue of coercion. My question is more about the nature of the training in coercion. What can we expect to see in that? Any of the lawyers who are in the chamber who have been involved in this area of law would know that that is an extraordinarily complex and subtle matter. I appreciate that the regulations and the details have to be worked out, but can the Premier give any outline of the sort of training that medical practitioners will have to enable coercion to be detected, particularly as there is no requirement whatsoever for the medical practitioner to know the patient at all?

Mr M. McGOWAN: There is already training for doctors about coercion because people make healthcare decisions all the time. Indeed, someone might make a decision not to have food or water in their last stages. That is exactly the same situation. General practitioners already refer people for further assessment if there is any concern about coercion. Just to be clear, when the consulting practitioner cannot determine whether the patient is acting voluntarily and without coercion, they must refer the patient to a person with the appropriate skills and training to make that determination. This may include experienced registered health practitioners; healthcare workers, including social workers; or police officers with skills and training to determine whether a person is acting voluntarily and without coercion. They may also refer the matter to existing authorities, such as the Western Australia Police Force, if they believe a person is being coerced to undergo voluntary assisted dying. The bill makes it a crime to unduly influence a patient in such a manner. As I said, people currently refuse food and water or treatment and, ultimately, it has the same outcome. It is just much slower and far more painful. Doctors have to deal with those situations as well.

Mr Z.R.F. KIRKUP: I have not gone through any of the eligibility criteria questions that I have. I am conscious that some members may have had similar questions. If I can, I will cover off a few clarifications very quickly. The minimum age of 18 years is stated in the legislation. Is there a minimum age for people to initiate access to voluntary assisted dying? I realise that they cannot make a final decision or access it until age 18, but is there a minimum age for the first request?

Mr M. McGOWAN: People cannot make the first request until they are 18 years old. I imagine that individuals of that age will be rare, but they would probably have gone through considerable suffering up to that point.

Mr Z.R.F. KIRKUP: Obviously, that means that a parent or guardian cannot act on their behalf to do that before that time.

Mr M. McGowan: No.

Mr Z.R.F. KIRKUP: Under clause 15(1)(b), the person must be an Australian citizen or permanent resident. Is that the normal definition of permanent residency status as conferred by the commonwealth?

Mr M. McGOWAN: Yes, it is the definition of permanent resident under the commonwealth Migration Act and the definition of citizen under the Australian Citizenship Act.

Mr Z.R.F. KIRKUP: Is there a way that a practitioner might try to establish the ordinary resident time—so, the time for which a resident has been an ordinary resident of Western Australia? They would obviously try to backdate that by 12 months in some way, shape or form. Does the Premier's advice indicate how that might be achieved in a practical manner?

Mr M. McGOWAN: The applicant, or patient, would need to provide evidence—any of the normal things such as a lease document or driver's licence—to show that they have been a permanent resident in the state for a certain period.

Mr Z.R.F. KIRKUP: I am conscious that perhaps in a remote or regional Aboriginal community, those types of arrangements might not be in place, which is possible in some communities that might not have access to driver's licensing, for example, or a trust might pay their bills for them. Is a statutory declaration or anything like that suitable in that case?

Mr M. McGOWAN: That might be one aspect of evidence to allow for that. I would expect that in those circumstances, the individuals would most probably have lived in the state for their entire life.

Ms M.M. QUIRK: I return to the assessment process and the eligibility criteria under clause 15(1)(c)(iii), which states —

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

We are all in fierce agreement that the test that is applied there is subjective and relates to the individual. However, I am not sure I got a comprehensive response to my concern about how we protect those who have few supports, maybe a history of mental health or depression and little or no family from being considered a more suitable candidate than someone who has the capacity to have a greater level of resilience. The reason for asking this is that those kinds of people might be either subjected to coercion or simply assessed as having a greater degree of existential suffering.

Mr M. McGOWAN: We are trying to make sure that the legislation is available to all people who meet the criteria in Western Australia, whether they are rich or poor or from a regional area or the city. If someone meets the criteria, the legislation allows them to make an application in those circumstances. A range of protections will be in place to ensure that the person is acting voluntarily and is not of unsound mind.

Ms M.M. QUIRK: I suppose this is analogous to substantive quality in the sense that everyone is considered equal but the outcomes are unequal, and so it is with this clause. Because it is person-centred and because it is subjective, we look at the individual circumstances of the person making the request. Those who have less going for them, if I can use the vernacular, are more likely to be assessed as suitable. How do we ensure that the outcomes are suitable in all the circumstances?

