# *Death with Dignity Bill 2016*
# *South Australia*
# *Committee Stage Debate*
# *November 16-17, 2016*



*Standing Orders Suspension*

**The Hon. J.J. SNELLING (Playford—Minister for Health, Minister for the Arts, Minister for Health Industries) (22:19):** I move:

That standing orders be so far suspended as to enable an adviser to be seated in a chair on the floor of the house adjacent to the seat occupied by the Leader of the Opposition with the purpose of advising the member for Morphett during the committee stage of consideration of the Death with Dignity Bill.

**The SPEAKER:** An absolute majority of the house being present, I accept the motion. Is it seconded?

**An honourable member:** Yes, sir.

Motion carried.

## *Committee Stage*

Clause 1.

**The Hon. M.J. ATKINSON:** I move:

Amendment No 1 [Atkinson–1]—

Page 1, Title—Delete 'Death with Dignity Bill 2016' and substitute 'Assisted Dying Bill 2016'

The vote that has just occurred is an historic vote, and now we come to consider the detail of the bill. I am moving this amendment because the title of the bill is obviously tendentious. It is a title designed to have persuasive value and to be just a little propagandistic. It implies that there is no death with dignity now, there will only be death with dignity with the bill, and it is unnecessary.

The house has now voted for the principle of the bill. Everyone who has voted for the second reading has voted for the principle, and it is no longer necessary to have a title for the bill which is in any way other than neutral. Obviously, the member for Morphett is not the first person to move a bill with a tendentious title. The government of

which I was a member—

**Mr Marshall:** How many did you move—

**The CHAIR:** Order!

**Mr Marshall:** —with dodgy titles?

**The Hon. M.J. ATKINSON:** Sorry?

**Mr Marshall:** How many did you move with dodgy titles?

**The Hon. M.J. ATKINSON:** I think I wanted to call one bill the hoon driving bill, and I was restrained by the Liberal opposition and forced to call it, I think, misuse of a motor vehicle bill, which is so much duller.

My view is we have got to a stage in the debate where we can now move to a studied neutrality and describe the bill in a neutral way, namely the Assisted Dying Bill, which I do not think either side can object to. I think it would certainly be a good way to start the deliberation on the bill to move to a carefully considered neutrality in the use of language. The time for a title such as the bill has has passed. The house has accepted the principle of active voluntary euthanasia or physician-assisted suicide, call it what you will. Now I think is the time to move on in a matter of fact way.

**Dr McFETRIDGE:** I cannot support this amendment. This bill is about giving people with a terminal illness in South Australia autonomy over the end stage of their life. It is about giving people who are dying in extreme circumstances the ability to access support to then take charge of their own life. It is not about assisting them to die. They cannot change the fact that they are going to die. What they want is that autonomy. They want that dignity in that final stage of their life.

It is much more than assisting them. It is much more than just somebody giving a helping hand. It is about giving them the confidence and the ability to not die in many cases. As we are seeing in Canada, Oregon and other places, people are given the opportunity to obtain a prescription and then choose not to undertake voluntary euthanasia. It is not about dying; it is about enhancing everything we do for this person at the end of their life. It is about enhancing the palliative care for these people. It is about enhancing their mental state and their mental resilience. It is about having medical care. It is about having support for these people so they can then go and make that decision themselves—a voluntary decision. It is not about assisting them to die.

In some cases, if these people are in such a deplorable position with, say, a mouth tumour, oesophageal tumour or some other muscular skeletal condition where they just cannot move and cannot physically self-administer, in this legislation they can be assisted to undertake their final wish. They have that autonomy. This is about giving them that dignity, that little bit of self-worth, and to say this is about assisting them dying is going to take that away. I cannot support this change. This is about dignity in death.

**The Hon. J.J. SNELLING:** I support the amendment of the member for Croydon. I

believe this is a misnomer. It was pointed out in the briefing yesterday by Palliative Care South Australia that they also felt that the title of the bill was a misnomer. It does imply that those people who die in South Australia at the moment, who die with excellent palliative care, do so without dignity, and that could not be further from the truth. To imply that only those who have access to euthanasia or are euthanased have a dignified death I think is grossly inaccurate, and I support the amendment of the member for Croydon to the title of the bill.

**Dr McFETRIDGE:** I do not know whether that was a question or more of a statement, but I will reiterate what I have said. This is about people who have voluntarily requested access to medication that will then allow them to die on their terms. It is not about actually assisting them in every case. In some cases, yes, but it is about the whole circumstances around that person's end of life. It is not just about the actual dying. It is about the whole lead-up—the 12-month lead-up under the amendments that I am proposing—to that person's expected death from the medico's prognosis. It is about that whole journey and making sure that journey is as gentle as it can possibly be so that person's dignity can be preserved at all costs.

We have heard members in this place speak about some of the terrible things that you see with patients at this end stage. They are regurgitating their faeces, vomiting or have pulmonary oedema and are drowning in their own fluids. These people obviously may not be able to self- administer and they may need some assistance, but even that is giving them that last piece of support, that dignity. This is about dignity in dying and not about assisting someone to die. Anybody who thinks that this is a brutal act in any way, or a callous act or a harsh act, is so wrong. It is about respecting these people, honouring their wishes and respecting the autonomy of those wishes.

The Consent to Medical Treatment and Palliative Care Act talks about the human rights that these patients have. It talks about getting their consent. It talks about communicating with the patient. It talks about giving that patient dignity. That is what this is about. It is not about assisted dying. It is a far too simplistic a title to encompass the whole spectrum of issues involved in this issue, in this whole process, in this voluntary act.

If members cannot see that, then they really need to go and have a look at the wonderful work the palliative care people are doing in our hospices and in our hospitals and ask them about the conditions they are dealing with. Find out the fact that even the palliative care associations say that they cannot stop painful deaths. They do not see controlling the end stage issues, conditions, symptoms, clinical signs of a patient with supporting their death, but that death is on that patient's terms. It is a death that that person is requesting.

I cannot agree with this title. It is just far too narrow, it is far too wrong and it is trying to brutalise what should be a very, very sensitive and emotional time for not only the person but their family and all their relatives around them, and it should be respected. That autonomy, the human rights of that person, as we already have in

legislation, should be respected, and so this title cannot be supported.

**The Hon. S.W. KEY:** I want to ask the member for Croydon what his real reason for wanting to change the title is.

*An honourable member interjecting:*

**The Hon. S.W. KEY:** I should be able to ask my question without interruption, I would have thought. I am interested to know why, at the last minute, you would want to change the title of a bill that you have made very clear that you do not support anyway. I wonder if this is a reason to hold up proceedings tonight or if you truly think that. I know that you can be quite pedantic on wording and this is something that we like about you, but I am wondering why this is happening tonight at this time. Why you did not have the courtesy of raising this issue, as the member for Kaurna and other members who have had concerns about the bill have done, so that we would spend quite a few minutes at the start of this debate, which you call an historic debate, on the title of the bill?

**The Hon. M.J. ATKINSON:** It seems a pity that the member for Ashford would open the committee stage of the bill, having obtained an historic victory, by impugning my motives. Until 10 minutes ago, the bill was not passed. It was a distinct possibility at the beginning of today that the bill was not going to pass its second reading, in which case there would be no occasion to consider the title of the bill. Moreover, each member only had 10 minutes to speak on the bill and, if I had addressed in my second reading contribution the title of the bill, then I would have lost a great deal of time and not been able to say all that I wanted to say.

Names are important. The names of things are very important and they tell us a lot about that which is named. There is no suggestion in this rather neutral title that I am trying to brutalise patients who are dying. There is no evidence for it; it is illogical. There is nothing here impugning autonomy. The member for Morphett seemed to be arguing that the bill, which he has just carried in an historic event, is not principally about dying.

I am sorry, it is all about dying. That is what we have been discussing here today. Dying is in the title of his bill, so he can hardly deny that the bill is principally about dying. Moreover, the member for Morphett argues that the people in Oregon who qualified for active voluntary euthanasia or physician-assisted suicide who apply for the procedure and then do not go ahead with it—that somehow invalidates the argument I have put because they do not ultimately die.

It does not take much to turn around that argument, have a look at it and realise that it is illogicality on the fly. Of course the bill is about assisted dying. What the member for Morphett did in his contribution was fight the second reading battle over again, a battle he has just won. No-one is impugning the human rights or dignity of a dying person by giving the bill a neutral name.

I am not giving the bill a pejorative name. I am not trying to call it the 'mercy killing bill' or some moniker that the Right to Life movement might give it. I am not trying to call it the 'state- sanctioned killing bill'. I am trying to give it a simple and neutral name

because, as I said, the time for boosterism about the bill is over. We are now down into the nuts and bolts. The devil is in the detail.

I was particularly—well, I would not say hurt because I have been in this place long enough to avoid being hurt in debate, but in regard to the idea that somehow I impugned palliative care in my choice of name, my response to that is that I was on the Select Committee on the Law and Practice Relating to Death and Dying for two years from, I think, 1991 through to 1993, along with Martyn Evans, Jennifer Cashmore, Vic Heron, and I think there were others.

That was the bill that brought about the Consent to Medical Treatment and Palliative Care Act. I was a member of the committee that brought about the growth and prospering of palliative care in South Australia. So, to say that, by proposing to amend the bill from the tendentious Death with Dignity Bill to the neutral 'assisted dying bill', I am somehow harming or impugning palliative care is plainly a nonsense.

Amendment carried; clause as amended passed.

Clause 2 passed.

Clause 3.

**Dr McFETRIDGE:** I move:

Amendment No 1 [McFetridge–1]—

Page 4, line 13 [clause 3(3)]—Delete 'psychiatrist' and substitute 'mental health professional'

This is an agreed amendment, where we have agreed that a psychiatric or mental health assessment should be undertaken. I have listened to the persuasive arguments of many people, particularly the member for Kaurna, I have consulted with the stakeholders involved with this and we have agreed that, because this is a very important issue, this is reasonable. Members should be very comfortable with the fact that this amendment is being made. If this amendment gets up, there is a series of amendments that are consequential to this amendment.

The reason we are using the term 'mental health professional' is that, under the regulations that are envisaged for this bill, the availability of a psychiatrist may not be there but a clinical psychologist may be there. So, we are more than happy to support this amendment and I thank the member for Kaurna for his cooperation on this.

**The Hon. S.C. MULLIGHAN:** Could the member for Morphett explain why the term 'mental health professional' is being used, other than, perhaps, countenancing both a psychiatrist or a psychologist in the amendment?

**Dr McFETRIDGE:** The use of the term 'mental health professional' encompasses a broader range of mental health trained personnel, and they are trained to a professional standard to deliver not only assessments but also management of mental health conditions. In this particular case, we are aimed at making that assessment of the person requesting voluntary euthanasia. The mental health professional wants to be

able to determine the ability of the person who is requesting voluntary euthanasia to understand the consequences of their request; they need to be sure that person understands the consequences.

The mental health professional needs to be able to explain to that person that their request is of a dire nature. People trained in clinical psychology, as well as psychiatry, are obviously able to do that. The availability of psychiatrists in South Australia is, unfortunately, very limited, particularly in rural and regional areas, and so to expand this via the regulations to encompass—as most members in this place would want—the availability to a mental health assessment is encompassed in this phraseology.

**The Hon. J.R. RAU:** This is sort of a question and sort of an observation: the term 'psychiatrist' is actually defined on page 3 of the bill and I think that is a fairly clear and crisp definition. The reference to 'mental health professional' does not, in my mind, constitute a clear and crisp definition. I can understand why one might consider potentially expanding it beyond 'psychiatrist', but is there some reason why it was not 'psychiatrist or other designated mental health practitioner by regulation'? That would have meant that there could at least be a conversation about whether or not we are talking about clinical psychologists or mental health nurses I am perturbed by the generality of the terminology 'mental health professional' because it could be a counsellor, it could be any number of people, depending on one's point of view.

**Mr PICTON:** If I could just add to the Attorney's comments on that and go back to the start about how I think this has happened. One thing I have been very concerned about is that I believe that there should be a check by a psychiatrist in the process, and that should not be an optional or a 'maybe' component but a definite component of it. In considering that, I understand that some people have suggested that maybe we should expand the definition of the term 'psychiatrist' to include the term 'psychologist', if it is going to be mandatory, given that there are not necessarily that many psychiatrists out there who might be available to do that. That is something I am open to doing.

It was suggested that this was an agreed amendment. To be honest, I saw the amendment when it was circulated in the parliament and I think it was trying to add in the psychologist element that had been discussed previously, but it has done so in a way that, in my belief, has made it more vague. What I have been trying to do from the outset is make this bill less vague. That does worry me. 'Mental health professional' adds an element of question and risk for members in this debate as to what exactly that would involve. I think the more things that are left up to regulation will create more doubt for members. So, that is something I do have a concern about in this provision.

That said, the other element of the member for Morphett's amendments he has circulated do include that this becomes a mandatory check. I absolutely think that is very important. However, if it could be made clearer that it was either a psychiatrist or a psychologist, then that would certainly help to make this section much clearer.

**The Hon. S.C. MULLIGHAN:** As a fledging legislator in this place, I understand

that it is appropriate that we engage in this discussion by asking questions of the member for Morphett, so I might pose my question as such. Does the member for Morphett believe that changing his amendment to specify 'psychiatrist' or 'psychologist' might make more members more willing to support the bill at the third reading stage?

**Dr McFETRIDGE:** I cannot disagree with the member for Lee. If my understanding of discussions with the member for Kaurna and the Attorney this morning were overly optimistic about accepting 'mental health professional' as a term to be included, I am more than willing to be assisted by the member for Lee, if that was the case. I think that fits in with the member for Kaurna's amendment.

**Mr WINGARD:** My question is to the member for Morphett, along these lines. As to 'psychiatrist' and 'psychologist', this is a key amendment for me and, to have 'mental health professional' added in, I just want an outline of what that actually encompasses. Does that encompass a social worker, a registered nurse, a palliative care specialist? What actually is encompassed in 'mental health professional'? That terminology seems quite vague.

**Dr McFETRIDGE:** The whole premise behind this was to allow 'mental health professional' to be prescribed in the regulations, and that could be as broad as the committee wanted it to be. However, I had envisaged that it would be somebody with more intense training in mental health, so it would be a psychologist or a psychiatrist, but certainly not a social worker.

**The Hon. J.R. RAU:** It might be of help to people to look at the member for Morphett's schedule of amendments. They are all basically on this one point, the whole lot of them. If you look at his amendment No. 12, which hopefully we will get to in about three minutes—that was a bit of humour, believe it or not—you will see that there is inserted there a definition of 'mental health professional'. All I can say is that deleting the definition clause at the beginning of the bill for 'psychiatrist' and inserting the definition of 'mental health professional' at a point later in the bill is, I think, a little confusing.

However, that said, my reading of that—and I would invite people to comment on this—is that clause 13 may be attempting to remedy that, but I am not sure about changing the definition, because clause 13 is going to invite us to insert a new subclause (5). Subclause (5), in its own terms, states 'In this section', meaning clause 13 and only clause 13. So, anywhere else where 'mental health professional' is used, it is arguable that that does not have the same meaning as it has because the definition inserted in clause 13 by the new subclause (5) would be a definition which is confined to clause 13. It looks as if the same terminology is used in clause 3 at least, and elsewhere. It is possibly a drafting point.

**The Hon. J.M. RANKINE:** Could the member for Morphett, for the benefit of the non-medical people in the gallery, please explain the difference in the qualifications and training of a psychiatrist and a psychologist?

**Dr McFETRIDGE:** It is quite easy, member for Wright. A psychiatrist first gets a

medical degree and then undertakes specialist training in psychiatry. It is a postgraduate degree. Having completed that postgraduate training, they can then become members of the Royal Australian and New Zealand College of Psychiatrists. They are able to undertake a lot more invasive treatments for their patients and they are able to prescribe medications, whereas a clinical psychologist is trained in psychology at a less intensive level, which is different from the investigation and diagnosis of psychiatric illnesses.

**The Hon. J.M. RANKINE:** So, a psychiatrist is much more qualified?

**Dr McFETRIDGE:** By the fact that they have undertaken a medical degree first, obviously they are more highly trained and they can prescribe drugs. If that is an issue for the member, I am more than happy to give her a lesson in medical training.

**The Hon. J.M. RANKINE:** In the debate there were a lot of concerns about the safeguards in this bill being watered down in the future. Would the member for Morphett agree that his amendment is the first step in watering down the protections in this bill?

**Dr McFETRIDGE:** Not at all.

**The Hon. J.M. RANKINE:** You just told the house that a psychologist is a lesser trained person than a psychiatrist. They are much more highly trained. You are also including mental health nurses, etc. Clearly, that has to be watering down. They are not medical practitioners. So, you are suggesting that, after two doctors assess a person, if there is concern about their capacity, they be referred to a mental health nurse or a psychologist who is not a medical practitioner.

**Dr McFETRIDGE:** This is going to be a long debate if this is the quality of the questioning. The fact that—

**The Hon. M.J. Atkinson:** There's no need to respond like that.

**The CHAIR:** Order!

**Dr McFETRIDGE:** There is no mention here at all of mental health nurses.

*An honourable member interjecting:*

**The CHAIR:** Order!

**Dr McFETRIDGE:** Remember what this is about. This is about providing assurances to the two specialist doctors—and we have agreed to those amendments—who will be the first and second practitioners, who, if they think a patient needs a psychiatric or mental health assessment, can then refer them to a psychiatrist or, as it says there, 'any other person or a class prescribed by the regulations for the purposes of this definition.' It is intended to give people who cannot access mental health professionals in rural and remote areas some opportunity to talk to people such as clinical psychologists.

**Ms REDMOND:** In relation to the definition, when I went through the amendments proposed by the member for Morphett, it seemed to me that I came to the same conclusion as that expressed by the member for Enfield—so we are at one, Attorney—

that the placement of the definition, because you have the definition appearing in clause 13 and it says 'in this section', would mean that it will appear only in that particular section of the act, and the other amendments that are being proposed in terms of the definition actually go right through the act from the very early clauses. Could I suggest to the member for Morphett that he might undertake to shift that definition back into the definitions clause at clause 3 of the legislation so that it is regularised throughout the legislation as it is currently mooted?

**Dr McFETRIDGE:** If this is in any way perceived as an effort or a change that is going to weaken this legislation, far be it from my intent. The negotiations that were undertaken in good faith to allow all South Australians in rural and remote areas to have access to mental health assessments, if they requested voluntary euthanasia, was the whole intent of this. If members, and we are in the hands of the house, think that there is a better way of phrasing this, then bring it on please because the whole intent of this is to produce world's best legislation, and we are a long way to that with other amendments that the member for Kaurna and I have agreed on.

**Ms COOK:** I support as well where the member for Heysen and the member for Enfield have gone in relation to the positioning of wording. I would ask if perhaps we could have some reflection on how we are talking about the professionalism of the clinical psychologists and clinical social workers who deal with patients day after day who have master's degrees, PhDs, significant levels of training and actually deal with patients constantly in regard to diagnosis, therapeutic intervention, tweaking of medications, prescriptions.

They do a whole range of services within the clinical setting therapeutically, both in and out of hospitals, and I think perhaps while this house is an expert on many things, it is not an expert on the role and practice of these particular professionals. Perhaps it is even something that can be defined between the houses, or we could come back to that tomorrow, but I think people are underestimating the capacity of these professionals to be able to participate in this process.

**Mr GRIFFITHS:** I am also concerned about this amendment on the basis of what amendment No. 12 says where it talks about anything else that is defined in the regulations where there is no opportunity to know what they might say, so at a minimum I support the member for Enfield and the member for Heysen on the suggestion for it to be moved back to the definitions because without that level of surety it is something I am very challenged by.

**The Hon. M.J. ATKINSON:** The member for Morphett says he wants world's best legislation. We were assured during the second reading debate that there would be no derogation from the strictness of the safeguards. We are not yet half an hour into the committee and already the mental health assessment which we thought at the second reading stage was to be by a medical practitioner, namely a psychiatrist, is now being delegated to another mental health worker. In this case, the first expansion would be to psychologists, including one of whom is my dear friend Quentin Black—

*Members interjecting:*

**The Hon. M.J. ATKINSON:** Yes, it is topical as it happens—and apparently we have now learned from the member for Morphett it is going to be extended beyond psychologists. So, we could not get half an hour in after the passage of the second reading and already the member for Morphett is derogating from the safeguards.

The other thing I want to say about world's best legislation is that where a bill is a conscience vote or free vote, and we do not have the normal legislative backup of the Crown Solicitor's Office or the Policy and Legislation section of the Attorney-General's Department, we do not have the process of cabinet, we do not have the process of parliamentary parties, while the debates are interesting and parliament is in many respects at its best and we learn a lot about each other, legislating in these circumstances is fraught. We finished the second reading debate at about 10pm. We have now gone straight into committee, with 35 clauses and a schedule and 30 amendments. I think that we are looking at world's worst legislative practice in the way we are deliberating on this bill.

**Ms Chapman:** Weren't you here for the planning bill? We had hundreds.

**The Hon. M.J. ATKINSON:** Well, yes—

*Members interjecting:*

**The CHAIR:** Order!

**The Hon. M.J. ATKINSON:** I was here for the planning bill but, as you know, it is not my practice as Speaker to make gratuitous comments from the chair. The saving grace in the planning bill was that—

**Mr van Holst Pellekaan:** What is the saving grace of the planning bill?

*Members interjecting:*

**The Hon. M.J. ATKINSON:** I have overstated the case, I admit it, but—

*Members interjecting:*

**The CHAIR:** I am on my feet, in case you cannot notice. That means you all have to stop talking and listen to the member for Croydon so that we can continue the debate.

*An honourable member interjecting:*

**The CHAIR:** We can do a lot of things, but not that. Let's listen to his contribution and move on.

**The Hon. M.J. ATKINSON:** The redeeming feature of the planning bill, as a matter of legislative practice, was that it had gone through a cabinet process, it had gone through a process in the government party room and in the government's caucus committee, and it had gone through a similar process in the opposition's party room. But this is a conscience vote, it is a free vote, and the member for Morphett is taking an enormous burden on himself in taking this legislation through.

