

Notes from the debate on the Voluntary Assisted Dying Bill 2019 in the Legislative Assembly

A considerable amount of time was spent debating the name of the Bill, with opponents arguing for the Voluntary Assisted Dying Bill to be changed to reference euthanasia.

Alyssa Hayden (Member for Darling): *I do not want to push this any further than we have, except to say that I find it a little disappointing, because the community I represent in Darling Range—the people out there—do not refer to this as assisted dying; they call it euthanasia. I take offence at being told that this is modern terminology and this is what modern-day people, the people who are up to date with everything, use. **I am telling the minister right now that people in Darling Range do not use that terminology. This legislation is meant to represent every single Western Australian, and particularly those who are vulnerable, not just those who are well-educated and learned and who live in Nedlands, with all due respect to the member for Nedlands.** It is also about the people who live outside the western suburbs—who live in the eastern suburbs and regional WA. We need to make sure that when we are delivering legislation this important, people do not have any doubt about what it is about. How often are we blamed by the community for talking bureaucratic—I will not say the word—rubbish nonstop, yet here we are with a very important bill with a name that sugar-coats it, because for some reason, the minister is afraid to say the words “suicide” and “euthanasia”. Call it for what it is.*

Opponents fundamentally disregard that people who will seek to access voluntary assisted dying are terminally ill and at the end of their lives.

David Honey (Member for Cottesloe) suggesting terminal ill people would repeatedly visit a doctor who is a conscientious objector to **“badger the doctor and force them to go through”** the process of refusing to participate, which simply includes informing the person and providing them with a pamphlet.

Alyssa Hayden (Member for Darling Range) suggesting terminally ill people who (by definition of the eligibility criteria to access voluntary assisted dying under the proposed Bill) would repeatedly visit doctors to gain access to voluntary assisted dying or delay administering the medication for 12 months.

Mrs A.K. HAYDEN: *From my understanding, the Attorney General has just said, basically, that the consulting practitioner can keep referring to a medical consultant, until they find someone who says, “Yes, this person is eligible.” **That could be done two times, four times, 10 times, 100 times or 200 times. There is no limit;** the person can keep referring. At some point, this process must be exhausted, otherwise it is just doctor shopping; they can keep going around until they find a doctor who says yes. If 200 doctors say, “No, that is not correct”, and they finally get one who says yes, I am guessing that the 200 doctors who said no would be the safer bet to go with.”*

Mr J.R. QUIGLEY: *That would be an impossibility, as the member would well appreciate. The person will need to be, within the balance of probabilities, six months from death,*

which, by my count, is 183 days. To suggest that they would go to 200 doctors in 183 days is preposterous.

Mrs A.K. HAYDEN: *If I am the patient and I have decided to self-administer and euthanase myself, I can do this and then say, "I'm not doing it today." Is there a time frame in which I have to administer it? Will the substance still be valid? Does the substance have an expiry date? I understand that the minister said that a delay is a delay and revoking is a different issue. I could take the substance home and administer it tonight, tomorrow or next month, but could I do it in six months or a year down the track?*

Mr R.H. COOK: *I can assure the member that, by definition alone, they would not delay it by a year. The short answer is no.*

Mrs A.K. HAYDEN: *I thank the minister. I understand that a person may not be eligible for a certain reason, such as that they have not been in the country for 12 months, but once the 12 months passes, they will be able to reapply. What if they have been disqualified for another reason, such as for being coerced, because they were not acting voluntarily, or for a more serious matter? **Will they be able to keep reapplying? Is there a limit?** It will be a waste of the tribunal's time if it has to keep coming back with the same answer once, twice or three times. How many times will a patient be able to apply if they keep getting knocked back for the same reason?*

Mr R.H. COOK: *I want the member to bear in mind that this is someone who will be making an end-of-life choice. This will be someone who is extremely frail and is coming to the end of their life.*

A constant theme of distrust of medical professionals came through the contributions of opponents.