Mr M. McGOWAN: If the practitioner is uncertain that the person is acting voluntarily or if there is concern that the person does not have decision-making capacity, there is a requirement to refer them for further assessment if they apply to access it. As I said, we want to make sure that it is available broadly to people across Western Australia who are in their last six months of life and who are undergoing intolerable suffering. We want to make sure that it is available not just to people of means, but to other Western Australians as well.

Ms M.M. QUIRK: Before I ask the Premier another question, I am grateful that the Minister for Community Services has pointed out that I might have said something I did not mean to say. I might have used the vernacular when describing vernacular, so for the purposes of *Hansard*, please expunge the vernacular immediately. Luckily there were no children in the public gallery at the time.

Clause 15(1)(c)(i) states that the disease, illness or medical condition needs to be "advanced, progressive and will cause death". The equivalent Victorian legislation also contains the requirement that it be incurable. What consideration was undertaken of the wording for this clause and why is "incurable" not included?

Mr M. McGOWAN: The Victorian act requires that in addition to the other diagnosis criteria, the patient must be diagnosed with a disease, illness or medical condition that is incurable. That criteria has not been included in the Western Australian bill for two reasons. Firstly, the Western Australian bill already requires that the person have a disease, illness or medical condition that is advanced and progressive and will cause death within a time frame of six months or 12 months in neurodegenerative conditions. Secondly, it is not appropriate to require a person to exhaust all treatment options which may result in the disease, illness or medical condition being completely cured and through which the person's quality of life would be significantly compromised or lost. Every person should be able to determine which treatment options they wish to adopt. An adult patient of sound mind may refuse medical treatment even if that refusal may lead to their death. The bill does not require a patient to undergo treatment that will prolong their life or that might cure them, because to do so would cut across the fundamental principle of patient autonomy. The issue around "incurable" essentially is that if that term were included, it would therefore potentially require a patient to undergo treatment options that they may not wish to undergo.

Mr Z.R.F. KIRKUP: I refer to the previous conversation we had about a statutory declaration for somebody who might be from an Aboriginal community. I am conscious of the government's efforts to try, and the minister's comments in the past about trying, to stop people who might be coming to Western Australia to access this, regardless of their length of stay or residency status. Is any mechanism in place that would stop somebody from

travelling from another state or territory and signing a stat dec and going through the process within nine days? Obviously, they would have to be eligible, but a key component of their eligibility is their residency status. I am conscious that we should try to restrict any ability for this to be accessed by somebody simply for tourism, if we want to call it that, or someone who is interloping. A statutory declaration obviously can be flouted. Given that the person might not be bound by the law if they successfully access voluntary assisted dying within the nine days, are there any mechanisms to stop that? Can the Premier point to anything that ensures that there are strict requirements for residency for 12 months, outside of showing a stat dec?

Mr M. McGOWAN: This provision is identical to the Victorian provision. Obviously, if a person falsifies a statutory declaration, that is an offence under law, but if they are in agony and have six months to live, that is probably not their highest concern. The requirement is for a person to show that they are a resident of Western Australia. A number of doctors and medical professionals would examine the individual and they would need to be satisfied of that.

Dr M.D. NAHAN: I want to explore the issue the member for Girrawheen raised. It quite surprised me and I want to get this clear. For example, a person meets all the criteria under the bill except their diagnosis is for a disease that will kill them in six months if they do not do anything, but the expectation that they will live is high if they do something. Let us say, it is a tumour. If the tumour is cut out, the person could live beyond six months. If it is left in, they will die in six months. I accept that. I believe the bill will leave that decision to the patient. The patient would not have to take the action if they did not wish to, even if the action would sustain life, whether or not the action would be debilitating—that is, some actions could destroy the body. I can understand that. Some actions would not be debilitating, such as the excision of a tumour in certain circumstances. I am concerned that this legislation could allow someone to access suicide under these restrictive conditions. I do not think it would be very common. I will not argue that it is; I think people fight for life. If people are given a pathway to live, they will take it. But, sometimes, one or two will be excessive. I think that is why the Victorian legislation has a definition of "incurable". Could the Premier discuss this?

Mr M. McGOWAN: As I said earlier, it is a principle of patient autonomy for people over the age of 18 that we do not force them to have treatment if they do not wish to, provided that that person is competent. I think we probably all know people who have decided either not to go through with treatment because the treatment might extend their life for a short period but their quality of life would diminish, or to start treatment but find they do not want to keep going with it and stop. The alternative is that we force people and tell them they must go through that treatment or else they cannot access voluntary assisted dying when they have six months or less to live. I do not want us to go down that road. How could we say that to someone? I do not know what I would do in the circumstances, but I suspect I would want to enjoy the time I have left and go and see some of the places around the world that I have not seen but would like to see.