We have only just finished the historic second reading, which was carried, and now we are into a clause by clause consideration and it is just after 11pm. This is world's worst legislative practice. This bill deserves a better consideration, and I have foreshadowed to the member for Colton, and those who are in charge of this bill, that my view is that we should report progress and resume at a more seemly hour when we can better deliberate.

**Dr McFETRIDGE:** The whole intent of this bill, in discussion with stakeholders and the member for Ashford, considering all previous legislation that has gone before, in discussion with the member for Kaurna and other members, and certainly with the assistance of the Attorney, that was the attempt—I am not a lawyer. I am willing to accept the cogent advice of the member for Croydon, and we can discuss this between the houses.

**The Hon. M.J. ATKINSON:** The idea that an active voluntary euthanasia bill or a physician- assisted suicide bill can be fixed up between the houses is just as absurd as—

**An honourable member:** That's how the government works.

**The Hon. M.J. ATKINSON:** Yes, the government sometimes does work—

*An honourable member interjecting:*

**The Hon. M.J. ATKINSON:** —that way, but this bill—

*Members interjecting:*

**The CHAIR:** Order!

**The Hon. M.J. ATKINSON:** I hope *Hansard* will record the degree of heckling I am receiving. That is fair enough—you do not get much of a chance to heckle me most of the time.

**An honourable member:** You're sooky lala.

**The Hon. M.J. ATKINSON:** No, I am not being sooky lala at all. What I am saying is that the principle of this bill deserves better than legislation on the fly, and that is what fixing it up between the houses is.

The committee divided on the amendment:

*While the division bells were ringing:*

**The Hon. M.J. ATKINSON:** On a point of order, I notice that since the bells have been ringing for quite a while members have left the chamber during a division; is that permissible?

**The CHAIR:** Well, you know it is not, and I am busy talking. Who would name them, sir?

*Members interjecting:*

**The CHAIR:** I am sorry, I cannot look at everything. If the Speaker has seen

someone leave the room, he can tell me who they are.

**The Hon. M.J. ATKINSON:** A number of members left the chamber after the bells had been ringing for some time, and one of those is the member for Finniss.

**The CHAIR:** So, this where we call you Dobber Croydon. My advice is that we cannot do anything, so lock the doors. You can take it up with the member for Finniss later.

Ayes ..... 15
Noes .....13
Majority ..... 2

**AYES**

| | | |
|---|---|---|
| Bignell, L.W.K. | Cook, N.F. | McFetridge, D. (teller) |
| Chapman, V.A. | Digance, A.F.C. | Sanderson, R. |
| Brock, G.G. | Marshall, S.S. | Key, S.W. |
| Close, S.E. | Redmond, I.M. | Pisoni, D.G. |
| Caica, P. | Hughes, E.J. | Weatherill, J.W. |

**NOES**

| | | |
|---|---|---|
| Atkinson, M.J. (teller) | Bettison, Z.L. | Hildyard, K. |
| Gee, J.P. | Griffiths, S.P. | Picton, C.J. |
| Mullighan, S.C. | Odenwalder, L.K. | Wingard, C. |
| Rankine, J.M. | Rau, J.R. | |
| Wortley, D. | Gardner, J.A.W. | |

Amendment thus carried.

**Mr PICTON:** I move:

Amendment No 1 [Picton–1]—

Page 4, line 13 [clause 3(3)]—After 'will' insert:

, in the case where it is not reasonably practicable for a consultation, examination or assessment to be conducted in person due to the remoteness of the person's location,

This amendment deals with the definition of having assessments made under the act. It is essentially about telehealth provisions. As the bill is currently drafted, any of the assessments or examinations that a doctor or psychiatrist or now mental health professional would make would be available to do via telehealth mechanisms, as defined in regulations under the bill. That is something I am nervous about, and I think a number of people are nervous about.

When we had the briefing from palliative care professionals yesterday, which I thought was very good, it was something they raised as a significant issue: the fact that these consultations with people at the end of life are very sensitive, they are very long,

they need a lot of care, and they believe that they need to be in person. So, I am amending this to say that telehealth should only be an option where there is a significant remoteness that is a factor in this case. Somebody in Adelaide would not be able to access these provisions but would have to be examined in person, but somebody in a very remote location might be able to if there is no other option to do that.

**Dr McFETRIDGE:** I do support this amendment. I am very pleased that I have worked with the member for Kaurna on this, and I think it is a very sensible amendment.

Amendment carried.

**The Hon. M.J. ATKINSON:** I move:

That the committee report progress.

I would like briefly to speak to it.

**The CHAIR:** We do not think that is allowed.

**The Hon. M.J. ATKINSON:** I do not think there is anything in the standing orders that would prohibit it.

**The CHAIR:** Hang on, we are just getting advice.

**Mr GARDNER:** Can I refer to Speaker Atkinson's ruling on where standing orders are silent and whether speeches may be made on procedural motions. As was tested in this house four weeks ago, when a member was named, Speaker Atkinson ruled that the assumption should be, therefore, that the person in the chair can rule that no speeches be given.

**The CHAIR:** The infallibility of Speaker Atkinson is not in question. However, I am not sure what you would need to speak on reporting progress for.

**Mr GARDNER:** It is a procedural motion.

**The CHAIR:** That is right.

**Mr GARDNER:** Standing orders are silent.

**The CHAIR:** In my own humble way, I have come to the position that we just vote on it.

Motion negatived.

Clause as amended passed.

Clause 4.

**Mr GRIFFITHS:** I note that a person will be taken to have an impaired decision-making capacity in respect to the decision, and then it sets out criteria for that. Who determines that that is actually the case?

**Dr McFETRIDGE:** Thank you, member for Goyder, for your question. The two specialists— the first practitioner will be a specialist, if our agreed amendment proceeds—who will then refer that person to a mental health professional, and then that

impaired decision-making capacity suspected by the first practitioner will be investigated. That process could also be repeated by the second specialist doctor, who is the second practitioner. If they suspect that there is any impaired decision- making capacity, then it will be referred off to the mental health professional. It is a very secure form of making sure that the person who is making the request is able to fully comprehend the consequences of that request.

**The CHAIR:** Any further questions on clause 4? Any further questions on clauses 4 to 7?

**The Hon. M.J. ATKINSON:** I do not recall consenting to considering the clauses en bloc.

**The CHAIR:** The reason I do that is that there are no amendments pending for those clauses. Members are able to say that they have a question. We do not usually move them one at a time.

**The Hon. M.J. ATKINSON:** I think this is a bill which calls for clause by clause careful consideration and therefore—

**The CHAIR:** Only if the committee says they wish to debate a clause. Everyone has ample time to say no, as the member for Goyder just did at clause 4. If anyone wants to debate clause 5, they can certainly say, if they are happy to go to 4, not 5. I am only asking because there are no amendments until clause 8. If anybody has a question on anything beyond clause 4, I am happy to wait. Are there any questions on clauses 4 to 7?

**The Hon. M.J. ATKINSON:** It is not a question, but I want to express my concern about the idea that a person is capable of consenting—

**The CHAIR:** Are you still on clause 4?

**The Hon. M.J. ATKINSON:** Clause 4, yes. My understanding is that one can speak on the clause; one does not have to ask a question. It does not have to be in an interrogatory form, for the benefit of the Leader of the Opposition, who is interjecting out of his seat. I am paying a heavy price for my Speakership. The idea that a person is capable of consenting, who can only retain information for a limited time, concerns me and the idea of fluctuating between decision-making capacity and impaired decision-making concerns me and I was wondering if the member for Morphett might give us a fuller explanation. It seems to me that the bill could benefit from the euthanasia request being valid for only a statutory period rather than indefinitely, especially if it were obtained at the time of the fluctuation in decision-making capacity.

**Dr McFETRIDGE:** I refer the honourable member to the Consent to Medical Treatment and Palliative Care Act 1995. Section 4—Interpretations provides:

(2) For the purposes of this act, a person will be taken to have 'impaired decision-making capacity' in respect of a particular decision if—

(a) the person is not capable of—

(i) understanding any information that may be relevant to the decision (incuding information relating to the consequences of making a particular decision); or

(ii) retaining such information; or

(iii) using such information in the course of making the decision; or

It is already in the legislation that this house supported when it amended this legislation in July 2014.

**The Hon. J.M. RANKINE:** This is an issue I raised in my speech. I want to know who and how a decision would be made that a person has impaired decision-making capacity. How and by whom are they assessed as being capable at a particular point in time in making the decision to try to access euthanasia?

**Dr McFETRIDGE:** I suppose the simplest thing is to refer the member to clause 11(1)(b) and 12(1)(c)(i). The person is an eligible person. They have to be satisfied, and part of that is that decision-making ability.

**The Hon. J.M. RANKINE:** I have a further question. I am trying to understand who will be able to assess whether this person, who has impaired decision-making capacity, is, at a point in time, not impaired in applying for access to euthanasia. Are you saying it is the GP they visit, who may not be a specialist, for example, in dementia? This is really concerning. In one part of the act you say that people have to have full decision-making capacity, and in this clause you allow people who do not have full decision-making capacity, whose decision-making capacity fluctuates, to actually apply to access euthanasia.

**Dr McFETRIDGE:** The advice I am given is that under 10(1)(b) the eligible person is examined and assessed by a medical practitioner in accordance with section 11. That is repeated again for the second medical practitioner. Then, under 11(1)(b), 'the medical practitioner must satisfy themself that the person is an eligible person'.

**The Hon. J.M. RANKINE:** When people go to a medical practitioner and say, 'I want to access euthanasia', do they have to be well known to the doctor? Could it be someone accessing the doctor for the first visit? How would they know whether their decision-making capacity is impaired or not? I mean, this is your bill; you should know.

**Dr McFETRIDGE:** To become an eligible person, you have to have a diagnosed terminal illness. If the amendments of the member for Kaurna are agreed on, the person they present to will be a specialist, not a general practitioner, as people are saying in this place; it is a specialist. The specialist will then assess, as is required under clause 10(1)(b), whether they are an eligible person then, under clause 11(1)(b), that medical practitioner or that specialist will have to satisfy themselves that the person is an eligible person.

If they think that the person is well enough to proceed to then be assessed by the second medical practitioner, the specialist, then that medical practitioner, under clause 12(1)(c)(i), 'the person is an eligible person', will have to satisfy themselves that that person is not of impaired decision-making capacity. It is an extra safeguard in there.

**Ms COOK:** Could I ask the member for Morphett whether the fluctuation of people's cognitive abilities during terminal phases of their illness is related to the pathophysiology that they are experiencing: be it a period of low oxygen levels which then return to normal, which leads them to be able to be cognitively intact one minute, then unable to be cognitively intact the next, be it secondary to the use of an opiate medication which has been taken for the relief of their pain or be it a benzodiazepine that is being used to relax them at some point?

Are they then using objective data based on many mental state exams, such as the Glasgow Coma Scale or post-traumatic amnesia testing? I could reel off probably 50 cognitive assessments that are used by clinical therapists to assess cognitive function.

**Dr McFETRIDGE:** Thank you, member for Fisher.

*Members interjecting:*

**The CHAIR:** Order!

*Members interjecting:*

**Dr McFETRIDGE:** All of the above and more.

**The CHAIR:** The member for Davenport.

*Members interjecting:*

**The CHAIR:** Order! We do not want a separate conversation in the back, please.

*Members interjecting:*

**The CHAIR:** The member for Davenport has the floor and he is entitled to be heard in silence.

*Mr van Holst Pellekaan interjecting:*

**The SPEAKER:** Member for Stuart!

**Mr DULUK:** Thank you, Chair. Further, in determining decision-making for someone who has fluctuating capacity, does it need to be the same specialist or GP who makes that decision on an ongoing basis, or can it be a different specialist each time making that judgement call for someone who is in a fluctuating position?

**Dr McFETRIDGE:** The process that the person is going through when they make the request for voluntary euthanasia is that they are going to be assessed by that first specialist doctor, who will in most cases have been associated with that patient for a long time. It will not be just a chat with the patient. They will have reams of tests, pathology results and background objective information about the physical condition of that patient.

During the assessment of that patient, those numbers of visits, that specialist will have been able to ascertain whether that person is of impaired decision-making. Section 4(2) of the Consent to Medical Treatment and Palliative Care Act allows that there may be fluctuations in that decision- making capacity. That is already in the legislation, so we

are not doing any more or any less.

**Mr DULUK:** I appreciate that but, in determining a patient's decision-making ability when they are in a fluctuating state, does the specialist need to be the same specialist making that on several occasions or if, for example, you are a regional patient and you are perhaps based in Whyalla, your oncologist is on leave and the locum Dr Jones comes in, can the locum also have that ability to be the specialist who makes the decision about your capacity to make a decision?

**Dr McFETRIDGE:** In the stages they are going through, you cannot have a locum assessing these people unless they are a specialist, under the intent of this legislation. What we are intending here is that that person will be assessed by that first specialist. If they then go through the whole process of being assessed by the second specialist and that specialist thinks that they do not have impaired decision-making, then they are able to lodge the request with the two witnesses as per the legislation and the proposed amendments that I have agreed to.

There will then be an ongoing revisit by the first specialist, and that person will be the specialist who has had the longest history with this patient. There will be a 28-day review of that request. The reason we are doing that is so that we can be sure that there is no impaired decision- making capacity in what may follow up as further requests and the further timing of undertaking an act of voluntary euthanasia. This is all about adding those safeguards. It has to be the specialist. They have to have gone through this whole process.

**Ms COOK:** Could I just ask the member for Morphett if, in this circumstance, it really makes any difference if it is the same doctor or another doctor when using objective cognitive assessments that are based on scientific proof and measured data of the outcomes of the tests. These are tests that have been used for tens of thousands of patients across the world to assess their cognitive function, and people who have had training for 10 or 14 years are highly trained in the delivery of these tests, so they will get the correct result. There have been randomised trials on this, have there not? From one patient to another, it makes no difference.

**Dr McFETRIDGE:** Thank you to the member for Fisher for that advice. She is quite correct in the advice she has provided to the committee.

**Ms REDMOND:** I thought I would ask a question of the member for Morphett just to clarify that I have this correct. As I read the bill, first of all, an eligible member makes the request for voluntary euthanasia. Firstly, they have to complete a voluntary euthanasia request form. They are then examined and assessed by a medical practitioner in accordance with clause 11, and that means that they have to initiate the consultation and the medical practitioner must satisfy himself—not 'themself' as is currently in the bill, but we will leave the grammar aside—that the person is eligible, so they have tested against those things that we have already discussed.

Having done that, the person is then examined and assessed by a second

independent medical practitioner in accordance with clause 12, which then sets out that it must be a practitioner who is independent of both the medical practitioner referred to on the earlier occasion and of the person. This second practitioner has to examine the person and satisfy themselves again that they are eligible in accordance with the provisions, and that the earlier provisions are being complied with. On both occasions, when examined by those doctors, each doctor has to give information about the nature of the request and all the various things that are set out in paragraph (c).

Having done that, the person then needs to be seen by a mental health professional. I just wanted to clarify that I am correct in my reading of the various checks and balances that you have set out in the bill.

**Dr McFETRIDGE:** You are 100 per cent correct, member for Heysen.

Clause passed.

Clause 5.

**Mr GRIFFITHS:** I am seeking an explanation. I am talking about clause 5(5) where, for the purposes of various acts, it provides:

> ...a failure by a health practitioner to comply with this Act will be taken to constitute proper cause for disciplinary action against the health practitioner.

My question relates specifically to the use of the word 'comply'. Given what the act creates as an action, does 'comply' extend to that? What does 'comply' mean in relation to the other acts? I am looking for an explanation. I want to make sure that those medical practitioners who do not support voluntary euthanasia will not be liable in any way for not being prepared to be involved.

**Dr McFETRIDGE:** The consequences of a practitioner not complying with this act are severe. Under the Health Practitioner Regulation National Law (South Australia) Act 2010 a practitioner could be struck off. There are some dire consequences if they do not comply with this act.

**Mr GRIFFITHS:** I understand that there are requirements for them to conduct themselves in certain ways. I can appreciate that, but does 'comply' extend to compulsion?

**Dr McFETRIDGE:** There is no compulsion under this.

Clause passed.

Clauses 6 and 7 passed.

Clause 8.

**Mr PICTON:** I move:

Amendment No 2 [Picton–1]—

> Page 6, lines 17 and 18 [clause 8(b)]—Delete paragraph (b)

Currently, section 8(b) provides that no-one will incur any criminal or civil liability by:

(b) selling or supplying material or equipment (not being a drug) that is, or is to be, used for a purpose relating to voluntary euthanasia.

This has certainly made me very nervous. We have all seen stories over the last decade or so of death kits and the like, and I would hate for this bill to make that sort of action legal. I also believe that we should be very clear that that sort of sale is not allowed and, in fact, it should not need to be allowed because the emphasis of this whole bill is on using a drug. I am not aware of any equipment that would actually need to be used for the purposes of this bill.

**Dr McFETRIDGE:** I have had discussions with the member for Kaurna and I agree to this amendment.

**Mr DULUK:** For clarification, I am keen to know why the member for Morphett had paragraph (b) in there in the first place? What was the thinking behind that?

**Dr McFETRIDGE:** The initial intent was to allow the sale and supply of IV lines, cannulas and that sort of thing that we now understand would be considered part of routine medical supplies and not specifically associated with this, so it is to rule out any confusion.

Amendment carried; clause as amended passed.

Clause 9.

**The CHAIR:** We are looking at a series of amendments on schedule 1 in the name of the member for Kaurna. They are all different so we are doing them one at a time.

**Mr PICTON:** I move:

Amendment No 3 [Picton–1]—

Page 6, line 35 [clause 9(2)(b)(ii)]—Delete 'acceptable to the person' and substitute 'reasonable'

This is something that I think is very important and it is mentioned in my second reading contribution. In the previous bill, there was an effort by a lot of people to try to put in something to say that palliative care and medical care need to be explored first before making an application under this act. An amendment to that effect has been put in but it has been put in to state that it is 'acceptable to the person', which I and a number of other members were particularly nervous about. We think a better test would be 'reasonable' on the basis that we would not want to risk people being unreasonable in the circumstances of completely denying to even explore medical care or palliative care.

**Dr McFETRIDGE:** In discussion with the member for Kaurna, I agree to the amendment.

**Mr KNOLL:** I have a question more generally on clause 9, if this is the appropriate place to ask it.

**The CHAIR:** More generally, before we amend it? Do you think that is wise? Alright, off you go.

**Mr KNOLL:** Member for Morphett, I am seeking to understand what 'terminal medical condition' means. The reason I ask this is that obviously it is a term that is used far and wide throughout the bill and I am seeking to understand whether discretion is given to doctors as to how to interpret 'terminal medical condition'. I will give some examples. There are terminal medical illnesses such as motor neurone disease, something we have talked about here quite consistently as being something that we probably all envisage is a terminal medical condition. But what happens when somebody has heart disease, in the form of a heart attack that could kill them? Is that considered a terminal medical condition?

For instance, do complications arising out of cystic fibrosis constitute a terminal medical condition, or even something as simple as diabetes, which can kill people? Asthma can kill people. So we have a whole series of conditions that could be considered by some to be terminal medical conditions which may actually broaden the definition from what I think people in this place might commonly think 'terminal medical condition' means, to actually meaning something much more broad or interpreted much more broadly by doctors.

**Dr McFETRIDGE:** Thank you, member for Schubert. Clause 9(4) provides:

> For the purposes of this section—
>
> (a) a person is suffering from a terminal medical condition if he or she has an incurable medical condition (not being a mental health condition) that will cause the person's death (whether directly or as a result of related medical consequences);
>
> (b) the question of whether a medical condition is incurable is to be determined by reference to medical treatment that is, at the time a particular request for voluntary euthanasia is made, reasonably available to the person suffering from the condition and does not include treatment that is experimental in nature or otherwise extraordinary;
>
> (c) a reference to a terminal medical condition causing suffering will be taken to be a reference to—

And it goes on about suffering. The reference to a terminal medical condition is that there are no further treatment options or reasonable available medical treatment.

**The Hon. M.J. ATKINSON:** The point of a committee stage of a bill is that when a member asks a question about the meaning of a provision, the minister in charge of the bill, or in this case the private member in charge of the bill, then explains the provision by the use of words other than the terms of the legislation.

We all know the terms of the legislation; we are taken to know the terms of the legislation because we have the bill before us. So, what I would like the member for Morphett to do is answer the member for Schubert's question using his own words and explicate the provision and address the nub of the member for Schubert's question, which he has not done.

**The CHAIR:** Member for Schubert, had you read further down the page when you asked the question?

**Mr KNOLL:** I certainly had but there is nothing further in that. Diabetes is

technically incurable, unless we have found a cure.

*Members interjecting:*

**The CHAIR:** Order!

**Mr KNOLL:** Paragraph (a) states:

...directly or as a result of related medical consequences...

I think that it is a valid question. Heart disease can be ameliorated certainly in various ways but, let me put this a different way, member for Morphett: can you rule out cystic fibrosis, diabetes and heart attack from being caught up in this legislation?

**Dr McFETRIDGE:** Yes.

**Mr GRIFFITHS:** My question refers to 9(2)(b)(ii) and the specific words 'reasonably available'. I want an explanation about what that means and the context that it is expressed in, because I have read the rest of the clause but I have asked myself: does 'reasonably available' mean location, cost and also availability? Subparagraph (ii) says:

...having regard to both the treatment and any consequences...

Treatment involves cost, location and availability also. I am looking for some details there.

**Dr McFETRIDGE:** I do not think the term 'reasonable' is listed in the act's interpretation but it is a well understood term that is used in legislation, and it is what is reasonably available under reasonable circumstances. Perhaps that may not completely answer your question but the use of that term is quite common in legislation. In fact, the member for Kaurna had an amendment where he was replacing one clause with the word 'reasonable' because it means what it says.