Liza Harvey (Leader of the Opposition and Member for Scarborough) told a story "We all know that doctors like to keep information to themselves. I know many people in here, like me, have probably been to the doctor and had various different tests. The doctor might verbally tell them those tests results. Indeed, I had a CT scan on my knee and was told by the radiological clinic that they would not provide me with a copy of the scan and that it was going to go straight to my general practitioner and the GP could tell me what was in it, which I thought was a bit condescending, to be quite honest. I want to look at my knee at home by myself, or even on my phone, through an app, as is available through some other providers. Some doctors are quite paternalistic with patients..."

David Honey (Member for Cottesloe) suggesting cultural different may mean medical practitioners value life differently.

Dr D.J. HONEY: *I have a concern about clause 16(2)(c). One of the issues for the coordinating practitioner is in determining whether the person has capacity or is suffering from any particular mental health condition or, as a number of us have discussed a number of times, whether the person is subject to any undue influence. One issue that could have a dramatic effect on the assessment of a patient—this was certainly a contributor to the case I mentioned yesterday—is cultural differences. Someone who comes from a vastly different culture might not be familiar with our community, and I recognise that we have a diverse community. I am wondering if that might be a confounder here—that an assessment might be affected by those cultural differences. We see again and again at a societal level that we are very empathetic about people within our society and community. **If someone is killed in Cottesloe, it is a dramatic thing and affects everybody in that community and in Perth more generally; but if someone is shot in Beirut, or 100 people are shot in Beirut, they are not part of our community and not part of our society, and I know that some people may care, but in large part, people ignore it.** We see that time and again. I wonder whether that could end up being an issue if we have people involved in this process who have not spent a lot of time in our community. Cultural differences may lead to inaccurate assessments.*

Peter Katsambanis (Member for Hillarys) suggesting a medical practitioner may break their arm when in a room with a terminally ill person who is accessing voluntary assisted dying.

Mr R.H. COOK: *Thank you, Deputy Speaker and thank you, member. I disagree with the member's interpretation. A coordinating practitioner can only transfer their role as the administering practitioner if they are unable to administer it. Therefore, if they are in the room with the patient, they, by definition, could administer the voluntary assisted dying substance.*

Mr P.A. Katsambanis: *Maybe they're still unable. Maybe their arm is broken.*

Mr R.H. COOK: *Member, there may be a whole bunch of other scenarios. I just think the member's interpretation of clause 62 is incorrect.*

Margaret Quirk (Member for Girrawheen) questioning the ethics of nurse practitioners.

Ms M.M. QUIRK: *I think the minister has pointed out that this is not the path that Victoria has gone down, because it does not have the same issues about remote and regional areas as Western Australia. There is a subtle ethical difference between nurse practitioners and physicians that I do not think this provision has necessarily picked up, and I am not confident that the CEO will even address it. I am not by any means diminishing the skill of nurse practitioners, but there is not the same history involving an ethical framework. As I understand, there have only recently been discussions about an ethical code for nurse practitioners, and nurse practitioners very much see their role as advocates for the patient. There could be some conflicts about their perceived obligations to advocate for the patient, as opposed to maybe having the independence to balance the ethical complexities in a fraught area such as this. I raise that as an issue that concerns me. At least, at the end of the day, and the minister has been saying this throughout consideration in detail, there is a well-established ethical framework for medical practitioners. Although I recognise that nurse practitioners operate professionally, there is not that same consensus about ethical obligations and to whom they are owed.*

Opponents argued for the need to place restrictions to limit who a terminally ill person can nominate as their contact person throughout the voluntary assisted dying process.

Sean L'Estrange (Member for Churchlands) took issue with a person's right to choose their own contact person.

***Mr S.K. L'ESTRANGE:** I would have thought that as a minimum there might be some sort of literacy standard for the contact person, irrespective of the relationship that that person has with the patient, given their role.*

***Mr S.K. L'ESTRANGE:** Should there be a provision in the legislation to make sure that that contact person, whoever it is, is competent to carry out their role?*

***Mr S.K. L'ESTRANGE:** What if somebody were to choose a contact person who might have—this is what we mentioned earlier to the health minister—issues around reading, and there are instructions that go with the substance that has to be administered? What if they did not fully understand their obligations under the bill because they are not an educated person? They might be known by the patient, closely or not. It does not matter. They just have to be 18 years of age.*

...What if there were somebody who had a track record—for example, a criminal record—in which they might be very close to, and do everything right by, the patient, because they are close to that patient, but they may have another light outside that and they are handling this substance that could put the community at risk?