Dr M.D. NAHAN: I think this example will be at best a rarity, but our task is to look at concerns about second-order effects. Let us map out something. A conscious person with decision-making capacity has been given a diagnosis that they have a disease that is likely to kill them within six months. However, there is a chance of a cure if an action is taken that would not have second-order debilitating effects, such as chemotherapy and other treatments, and that would take the person's life way beyond six months. In other words, the disease is not incurable. There is a pathway in this legislation for someone without a great deal of physical pain—no doubt the pain would be mental—to avoid a cure and access VAD. I do not think many people would take that pathway but we are looking for oddities here. I would say that someone who is confronted by that situation and takes that pathway would have a psychological problem—humanity fights for life—but we do not have the ability to force someone to see a psychiatrist in these extreme positions. Would the Premier agree that there is a pathway for a person who has been given a terminal diagnosis and expects to die within six months, but the disease has a non-debilitating treatment, to choose to not take the treatment and to access VAD?

Mr M. McGOWAN: As the member said, people fight for life.

Dr M.D. Nahan: Some do.

Mr M. McGOWAN: An individual in that situation can go out to the back shed and take matters into their own hands if they do not want to live. All I would to say to the member is that people fight for life. This legislation is about ensuring that people who want to can choose not to go through further suffering or painful treatment. As the member said, the treatment might not be chemo or whatever, but it may involve amputation, which the person does not want to go through, or some sort of surgery that would mean that they could no longer operate their limbs and they do not want to go through that surgery. It is a matter of individual choice for the person in those circumstances. I think it would be impossible to try to construct a bill that would require people to undertake treatment.

The ACTING SPEAKER: Member for Riverton, is it the same question?

Dr M.D. NAHAN: I want to explore something very quickly.

The ACTING SPEAKER: That would be great.

Dr M.D. NAHAN: I think it is a very important issue, by the way. My point is on access to mental health screening. We have heard of many instances in which a person gets a death penalty by a diagnosis and they go into shock. It is very common to get existential trauma. I fully understand that. It often leads to death, by definition. There is a pathway in the legislation for someone who is traumatised mentally and who has just given up to use VAD. They perhaps have a curable disease, but if it is not acted upon, it will kill them in six months. They could have mental impacts and are no doubt suffering—mental disease can cause some of the most terrible pain. I am concerned we do not have a pathway in this bill to filter out those people because there is no necessity for psychiatric treatment—or maybe we do.

The ACTING SPEAKER: Shall I take that as a comment, Premier?

Mr M. McGOWAN: Doctors, in conjunction with patients, make decisions every day about these sorts of issues—whether a patient is going to continue to have treatment and their options. Doctors are trained, as part of their medical degree, in psychology, mental capacity, psychiatric matters and assessing competence. They currently do that with patients every day. If there is any doubt about a person's mental capacity or competency, they are required to refer them for further assessment.

Ms M.M. QUIRK: I intend to move an amendment on this clause but I have another amendment first. Since we are on this topic —

The ACTING SPEAKER: Member for Girrawheen, I note that we have had about six questions on the definition of "incurable".

Ms M.M. QUIRK: We have had none from me, Madam Acting Speaker.

The ACTING SPEAKER: Two from you.

Ms M.M. QUIRK: I did not get the answer I wanted so let me try again.

As the Premier has pointed out, the word "incurable" is in the Victorian legislation; it is not in the Western Australian legislation. The reason advanced by the Premier was that it was redundant because we have in our legislation the phrase, "is advanced, progressive and will cause death". That phrase also occurs in the Victorian legislation, which leads me to ask: What sort of discussion or consideration was there on omitting the word "incurable"? Did it come up in community consultations? I am trying to work out the process by which this word was omitted.

Mr M. McGOWAN: I outlined before why the word "incurable" is not included, which I think is a very reasonable part of it. As I understand it, there was a range of discussions within government with members of the panel and the chair of the panel on whether the term "incurable" would continue. The term "incurable", to some degree, is very subjective. People might say that there is some treatment available in Korea, Russia or Dubai that might cure them. It could very well make the entire process very difficult for people who want to access voluntary assisted dying. As I also said, it could be interpreted as making it a requirement that a person undergo some form of treatment that they do not wish to undergo. I am familiar with people who have suffered from brain tumours who did not want to go through an operation that might turn them into a paraplegic. That is their choice. I suspect that if I were in that situation, I would not want to go through that operation either.

Ms M.M. QUIRK: Given your advice, Madam Acting Speaker, I will wind this up very quickly. Maybe the Premier could get some advice from his advisers. I wonder whether the term "incurable" is directed towards scenarios such as those in the Northern Territory in which people were judged to be incurable but it was really a paucity of decent specialists in the Northern Territory. In fact, there is one fairly infamous case in which the disease that was diagnosed as incurable was readily curable with no long-term effects. I think that needs to be considered. That is why it is not really a redundant term. It covers that aspect to make sure that the level of diagnosis is rigorous.