**Mr GRIFFITHS:** The reason I asked the question is because 9(2) refers to this being 'an eligible person'. I then read that into it and had some concerns about its potential implications. I do not want it to be that, either through location or whatever, palliative care is not an option for those people, and that this might be the option that they find themselves forced to pursue. I know you have talked at length, and I completely agree with the fact that you do not want to have circumstances where people are forced or coerced by others to pursue this. I wanted to raise this point and express concern because it is very important to me how the words are expressed and in what context.

**The Hon. J.R. RAU:** I have a question and I have been set on this path by the member for Schubert, as often happens. Clause 9(2)(c) which sets out the eligible person criteria says, amongst other things, that the death of that person has become inevitable and it uses the term 'inevitable'. Subsequently in subclause (4)(e), the term 'inevitable' is defined, it seems to me, and, in defining it in 4(e) it is made clear that there is no time limit on it.

My question, in answer to the question raised by the member for Schubert is:

might that not actually mean that we are capturing here things like cystic fibrosis, diabetes, cardiac issues, asthma, whatever, because, you see, every person's death is inevitable as far as I am aware, and so there clearly has to be more than just the inevitability of death. I am following up on that question as to whether we can have much confidence about whether what we might regard as simply chronic illnesses might not be captured by that.

**Dr McFETRIDGE:** The Attorney is referring to subclause (4)(e). I have an amendment filed, and I understand that the member for Kaurna has a very similar amendment filed, that changes the whole time span for the inevitability; if we want to move to that amendment, I am more than happy to do so.

**Mr DULUK:** Staying on subclause (2)(b)(ii) and the last line, 'the person's suffering in a manner that is acceptable to the person', member for Morphett, are you saying that in terms of being eligible it needs to be acceptable to the person over acceptable to the specialist who will be determining whether someone is eligible?

**Dr McFETRIDGE:** That is the actual change the amendment is talking about: it is removing that and inserting the word 'reasonable'. The problem we have at the moment is that we are getting into general questions on this clause without actually sticking to the amendment. So, if we could fix that amendment and then move on to subsequent amendments, that might be very helpful.

**Mr KNOLL:** Member for Morphett, who decides what is a terminal medical condition?

**Dr McFETRIDGE:** The first specialist, the second specialist. The patient has probably been to a team of medical experts to be assessed and, hopefully, given a definitive diagnosis on what their condition is and then, unfortunately for them, that condition has been deemed terminal.

Progress reported; committee to sit again.

*Parliamentary Procedure*

**STANDING ORDERS SUSPENSION**

**The Hon. P. CAICA (Colton) (23:52):** I move:

That standing orders be so far suspended as to enable the house to sit beyond midnight.

**The DEPUTY SPEAKER:** An absolute majority not being present, ring the bells.

*An absolute majority of the whole number of members being present:*

**The DEPUTY SPEAKER:** As an absolute majority is present, I accept the motion. Is it seconded?

**An honourable member:** Yes.

Motion carried.

*Bills*

## DEATH WITH DIGNITY BILL

*Committee Stage*

In committee (resumed on motion).

Clause 9.

**The Hon. J.M. RANKINE:** I would just like to clarify something with the member for Morphett. Can he alert the house to where in this legislation there is mention of specialists and/or any team of medical experts? My reading of the bill refers to medical practitioners and other persons. There is no mention anywhere of anyone with any specialisation as far as I can see and, in fact, as far as I understand, it could be your local GP undertaking these assessments.

**Dr McFETRIDGE:** I thank the member for Wright for her question. I cannot pre-empt the decision of the house, but certainly the amendments that the member for Kaurna and I and others in this place have been working on and considering with stakeholders—I refer you to amendments Nos 12 and 14, where:

> (ab) the medical practitioner must be a specialist, or otherwise have expertise, in terminal medical conditions of the kind from which the person—

We have not got to those yet, but let's proceed. I would love to get to those now, but I am certainly happy to indicate to the house that I will not be objecting to those, and so we are in the hands of the house on those. I think it is a very good amendment.

**The Hon. J.M. RANKINE:** So, they are not in this bill but likely to be inserted, perhaps. I also want to ask, in clause 9(2)(c):

> the person's death has, disregarding any medical treatment...become inevitable by reason of the terminal medical condition;

I did not go into detail in my second reading speech about personal circumstances, but let me put this scenario to you. My father suffered three strokes and I was asked by the doctor to prepare my mother and my sister for his death. He suffered some significant disabilities. Would he be covered by this clause? Would it be considered that his death was inevitable, being that he had a debilitating injury, there was no cure for him and his death was inevitable, if not imminent?

**Dr McFETRIDGE:** Thank you, member for Wright. I am not a medical practitioner. I am not in a position to give a qualified opinion on your description of your father's condition, but I refer you to amendments that have been filed to that particular clause that do change the period of the prognosis to, in my case, 12 months. I understand there is a similar amendment that has been filed by the member for Kaurna which talks about six months, and we can deal with that at the time. But, certainly, if we can get to that clause, I think you will find that your concerns, even in my unqualified opinion, will be satisfied.

**Ms REDMOND:** I just want a point of clarification from the Chair. My recollection was that the member for Kaurna had actually moved his amendment No. 3 and that we

were discussing that when you allowed a question from the member for Croydon and others, subsequently.

**The CHAIR:** Yes.

**Ms REDMOND:** So, we have ended up in a situation where we are having a general discussion, and a lot of the general discussion I think could be circumvented.

**The CHAIR:** We will try to bring members back to perhaps looking at the amendments.

**Ms REDMOND:** Could I suggest we deal with amendment No. 3.

**The CHAIR:** We have done our best to accommodate members, but I think it is time that we try to look at the amendments to this clause, which are just changing the wording. Then let's discuss the amended clause, which is what I perhaps put to you, member for Schubert, at the very beginning. Can members perhaps think of that as a way around and then generally discuss the amended clause? Can we think about that? Let's try to deal with amendment No. 3 on schedule 1, which replaces in clause 9 'acceptable to the person' with the word 'reasonable'. Are we happy to look at that and put that?

Amendment carried.

**Mr PICTON:** I move:

Amendment No 4 [Picton–1]—

Page 6, lines 36 and 37 [clause 9(2)(c)]—Delete 'disregarding any medical treatment that may be administered to prolong the person's life'

**The CHAIR:** Does anyone have any problem with removing those words?

**Dr McFETRIDGE:** I congratulate the member for Kaurna on moving the amendment; it is a very sensible amendment.

**The CHAIR:** Member for Goyder, what is the problem with removing the words?

**Mr GRIFFITHS:** I understand the intent, but I seek an explanation on why the amendment has been put.

**Mr PICTON:** I think this amendment was to clarify the meaning of 'inevitable'. The genesis of this amendment came from something the Attorney raised as an issue where, in judging 'inevitable' by saying that we disregard any medical treatment administered to prolong the person's life, it adds extra vagueness but also runs counter to some of the other provisions that we now have in terms of saying that we would like people to explore medical treatment and that we should factor in the medical treatments that could be provided.

Amendment carried.

**The Hon. J.M. RANKINE:** Madam Chair, I did have questions about even the amended clause 9(2)(c).

**The CHAIR:** What we are trying to do, though—

**The Hon. J.M. RANKINE:** We have accepted the amendment, but the amended clause I still have a question about.

**The CHAIR:** What is the question? Let's listen to the question.

**The Hon. J.M. RANKINE:** I did start asking the member for Morphett about the circumstances of my father. Much of my concern in relation to this bill is about the capacity and capability of the medical profession. We all know really good doctors and we also know some not so good doctors. The doctor who was treating my father had been treating him for some time and his diagnosis was that his death was imminent, that he had suffered disability, that the next stroke was going to take him and that that was nearby.

On reading of this clause, my father could have well been encouraged to apply to be euthanased because his life had changed significantly. The fact of the matter is he lived for another 20 years. My concern is that people are going to get advice in a point in time, and life circumstances can change and can improve, so using the word 'inevitable' by reason of a terminal medical condition is really vague and open-ended and can put people at considerable risk.

**Dr McFETRIDGE:** Thank you, member for Wright. I am very pleased to hear that your father was able to live for another 20 years with the excellent medical care. If you read the two amendments on file, one from the member for Kaurna and one from me, on this particular clause, it says that a person's death will only be taken to have become inevitable at a particular time if, by the standards of a reasonable medical opinion, a person's death is likely to occur within 12 months of that time (as provided by my amendment) and six months (as provided by the member for Kaurna's amendment). We can talk about that when we get to the amendment, but this eliminates—

*An honourable member interjecting:*

**Dr McFETRIDGE:** Yes. **Ms COOK:** It is very loose as to what is a question versus what is a statement in this place, isn't it, but anyway I will have a crack.

*An honourable member interjecting:*

**Ms COOK:** Yes, that is part of it. I just was reflecting on the discussion around a stroke being a terminal medical condition. I have worked in neurological, rehabilitation, intensive care and a whole range of clinical areas, and I have never heard the words 'terminal medical condition' used in relation to a patient who sounds very similar to the one that the member for Wright is talking about. I am not sure whether the member for Morphett can shed any light on that at all. I have not heard it used.

**Dr McFETRIDGE:** A stroke—look, I am not a medical practitioner for humans. I have never heard the term 'terminal' applied to stroke.

**Mr KNOLL:** In relation to 'terminal medical condition', I asked a series of questions in relation to a number of specific diseases that the member for Morphett was happy to

rule out as being a terminal medical condition. In a subsequent answer he went on to say that he is not a doctor and he cannot make those determinations. I find it difficult on the one hand for the member for Morphett to claim that he is not a medical doctor but then to be able to give me a definitive answer on a series of medical conditions. So, I will ask this question: if a doctor and then a second doctor at this stage (but potentially in the future with the amendments it could be a specialist) decides that someone who has extremely bad diabetes ticks all the boxes in relation to being available for voluntary euthanasia, who is to stop those doctors from making that determination?

**Dr McFETRIDGE:** I am not a medical practitioner, and I am guided and advised by a number of people in this place who have far more experience in this area than I—the member for Fisher for one and my worthy adviser another. The advice that particularly the member for Fisher was able to give the committee—and if she wants to elaborate on that, I would be more than happy to receive that advice to assist the member for Schubert. The terminal medical condition is as defined in the bill, and if others can do better than that, I think the committee would welcome that advice. But you are really talking about the end stage of serious diseases that have been diagnosed, but I will hand over to the member for Fisher because I am sure she would like to add to the information for the committee.

**Mr KNOLL:** Sorry, Chair?

**The CHAIR:** Hang on a second. The member for Morphett is allowed to speak, and if I recognise the member for Fisher she is allowed to speak, too, and you will get another turn straight away. Member for Fisher.

**Ms COOK:** Thank you, Madam Chair. In terms of the discussion around diabetes, it is actually a reversible condition in many circumstances. We have come a long way with our health care regarding diabetes. What the member for Schubert might be referring to is a complex patient who has suffered from diabetic nephropathy, neuropathy and retinopathy, perhaps. That might be a patient with fulminating and full anuric, or lack of urine, renal failure, where they are unable to pass urine. They do not qualify for a renal transplant. They then suffer secondary heart disease due to remodelling of their cardiac muscle, so their heart does not pump their blood around their body.

It might be nephropathies and vascular conditions which cause them to lose both of their legs above the knees, having bilateral amputations. They cannot feel when they are lying on things in their bed, so they form fulminating, full fist-size ulcers in their buttocks. It could be that that diabetic patient might, if they are capable and competent, put their hand up and say, 'Could I access the voluntary euthanasia process?' But in the vast majority of cases, I would say no. That would be my input.

**Mr KNOLL:** Fantastic—except that my question was: where two doctors decide that it is a terminal medical condition, is there any other recourse to challenge that decision, or is that simply the end of the process?

**Dr McFETRIDGE:** I am looking forward to proceeding with the amendments,

because then members may be absolutely, 100 per cent clear that these two practitioners are going to be registered specialists. These two practitioners will be independent of each other. They will not just be talking to the patient, they will have access—in this case, if you heard my second reading winding-up speech, most of these people are about 70—to years and years of medical history at their fingertips. They will be able to access reams of all sorts of special tests, from the 50 or 60 specialities that are at their beck and call, to come up with critical, definitive diagnoses of not only that patient's current condition, but the prognosis for that patient.

This is where, in the next amendment we are talking about, in (c), we are bringing it back to 12 months. That doctor, that specialist, will know whether there are complicating factors, as laid out by the member for Fisher, that have caused other conditions, comorbidities—I forget the list of examples that the member for Fisher used—that could then contribute to a terminal medical condition. But diabetes in itself, I am advised, is not only manageable, it is reversible. I would have thought that the particular circumstances which the member is talking about are well and truly taken care of by the fact that we have two specialists looking at this person, and not just a point of time.

**Mr KNOLL:** That still does not answer my question, except that maybe in his answer he is saying that if two doctors, one doctor and one specialist, decide that it is, then it is, and that is the final word on the topic. I was listening intently to the member for Kaurna's second reading speech, where he talked about Dr Philip Nitschke, and was not that comfortable with some of the words of that. I think the fear of many of us in this place is the fact that there will be those who are predisposed towards allowing this to go for a much wider group of people, and there is no recourse if two doctors decide.

The other thing I would put is that, based on the fact that it is the say so of two doctors, the member for Morphett cannot rule out the fact that potentially this could be used in a much wider set of circumstances than I think we are contemplating. If I can come to my question, member for Morphett, what is the difference between a 'terminal medical condition' and a 'terminal medical illness' or 'terminal medical disease'?

**Dr McFETRIDGE:** It is all in the nomenclature, member for Schubert. **The CHAIR:** I need to draw members to look at the amendment, which is actually inserting a couple of extra lines. Can we look at trying to pass this amendment?

**Ms REDMOND:** Which amendment, Madam Chair? Are we on No. 4 at the moment?

**The CHAIR:** I will ask the member for Kaurna to move amendment No. 5 because we have already moved amendment No. 4 and had questions after we moved it. What would you like to ask?

**Ms REDMOND:** I am happy to wait for the member for Kaurna to move amendment No. 5 and then I will ask a question about it.

**Mr PICTON:** I move:

Amendment No 5 [Picton–1]—

Page 7, after line 8 [clause 9(3)]—Insert:

(d) suffering from a chronic, but not terminal, medical condition;

(e) at increased risk of suffering from a terminal medical condition,

Essentially this is to add clarity that chronic diseases that are not terminal diseases, and also people who are at risk of developing a terminal disease but have not yet done so, should not be classified as having a terminal disease. It may not necessarily be needed, but I think for complete caution it is better to set this out.

**The CHAIR:** And the member for Morphett is happy with that? **Dr McFETRIDGE:** More than happy with that ma'am—an abundance of caution. **The CHAIR:** And the member for Heysen has a question on this?

**Ms REDMOND:** I just want to clarify the whole of clause 9 and make sure that I am understanding it correctly in the format it will have once the amendments of the member for Kaurna and potentially the member for Morphett pass. There are five amendments on file for the member for Kaurna on this clause and we are now dealing with the third of those.

As I understand it, member for Morphett, the situation is that, under clause 9 a person must be a competent adult, they will have to be suffering from a terminal condition (and that is that it has to be an incurable medical condition—not a mental health one, but an incurable medical condition) that will cause their death and that they then are in a situation where their death has become inevitable.

With all of those things in place, it is still the case, taking on board the member for Kaurna's current amendment, that the person is not eligible, even if they get through all of that, just because of advanced age—it is not sufficient for them to be suffering from a disability of whatever kind, it is not sufficient for them to be suffering from a mental health condition, and under the two new amendments nor is the sufficient for them to be suffering from a chronic but not terminal medical condition, or at increased risk of suffering from a terminal medical condition. Am I correct in my understanding thus far of clause 9?

**Dr McFETRIDGE:** My investment in that fine-toothed comb and magnifying glass was well deserved: you are 100 per cent correct.

Amendment carried.

**The CHAIR:** Amendment No. 6 is fairly basic—we are just going to delete (d) in clause 9 on page 7, lines 32 to 37. Is everyone happy with that? We have done amendment No. 5; we are now looking at amendment No. 6, and the member for Kaurna will move that for us.

**Mr PICTON:** I move:

Amendment No 6 [Picton–1]—

Page 7, lines 32 to 37 [clause 9(4)(d)]—Delete paragraph (d)

**The CHAIR:** It is pretty basic; it does not really need an explanation. You are happy with that, member for Morphett?

**Dr McFETRIDGE:** I am, thank you, Madam Chair.

**The CHAIR:** Member for Croydon has a question?

**The Hon. M.J. ATKINSON:** I do not have a question, I have a statement. I support the amendment wholeheartedly. I do so because one of the worst features of the other bill before us was that these matters would be determined entirely subjectively, and a person was suffering intolerably if they said they were suffering intolerably, and it is a material improvement to this bill that this amendment is made.

Amendment carried.

**The CHAIR:** We have a new amendment. We have some procedural matters we are dealing with here at amendment No. 7, which talks about the length of time. There is amendment No. 7 on schedule 1 of the member for Kaurna, but that also takes into account that we have another amendment here on schedule 3 in the name of the member for Morphett, but the new amendment we have is amendment A2 in the name of the member for Croydon, and his amendment calls for a period of three months. The wording is exactly the same on each of the amendments except for the number.

**The Hon. S.W. KEY:** I do not seem to have the amendment from the member for Croydon.

**The CHAIR:** A2 is coming. It is very fresh; it is coming.

**The Hon. S.W. KEY:** I would have thought that seeing we are talking about it now, we should have it right now. I would like to thank the member for Newland for providing me with this amendment that is proposed. I would like to ask the member for Croydon where he came up with three months.

**The CHAIR:** Before we go into that, we need to actually move the amendment before we discuss it.

**The CHAIR:** I want to make members aware that this amendment to clause 9(4)(e) is basically the same, except for the amount of time involved. That being the case, we will deal with the lowest number first, and then we can deal with each of them after that. You will have to amend three, to six, to 12.

**The Hon. S.W. KEY:** My question still stands. I would like to ask—

**The CHAIR:** We just need the member for Croydon to move it first, and then we can discuss it. Member for Croydon, you are going to move your A2?

**The Hon. M.J. ATKINSON:** Yes. I move:

Amendment No. 2 [Atkinson–1]—

Page 7, lines 38 to 40 [clause 9(4)(e)]—Delete paragraph (e) and substitute:

> (e) a person's death will only be taken to have become inevitable at a particular time if, by the standards of reasonable medical opinion, the person's death is likely to occur within three months of that time.

My view is that if we are going to introduce active voluntary euthanasia or physician-assisted suicide, it is best determined and applied in the terminal phase of a terminal illness. That was always what was discussed when I was on the Social Development Committee inquiry into euthanasia, in the law and practice relating to death and dying select committee, that euthanasia in its most circumscribed and limited form was in the terminal phase of a terminal illness. One of the reasons the member for Ashford's bill was inevitably going to defeat is that it was not so limited.

The committee now has a choice for a very broadly expressed change, whereby the inevitability of the death is judged 12 months out, which is what the member for Morphett offers us in his amendment. I trust that it is the member for Morphett's amendment—12 months? The member for Kaurna sets it at six months and I set it at three months because if active voluntary euthanasia was to become lawful it should do so, at least in the beginning, in its most limited form, namely, the terminal phase of a terminal illness. That is why I choose three months. There are seasons in a person's life, and I think this is one season that would be an appropriate time in which we could say that death is inevitable.

**The Hon. S.W. KEY:** I would like to know on what medical advice and experience you would, first of all, go back to a terminal phase of a terminal illness, which we have already discarded as a criterion. We have just been through a whole lot of clauses that talk about what the criteria are. The terminal phase of a terminal illness does arc back to a few decades ago when you were on that committee, but also to previous bills that have not been accepted in this place—probably not for that reason, but they have not been accepted. Secondly, I want to know on what medical basis you would come up with three months, as opposed to six months, as opposed to 12 months.

**The Hon. M.J. ATKINSON:** My decision is no more based on medical expertise than the member for Kaurna's six months or the member for Morphett's 12 months. It is not essentially a medical question; it is a question of policy. It is a question of politics. It is a question of philosophy. My philosophy has always been in the house that, if we were to have active voluntary euthanasia, it was to be confined to the terminal phase of a terminal illness.

We were assured earlier in the debate that there was not going to be mission creep, if you like, that there were not going to be amendments come in that would loosen the definitions and make assisted dying more freely available, more easily available, available on broader criteria. We had a debate around that, and we were assured that was not the case. What I am putting to the committee is that we should start circumscribed—namely, judging inevitability a season away, three months, rather than six months or 12 months. If after a period we want to determine that the terminal phase of a terminal illness can be 12 months out or six months out, we can do that based on

experience and our political philosophy. However, my amendment is proposing to start circumscribed, and then we can make an assessment later on.

So the short answer to the member for Ashford is that I do not do it on the basis of medical expertise. I do not pretend to have medical expertise, but I did serve on two committees of the parliament inquiring into it, and I have given expression to what they thought would be, I think, the best introduction of euthanasia, and that would be terminal phase of a terminal illness.

**Ms REDMOND:** It is my understanding that terminal with 12 months to live, as diagnosed by two doctors, is actually already accepted by the Australian insurance industry, so it would seem to me that there is not a lot of credence in the member for Croydon's argument. Overseas six months is common (in the US, for instance), but already in Australia in the insurance industry they accept that it is terminal if it is diagnosed by two doctors as within 12 months to live.

**The Hon. M.J. ATKINSON:** With respect, that is not my argument.

**Mr PICTON:** While the others have been speaking I have been receiving some interesting advice from the Clerk about this procedure. We have a situation where there are three amendments: the member for Croydon has moved that the limit be three months; I had originally moved six months; and the member for Morphett has moved 12 months.

Let me say from the outset that I am open to having a discussion about these time limits. However I have been advised that, because the standing orders say that these motions should be moved in a particular order based on the lowest number, I should move to insert 'six' into the Member for Croydon's motion, and then if the member for Morphett wishes to proceed with his 12 then he should move a similar motion to do that.