This was the State Government's response to the questions relating to the contact person.

***Mr J.R. QUIGLEY:** As far as criminality goes, already under the Medicines and Poisons Act, criminals can be prescribed with schedule 4 and schedule 8 drugs, which are lethal. That is already in the poisons act. The member said that a patient might choose a contact person who had a criminal record. That might likely be the case in Indigenous communities, which the member does not care about. That might well be the case.*

***Mr J.R. QUIGLEY:** It might well be the case in Indigenous communities that the person wants their son as the contact person and that son may have a criminal conviction and have been to jail under the former government's mandatory sentencing laws, but they can still handle and still be prescribed schedule 4 and schedule 8 drugs. There is no limitation on prescriptions under the medicines act, as the member well knows. In relation to treating patients with a history of substance abuse, persons with a history of substance abuse within the previous five years, or recorded as oversupplied or drug dependent, can be authorised to receive section 8 medicines. Even though they have a history of drug abuse, under the medicines act, they may be prescribed section 8 medicines. ...*

This patient will have their choice... when it comes to drawing his last breath. This government will not pass a law regulating who must be present or whether the person can die in peace and solitude. That is their choice, the same as the member has.

Advocating for every person who accesses voluntary assisted dying to be autopsied after death and have their matter referred to the coroner automatically.

These were both raised by **David Honey (Member for Cottesloe)**.

Dr D.J. HONEY: *Why is there no compunction in this bill to have an autopsy? I am not concerned with a great majority of circumstances. I know, as the minister knows, that in the great majority of circumstances, this process will go forward as people want it to go forward and the estimated time of death will probably be reasonably accurate, but we also know there are people who will take this to the fringe. There will be VAD practices, wherein two practitioners will set up the equivalent of a Nitschke-type practice, that will test this legislation to its limits; they will take it to its limits. That will happen. Why? That is the nature of people. Some people will take this to its limits. I know it is the genuine intention of the minister and the people who put this bill together that that is not allowed to happen.*

Dr D.J. HONEY: *Why is this type of death not automatically referred to the coroner? I know that that may come up later in the bill, and I will not duplicate questions if we consider those questions now, in the spirit that we have continued in so far. Why is it? How do we know that there will not be people who will operate at the fringes, who will, in fact, falsify that information and make a misdiagnosis of the estimated time of death to bring people into the envelope of this legislation? If it is not reviewed by the coroner, how will we know that? Otherwise, it is just bits of paper. I would like to understand why that is not a compulsory part of the legislation.*

Questioning how a person might choose to self-administer the medication

Tony Krsticevic (Member for Carine) questioned how a terminally ill person may choose to self-administer the medication.

Mr A. KRSTICEVIC: *The clause states that the person administers a prescribed substance to another person. I just want the Premier to explain to me the word “administers”. In what way, shape or form can a person, obviously other than the individual, administer the poison to the patient?*

Mr M. McGOWAN: *It would be injected, poured down their throat or put into their food.*

Mr A. KRSTICEVIC: *If, for example, a husband and wife are at home and the husband who is terminally ill has the medication and decides that the time has come and says to his wife, “I’d like you to make me that chicken soup that I like so much and I’d like you to put the poison in there. I’d like to eat my chicken soup and pass away”, and she brings the chicken soup to him, puts it on the table and he eats it, is she in any way, shape or form involved in the administration of that poison?*

Mr M. McGOWAN: *In the case the member gave me, the husband has administered the medication.*

Mr A. KRSTICEVIC: *Taking that one step further, let us say the husband is too ill to lift the spoon to his mouth and ingest the soup and asks his wife to feed him the soup, and the wife feeds him the soup because he is not well enough, but he is meant to self-administer. Would the wife commit an offence if she feeds her husband and he passes away from that medication?*

Mr M. McGOWAN: *Yes.*