Mr M. McGOWAN: The advice I have is that it has nothing to do with the Northern Territory legislation.

Mrs L.M. HARVEY: Subclause (1)(c)(i) provides that a person has to have a condition that is advanced and progressive and will cause death. I want to examine the nexus between that provision and subparagraph (iii), which refers to a medical condition that is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable. Obviously, people suffering from some diseases could have a prognosis of six months but not necessarily be symptomatic. A person might have some medical intervention that relieves the symptoms. They might have a prognosis of six months but they may be suffering emotionally. They might be suffering through a grieving process. They might be suffering from trying to manage the knowledge of their impending demise with their family members and friends. Indeed, there may be workplace and other pressures on a person when they are

diagnosed with a terminal illness: "How do I sell my business before I die? How do I finalise my affairs? What will happen with my mortgage?" All these issues cause intense suffering for an individual when they have a prognosis of a terminal disease. What I am trying to understand, and I think it is important that this place gets on the record, is whether a patient will need to be symptomatic. If a person has a terminal disease but is otherwise well, but a whole bunch of other pressures are feeding into intense emotional suffering, I would not like them to access VAD inappropriately. I completely accept that there are a lot of diseases the suffering from which is not linked to pain and other things. It is more just a matter of understanding that for a person to access voluntary assisted dying, they would need to be symptomatic and not check out too early.

Mr M. McGOWAN: The requirement under the legislation before us is that the suffering must be related to the disease that is going to kill them. That is the requirement and that is what the medical practitioners will need to assess. That is the nexus, if you like. As numerous members have said, people generally want to stay alive. I think it is a matter of common understanding that people would make this decision at such a point that their suffering became intolerable. The advice I have is that it is highly unlikely that people would have less than six months to live and have no symptoms.

Mrs L.M. HARVEY: I disagree with the Premier's last comment, because people can have less than six months to live and be comfortable and not be symptomatic, but I am very heartened and would like to get on the record that tying the suffering to the disease that has been diagnosed is a very good thing. I am pleased that that intention has been recorded in *Hansard*.

Dr M.D. NAHAN: I have a brief point on that. Following up on what the Leader of the Opposition said, and to be clear, we have discussed what suffering means and it has many aspects. In the case that the Leader of the Opposition mentioned, once a person gets a diagnosis, they go into psychological trauma. It is not related precisely to the disease; it is just the fact that they have the diagnosis. Is that suffering of the terminal nature? It is not physical pain; it does not emanate physiologically from the disease, but from the fact that they have been given the diagnosis. Is that sufficient suffering to warrant accessing VAD?

Mr M. McGOWAN: Clause 15(1)(c) says —

> the person is diagnosed with at least 1 disease, illness or medical condition that —
>
> …
>
> (iii) is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable;

There is a direct nexus between the disease and the suffering. As we said before, the suffering can be of different types, but it has to be linked.

Ms M.M. QUIRK: The member for Dawesville referred to the eligibility criterion in relation to residency that is set out in clause 15(1)(b). This bill refers to a person being an Australian citizen or permanent resident, which is crystal clear. Subparagraph (ii) says —

> at the time of making a first request, has been ordinarily resident in Western Australia for a period of at least 12 months;

We could have a situation in which someone who is resident in another state gets a diagnosis and moves to Western Australia. The way to overcome this is to have the wording in the Victorian legislation—"is ordinarily resident in Victoria and was ordinarily resident in Victoria for at least 12 months at the time of making a first request". Sorry; I thought the Premier was listening.

Mr M. McGowan: I am listening.

Ms M.M. QUIRK: What I am saying, and what the member for Dawesville has said, is: surely this is an opening to people travelling to Western Australia so that they can access the provisions of this legislation. As I said, if we had the wording that is in the Victorian legislation, that would certainly avert that occurring.

Mr M. McGOWAN: What was contained in the Victorian clause was not supported by the Department of Health and the drafters because it did not materially add to the clause, as the clause already contains a requirement for an eligible person to have been ordinarily resident in Western Australia for 12 months. It is also not consistent with the legislative drafting conventions in Western Australia and the common law definitions of "ordinarily resident".

Ms M.M. QUIRK: I am not going to argue the point. There is quite a clear distinction; the member for Dawesville pointed it out. However, I move —

> Page 12, after line 3 — To insert —

(ia) is ordinarily resident in Western Australia; and

That will cover the criteria of those who live in Western Australia who might go away somewhere then come back and after 12 months can make an application. It shuts the loophole.

Debate interrupted, pursuant to standing orders.

[Continued on page 6600.]