If we did not do that and the member for Croydon's three-month amendment was to be put and lost, I would not be able to put my six month amendment and the member for Morphett would not be able to put his 12 month amendment. I think that is odd, but that is the advice from the Clerk, that we would not be able to do that. Because of that, and because I think that there absolutely needs to be a time limit and I would be worried if member for Croydon's amendment was put and lost that we would not be able to do that, I move:

To amend the member for Croydon's amendment by removing '3' and inserting '6'.

**Dr McFETRIDGE:** I have said from the word go that I want this legislation to be as safe as it possibly can be, and listening to the member for Croydon about the three months, he wants it to be as safe it can be. So I think a safe and acceptable compromise is the six months amendment moved by the member for Kaurna. I am more than willing to accept that.

**The Hon. S.W. KEY:** I want to ask the members for Morphett, Kaurna and Croydon whether they have had an experience where someone who has cancer, for

example, when they ask how long they have probably got, sometimes the answer will be, 'Well, you've got two weeks,' and sometimes the answer will be, 'You might be around for a couple of years,' (which may or may not be correct). Quite often, and certainly in the experience of my family and with my friends, the prediction is not correct.

I am just wondering, if someone is told that maybe they have two years, how this would help that particular person who fitted all the other criteria, having this very rigid three months, six months or 12 months. I would just like them all to answer how we actually deal with that.

*Members interjecting:*

**The CHAIR:** Order!

**Mr PICTON:** I am very happy to answer on behalf of myself. I have been very clear in my second reading speech and elsewhere that I strongly believe that this should be for a limited number of people, and this is a pretty important clause in terms of that objective. The way that I came up with this amendment for six months was by looking at the Oregon legislation, where they have a very similar to identical clause, in terms of it being a prognosis of six months or less.

I absolutely accept, in terms of what the member for Ashford is saying, that this might not necessarily help everybody who has a different prognosis from their doctor for a longer period of time. However, I see this as an important safeguard for keeping this at the terminal phase of a terminal illness, as was previously discussed by the member for Croydon.

**Dr McFETRIDGE:** I would obviously have preferred to stay at the 12 months with my amendment, because federal superannuation law defines 'terminal' as 12 months. The Financial Services Council of Australia information is that the most is 12 months. In fact, in relation to claiming a terminal illness benefit by these particular super members, the regulations state:

> ...a terminal medical condition exists in relation to a person at a particular time if the following circumstances exist:
>
> (a) two registered medical practitioners have certified, jointly or separately, that the person suffers from an illness, or has incurred an injury, that is likely to result in the death of the person within a period (the certification period) that ends not more than 24 months after the date of the certification;

So, it is out to 24 months. For the sake of making sure that this is going to be acceptable to members with an abundance of caution and despite the federal law, despite superannuation companies, I am happy to support the six months.

**The CHAIR:** The member for Waite has a question.

**The Hon. M.J. ATKINSON:** I was asked by the member for Ashford to respond, and I am.

**The CHAIR:** Okay, sorry. Off you go.

**The Hon. M.J. ATKINSON:** By the member for Heysen and the member for Morphett talking about the policy of insurance companies regarding when a condition can be deemed to be terminal or what a superannuation trust deed says, they have a tin ear for the sad music of humanity because we are talking about something completely different here. We are talking about active voluntary euthanasia or physician assisted suicide. We are not talking about the policies of insurance companies or superannuation trustees. This is a policy question. This is a philosophical question. It is not an accountancy question or an actuarial calculation.

The question of the number of months is a question for you to decide in accordance with your conscience and what you think the policy should be. It cannot be determined for us by some corporation. There is a great risk. The higher this number is, the greater risk there is that there will be a serious error in the prognosis. Obviously, you are going to be more accurate if your prognosis is three months out than six months out or 12 months out.

I am informed that in Oregon, which has had physician-assisted suicide because the people voted for it in one of those American citizens-initiated referendums that I know the member for Ashford is so keen about (I jest—not), there are plenty of examples of people outliving the six-month statutory period even by years. To make the prognosis as accurate as possible, I say three months is the appropriate figure. It is the most accurate figure and philosophically it is best because it starts off the assisted dying legislation in the most circumscribed form.

Do I have some experience about prognosis of terminal illness? Yes, I do because I have been at a deathbed at St Andrew's Hospital only in recent weeks. My own father had a disseminated pancreatic liver and disseminated cancer, and he was given three months to live, and he did not make that.

**The Hon. M.L.J. HAMILTON-SMITH:** My question is to the member for Morphett. In hearing these amendments, whether it is three months or six months, does this clause 9 or any other part of the bill have any provision for it to be an offence should anyone solicit or attempt to coerce a doctor into a prognosis? For example, if the hospital management, in an effort to clear beds for other patients, tried to impose a policy or to set about arrangements where doctors were encouraged to tighten or shorten their prognosis, is that something that the member has considered?

I imagine doctors would resist this, but hospital management can be very persuasive, particularly when there is an effort to clear beds. Similarly, family members could be very persuasive if, for one reason or another, they wanted to bring the matter to a conclusion. So, is it an offence anywhere in the act to attempt to coerce or solicit an earlier prognosis from a doctor under these arrangements?

**Dr McFETRIDGE:** We will get to clause 27 eventually, but Part 4—Offences provides:

27—Undue influence etc

A person who, by dishonesty or undue influence, induces another to make a request— and this has to be a request from the person who is requesting it— for voluntary euthanasia is guilty of an offence.

Maximum penalty: Imprisonment for 10 years.

**The Hon. M.J. ATKINSON:** My question is: what if the person seeking to be categorised as terminally ill offers the doctor an inducement? How is that dealt with?

**Dr McFETRIDGE:** There is a code of practice, a whole code of ethics, that governs the role of these specialists. If they are found guilty of an offence under the national health practitioners act, there are serious penalties for that offence.

**The Hon. S.W. KEY:** I just want to make the point first of all that I actually agree with the sentiment expressed by the member for Croydon with regard to this legislation—I totally support that. I do not support three months because I think it is too short a period, and I think it is too prescriptive. My understanding of why the Oregon legislation has a six-month provision in it is because that is when the palliative care provisions kick in in that state, and a lot of the American legislation is connected to when people can actually access palliative care.

While I do not particularly want to disagree with anybody in here, I just think that three months is too short a period. I would prefer that we stick to 12 months but, in listening to what the member for Morphett has just said—and it is his bill—it seems to me that the six months is reasonable, but it is based on palliative care services, not on when someone gets a prognosis about their particular terminal medical condition.

**Dr McFETRIDGE:** To give the member for Croydon some further information, you are going to have to bribe the two specialists and the psychiatrist and then, under division 1, clause 8, the Note provides:

Section 13A of the Criminal Law Consolidation Act 1935 makes it an offence to aid, abet or counsel the suicide or attempted suicide of another.

**The Hon. M.J. ATKINSON:** That really does not address the question. It appears the member for Morphett is now admitting that there is nothing in his bill that makes it unlawful for the person seeking to be categorised as terminal and receive the procedure to make an offer or an inducement to a doctor to categorise him or her under the bill. The member for Morphett may say, 'The person is going to die anyway and if her or she succeeds they will be beyond the jurisdiction of the courts,' but the point is that it could be that the person is not eligible and is seeking to be made eligible by offering an inducement. As I read the member for Morphett's answer, there is nothing in the bill that addresses that.

**Dr McFETRIDGE:** There is nothing to stop people trying to bribe members of parliament either.

*Members interjecting:*

**Dr McFETRIDGE:** They can try, but there is a code of ethics for every specialist—every doctor, in fact, and every medical health professional.

**The Hon. A. Koutsantonis:** The one that says 'do no harm'? **Dr McFETRIDGE:** The code of ethics that they are governed by: 'and, above all, do no harm'. They are bound by that code of ethics, so that is what stops any inducement.

**Mr WINGARD:** My question is to the member for Kaurna. I was wondering whether he had any more information about the six-month time period in Oregon—I know he has done a lot of work in that space—and if there are any other experiences as to why the six months was a good length of time that they use there?

**Mr PICTON:** I would not want to overstate my expert knowledge of the entire research of this area in the state of Oregon. I saw that the bill, as it stood, said that a terminal illness could be any length of time at all, and that was something that was raised by a number of people as being a problem. I then took to thinking: how would you address that? I looked at what was in place in Oregon where they do have the six months. There are arguments from other people that that is related specifically to their healthcare system. Although I would say that, even if that is the case, the fact that it has been in operation and has been able to operate there shows that there is an example where it does work.

I am not wedded. If other people have other ideas, whether it is three months, I am open to a discussion about that. There might be other ways that people would want to define the section, whether it be, as the member for Croydon said, the terminal phase of the terminal illness. However, the device in my amendment of using six months was to try to get to that point where it is the terminal phase of the terminal illness.

**Ms REDMOND:** In relation to the matter raised by the member for Croydon, it seems to me that, as well as the clauses that the member for Morphett used in his response and, indeed, the reference to the Criminal Law Consolidation Act which, as he said, is noted at the note under clause 8, there is also a provision in clause 28 of the bill prohibiting a person from making a false or misleading statement.

It would surely be necessary for a person trying to make an attempt to bribe a doctor, apart from the doctor's obligations, to have to make a false or misleading statement, again in contravention of the act. I have a suspicion that the member for Croydon might have been aware of that when he suggested that the member for Morphett's answer might suggest a person is going to die anyway, so putting him in gaol for 10 years might not matter.

**The Hon. M.J. ATKINSON:** I think my point was that a patient who was not entitled to come under the provisions of the law might offer an inducement to one of the doctors or one of the mental health workers, who have been included in the scope of the bill now, in order to certify that person as being eligible for its provisions. Those who are supporting the bill have not been able to point to anything in the bill that deals with that person who offers the inducement. There is only the code of ethics dealing with the medical practitioner and they do not know what code there is dealing with the mental health worker who has been amended into the bill by the member for Morphett's

amendment. My point to the member for Heysen is that a person who is not eligible will live.

**Ms REDMOND:** This brings back old times, Madam Chair, being here late at night arguing across the chamber with the member for Croydon.

**An honourable member:** The good old days.

**Ms REDMOND:** I just want to clarify that on this point it seems to me to be really a nonsense proposition that someone who is not in a position to get through the hurdles that are put in place by this bill—that is, that they have to make a formal request, it has to be assessed by a medical practitioner and that medical practitioner then has to explain a whole range of things to them and make an independent assessment of the condition and that they meet the eligibility criteria, then refer them to another person, who is a specialist, who goes through a long process with them, who then refers them to a psychiatrist or other mental health practitioner—would actually be in a position to simply commit suicide were they so minded rather than having to go through the whole process of this bill.

I would suggest, therefore, that the member for Croydon's attempt to thwart the bill is based on his dislike of the provision in general, rather than on the inability of the bill to accommodate all the exigencies that in reality could exist.

**The CHAIR:** The amendment to the amendment is to replace the number 3 with the number 6.

**The CHAIR:** Before we go any further, I want to make absolutely certain that members understand that by voting for '6' you remove '3' altogether from the equation. The question before the house is that the amendment to the amendment is agreed to. So that means '6' supersedes '3'.

The committee divided on the amendment to the amendment:

Ayes ..... 26
Noes .....2
Majority ..... 24

**AYES**

| | | |
|---|---|---|
| Bettison, Z.L. | Bignell, L.W .K. | Brock, G.G. |
| Caica, P. | Chapman, V.A. | Close, S.E. |
| Cook, N.F. | Digance, A.F.C. | Gardner, J.A.W. |
| Gee, J.P. | Griffiths, S.P. | Hildyard , K. |
| Hughes, E.J. | Key, S.W. | Marshall, S.S. |
| McFetridge, D. | Mullighan, S.C. | Odenwalder, L.K. |
| Picton, C.J. (teller) | Pisoni, D.G. | Redmond, I.M. |
| Sanderson, R. | van Holst Pellekaan, | Weatherill, J.W. |
| Wingard, C. | D.C. Wortley, D. | |

**NOES**

Atkinson, M.J. (teller) Rankine, J.M.

Amendment to the amendment thus carried.

**Mr GARDNER:** Point of order, Chair: regarding the exuberance displayed by the member for Croydon in finding that he had a counterpart in voting against that proposition, under Speaker Atkinson's ruling, expressing joy or opposition to a vote is in defiance of the house and he has threatened to name members for doing that.

**The CHAIR:** I do not know that we need to be that pedantic this late at night. Amendment as amended carried; clause as amended passed.

Clause 10.

**Mr PICTON:** I move:

Amendment No 8 [Picton–1]—

Page 8, line 10 [clause 10(1)(d)]—Delete '(if so required)'

This is the first of three amendments that would seek to make what was to be a psychiatrist assessment but is now, at least for the moment, a mental health professional's assessment to be mandatory under the act and deleting the 'if so required', and then my amendments Nos 13 and 15 later on would do the same.

**Dr McFETRIDGE:** I have had some discussions and consultation on this, and we support the amendment.

**The CHAIR:** We are following the debate closely; we are looking at Amendment No. 8 on schedule 1 and Amendment No. 2 on schedule 2. There is just some procedural work to be done around the words.

**Mr PICTON:** For the benefit of the house, there has been some discussion. I have moved this amendment to ensure that the psychiatrist test would have to be mandatory, and that was originally my proposition. Because the member for Morphett in his amendments proposes that it be a mental health worker, he has a slightly different change to this section, whereas my change would keep it as a psychiatrist. I still believe that should still be a psychiatrist. I clearly voted against the previous amendment on 'mental health worker' because it was a bit too vague. We have been advised that we have to move mine before the member for Morphett's. We have another choice in terms of 'psychiatrist' again at this point.

**The CHAIR:** The member for Morphett's amendment No. 2 on schedule 2 is no longer being proceeded with; is that correct? Member for Morphett, are you happy to withdraw amendment No. 2 on schedule 2, or are you not going ahead with it?

**Dr McFETRIDGE:** I will not be proceeding with it.

Amendment carried.

**The Hon. J.M. RANKINE:** My question is about clause 10(1)(c). I would like the

member for Morphett to explain to the house—

*Members interjecting:*

**The CHAIR:** Order! The member for Morphett is being asked a question, which he will not hear unless he is looking at the member for Wright.

**The Hon. J.M. RANKINE:** —how we determine the independence of a medical practitioner. It is required that a second assessment be undertaken, and in a number of places it is referred to as an 'independent medical practitioner'. Is that someone working in two different practices? Is it someone with a different billing code? What happens in the circumstance of a country town when there are two GPs perhaps working in that country town? What constitutes independence? Is independence breached if people have done their training together or worked in the same hospital together? I think we need to be really clear that what we are not agreeing to here is a 'tick and flick' process, which I have personally experienced by so-called independent doctors.

**Dr McFETRIDGE:** Once we get to these amendments, these will be two specialists. Whether they work in the same practice, adjacent practices or completely different practices, they are bound by a code of ethics to provide completely independent assessments of the particular person based on their clinical history and test results. I am advised, member for Wright, that the independence of the two doctors is a regulatory decision (the code of ethics) but for the sake of informing the committee, perhaps the member for Fisher might be able to give us some information.

**Ms COOK:** I want to refer members to the situation where you have a patient in an intensive care unit who has had a significant trauma or brain injury and, as a consequence, requires assessment for a diagnosis of brain death. For decades, doctors have been able to practice independently and autonomously and in good faith to diagnose those patients with brain death, and this is no different.

**The Hon. J.M. RANKINE:** I beg to differ, and thank the member for Fisher for continually coming to the aid of the member for Morphett, who cannot answer questions about his own bill. One would wonder why that is. There are many examples where doctors are supposed to act independently and they simply do not. There is no definition in here, no criteria in here, about what constitutes independence as far as these medical practitioners are concerned. As far as I can hear, the member for Morphett cannot articulate what that might be.

**Dr McFETRIDGE:** If the member for Wright has evidence of malpractice she should give that evidence to the regulatory authorities and not cover it up.

**The Hon. J.M. RANKINE:** The fact of the matter is that when situations occur and there are requirements under legislation—

*Dr McFetridge interjecting:*

**The CHAIR:** Order!

**The Hon. J.M. RANKINE:** —when doctors do not—

*Dr McFetridge interjecting:*

**The CHAIR:** Order, member for Morphett!

**The Hon. J.M. RANKINE:** —act independently, when they do not act according to the law—

**Dr McFetridge:** Prove it.

**The Hon. J.M. RANKINE:** Don't tell me, 'Prove it.' I can prove it all right.

*Dr McFetridge interjecting:*

**The CHAIR:** Order!

**The Hon. J.M. RANKINE:** I can prove it all right. I am not breaching other people's personal information. What I can tell you is that it happens, and it happens when people and families are under the most stressful circumstances. When a senior doctor makes a decision, other doctors will not overturn it. They might be required to act independently. They are required by law to act independently, and they do not do it. You do not have anything in this legislation that indicates or stipulates what independence would be. It could be two doctors in two different practices referring patients to one another; it could be two people in the same practice, as you have just said.

**The Hon. J.J. SNELLING:** The member for Morphett has challenged the member for Wright to prove an example of doctors behaving badly. He just needs to look at the chemotherapy bungle, where doctors behaved very, very badly and were actively engaged in a cover-up.

**The CHAIR:** I am not sure that's helpful.

*The Hon. A. Koutsantonis interjecting:*

**The CHAIR:** I know.

**The Hon. J.J. SNELLING:** This view that doctors are somehow always right and never get it wrong and are somehow perfect individuals is absolute bunkum. Like any other profession, including politicians, doctors occasionally get it wrong. I would absolutely support the comments of the member for Wright. You would not have a regulatory authority, you would not have AHPRA, you would not have a medical board, if it was a situation where all our doctors were perfect and never got it wrong or behaved badly.

**Ms REDMOND:** Member for Morphett, am I correct in my understanding—

**The CHAIR:** Member for Morphett, you need to listen to the member for Heysen.

**Ms REDMOND:** He always listens to the member for Heysen, Madam Chair. I can guarantee it. Member for Morphett, am I correct in my understanding that the use of the term 'independent' in clause 12 at least, and possibly another clause later on, is quite common in terms of legal interpretation that independence is a generally understood term. When one says that the assessment has to be by a person, the second medical

practitioner must comply with the following provisions:

the medical practitioner must be independent of both the medical practitioner referred to in section 11 and the person;

They then must examine the person, and that is a commonly understood ordinary everyday use of the word 'independent' that means they do not have any particular relationship and will assess independently the situation of the person who has come to them.

**Dr McFETRIDGE:** Absolutely right.

**The Hon. A. KOUTSANTONIS:** Member for Morphett, I would like to inquire: what is the consequence of a doctor acting inappropriately under the scenario that the member for Heysen just articulated, if they did not act independently? Is there a penalty within the bill, or are you relying on the ordinary codes of conduct that apply under the medical practitioners board and AHPRA?

**Dr McFETRIDGE:** Under clause 5(5), for the purpose of the Health Practitioner Regulation National Law (South Australia) Act 2010 and the Health Practitioner Regulation National Law, a failure by a health practitioner to comply with this act will be taken to constitute a proper course for disciplinary action against the health practitioner.

**The Hon. A. KOUTSANTONIS:** Could you please define what the potential disciplinary actions are?

**Dr McFETRIDGE:** I remember speaking in this place for over three hours on this particular piece of legislation which was mirror legislation which passed through Queensland. I remember threatening to read 300 pages of *Hansard* into this place if it was not included in the schedule, because it is an extensive piece of legislation covering the health practitioner regulations. It is a national law, it is really extensive, and I am afraid I cannot give you that 300 pages word for word.

**The Hon. M.J. ATKINSON:** I just wanted to say how powerfully nostalgic it is to be in opposition again.

**Ms Redmond:** It's a wonder you can remember it.

**The Hon. M.J. ATKINSON:** Yes, it is so long ago, as the member for Heysen interjects, it is a wonder I can remember it.

**The CHAIR:** I am afraid it is like bike riding, isn't it? You never forget. What is your contribution?

**The Hon. M.J. ATKINSON:** Yes, my contribution is that I do not want to pour kerosene on the deliberations at this stage, but there is some other legislation, the name of which escapes me at the moment, which requires two doctors to agree. Of course, that provision quickly became a complete dead letter in which two doctors can be found to tick off on anything basically, and the provisions of that particular legislation are no longer operative. But I will not detain the committee with that example.

First of all, I think the two-doctor provision in the bill will also become a dead letter because it will be easy to find two medical practitioners who not only support the bill philosophically but support the member for Ashford's view of what the legislation should be the legislation and the trajectory of this legislation in Holland and Belgium. We know that in Belgium the reporting provisions are just honoured now in the breach. Doctors who simply defy the provisions of the law in order to provide people with euthanasia whom they think should have euthanasia are now celebrities in Belgium.

We know what the trajectory of this will be: two doctors who are philosophically committed to suicide for people who think they need it will be found, and the provisions will gradually, though it will probably take a few years, be ignored. I would put to the member for Morphett that it would be best, in maintaining the integrity of the medical profession, for the Australian Medical Association, the South Australian branch, which we know has doubts about the desirability of this legislation, to establish a panel of doctors from which one doctor would need to be chosen. That would ensure the integrity of his law.

**Mr GRIFFITHS:** My question follows on from subparagraph (c), raised by the member for Wright, and it is a matter of process for me. I am working on the basis that, from subparagraph (b), the assessment has been undertaken and the medical practitioner has determined that there is justification for it. Then the requirement is to go to the second independent medical practitioner. My dilemma is: what if that person says no?

What if that independent practitioner does not believe that it is an appropriate action for the individual to undertake? Does that stop the process completely, or is there an opportunity for the ill person to go to another subsequent practitioner? Indeed, is there a number that stops the whole process? Can you be knocked back once, twice, or whatever number of times?

**Dr McFETRIDGE:** Thank you, member for Goyder, for that question. Were you asking about the first practitioner?

**Mr GRIFFITHS:** No, the first practitioner has accepted that there is cause for it to be supported, but the second, and potentially subsequent practitioners, does not believe the cause actually exists and they are not prepared to endorse it. How often can you continue to go to practitioners before you find one who says yes?

**Dr McFETRIDGE:** The refusal by the second doctor could be for many reasons, and they are set out in clause 12. The reasons a doctor can refuse that include: in their opinion the person is not of sound mind; the decision-making ability of the person is adversely affected by their state of mind; the person is acting under any form of duress, inducement or undue influence. If that is the case, the first practitioner must refer the person to a mental health professional under section 13 of the act. I think that would satisfy your concerns.

**The Hon. A. KOUTSANTONIS:** Does that mean that if a terminally ill patient

seeks the opinion of two independent doctors and one disagrees, there is an automatic referral to a mental health practitioner for evaluation against that patient's will?

**Dr McFETRIDGE:** This whole process is based on a person with a terminal disease voluntarily requesting access to voluntary euthanasia, and I am looking forward to getting to those clauses so that we can keep this in context. If the first specialist has acceded to their request, after examination and assessment of their mental health condition, and the second specialist disagrees, that comes under the same clause where the person is of sound mind, with decision-making ability, and the person who is making that request and who is doing that voluntarily is accepting the fact that this is going to happen. They accept the consequences of them undergoing this whole process. There is no coercion, and if they are not happy they can withdraw their application.

**The Hon. A. KOUTSANTONIS:** I think what you are saying to the committee is that a terminally ill patient gets an independent medical practitioner, you say specialist—

**Ms Redmond:** Well, that's according to an anticipated amendment.

**The Hon. A. KOUTSANTONIS:** Anticipated amendment—the committee can only deal with what is before it now, but I accept what the member is saying, that it is going to be a specialist. The specialist says yes, proceed. There is a second independent specialist medical practitioner who says no. If the patient wishes to proceed, they are referred back to a mental health practitioner, whatever that is, they do an evaluation, and then the patient is free to go out and seek two new independent verifications or one verification? I suppose the point is: do you start again after you have gone to a mental health practitioner, or do you simply need to go to one other? Has not the member for Goyder uncovered what is actually going to occur here, which is doctor shopping?

**Dr McFETRIDGE:** When the person with a terminal disease has voluntarily made the request, they then go to the second specialist. That specialist says no for some particular reason in one of these clauses here. When that person goes back to the first practitioner, the specialist, that first specialist would consider the other doctor's report and refer the person off to the mental health professional. Then, before that request or any further requests could be acceded to, that doctor would have to be certain that person is of sound mind, the decision-making capability of that person is not affected by their state of mind—all of those conditions set out in those clauses there. The need to ensure that that process is being followed to protect the patient is there and the referral back will cover the need to be certain. It is a written report as well, as most of them are.

**The Hon. J.J. SNELLING:** The question is: if the second doctor says no, what is there to prevent the patient from then seeking further opinions from other doctors until he or she finds a doctor who says yes? What is there in the legislation that is currently drafted to stop someone from doing that? If that is the case, then inevitably chances are you are going to find a doctor somewhere who will say yes. Is there something in the legislation that prevents a patient from simply continuing to go to doctors or specialists until that person gets the answer they want?

We know very well that insurance companies do this all the time. There are doctors who specialise in personal injury law, who are essentially guns for hire, either for insurance companies or indeed for the other side. That is well established. What is there to prevent a patient from simply continuing to go to different doctors in the face of a no until the patient gets the doctor with the answer they want?

**Dr McFETRIDGE:** I would have thought that the six-month time line we have just put in would be a significant impediment. With the process that a person would have to go through by referring back to that first practitioner, who would then have to examine them, it is possible that they could then seek a second opinion if they were not comfortable going back to the practitioner they had already been dealing with. That is no different from any person seeking a second opinion. However, the need for the process to be followed and the need then for a referral to a mental health professional, as is required, would still be there. So, if there is any doubt, you still have those safeguards.

**The Hon. J.J. SNELLING:** I do not want to labour the point or keep the committee back any longer, and I may have missed something in the bill, but if you go to a doctor, be it your first doctor, and that doctor says, 'No, I don't think you fit the criteria set out in the legislation for euthanasia,' do you then go to another doctor who perhaps again says no? You said six months and I heard the member for Heysen say six months; I presume you are saying that within six months the person is dead anyway and it would take longer than six months. If the only protection is that you would be dead before you had exhausted all the doctors in the state, I do not think that is particularly reassuring.

**Dr McFETRIDGE:** The checks and balances are there, no matter which doctor or specialist they see. If that person does not fulfil the requirements to become an eligible person, then they are not an eligible person. They have to accept the decision of the doctor.

**The Hon. J.J. SNELLING:** Unless, of course, they go to another doctor who has a different opinion.

**The Hon. J.M. RANKINE:** Is it not correct, member for Morphett, that if you go to doctor No. 1, specialist No. 1—if we get that amendment up—and you are approved and you go to specialist No. 2, and specialist No. 2 says, 'No, you go back to specialist No. 1,' who would then refer you on to a mental health worker, who could, in fact, be of much lesser qualification than the specialist who has rejected you. They could approve it, so essentially you can access euthanasia with the approval of only one medically qualified person.

**Ms REDMOND:** I want to clarify something based on the member for Wright's question. My understanding—and perhaps the member for Morphett can correct me if I am wrong—is that it does not happen the way the member for Wright is suggesting. In fact, if you go to the first doctor, and bear in mind that the first doctor has to do a whole range of things, they have to satisfy themselves that the terminal illness and all those things exist, that the person is not under duress and making the application and so on

and so forth, all the things we have already been through. They have to be an eligible person and within the time frame that we have already agreed to, and so on.

They then get sent to a second specialist, and if that person does not agree it is not the case that the person then goes straight off to a psychiatrist; they have to get through the second hurdle.

Clause 10 actually says that to make the request for voluntary euthanasia the eligible person must complete the relevant parts of the request, then they are examined and assessed by the medical practitioner, then they have to go to the second independent medical practitioner, who will be a specialist (in fact, I think they are going to be specialists who have a specialist knowledge in terminal illness). Only then, after getting through that and getting a positive report in terms of meeting the requirements according to that second independent person, do they get the referral to the mental health practitioner.

Before I sit down, the member for Playford, in his question, made a comment which I think must be traversed by me. Before I took the possibly unwise decision of lowering myself in the public estimation—lawyer was already pretty low, and I spent about 30 years in that occupation before I lowered myself even further and came into something even lower in the public estimation by coming in here—I spent a lot of my 30 years as a lawyer in personal injury law and, on behalf of the doctors I dealt with over those 30 years, I absolutely reject the assertion of the member for Playford that doctors in personal injury law are essentially guns for hire.

Without fail, with the doctors I dealt with during an extensive career in that particular area, managing what at the time were some of the biggest claims in the state, I never, ever came across a doctor who was a gun for hire. They all played it straight down the line.

**The Hon. J.M. RANKINE:** I thank the member for Heysen for trying to answer that question, but in fact she has not. Clause 12 is about the examination and assessment by the second medical practitioner, and clause 12(3)(c) provides that if the medical practitioner sets out that they are of the opinion that the person is not or may not be of sound mind, the reasons why they would refuse it. It then goes on to say that the medical practitioner referred to in section 11, which is the first assessing doctor, 'must refer the person to a psychiatrist for an examination and assessment in accordance with section 13.'

So, now we know it is not a psychiatrist, it is a mental health worker, and it is the first medical practitioner who is referring that person on to the mental health worker. So my question is: if the mental health worker gives it a tick, do people get approval to access euthanasia by being approved by one medical person and a mental health worker?

**Dr McFETRIDGE:** To put this issue to rest, it would not matter if you saw two doctors, three doctors, four, five, six specialists. The bar never drops. You have to have

a terminal illness. You have to be assessed as an eligible person by two doctors. The bar never drops.

*The Hon. J.M. Rankine interjecting:*

**The CHAIR:** Order, member for Wright!

**The Hon. J.M. RANKINE:** I am sorry, but the member for Morphett has not answered my question. Is it not correct that a person can be approved to access euthanasia by being approved by the first assessing practitioner and a mental health worker?

**Dr McFETRIDGE:** I do not know what assurances I can give the member for Wright, but the bar never drops. The person has to be assessed by that specialist; they have to be an eligible person. If the second specialist is of the opinion that the person is not of sound mind, has any problems in any of the issues that are laid out in the legislation, that person has to be referred to a mental health professional. The bar never drops.

**The CHAIR:** Each member has had several questions here. The member for Goyder has not.

*The Hon. J.M. Rankine interjecting:*

**The CHAIR:** May I finish? The members on my right have had several questions. The member for Goyder has a question.

**Mr GRIFFITHS:** I have not received a satisfactory answer yet, because the six-month inclusion that we recently voted on is a key issue for me, too. What if one professional says yes to these six months, but the next one says, 'No, that's a longer period.' That could be relative to the experience that they have in treating that illness in particular, or a variety of things. Therefore that person is out of the equation, so you have to go through another specialist or independent medical practitioner. They might say it, or they might not. We still do not have any stipulation that I have read in here, or that you have explained to me, that assures me that the opportunity is not there to visit multiple practitioners until you get the answer that you want.

**Dr McFETRIDGE:** To make this perfectly clear, the person who has a terminal illness goes to the first specialist, and in most cases—I think the nurses here would probably be better qualified than I to say about their experiences—that first specialist has probably been dealing with that patient for a long time. They have made the assessment that that person has—

*The Hon. A. Koutsantonis interjecting:*

**Dr McFETRIDGE:** The first one. It is the first practitioner I am talking about here. They have made that assessment. The first practitioner has made that assessment. They have determined that the person now, after our amendment, to be an eligible person has less than six months to live. They have determined that they understand the consequences of their condition and the consequences of their request, and they are

then sent off to that second specialist. The second specialist really is just confirming what the first specialist has said.

*Members interjecting:*

**The CHAIR:** Order!

**The Hon. J.M. Rankine:** That's the point.

**The CHAIR:** Order, member for Wright!

**Mr GRIFFITHS:** No, it talks about independence; therefore, they have to be their own thoughts.

*The Hon. J.M. Rankine interjecting:*

**The CHAIR:** Member for Wright!

**Dr McFETRIDGE:** Confirming as in—

*Mr Griffiths interjecting:*

**Dr McFETRIDGE:** No, you are misunderstanding me, member for Goyder.

**Mr GRIFFITHS:** Okay.

**Dr McFETRIDGE:** Their job is to confirm the first assessment—that is their job.

**Ms Redmond:** Or not.

**Dr McFETRIDGE:** Or not, that's right. If they do not do that—

*Mr Griffiths interjecting:*

**Dr McFETRIDGE:** No, wait, please.

**Mr GRIFFITHS:** Their job is to make a determination as they see it.

**Dr McFETRIDGE:** Exactly, to confirm or not. They will make that independently—that is the job. They will do it independently, and you would expect nothing less because the second person is a specialist as well. What happens is that now it is a mandatory assessment by a mental health professional. If there is any doubt, they go off to that mental health professional anyway with the concerns of that second doctor.

If the opinion that is arrived at is that that person is no longer an eligible person because of the state of their mind, it will not be about the terminal illness. There might be some variation on the prognosis perhaps, but on the fact that the person has the terminal illness, there will be, as I said before, reams and reams of tests. There will be a mountain of objective data and results that both those doctors will be relying on.

If that second doctor is of the opinion—a completely independent opinion of that of the first doctor—that that person is not an eligible person, then that report has to be written and sent back to the first doctor. That first doctor will then have to reassess that person's eligibility by themselves. If circumstances change—and this is like any second opinion—you can go and see a different second doctor as a second specialist, sure, but the bar does not drop. They still have to be an eligible person, and that is all part of the

checking process.

In fact, I think, in many ways, it is an added benefit because you are really getting a third opinion—not just two, you have three. If that third doctor does not agree, then that person is not an eligible person. That third doctor is still, under this, a second practitioner. The report is done, and that goes back to the first practitioner, and they go through there again.

I am not saying that you are saying this, but if there is an assertion out there that there is going to be some dodgy specialist who is going to risk 10 years in gaol—not only their licence but 10 years in gaol—for making a false statement here, and be prosecuted under the national law, then I do not know what I can do to assure you, because the bar has never dropped. The assessments are there. The assessments are critical, the assessments are crucial and they are objective assessments, other than the six months.

**The CHAIR:** We have had several questions on this particular business, which is prior to what we were talking about. We still have two amendments on clause 10, which still gives us plenty of time to discuss clause 10, so I think it would be the right time now to look at the member for Kaurna's amendment [Picton-1] 9, which amends clause 10, and there is still plenty of time to discuss clause 10.

**Mr PICTON:** I move:

Amendment No 9 [Picton–1]—

Page 8, line 36 [clause 10(3)(b)]—Delete 'until it is revoked in accordance with this Act' and substitute:

until—

(i) it is revoked in accordance with this Act; or

(ii) 28 days have elapsed after the day on which the request was made and the request is not extended under subsection (3a),

whichever occurs first.

I will talk about both amendment No. 9 and No. 10, but move only amendment No. 9. Both these amendments are to add in that there is a limit in terms of how long the authority would last (28 days), after which the first doctor, who presumably would be the treating doctor, would just need to certify that the conditions are still in place as per when it was originally authorised. This is an important safeguard to protect against anything that might change in that circumstance or whether there might be any coercion of the person.

**Dr McFETRIDGE:** I accept that amendment.

**The Hon. A. KOUTSANTONIS:** You said earlier, member for Morphett, that the first practitioner would probably be your treating doctor. When the member for Ashford's bill was first contemplated, one of the most—

**Dr McFETRIDGE:** I missed that comment, sorry?

**The Hon. A. KOUTSANTONIS:** You said that generally the first practitioner, the

first specialist, would probably be your treating doctor. One of the most persuasive arguments as a safeguard, without wanting to embarrass him, was one Andrew Denton made about the safeguards in place on the west coast of the United States, where the treating doctor, who knew you and who was treating you, was one of the people who would make one of these assessments, but you have no requirement for the treating doctor to give an opinion on the terminal illness of the patient. There is no requirement, so you can have a treating oncologist and go to two other independent doctors, but not to your treating oncologist.

One of the safeguards that gave me a lot of comfort was that it was your treating doctor, who knew you and who had been treating you from start to finish for the disease, who was involved in the approval process for the voluntary euthanasia. You have no such requirement in this bill. Without wanting to be a smart alec, I can imagine a situation, which probably is not that farfetched if you do not have this safeguard in place—and I am not inclined to move an amendment—where a patient has an oncologist who thinks that the cancer is treatable, but their opinion is not sought. They take their diagnosis to two other independent doctors and they are able to access voluntary euthanasia.

As a suggestion, if this bill is to succeed—and I do not want it to succeed—I would have thought that the treating oncologist, who knows the patient best and who has been with the patient from diagnosis to treatment plan throughout the entire process, should at the very least be required to be part of the process, rather than have the ability of the patient to then go to someone else. I think you are assuming, quite properly, that in a world of everything working well that patients would consult with their treating doctor first and then go to a second doctor for an opinion, but there is no such requirement in this bill. Would it not be a better safeguard that the treating doctor for the terminal illness be the first person consulted?

**Dr McFETRIDGE:** The doctor knows best and the family doctor relationships that we have enjoyed in this country for many years do still exist. The particular group of patients, the people we are talking about, have been diagnosed with a terminal illness. To be diagnosed with a terminal illness there is probably going to be a range of specialists who you have dealt with. I can guarantee that they will get to know your full clinical history across the years; they will know you inside out. They will know, because of their speciality. By the use of the term 'specialist' they are looking at this particular condition because they have expertise in that area. They are able to determine the extent of the invasion.

**The Hon. A. KOUTSANTONIS:** If your oncologist is treating you, the specialist is treating you for a terminal illness, is that the person you consult, or can you go somewhere else?

**Dr McFETRIDGE:** As a patient, you have the right to refuse treatment from a particular doctor, but if you have a terminal illness and you have been given a prognosis of six months to live— these people want to live; they want to get the best treatment they

can. This is where the amendments that the member for Kaurna and I have agreed on—the medical practitioner must be a specialist or otherwise have expertise in terminal medical conditions of the kind from which the person is suffering, being the terminal medical condition referred to in section 92B. The oncologist can be the specialist and then—

**The Hon. A. KOUTSANTONIS:** I am not trying to be difficult with the member for Morphett, as I have a great deal of respect for him. The most persuasive argument I had from anyone in favour of this bill was that the treating specialist who is treating the terminal disease—not a GP, not the family doctor, but the specialist. You can be treated for a terminal illness and the opinion of the doctor who set out your treatment plan is not consulted on the voluntary euthanasia. The safeguards in Oregon, I am advised—and I could be wrong—where this system of euthanasia I think has been universally accepted as working best in the world, requires that treating specialist to be the first person consulted on the voluntary euthanasia, and you have no such provisions in this bill.

I am simply asking the question. I am not talking about a GP we have known all our lives. I am talking about being referred and going to an oncologist. You have cancer and you get a second opinion and the treating doctor for the terminal illness, under this legislation that parliament has agreed to up to this point, is not the person who will be consulted technically for the voluntary euthanasia. You can go to two other specialists who have not been involved in your treatment plan. Surely one of the safeguards in your bill must be that the treating specialist be the first person consulted, as it is in other jurisdictions. If you want this bill to succeed, surely that is the very minimum safeguard that you put in place.

**Dr McFETRIDGE:** I point out that there are clauses later on that we will examine where no medical health practitioner can be coerced or forced into participating in this treatment. In fact, even the member for West Torrens said that it is more than likely that that practitioner will be the person who has been dealing with that particular person for the initial investigations, the workup, the whole treatment. If they have an objection, whether it is some fundamental objection of faith or some other ethical reason that they do not want to treat this patient, that is in here. It should be in the best interests of the patient to be given the best access to care. That is what is happening with two specialists looking at the patient.

There is no guarantee that the patient will not choose to go somewhere else, for instance, if they move—who knows? There is a whole range of reasons. There is an extra safeguard now. There are three: the two specialists and the mental health professional examining this patient, so you are getting the complete medical history. It would be very nice. I have had a relationship with medical practitioners for many years and I have the utmost faith in them. One of them tried to tell me that I was having a heart attack. He did some blood tests and said, 'You're having a heart attack. Go to hospital. Phone an ambulance straightaway.' He was wrong, fortunately, after myriad tests, but he proved that a politician had a heart.

What we have here is two specialists and a mental health professional all having to sign off on this document. It would be lovely to have that, but we cannot make it obligatory because, if people want to opt out, they can. In an ideal world, we would go back to that relationship and, in reality, I think in most cases that would still exist.

**The CHAIR:** Can we concentrate on amendment No. 9 that we are looking at?

**The Hon. S.W. KEY:** I want some clarification from the member for Morphett. My understanding of the process, and certainly from my own experience with family and friends, is that your family doctor and then your main treating doctor—you might have a number of doctors or specialists who are dealing with your terminal medical condition—may not necessarily have an agreement with a particular palliative care centre, hospital or place where you may be going to get treatment. It is not always very easy to go from the person you are most familiar with into hospital or palliative care and have the same person.

As much as I understand the point the member for West Torrens is making—and I agree, I think it would be preferable—someone has six months to go, they are on their last legs and we are going to put them through this amazing process to assist them when they have met the criteria that qualify them to access voluntary euthanasia. I think we need to get back to the reality of what actually happens when people do have a terminal medical condition.

We have now limited it to six months and, as I said earlier, I think that is a bit harsh, but that is what we have agreed to. Someone supposedly has six months to go and we are going to make them go through all these hoops unnecessarily. They will also have to somehow cope with whatever the system presents them with because in some cases they will have agreements and in some cases the doctors will not have agreements.

In my mother's case, for example, her doctor and her specialist could not go to the Mount Barker palliative care centre because they did not have an agreement with that particular hospital, so she had to then negotiate with a whole lot of new specialists and doctors in her last two weeks of life. That is not uncommon. The same thing happened with my brother-in-law. He was getting specialist treatment in one particular area and ended up dying in another hospital with his doctor not having access to him because the doctor did not have agreement with that particular hospital. We have to be a bit realistic about what we are actually arguing here. It seems to be cruel and harsh, in my view.

**Dr McFETRIDGE:** I agree with you 100 per cent, member for Ashford. I am also advised that, under the Medicare rules, if you change specialists you need a new referral. People are not going to chop and change their specialists. They will tend to have been with the same specialist and the same practitioners for a long time. Remember that these are people with a terminal medical condition.

**The CHAIR:** We need to look at amendment No. 9 in the name of the member for Kaurna, which is what we are talking about, so if we have some specific questions about

amendment No. 9— what is your specific question about amendment No. 9, member for Stuart?

**Mr VAN HOLST PELLEKAAN:** My question is actually about clause 10.

**The CHAIR:** We are looking at the amendment to clause 10, so if you want to look at amendment No. 9 and ask a question about that. You can ask any question you like about amended clause 10 when we get to it. At the moment we are looking at the amendment.

**Mr WILLIAMS:** I am not sure whether this is the appropriate place, but—

**The CHAIR:** We will certainly tell you.

**Mr WILLIAMS:** I will take your advice.

**The CHAIR:** I hope you do. Next question.

**Mr WILLIAMS:** I have been upstairs listening to the debate for some considerable time and some matters of curiosity have risen in my thoughts. It seems to me that we are grappling with putting in safeguards and—

**The CHAIR:** No, we need to actually bring you back to amendment No. 9. Do you need the schedule? We have a copy of it here. We are looking specifically at this and then you can range on the amended clause 10 later. So, if you have a question—

**Mr WILLIAMS:** I am quite happy to ask my question at that point, if you want to put the amendment.

Amendment carried.

**Mr PICTON:** I move:

Amendment No 10 [Picton–1]—

Page 8, after line 36—After subsection (3) insert:

(3a) Subject to this Act, a request for voluntary euthanasia will be taken to remain in force for a further 28 days after the period referred to in subsection (3)(b)(ii) has elapsed if the medical practitioner referred to in section 11—

(a) certifies on the voluntary euthanasia request form relating to the request that—

(i) the opinion of the medical practitioner in respect of the matters referred to in subsection (1)(g) has not changed; and

(ii) it is appropriate that the request remain in force for a further 28 days; and

(b) complies with any other requirement set out in the regulations for the purposes of this paragraph, (and the request may be further extended under this subsection).

(3b) An extension of the period within which a request for voluntary euthanasia remains in force—

(a) may only occur at the request of the person who made the request; and

(b) cannot occur once the request has been revoked or otherwise ceased to be in force.

As I said before, this is connected to the previous amendment.

**Dr McFETRIDGE:** This is an extra safeguard and I think it is a very good thing. Twenty- eight days is not too onerous. In fact, I think that most people who are at this stage of a terminal illness should be receiving numerous visits from health practitioners, and the member for Kaurna's amendment is quite a good one to keep reassessing that patient.

**The CHAIR:** Are there any questions on amendment No. 10? Member for Goyder, what is your question on amendment No. 10?

**Mr GRIFFITHS:** I do, because it refers to regulations which may come into force and that is a frustration I have with many pieces of legislation. We are required to consider what the potential might be for regulations but we do not know what the detail of it is, whereas I consider them quite important to the thrust of the legislation. The member for Morphett, are there any draft regulations?

**The CHAIR:** Where are you looking in amendment No. 10 about regulations? Sorry, (b), right.

**Mr GRIFFITHS:** Yes, thank you.

**Mr PICTON:** In terms of the regulations, I presume you are referring to (3a)(b), where it says that it would comply with any other regulations. I believe that has been drafted on the basis of providing that if we wanted to add any additional safeguards that should happen at that point, then we could do that later. The key bit, from my point of view, is in there already in (3a)(a), but even if we did not have (3a)(b), I would see that, potentially, you could add regulations under the general regulation-making power that would apply to that section.

**Dr McFETRIDGE:** I can help the member for Goyder. The main purpose of regulations under this type of legislation, I am advised, is to set out the forms that have to be filled out.

Amendment carried.

**Mr WILLIAMS:** I want to ask the member for Morphett, who has brought this matter before us: it seems to me that the big question for a number of members is about the safeguards. The bill has in it, supposedly, a number of safeguards and the person seeking the request has to jump through a number of hoops, which is fine. My question goes to who polices the hoops that are actually being jumped through?

I understand there is a proposition in the bill that, at the end of the process, after the person has been euthanased, there is a report to the Coroner. Is there a proactive process that guarantees that all those processes are undertaken and signed off? For instance, would there be some sort of register whereby, as each of the processes are passed, the documentation is lodged, and before the final approval is given somebody

has to ensure that all the processes have been completed?

I ask that question because it is my understanding that—notwithstanding in other jurisdictions, and particularly in Europe, where supposed safeguards not dissimilar from those we are discussing here were put in place—with the effluxion of time there has been a certain laxness about the way the safeguards are abided by. My understanding is that shortcuts have indeed been taken, and this is one of the matters that I raised in my second reading contribution in the short time available: that I had a concern about shortcuts. I have a concern that, as hard as we might try to build a system of safeguards, there will be ways to circumvent them.

There will be ways to circumvent them, whether it be through deliberate acts or through just a casual attitude, which becomes more and more casual with time, I guess. Then, all of a sudden, we have in practice something that is quite different from what is proposed here. How can we all be assured that the safeguards that are being proposed, supposedly strong safeguards, are being adhered to and how can we be assured that every one of those hoops has been jumped through before the final okay has been given?

**Dr McFETRIDGE:** Thank you, member for MacKillop. In most of the acts we deal with—the Consent to Medical Treatment and Palliative Care Act and various health acts—and in this particular bill, there are clauses which ensure that the records are being kept. There are standards of medical practice for any doctor, and in my own practices I had to maintain accurate records. You can be brought up on disciplinary charges if you do not keep the correct records. Clause 10—How to make a request for voluntary euthanasia, subclause (4) provides:

> The medical practitioner referred to in section 11 must keep the following documents in respect of each request for voluntary euthanasia made by a person—
>
> (a) the voluntary euthanasia request form; and
>
> (b) the written reports provided to the medical practitioner under sections 12 and 13 (if any); and
>
> (c) if a request for voluntary euthanasia is made in accordance with subsection (5)—the audio-visual record under subsection (5)(b),

If we then go to clause 22—Report to State Coroner:

> (1) A medical practitioner, registered nurse or nurse practitioner who administers voluntary euthanasia to a person must make a report to the State Coroner within 48 hours after the person's death...
>
> (2) A medical practitioner to whom a request for voluntary euthanasia is made must, as soon as is reasonably practicable after becoming aware that the person who made the request has self- administered voluntary euthanasia pursuant to the request, make a report to the State Coroner.

So, there are the particular documents that the practitioner has to keep, and then there are the reports to the Coroner. Under the member for Kaurna's amendments, the Coroner would then be required to keep records of the number of people accessing voluntary euthanasia. That will then be incorporated into a ministerial report that has to

be tabled in this place every year.

**Mr WILLIAMS:** I must admit that I am not satisfied with the answer, because, as I mentioned that earlier, my understanding is that the report made to the Coroner is after the event. My question is: how can we be assured, if we establish all these hoops, that in practice they will actually be jumped through? How can we be assured? It is not uncommon in our society for obligations to be circumvented because they are never policed. We have a law that says that you have to abide by a speed limit, but people only abide by the speed limit because of the policing function that occurs.

*Members interjecting:*

**The CHAIR:** Order!

**Mr WILLIAMS:** Let me rephrase that. Not all people obey the speed limit, and the reason they do not all obey the speed limit is that they can damn will get away with it. We know that not all people obey the speed limit because the state collects close to $100 million a year because of that fact. We know that the policing function is a very important function to ensure that the laws that we make are indeed abided by. My listening to the debate and the concerns expressed by a number of members goes to the very heart of this question; that is, they are very concerned about the checks and balances.

It appears to me that there are not any real checks and balances in this bill. It appears to me that, after the event, a report is made to the Coroner. Does the Coroner knock on the door of the doctors concerned? Does the Coroner check that the paperwork that has been sent to him actually reflects what happens? What I am saying is that I would have thought that, in such an important matter as this, if we are going to accept that the checks and balances are doing what we all hope they will do, there is some process by which there is an audit before the event, not a casual sign-off after the event. That is my concern. Well, my concerns are probably a bit more fundamental than that, but I think this particular point—

*Members interjecting:*

**Mr WILLIAMS:** I'm sorry, I've been sitting up there about four hours listening to this—

*Members interjecting:*

**The CHAIR:** Order! I think the member for Morphett understands your question, member for MacKillop; he is going to answer it now.

**Dr McFETRIDGE:** My good friend the member for MacKillop is always very good at thorough questioning of ministers in this place, and he is doing a diligent job now. I can answer his question. Under the report to the State Coroner (I should have continued on), it says in 22(3):

(3) A report under this section must be in the prescribed form and must be accompanied by—

(a) a copy of the voluntary euthanasia request form; and

(b) a copy of any report or other document required to be kept under section 10(4)(b) and (c); and

(c) any other information required by the regulations.

Clause 10(4) provides:

The medical practitioner referred to in section 11 must keep the following documents in respect of each request for voluntary euthanasia made by a person—

(a) the voluntary euthanasia request form; and

(b) the written reports provided to the medical practitioner under sections 12 and 13...

That is from a medical mental health practitioner. That doctor obviously will have access to reams and reams of clinical history on their patient, including all of the pathology and all of the other investigations that have been undertaken. Those will be provided to the Coroner as part of their reporting, and that can be included under the regulations if the member for MacKillop really wants to go there.

I can assure the member for MacKillop that under the report to the State Coroner, with a maximum penalty of $5,000 plus the penalties, and I am just looking for a clause now, there are significant penalties for malpractice under the Health Practitioners National Law for not maintaining clinical standards and abiding by the code of ethics where you can be struck off. So, there are significant penalties and significant incentives for these treating specialists to keep all the records, to cross all the t's and dot all the i's so that they cover their own backsides.

**Ms COOK:** I have listened a lot to people and their questioning and their desire for clarity around the medical profession. I understand that, as with anything, there are people around who have negative experiences or different experiences with medical officers. These are medical specialists we are talking about. They finish year 12, they do their medical degree which is six years, they do an internship.

*Ms Redmond interjecting:*

**Ms COOK:** They spend some time as an RMO. They go through a rigorous process to be selected as a surgical trainee or oncologist, and this might take another six to eight years. They often travel overseas. They invest tens of thousands of dollars into this journey to become a medical specialist. Their mission is not to blow it on some blown-up lie, some fabrication of a condition, for a person who allegedly is doctor shopping which is just a disgraceful accusation around medical specialists who have been training for all those years. I cannot believe I am defending the doctors like this. No, I love the doctors. I am only joking.

They are medical specialists. I would agree or have some empathy if we were talking about a junior RMO or an intern. These people are specialists. There are processes to access terminations, to have your leg cut off, to be declared brain dead. There are prescribed procedures laid out under the various acts which have to be

adhered to in regard to medical processes. This is no different. We have a process where they are referred from one doctor to another, where they make the independent assessments, they document those things, they use enormous amounts of objective and scientific data to make their diagnosis. I think people are being erroneous.

**The Hon. J.M. RANKINE:** The difference between this and other things that these specialists do is that this is not about healing or treating or caring for someone. This is about ending their life.

*Ms Cook interjecting:*

**The Hon. J.M. RANKINE:** It is quite different circumstances.

**Ms Cook:** Absolutely not.

**The Hon. J.M. RANKINE:** It is absolutely different circumstances. The member for MacKillop has asked the member for Morphett very clearly whether there is a register and whether there will be monitoring of people's applications prior to euthanasia being enacted. Can the member for Morphett clarify for this house that in fact the only record/register will be that of the Coroner after the fact, apart from personal records held by individual doctors? So, there will be no central monitoring or collating of information, ensuring that all of the procedures have been correctly applied before a person accesses euthanasia.

**The CHAIR:** I think the member for Morphett has answered that question.

**The Hon. J.M. RANKINE:** No, he didn't. He actually referred to the Coroner, and the Coroner is after the fact. There is nothing before the fact.

**The CHAIR:** He has provided the best answer he can. We need another question. The member for Stuart.

**The Hon. M.J. ATKINSON:** Point of order.

**The CHAIR:** I am sorry, I had called the member for Stuart.

**The Hon. M.J. ATKINSON:** I am very close to dissenting in your ruling because it is so manifestly wrong.

**The CHAIR:** As I heard the member for Morphett give his best answer to the member for MacKillop—

**The Hon. M.J. ATKINSON:** It is not the function of a presiding officer to tell the house or a committee whether an answer has been adequate or not.

**The CHAIR:** No, all I said is I think he has answered that question to the best of his ability. Do you have something more to the answer?

**Dr McFETRIDGE:** I can tell the committee that the information that I have provided to the committee is information that I have been advised is the current and intended situation.

**The CHAIR:** The member for Stuart had the call. I am not sure how we can do

much better than that. Member for Stuart.

**Mr VAN HOLST PELLEKAAN:** As this house knows, I have deliberately done nothing to block this bill, and I have deliberately done nothing to try to shepherd it through either. I have read it very carefully and I have two particular concerns about it, one of which I want to address right now. It has been skirted around just a little bit. There have been plenty of questions close to this topic, but none of them exactly. The clauses are Nos 10, 11 and 12, member for Morphett.

Given that we have agreed so far with the passage of the bill that a person would have to be identified as being terminally ill, with the prospect of dying within six months, and with regard to him or her seeking the medical advice or assessment necessary to qualify for the option to proceed with voluntary euthanasia—and totally separate to the issues the Treasurer was talking about, about whether it was their own doctor or another doctor, and I am not talking about doctor shopping—would it be possible for a person in this situation, for whom we all feel great sympathy, to have one doctor say, 'Yes, I have assessed you and you qualify,' to go to another doctor who says, 'I have assessed you, and you do not qualify,' for any range of reasons?

It might be because the second doctor thinks that your life expectancy is 12 months, not six months, or any other medical reason that I do not pretend to be able to identify. Doctor No. 1 says, 'Yes, you qualify according to this legislation.' Doctor No. 2 says, 'No, you don't qualify according to this legislation.' Can the patient then go on and seek an assessment from doctor No. 3? Doctor No. 3 might say, 'Yes, you qualify,' or 'No, you don't.' Could the patient go to doctor 4 or 5? Could the patient, in a relatively short period of time, seek advice from three, four or five doctors? The first one assesses the patient as qualifying and the last one assesses the patient as qualifying. Would that be enough for that patient to qualify? Potentially, the patient has seen five or six doctors.

*Ms Redmond interjecting:*

**Mr VAN HOLST PELLEKAAN:** No, member for Heysen, that is not what I am talking about at all.

*Ms Redmond interjecting:*

**Mr VAN HOLST PELLEKAAN:** No.

**The CHAIR:** Order! No side conversations.

**Mr VAN HOLST PELLEKAAN:** Potentially, in a fairly short period of time, because the six months is about an assessment of the patient's life expectancy—

**The CHAIR:** Do you understand the question, member for Morphett?

**Dr McFETRIDGE:** I do.

**Mr VAN HOLST PELLEKAAN:** I have not quite finished the question. Would it be possible for the patient to go to perhaps four or five doctors? The first one says, yes, the patient qualifies, two or three in the middle say that the patient does not qualify and the

last one says, yes, the patient does qualify. Under this legislation, would that mean that the patient would be eligible to proceed with voluntary euthanasia, although the majority of doctors, or even potentially one doctor from whom the patient has asked for assessment, says that the patient would not qualify?

**Dr McFETRIDGE:** The member for Stuart is a good friend of mine, and so I will not just dismiss his question by saying we have gone through all of this before.

**Mr VAN HOLST PELLEKAAN:** No, we have not.

**Dr McFETRIDGE:** We have. We have been through this half an hour or so ago. I suggest that if he wants a further explanation or some of the details on this, read the *Hansard*. The first specialist, the treating specialist, is going to make those determinations and make sure the person is an eligible patient. They go to the second specialist, and if the second specialist disagrees then it is referred back to the first specialist plus the mental health professional, and yes they can go and see another specialist.

Under no circumstances do the requirements for that assessment diminish, dilute or disappear in any way. The bar never lowers on this. If the first specialist, who is often the person with the longest relationship with this person, is still of the opinion that this person is not eligible, they should encourage that person, if they have six months to live and this is their choice, to go and see somebody else. If they disagree, well, we all go to doctors and we all get second opinions.

**Ms REDMOND:** Just to clarify what the position is of the member for Morphett. As I understand it, member for Morphett, the situation is that you go to the first medical practitioner and that person is basically the person who is then going to oversee the process, and you will be sent off to others. If you go to someone else and that person makes their assessment, clause 12(2) provides that as soon as is reasonably practicable after the examination and assessment by the second specialist, that specialist must provide back to the first specialist the report as to that assessment.

If that is a negative assessment, there is a provision that says that the first practitioner cannot simply dispose of that report or any other subsequent reports. If there was a situation where a person was seeking to access the provisions of the legislation and got through the first barrier by going to the first doctor, went to a second doctor and got knocked back—to use a colloquialism to describe the process—there must be a written report going back to the first doctor. He has to keep that report. If the person then goes to another doctor and there is again a negative response, that written report also has to go back to the first doctor.

On the member for Stuart's proposition, there would even be a third doctor, before going to a final doctor who gives a positive report. All of those negative reports would have to be kept by the person who is then going to put his specialist practising certificate on the line to sign off in the face of three negative reports from specialists—anticipating the member for Kaurna's amendment—who are specialists in the particular area of

illness from which this person is going to die, and they are specialists in terminal illness in that area.

There are three reports on the member for Stuart's supposition, all negative. The member for Stuart is supposing that the person who is going to have to sign the certificate—with those three certificates being kept on his record and facing being struck off—that they would then be prepared to sign off on it. It is possible, but I would suggest to the member for Morphett—and he might care to agree or disagree—that that would be a highly unlikely scenario.

**Dr McFETRIDGE:** The member for Heysen is perfectly correct.

**The Hon. J.M. RANKINE:** I would like to help the member for Stuart a little in his query. Certainly the member for Morphett has not been able to help, so maybe I can. There is nothing that I can find in this legislation that says you need to go to another specialist if the second one writes a report and does not recommend that you have euthanasia. What it does say—

**The CHAIR:** Is this question to the member for Morphett?

**The Hon. J.M. RANKINE:** Yes, it is to the member for Morphett and I am helping him. Maybe the member for Morphett can confirm that, if you are rejected by the second specialist, they report back to specialist No. 1 and specialist No. 1 must then refer the person to a mental health practitioner for examination and assessment. My question to the member for Morphett is: please clarify that that is the case. Secondly, once that is done, you do not need to see another specialist. There is nowhere in this legislation that says you need two specialists, if the second one rejects you. You can play funny buggers over there. You are shaming this house in your lack of knowledge of your own legislation.

**The CHAIR:** The member for Morphett will answer your question.

**Dr McFETRIDGE:** We know we are getting tired.

**The CHAIR:** Order! Just answer the question, please, member for Morphett.

**Dr McFETRIDGE:** The member for Wright should read the legislation. She has been a minister, she should understand legislation—

**The CHAIR:** Order! Just answer the question please, member for Morphett.

*The Hon. J.M. Rankine interjecting:*

**The CHAIR:** Member for Wright!

**Dr McFETRIDGE:** Clause 10(1) provides:

> (a) first, the eligible person must complete the relevant parts of a voluntary euthanasia request form;
>
> (b) second, the eligible person is examined and assessed by a medical practitioner in accordance with section 11;
>
> (c) third, the eligible person is examined and assessed by a second and

independent medical practitioner in accordance with section 12;

(d) fourth, the eligible person is— under our amendments, 'examined and assessed by a mental health professional'—

(e) fifth, the eligible person presents the completed voluntary euthanasia request form to the medical practitioner referred to in section 11—

the first medical practitioner. You always have to have two opinions—always. It is quite clear.

**The Hon. J.M. RANKINE:** Can the member for Morphett confirm that, if the second practitioner does not recommend that, the referral goes back to the first practitioner who must refer you to a mental health worker and, once they get that report, a decision is made. There is no need to get a further specialist to confirm the condition. So, the member for Stuart 's concern about doctor shopping, I understand that. This legislation means that you do not actually have to do that. All you need is the approval of doctor No. 1. If doctor No. 2 says no, it goes back to doctor No. 1, who gets a mental health professional to do the assessment. Nowhere in here—

**The CHAIR:** Do you have an answer for the member for Wright, member for Morphett?

**Dr McFETRIDGE:** I can do no more than repeat my answer as before:

10—How to make a request for voluntary euthanasia

(1) An eligible person makes a request for voluntary euthanasia by taking the following steps in accordance with any requirements set out in this Division:

(a) first, the eligible person must complete the relevant parts of a voluntary euthanasia request form;

(b) second, the eligible person is examined and assessed by a medical practitioner in accordance with section 11;

(c) third, the eligible person is examined and assessed by a second and independent medical practitioner in accordance with section 12;

(d) fourth, the eligible person is— now, after our amendment, 'examined and assessed by a mental health professional in accordance with section 13', and then they go back to the first one.

**The CHAIR:** So, you really cannot add any more?

**Dr McFETRIDGE:** I cannot add to it.

Clause as amended passed.

Clause 11.

**Mr PICTON:** I move:

Amendment No 11 [Picton–1]—

Page 9, after line 37 [clause 11(1)]—Insert:

(aa) the medical practitioner must be a specialist, or otherwise have expertise, in terminal medical conditions of the kind from which the person is suffering (being the terminal medical condition referred to in section 9(2)(b));

**Dr McFETRIDGE:** I am happy to deal with amendment Nos. 11 and 12. They say exactly the same thing.

**The CHAIR:** No; 11 is different to 12.

**Dr McFETRIDGE:** Sorry, 11 and 14. They are the same.

**The CHAIR:** We are doing 11.

**Dr McFETRIDGE:** I am happy to agree with that, yes. Amendment carried.

**Mr PICTON:** I move:

Amendment No 12 [Picton–1]—

Page 9, after line 41 [clause 11(1)]—Insert:

(ba) without limiting paragraph (b), the medical practitioner must sight evidence of a kind prescribed by the regulations that the person has lived in the State for at least the preceding 12 months;

**Dr McFETRIDGE:** I am more than happy to support this.

Amendment carried.

**Dr McFETRIDGE:** I move:

Amendment No 3 [McFetridge–1]—

Page 10, lines 17 to 25 [clause 11(2)]—Delete subclause (2)

Amendment carried; clause as amended passed.

Clause 12.

**Mr PICTON:** I move:

Amendment No 14 [Picton–1]—

Page 10, after line 32 [clause 12(1)]—Insert:

(ab) the medical practitioner must be a specialist, or otherwise have expertise, in terminal medical conditions of the kind from which the person is suffering (being the terminal medical condition referred to in section 9(2)(b));

This is identical to the previous No. 11 that I moved.

Amendment carried.

**Dr McFETRIDGE:** I move:

Amendment No 4 [McFetridge–1]—

Page 11, lines 19 to 27 [clause 12(3)]—Delete subclause (3)

Amendment carried.

**Mr VAN HOLST PELLEKAAN:** I have a question on clause 12. Is there any limit to the number of times that a medical practitioner could fill the role of the second assessor?

**Dr McFETRIDGE:** No.

Clause as amended passed.

Clause 13.

**Dr McFETRIDGE:** I move:

Amendment No 5 [McFetridge–1]—

Page 11, lines 31 and 32 [clause 13(1)]—Delete 'this Part, an examination and assessment of a person by a psychiatrist' and substitute:

section 10(1)(d), an examination and assessment of a person

Amendment No 6 [McFetridge–1]—

Page 11, after line 32 [clause 13(1)]—Insert:

(aa) the examination and assessment must be conducted by a mental health professional;

Amendments carried.

**Dr McFETRIDGE:** I move:

Amendment No 7 [McFetridge–1]—

Page 11, line 33 [clause 13(1)(a)]—Delete 'psychiatrist' and substitute 'mental health professional'

Amendment No 8 [McFetridge–1]—

Page 11, line 34 [clause 13(1)(b)]—Delete 'psychiatrist' and substitute 'mental health professional'

Amendment No 9 [McFetridge–1]—

Page 12, line 5 [clause 13(2)]—Delete 'psychiatrist' and substitute 'mental health professional'

Amendment No 10 [McFetridge–1]—

Page 12, line 7 [clause 13(2)(a)]—Delete 'psychiatrist's' and substitute 'mental health professional's'

Amendment No 11 [McFetridge–1]—

Page 12, line 11 [clause 13(3)]—Delete 'psychiatrist' and substitute 'mental health professional'

Amendment No 12 [McFetridge–1]—

Page 12, after line 15—Insert:

(5) In this section— mental health professional means—

(a) a psychiatrist; or

(b) any other person of a class prescribed by the regulations for the purposes of this definition.

**Mr PICTON:** Is this consequential to the previous vote that we had on 'mental health professional', changing that from 'psychiatrist'? Is it general practice that these things flow through to the rest of the bill and so you are sticking to that previous amendment that was made at the beginning of the bill?

**Dr McFETRIDGE:** Yes, this is normal practice, but I can reiterate or confirm my

private conversation with you and the member for Lee earlier, that I will be happy to talk to you about this between the houses.

**Mr GRIFFITHS:** I know we have had a significant debate about this, but it is a reference to the fact that it says, 'In this section', only. I know we talked about the appropriateness of: therefore, does it only relate to this? Is that still an issue that could be addressed in a better way?

**Dr McFETRIDGE:** I am advised by the learned lawyers in this place that it may be better placed back in the definitions, and we will endeavour to make sure that that does happen.

**The Hon. S.C. MULLIGHAN:** I reiterate my concerns about devolving the role of the person who occupied the position of psychiatrist to this mental health professional definition. While I appreciate your offer to deal with this between the houses, it would be my suspicion that there will not be an opportunity to deal with it between the houses if that definition remains in the bill. Make of that what you will, but that is the importance of this issue.

**Dr McFETRIDGE:** I can give the committee, and particularly the members for Kaurna and Lee, my assurance that I am more than willing to amend this back to 'psychiatrist' but, given the hour, rather than doing it tonight we will do it at a later stage.

**The Hon. S.C. MULLIGHAN:** How?

**The CHAIR:** Between the houses.

**The Hon. S.C. MULLIGHAN:** I cannot make it any clearer how much of a threshold this issue is, not just for me but for a number of members, when it comes to this legislation. I have made it clear many times over, almost to anyone who will listen, what the major threshold issues for me are and the devolution of an important position in this sort of regime, that position being a psychiatrist, to some sort of ill-defined mental health professional is unacceptable.

My understanding is that, given that we have the very unexpected, and certainly not agreed to, devolution of the position of psychiatrist to a mental health professional at the first clause, which was amended, the only remedy for this can be that, after the completion of the consideration of all of the clauses and before the third reading, there is one last opportunity to revisit a clause. Unless it is remedied at that juncture, I can almost guarantee the member for Morphett that it will not have the opportunity to be amended between the houses.

**The CHAIR:** Member for Lee, can I just remind you that, with amendment [McFetridge-2] 1 which amended clause 3, we have already deleted 'psychiatrist' and put in 'mental health professional' once. Is that a problem for you as well?

**The Hon. S.C. MULLIGHAN:** Indeed, yes.

**The CHAIR:** Let's see how we can help here.

**Dr McFETRIDGE:** I can tell the committee that I will be withdrawing amendments 7 to 12 inclusive. To satisfy the threshold issue for the member for Lee and perhaps some others in this place, I understand that we can, in committee, revisit that particular clause that the member for Lee has those concerns about and then deal with it at a later stage.

**The Hon. M.J. ATKINSON:** Just to be clear, I am having a little trouble following what is happening. My understanding is I moved an amendment earlier which would have been what the member for Lee wanted, or resisted a clause—

**The CHAIR:** Sorry, this is at the very beginning. Your amendments were at the title and No. 3.

**The Hon. M.J. ATKINSON:** Yes, No. 3.

**The CHAIR:** Which has nothing to do with psychiatrists or mental health professionals.

**The Hon. M.J. ATKINSON:** I am just finishing, so I am sorry.

**The CHAIR:** We are now trying to withdraw amendments 7 to 12, which leaves the word 'psychiatrist'.

**Dr McFETRIDGE:** I seek leave to withdraw my amendments 7 to 12.

Leave granted.

**The CHAIR:** We are now looking at getting rid of those. We already have amendments 5 and 6 to clause 13, so we are now looking at amendments 16 and 17 [Picton-1] which are from the member for Kaurna. Amendments Nos 7 to 12 have been withdrawn, so we are not voting on them at all. We are now moving to amendments Nos 16 and 17 in schedule 1, which also affect clause 14.

**The Hon. M.J. ATKINSON:** Have we moved on from that previous clause?

**The CHAIR:** Sorry, underneath all of this writing, you are quite right, there is a little 14 hiding, apologies.

**The Hon. M.J. ATKINSON:** I do not think I was mistaken in my last contribution on the question the member for Lee raises. I resisted an amendment made by the member—

**The CHAIR:** Sorry, I thought you said you put an amendment.

**The Hon. M.J. ATKINSON:** —for Morphett. We divided on it and I lost.

**The CHAIR:** Yes, but we are now at the point, sir, where we are talking about it at the end. Before we finish the bill off completely, we will go back to that.

**The Hon. M.J. ATKINSON:** So we can simply recommit a vote on which the house has divided?

**The CHAIR:** I am looking at standing order 253, one of my favourite numbers:

After all clauses and schedules have been considered, the reconsideration of any of them may be moved.

It is a beautiful one, is it not? Keep that for future reference. The Member for Croydon is exactly right because under all of this writing is a small 14, so we are looking at amended clause 13.

Clause as amended passed.

Clause 14.

**Mr PICTON:** I move:

Amendment No 16 [Picton–1]—

Page 12, lines 20 and 21 [clause 14(1)(a)]—Delete '(who may, subject to subsection (2), be related to, or known by,' and substitute:

(only 1 of whom may be related to

Amendment No 17 [Picton–1]—

Page 13, after line 4 [clause 14(2)]—Insert:

(ab) a health professional who is providing health care to the eligible person;

Both of these amendments deal with witnesses. The first amendment states that only one of the witnesses can be a relative. The second amendment states that somebody involved in the health care of that person cannot be a witness. This is partially already covered in saying that a hospital employee cannot be a witness, but, of course, a lot of people receive care outside of a hospital or institution, so I think it needs to be extended.

Amendments carried; clause as amended passed.

Clause 15.

**The Hon. J.M. RANKINE:** This is about the revocation of a request for voluntary euthanasia. Clause 15(2) provides:

(2) A written, oral or any other indication of the revocation of, or of a person's wish to revoke, a request for voluntary euthanasia is sufficient to revoke the request...

Could the member for Morphett tell the committee how and where those revocations can be lodged and how a person giving an oral revocation could be assured that that was going to be enacted?

**Dr McFETRIDGE:** Clause 15(1) provides:

(1) A person who has made a request for voluntary euthanasia may revoke the request at any time.

So it can be done at any time. Subclause (2) provides:

(2) A written, oral or any other indication of the revocation of, or of a person's wish to revoke, a request for voluntary euthanasia is sufficient to revoke the request (whether or not the person is mentally competent when the indication is given).

That can be given in any form.

**The Hon. J.M. RANKINE:** Member for Morphett, to whom is the revocation given? If someone writes a written revocation, who is that given to and how is it lodged? How do you make sure that it is enacted? If someone makes an oral request, what do they verbally tell their doctor? Do they tell the nurse? Does someone record it on nursing notes or, if they are at home, how does anyone know that their request is going to be honoured?

**Dr McFETRIDGE:** Any and all of the above. Really, it is there—

**The Hon. J.M. RANKINE:** Member for Morphett, this is really serious. This is really important. When someone has permission to enact euthanasia and in whatever circumstances— perhaps like the lady that Dr Nitschke was going to help euthanase— perhaps they find out they are not as sick as they thought they were or they have just simply changed their mind, how do they revoke it?

I could say to you, 'I want to revoke my request,' but I get taken to hospital so who is telling the doctor? Who is telling the nurses? I go in and I am unconscious, for whatever reason, and he says, 'Well, she did ask to be euthanased.' Where is this recorded? How is it recorded and how can people be sure that their wishes will be carried out? And do not tell me 'All of the above', it just does not cut it.

**Ms REDMOND:** Could I perhaps make a comment that might be of some help to the member for Wright in terms of other legislation that we have dealt with? The member for Croydon and I had a very long debate in this chamber one night about a change to the law on rape in this state. We had quite a lengthy debate about the fact that, of course, it is the right of any person to change their mind at any point. We did not need to, in that case, traverse it. A woman who wants to change her mind can change her mind at any time and communicate that in whatever way she wants.

There are no records kept of it but it is nevertheless the law that was brought into this state, and I would submit to the member for Wright that the same thing would apply in this case. It may be that someone panics at the last minute and just puts up their hands. Any form of communication will be sufficient and it would be impossible for legislation to be drafted which would encompass the spectrum of the possibilities of the different mechanisms of communication that could be used and the different ways in which it could be given to a variety of people and/or recorded or not. So long as they make their changed intention known in some way, the obligation is then on the person receiving that message to obey the terms of the legislation.

**The Hon. J.M. RANKINE:** In fairness, something like this is quite different to the situation that the member for Heysen just outlined. No-one gives written permission to engage in sexual activity and then indicate, in whatever way, that they do not want to participate in that. They can certainly say, 'No, I don't want to,' and that is fine, but this is quite different. This is people, having gone through quite a significant process and being given approval to be euthanased and they want to change their mind and revoke that document. Who holds the document to start with and how can they revoke that

document? Who records it? Who ensures that those wishes are carried out?

**Dr McFETRIDGE:** The legislation as it is set out here, you really cannot make it more prescriptive. If somebody commits a crime because there is a revocation in place, they be at the full penalty of the law. There are significant penalties under the crimes act. I am no lawyer. A person can do that. This could be recorded with anybody. It says 'written, oral or any other indication' and later 'revoke the request' at any time. You cannot be any more prescriptive than that.

**Mr DULUK:** Picking up on what the member for Wright has been talking about, and I think it is a fair question, if there is to be a written indication revoking your request, to whom is that written request given?

*An honourable member interjecting:*

**Mr DULUK:** And, indeed, oral as well, and any other indication. For example, is a text message or an email sufficient as well? If it is written, to whom do you provide that written notice?

**Dr McFETRIDGE:** This is why it is so broad—because you can revoke this at any time. 'A written, oral or any other indication' can be given. It is sufficient. You cannot be more prescriptive than this. If it is an SMS, well, then—

**Mr DULUK:** I could write a note and put it in my top drawer. That is not revoking a request. It needs to be communicated to somebody to know that that request has been put forward. So, to whom would you give a written request in the case where you want to revoke your desire for voluntary euthanasia? Is there a register? Is it to your practitioner? If at the time that you are admitted and you are in hospital, do you give it to the head nurse on the ward? To whom do you give your notification to remove your desire for euthanasia? In fact, it is quite simple, and it is probably one of the most important bits in this whole piece of legislation in terms of a safeguard, and I am certainly not satisfied with the answer whatsoever.

**The Hon. S.W. KEY:** I am trying to think about the situation and trying to answer your question.

**Mr DULUK:** I am asking the member for Morphett.

**The CHAIR:** Yes, well, he is having think music, think of it that way, and the member for Ashford is talking while he is thinking.

**The Hon. S.W. KEY:** I am trying to think about some real situations. I think the questions are quite reasonable, and I understand exactly why you are asking them. I am assuming that someone is in palliative care, in a hospice or in a hospital. Somebody would be responsible for your case and your casenotes. It might differ in different settings, but somebody would look after the fact that you have made the request and gone through the process and have your records, probably your advance care directive and everything else that is relevant to you, your case and your condition.

That would be the first thing I would see. If a person were at home, I imagine that

someone would be responsible for your particular case and the fact that you are at home receiving care and, in some cases, palliative care. Under the Consent to Medical Treatment and Medical Care Act, there is a whole process for people to be able to revoke treatment, for example. There is a whole process for people to be able to communicate that they do not want this medication or that medication.

I am saying to people that I am trying to imagine what it would be like to be a person who has been identified as having six months to live, which is the limit we are putting on a person's likely life. They have a terminal medical condition, they qualify for everything, but then they change their mind. I suppose what we are saying here is that under those circumstances a person should be able to communicate, hopefully, in some way to say, 'I don't want to go ahead with it.' It is the same with medical treatment in all sorts of different settings. People make it clear.

At the moment, people say, 'I don't want to be fed. I don't want to have any liquid anymore. Because you won't assist me, I'm going to die slowly,' or, 'I'm going to stop having medication,' or, 'I'm going to take off my respirator off,' or, 'I'm going to take this sort of action.' What we are trying to do is to avoid people having to go to those lengths to end their life by their choice under all the criteria that we have got for them. The member for MacKillop is talking about jumping through hoops—I think that is a very interesting metaphor for someone who is on their last legs. We need to think about what would happen.

Obviously, if someone does not want to go ahead, it is a really serious issue. I completely understand what the member for Davenport and the member for Wright are saying but I think, at the moment, somehow, palliative care and people changing their mind about their treatment and medication is dealt with. It may not be dealt with fantastically, but it is dealt with. I have some faith that doctors and health professionals involved in this process would take this very seriously if they were thinking that the person had changed their mind and wanted to revoke their request.

**Ms REDMOND:** Like the member for Ashford, I understand the serious concern that people are expressing about this issue. Could I make a suggestion that under clause 11(1)(c) we may find some comfort. Clause 11(1)(c) requires that when you are going to the process of getting the consent to voluntary euthanasia approved:

> (c) the medical practitioner must give to the person the following information in writing:
>
> > (i) a diagnosis and prognosis of the terminal medical condition from which the person is suffering;
> >
> > (ii) information explaining the forms of treatment that are reasonably 5 available to treat the terminal medical condition from which the person is suffering and the risks associated with such treatment;
> >
> > (iii) information explaining palliative care options that are reasonably available to the person;
> >
> > (iv) information setting out the medical procedures that may be used to 10 administer voluntary euthanasia and the risks associated with the procedures;

> (v) information explaining that, just because a person makes a request for voluntary euthanasia, the person need not actually end their life;
>
> (vi) any other information required by the regulations for the purposes of 15 this subsection.

I would suggest that it might be appropriate to consider putting into the regulations, or maybe, if it gets to go between the houses, a provision that the possibility of changing your mind, even at the last instant, and communicating your change of mind in whatever manner, might be incorporated, either as a matter of something to go into that clause between the houses, or into the regulations in due course.

**The CHAIR:** Member for Morphett, how is that sounding to you?

**Dr McFETRIDGE:** I think the member for Heysen is giving some very good advice to this committee and I think the member for Ashford has also added to this. This is a very serious issue, so if there is a way that we can improve the safety of this, as I have said all through this, let's look at that—let's look at it either between houses or look at it under that subclause (11)(1)(c)(vi).

**The CHAIR:** The member for Davenport has a third question.

**Mr DULUK:** I have a third question and a clarification. I appreciate the member for Ashford's contribution, and I think you are probably right, the member for Ashford, in terms of how it may happen in a practical sense. But, that is not what is written into this legislation, nor should this legislation pass in its current form. We will then have a piece of legislation that will have to be dealt with and is silent on that consent.

There is that ideal world—and the member for Morphett has been in the ideal world for most of tonight—but that is not what we are actually dealing with here. The member for Heysen is probably right that there might be some regulations, but we have not seen the regulations. What you are asking the house, and especially those members who are possibly unsure in their position in terms of this bill, is to make a call that says the regulations between the houses will somehow provide us with information of how you can withdraw consent from possibly one of the most important clauses in the bill.

For me, I do not think that is a satisfactory response. It would be much better if we saw something right now that would actually be happening. The member for Morphett has not even indicated that a written slip to your specialist will be satisfactory to meet this. I do not think those who have written this clause have given any proper consideration as to how you withdraw consent and how that can be dealt with in the heat of the moment, especially where someone is placed in a hospital situation or away from home, away from a guardian, and away from a loved one who was there at that time of need.

**Dr McFETRIDGE:** I will be more than happy to look at this being covered in the regulations.

Clause passed.

New clause 15A.

**Mr PICTON:** I move:

Amendment No 18 [Picton–1]—

Page 13, after line 19—Insert:

15A—Revocation of request for voluntary circumstances where medical practitioner withdraws certification

(1) If, after a person makes a request for voluntary euthanasia but before voluntary euthanasia is administered to the person pursuant to the request, the medical practitioner who completed the certification required under section 10(1)(g) in respect of the request becomes aware that—

(a) the person was, in fact, acting under duress, inducement or undue influence in relation to the request; or

(b) any other opinion of the medical practitioner certified under that paragraph was not, in fact, correct,

the medical practitioner may withdraw their certification.

(2) Before withdrawing certification, the medical practitioner must, as soon as is practicable and in accordance with any requirements set out in the regulations, notify the following persons of the withdrawal of the certification (and the consequent revocation of the request for voluntary euthanasia):

(a) the person who made the request for voluntary euthanasia;

(b) the pharmacist to whom the prescription for the drug to be used to administer voluntary euthanasia to the person was sent;

(c) any other person prescribed by the regulations for the purposes of this paragraph.

(3) On certification being withdrawn—

(a) the request for voluntary euthanasia will, for the purposes of this Act, be taken to be revoked; and

(b) —

(i) if a drug to be used to administer voluntary euthanasia pursuant to the request has not been dispensed—the prescription for the drug will be taken to be void and of no effect; or

(ii) if a drug to be used to administer voluntary euthanasia pursuant to the request has been dispensed—the person who made the request must, as soon as is reasonably practicable after being notified under subsection (2), cause the drug to be destroyed or disposed of in accordance with the requirements set out in the regulations.

(4) Revocation of a request for voluntary euthanasia under this section will be taken to have effect from the time notice is given to the person who made the request under subsection (2)(a).

The reason for introducing this amendment is that, currently, if a doctor was to find out that information was not as it seemed at the time of granting the request, there would be no way for revoking that request, so this new section sets out a process for that.

**Dr McFETRIDGE:** This is a very good amendment.

New clause inserted.

Clauses 16 to 20 passed.

Clause 21.

**Mr PICTON:** I move:

Amendment No 19 [Picton–1]—

Page 16, after line 2—Insert:

(3) For the purposes of the *Births, Deaths and Marriages Registration Act 1996*, the fact that a person's death resulted from the administration of voluntary euthanasia must be recorded in the Register under that Act.

As members may know, the bill as it is currently drafted has a provision whereby the death certificates will primarily note that the cause of death was the terminal illness, rather than euthanasia. I have some nervousness about that. I would feel more comfortable if the register, which is a broader document held by the Registrar of Births, Deaths and Marriages, would note that this act came into play as well in the death of that person.

**Ms REDMOND:** I have no objection to what the member for Kaurna is suggesting, but I wonder whether what he is contemplating, just by way of clarification, is that both things be recorded? I would have thought that, for family historical purposes, for instance, they might want to know that Uncle Fred, or whoever it was, actually had terminal cancer. I have no difficulty with the idea that it be recorded that he then chose voluntary euthanasia, but we cannot just put that it was voluntary euthanasia without putting the actual underlying illness, which has to exist in any event for the person to access it. I do not think it needs any further amendment, but is the intention that the underlying terminal illness is recorded, as well as the fact that it has been by administered VE?

**Mr PICTON:** The answer to the member for Heysen's question is yes. The provision in the bill at the moment stays, which says that the primary cause is the terminal illness, so cancer or whatever the case may be. This is a new section which would say, in addition to that, that the register would also note voluntary euthanasia.

**The Hon. M.J. ATKINSON:** I support the amendment and commend the member for Kaurna for moving it. It is a very sensible addition which will ensure truthfulness in record-keeping.

**Mr WINGARD:** For clarification, with the recording of euthanasia as the cause of death, would the other terminal illness, for want of a better term, be recorded on the certificate as well or be kept in records—if motor neurone disease, for example, was the underlying terminal illness—for the purpose of upholding statewide statistics? Also, if, over the course of time, there was an increase in the level of deaths because of that disease, would it still be documented and kept in record?

**Mr PICTON:** The answer to that is yes because the section as it is at the moment

stays. It states that the record in the register will be for the primary cause of death for the terminal illness, whether that is motor neurone disease, cancer, or whatever the case may be, so that will still be there for all statistical purposes.

Amendment carried; clause as amended passed.

**Mr GRIFFITHS:** Chair, I must sincerely apologise to the house for this, but there is a question I have on clause 19(3).

**The CHAIR:** That is a long time ago now. One single question?

**Mr GRIFFITHS:** It relates to clause 19(3), that the administering authority of a hospital, hospice, nursing home could refuse to admit someone. I am a bit intrigued by this. There are multiple examples of it here, but what if it is a public hospital? Is it a decision made by Health SA to allow voluntary euthanasia? If that permission is not in place, does that mean that people who might wish to pursue it are unable to be admitted to public hospitals?

**Dr McFETRIDGE:** Member for Goyder, it is a good question. This is intended particularly for the religious institutions that have grounds to object to this legislation and the associated actions.

**Mr GRIFFITHS:** I can sort of recognise that, but because of the inclusion of the word 'hospital', it does not define it as being a private community or anything like that; it just talks about 'hospital', which can be, therefore, a public hospital, too.

**Dr McFETRIDGE:** I am advised that if this was to be requested in a public hospital, to accede to that request, for them to not decide to administer it, it would have to come to this parliament.

**Ms Redmond:** It's a public hospital.

**Dr McFETRIDGE:** It is a public hospital, yes.

**The Hon. S.W. KEY:** I am just seeking some clarification. Are you referring to clause 19?

**Mr GRIFFITHS:** 19(3).

**The Hon. S.W. KEY:** One of the things that I think we probably need to remember is that there has been a view all the way along that there are people who will personally have a conscientious objection wherever they work—whether it is public, private, faith, hospital, hospice— so we need to make a provision for them, and they should not be discriminated against for doing that. That is for an individual worker, doctor, whomever is appropriate.

With regard to the actual organisation itself, assuming this legislation gets up and we have assisted dying legislation in this state, it will be really important for different organisations to make it clear what their policy is. At the moment, for example, when you go to a particular hospital, particularly some of the faith hospitals, and you make it clear that there are certain things that you require—for example, you do not want to be

revived, you do not want to be kept alive unnecessarily, all those sorts of things—they are the things that are discussed when you go into that particular situation. In a public hospital, they also have those conditions.

It is very interesting that, when you look at what the reality is, at the moment many people make those provisions and/or, as I was saying earlier, refuse to have medication, refuse to have assistance, and make sure that they die for that reason. I think we have to get the legislation through, and then it will be up to organisations to make it clear what their policy is, and some of that may be disputed, but I think that is as far as we can go with that.

Clause 22.

**Mr PICTON:** I move:

Amendment No 20 [Picton–1]—

Page 16, after line 18—Insert:

(4) The Coroner must cause statistical information relating to deaths resulting from the administration of voluntary euthanasia during the preceding financial year to be included in the Coroner's annual report under section 39 of the Coroners Act 2003.

This relates to the section regarding the Coroner. The Coroner receives information under this bill but does not provide any information as to how things are going, so I have recommended that the Coroner should publish statistical information in its annual report.

**The CHAIR:** Member for Morphett, are you happy with that?

**Dr McFETRIDGE:** I am more than happy.

**The CHAIR:** The member for Light has a question. On this amendment?

**The Hon. A. PICCOLO:** Yes, this one and the previous one.

**The CHAIR:** Sorry? This one and the previous one?

**The Hon. A. PICCOLO:** Yes, please.

**The CHAIR:** It is very late but off you go.

**The Hon. A. PICCOLO:** With the recording on the death certificate, there are two things— one, that the person died from the primary illness, and also the euthanasia. I assume that will be a public document.

*Ms Redmond interjecting:*

**The Hon. A. PICCOLO:** It can be. What are the issues around privacy of the person's circumstances? What are the implications for a person, and I am not expecting legal advice but some assistance, in terms of any personal insurance they may have?

**The CHAIR:** Insurance?

**The Hon. A. PICCOLO:** Yes. The reason I raise it here is by insisting it be in the public document on the death certificate—and I understand why it has been moved that way. It makes that event public and, therefore, what the implications might be for that

person and their family.

**The CHAIR:** So, do you have that? It is about insurance as well.

**Dr McFETRIDGE:** I was distracted again. I am sorry, member for Light. Could you please repeat the bit about the insurance?

**The CHAIR:** He wants to know if the recording is going to be a public document.

**The Hon. A. PICCOLO:** I think these are both the member for Kaurna's amendments, and I am not disagreeing. But given that one of the objections I have is that I do not think this sort of thing should be a public process at all. I do not think people should be a public process. That will insist on that information being recorded publicly, therefore you remove that person's privacy, and that is one thing. The second thing is: what implications would it have? I understand there might be a provision later which protects people from any insurance implications.

**Mr PICTON:** I will attempt to answer. The Attorney might wish to provide any further information. What the bill says initially is that the primary cause, which would be the information that would then go on the death certificate, would be the cause of the terminal illness, then that is the bit that would be the most publicly accessible, although I would think that there are a few hurdles to jump before you get access to a death certificate.

What I suggested in my amendment was not adding into that information that would go into the death certificate but adding it into the register that the Births, Deaths and Marriages have, which as I understand it, and the Attorney may wish to add to, is a much broader file of information that they have access to. I am not of the understanding that the public could get access to all that information that sits behind what are the publicly attainable documents.

**Ms REDMOND:** I want to clarify that position because in my practice I spent many times in the Births, Deaths and Marriages office. It used to be the case that it was quite public. Virtually anyone could go in and get anyone's details—birth, death or marriage certificate—and in the last few years that has been dramatically tightened up. Unless you have an actual degree of consanguinity, which is the legal term for closeness of relationship, you will not be able (although you can apply) to access the information.

Further, on the question of insurance, my understanding is that because of the stuff that I put on the record before about the nature of the insurance industry's acceptance of terminal illness and so on, the fact that they have qualified by way of applying and being found to have a terminal illness under the act is actually more likely, I would suggest, to help an insurance claim than to hinder it. It will not affect anything like a suicide or something like that. It is a separate category.

Amendment carried; clause as amended passed.

Clauses 23 and 24 passed. Clause 25.

**Mr PICTON:** I move:

Amendment No 21 [Picton–1]—

Page 17, lines 19 to 22—Delete clause 25 and substitute:

25—Nominated person

A person who has made a request for voluntary euthanasia must, in accordance with any requirement set out in the regulations, nominate a person for the purposes of sections 25A and 26 (the *nominated person in respect of the request for voluntary euthanasia*).

25A—Storage of drugs

(1) A drug that has been dispensed for the purposes of administering voluntary euthanasia to a person must, except when it is being so used, be stored in a secure area in accordance with the requirements set out in the regulations.

(2) If a drug is stored in contravention of subsection (1), the nominated person in respect of the request for voluntary euthanasia is guilty of an offence. Maximum penalty: $5,000.

This additional change in amendment No. 21 is regarding the storage of drugs. A new section was added in the current bill that was not in the previous bill that the parliament discussed. However, it does not really nominate who is responsible for the storage and any mechanism for accounting them to make sure that they do what the act says they should do. So, I have added this extra section.

Amendment carried; clause as amended passed.

Clause 26.

**Mr PICTON:** I move:

Amendment No 22 [Picton–1]—

Page 17, line 28 [clause 26(1)]—After 'destroyed or disposed of' insert:

by the nominated person in respect of the request for voluntary euthanasia

Amendment No 23 [Picton–1]—

Page 17, lines 30 and 31 [clause 26(2)]—Delete subclause (2) and substitute:

(2) If the nominated person in respect of a request for voluntary euthanasia refuses or fails to comply with subsection (1), that person is guilty of an offence.

Maximum penalty: $5,000.

These follow on from the last amendments.

Amendments carried; clause as amended passed.

Clauses 27 and 28 passed.

New clause 28A.

**Mr PICTON:** I move:

Amendment No 24 [Picton–1]—

Page 18, after line 6—Insert:

28A—Alteration etc of documents

A person who knowingly alters, forges, conceals or destroys a request for voluntary euthanasia form, or any other document or instrument that indicates the wishes of a person in relation to a request for voluntary euthanasia, is guilty of an offence.

Maximum penalty: Imprisonment for 10 years.

This is adding a new offence, which almost comes word for word from the Oregon bill, to extend an offence relating to alterations, forgeries, and concealing and destroying documents relating to the voluntary euthanasia requests or any other instrument attached.

**The Hon. J.M. RANKINE:** In relation to that particular clause, does that also apply to revocations?

**Mr PICTON:** It is defined as 'any other document or instrument that indicates the wishes of a person', which I would take to mean that a revocation would indicate the interests of a person, if it was the person's own revocation. Potentially, the only revocation that might not be covered by this section would be a revocation on behalf of a medical practitioner, which might not fit into this definition.

**The Hon. J.M. RANKINE:** But it says 'indicates the wishes of a person in relation to a request for voluntary euthanasia'. So, it is any other document or instrument, but it is in relation to a request for euthanasia.

**Mr PICTON:** My interpretation of this would be that if you are indicating your request to revoke a euthanasia request, then that would be in relation to a request for voluntary euthanasia. I am happy to consider any other suggestions by any members in that regard.

**The CHAIR:** Member for Wright, are you happy?

**The Hon. J.M. RANKINE:** I would be happy if there are some things that are going to be dealt with between the houses that an inclusion be put in there to make it an offence to ignore a revocation as well.

**The CHAIR:** Member for Morphett, the member for Wright is asking if you would be happy to consider between houses doing something about revocations?

**Dr McFETRIDGE:** I am reasonably satisfied with what we have, but certainly I would be more than happy to talk to the member for Wright and do something between houses.

New clause inserted.

Clause 29.

**Mr PICTON:** I move:

Amendment No 25 [Picton–1]—

Page 18, line 8—Delete 'or 28' and substitute ', 28 or 28A'

This is a very simple follow-on amendment.

**Ms REDMOND:** This is consequential to the other one. Amendment carried; clause as amended passed. New clause 29A. **Mr PICTON:** I move:

Amendment No 26 [Picton–1]—

Page 18, after line 12—Insert:

29A—Prohibition on advertising voluntary euthanasia services

(1) A person must not advertise a voluntary euthanasia service. Maximum penalty: $50,000 or imprisonment for 6 months.

(2) Subsection (1) does not apply to—

(a) the provision of information to a person that is required or authorised under this or any other Act; or

(b) assistance or information relating to voluntary euthanasia provided to a person at the person's request; or

(c) an invoice, statement, order, letterhead or other document ordinarily used in the course of business; or

(d) an action of a kind prescribed by regulation for the purposes of this paragraph.

(3) For the purposes of subsection (1), a person *advertises a voluntary euthanasia service* if the person—

(a) takes any action designed to publicise or promote the provision of services relating to voluntary euthanasia (however described); or

(b) takes any other action of a kind prescribed by regulation for the purposes of this paragraph.

This is something I am pretty passionate about. I do not want to see anybody advertising a voluntary euthanasia service. I do not want to see it on billboards and I do not want to see it in the newspaper, so I think we should be very clear to prohibit any advertising along those lines.

**Dr McFETRIDGE:** I thank the member for Kaurna for his diligence with this bill, particularly in regard to a couple of these which relate to equipment and advertising. I think they are really good additions.

**Mr GRIFFITHS:** I completely agree with the amendment. I do not think there is any question about structurally how it works. Advertising for these services is abhorrent, and I agree with that, but how is it regulated? Can I presume that if someone through some method somehow finds some form of advertisement for someone to provide a service do they report it to police; is that how it is pursued? The police then take action against them?

**Mr PICTON:** I would think that the police would be the appropriate people to take action, and then they would bring somebody before the court if they did offend this particular section.

New clause inserted.

Clause 30.

**Mr GRIFFITHS:** Subclause (2) states that 'this section applies despite any agreement'. That is amazing to me, that agreements that are entered into by a firm to provide a level of insurance cover and by a person, willingly, who signed up for it, that suddenly the conditions attached to that are overwritten. I am just looking for some details.

**Ms REDMOND:** The intention of this is very much like other bits of legislation that are designed at consumer protection so that the insurance company cannot avoid the provisions of clause 30 by having a nice little section stuck into their insurance policy buried in the fine print, as it were, there is no way known that any person entering into an insurance policy, knowing that there was the protection here in the law, would actually seek to subvert it.

It is only an insurance company that would be seeking to avoid the consequences of clause 30, and the intention of that particular phraseology, which is quite common in consumer protection, is to make sure that the insurance company cannot say, 'Notwithstanding what your law says, this person has signed our agreement and our contract and they have dudded themselves.'

**Mr GRIFFITHS:** I have a question then. On the basis that South Australia passes this legislation, and for those who decide to have insurance from South Australia, what if an insurance company writes into a contract that there is a minimum qualifying period before a voluntary euthanasia can be undertaken by an individual, that you have to have been insured with this company for three, five or whatever number of years.

I am not saying that people would do this deliberately, but are you able to take out a substantial level of insurance on the basis of an existing illness, probably. That would also be a challenge because medical testing would occur before that. I understand that. I am really interested in whether there is any qualifying period. In the research you have done on overseas instances of this, is insurance dealt with in exactly the same way, or is there any form of concern?

**Dr McFETRIDGE:** The current situation with insurance is that it is referring to physician- assisted suicides and suicides. They are covered by insurance policies. You have to be insured for 13 months before the time of death. That is why, before I was comfortable with the 12-month period, that all the insurance companies that are willing to undertake insurance with life insurance have in their policies a clause for suicide, which this obviously is not, and it is at 12 months. They do not seem to have any issues with this.

Clause passed.

Clauses 31 and 32 passed.

Clause 33.

**Mr PICTON:** I move:

Amendment No 27 [Picton–1]— Page 19, after line 38—Insert:

(3) The Minister may, by notice in writing, require the Coroner to provide to the Minister such information as the Minister may reasonably require for the preparation of a report under this section.

The current bill states that the minister should give a report to the house on the operation of the act every year. The only problem with that is that the minister has no information upon which to give such a report because no-one is providing any information to the minister. I have suggested this amendment so that the minister can get the information from the Coroner that they would need to provide the information to the house.

Amendment carried.

**Mr GRIFFITHS:** This may be a silly question, and I apologise if it is. Clause 33 refers to the annual report of the operation of the act and that it goes to the minister. I am intrigued to know which minister it is.

**Dr McFETRIDGE:** This is, in reality, a public health act, so I would imagine that it is the Minister for Health, but the Minister for Health might want to comment.

**The Hon. J.J. SNELLING:** The government of the day assigns various acts of parliament to various ministers, so it could be the Minister for Health or it could be the Attorney-General.

Clause as amended passed.

Clause 34.

**Mr PICTON:** I move:

Amendment No 28 [Picton–1]—

Page 20, line 4 [clause 34(2)]—Delete 'before the fifth' and substitute:

after the second, but before the third,

Currently, the bill says that there would be a review undertaken after five years of operation. I think that that is far too long and that almost the earlier the better. I have recommended that between two and three years a review of the act should be undertaken. I should add that, if this were to get up, there would need to be a lot of work done and, since this was a private member's bill, and actually looking at this now and how it interrelates with all the acts and provisions and procedures in hospitals and across the health system generally, well before this review.

Amendment passed; clause as amended passed.

Clause 35.

**Mr PICTON:** I move:

Amendment No 29 [Picton–1]—

Page 20, lines 12 and 13 [clause 35(2)(a)]—Delete paragraph (a)

This was a very weird provision and I suggest we delete it. Amendment carried.

**Mr GRIFFITHS:** I have a question on clause 35(3)(e), which provides 'apply or incorporate, wholly or partially and with or without modification, a code, standard, policy or other document prepared or published by the minister or another specified person or body'. I am pleased that the Minister for Planning is in here, because with the Planning, Development and Infrastructure Bill, with the implementation of the Environment and Food Protection Area, he was very strong on the principle that it was not a ministerial decision but that it was a debate of the parliament to occur.

I am intrigued as to what the Attorney's position might be, and others in this chamber, about the fact that here we are allowing a minister to determine and to publish that. I understand that it would be disallowable, and I appreciate that, but that means it is able to be introduced again immediately. I compare that other legislation, which was also significant in its structure, and the Minister for Planning was quite outspoken on the fact that it was the parliament that makes the decision, not the minister. I just raise that point here.

**Dr McFETRIDGE:** I am advised that this is a standard clause in regulation-making clauses in legislation.

**The Hon. A. PICCOLO:** I am just trying to clarify, following on from the member Goyder's question, what is the purpose of 35(3)(a) and 35(3)(b), given 35(1)?

**Dr McFETRIDGE:** I am advised that these are standard clauses in this particular section of bills covering regulations.

**The Hon. A. PICCOLO:** That is like saying that the sky is blue because it is blue, that is what you are telling me. I am asking what the purpose is—

*Dr McFetridge interjecting:*

**The Hon. A. PICCOLO:** No, this is your bill— **The CHAIR:** Order! You have asked your question. You want further information? **The Hon. A. PICCOLO:** I would like an answer, a meaningful one if I could.

**Dr McFETRIDGE:** This is a standard clause. As it says, it allows you to make regulations of a general or limited application and make different provisions according to the matters or circumstances to which they are expressed to apply. It is a standard clause in all pieces of legislation.

**The Hon. A. PICCOLO:** Perhaps I will ask the question in a different way: what do clauses 35(3)(a) and (b) add to clause 35(1) that clause 35(1) is insufficient to cover?

**Ms REDMOND:** Could I perhaps make a contribution at this point?

**The CHAIR:** Yes, member for Heysen.

**Ms REDMOND:** I refer the member for Light to the idea that on occasions we have had legislation in this state after a meeting of ministers around the country where they have got together and come to a decision that they will have a national system. If we

ended up with all the states following our suit and we ended up with a whole set of different lots of legislation, and then subsequently years down the track they all got together and said, 'Let's standardise it and unify it so it can be used throughout the country,' that provision is what enables us to not have to go back and redo all the regulations exactly the same; we can just adopt a standard set.

**The Hon. A. PICCOLO:** That does not answer the question, actually. I understand what you are saying, but I do not think it answers the question. The question was quite simply: why do we need subclauses 35(3)(a) and (b), which clause 35(1) does not cover, given that clause 35(1) is very broad and gives the Governor enormous scope? The other thing is, if you are suggesting that we have some sort of national scheme, and that by regulation we agree to some of the states, are you suggesting we change the scheme without reference to parliament?

**Ms REDMOND:** I apologise to the member for Light because I thought we were still talking about the question originally raised by the member for Goyder on regulation on subclause (4). On regulations under subclauses (3)(a) and (b), they are quite standard ways of expressing the regulation-making power. If there are things that have not been contemplated, or circumstances that have not been contemplated, then yes, you are right; the Governor may make such regulations as are contemplated or necessary or expedient for the purposes of this act.

I would agree that it is broad enough, but over the years the standard wording of the way we express those things in the regulations—if you look at the regulation making power under any number of acts in this parliament in the past 10 years, it has been extended to those standard sorts of provisions to say that they may be of limited or general application. Rather than simply making a regulation, it is making it quite clear that you could say that we are going to make regulations, for instance, with respect to the remoteness question that came up very early in the debate. We might make a regulation about that, and these things will only apply in the case of things where people are in remote circumstances or something like that. It is really only to promote a full consideration, and it is not to derogate from that original regulation-making power in subclause (1).

**Mr GRIFFITHS:** It is a continuing question from the one that I raised. I will focus on the last couple of words in this sentence that I read out, where 'changes can be implemented or published by the minister or any other specified person or body'. If I can come to accepting that political responsibility rests with the minister—I understand that—instead of the parliament, as in the other example I quoted, I am very upset about the fact that we provide significant opportunity for another unspecified person or body to implement actions and policies here. I cannot accept those particular words. I think that is where there needs to be some modifications. Why are we giving this to someone when we do not even know who they might be, who is not an elected representative, but might make recommendations and all of a sudden it comes into force?

**Ms REDMOND:** I agree in essence with what the member for Goyder is saying,

and I have made the same objection, as indeed has the current Attorney-General over many years in this parliament, that often we would end up with a set of regulations that were actually the regulations under a national code. You are absolutely correct that it does derogate from the authority of the parliament.

It is done constantly in this place. It has been done the whole time that I have been in here. As I say, I remember the member for Enfield standing up when he was still in the back row, talking about the fact that he was objecting to regulations that were being agreed to nationally, but it is just the standard wording.

I have spoken to the drafter of this piece of legislation, and it is just standard wording that is put into the regulation-making power to accommodate the fact that if, in the future, there is some sort of national agreement that says, 'We can unify all this throughout all the states. Everyone just adopt our national code,' all you need to do, instead of having to bring it all through, is get the parliament to agree to adopt national code X, Y, Z, and that will then apply. It would still come back for debate through the parliament, and would still have the capacity to be disallowed.

**Mr GRIFFITHS:** I accept the response from the member for Heysen, but we are talking about legislation here that does not exist in any other state.

*Ms Redmond interjecting:*

**Mr GRIFFITHS:** No, my point is: why do we need to have provision for scope to make changes based on a national agreement when South Australia will be the only state that is actually considered in the legislation at this stage? Why are the words there?

**The CHAIR:** You have had three questions, member for Goyder, so we need to think about putting amended clause 35.

Clause as amended passed.

Schedule passed.

**Dr McFETRIDGE:** I move:

That clauses 3 and 13 be reconsidered.

Motion carried. Clause 3—reconsidered.

**Dr McFETRIDGE:** I move:

Amendment No 1 [McFetridge–1]—

Page 4, line 13 [clause 3(3)]—Delete ' mental health professional' and substitute 'psychiatrist'

Amendments 1, 2 and 3 in my name will rescind the original motion and remove the words 'mental health professional' and substitute 'psychiatrist'.

**The Hon. S.W. KEY:** I am just trying to clarify that this is to accommodate the points that were raised by the member for Lee in an earlier contribution to say that he

was uncomfortable about the fact that we had already dealt with the business and replaced 'psychiatrist' with 'mental health professional', so this is to address that particular issue.

**The CHAIR:** That is correct.

**The Hon. S.W. KEY:** So, the member for Morphett is trying to allay the concerns raised by the member for Lee and also the member for Kaurna, as I understand it, and maybe the member for Little Para.

**The CHAIR:** And to have continuity throughout the bill.

**The Hon. M.J. ATKINSON:** It is a really quite extraordinary manoeuvre given that I argued for this provision. The house heard all the arguments. The house divided on the matter. I lost the division and yet—

**The CHAIR:** I think this is the point where we say you were right. We acknowledge you. You are acknowledged as superior.

**The Hon. M.J. ATKINSON:** No, on the contrary. Obviously, my advocacy was inadequate.

**The Hon. A. PICCOLO:** I would just like to make a comment, if I am permitted. We were here, and the member for Morphett spent a lot of time defending the provision which he now wants to revoke. This really does beg the question: how reliable is this legislation going to be, if you are prepared on the same night—

**The CHAIR:** The member for Light needs to have a question about the actual amendment, rather than a statement, I am afraid.

**The Hon. A. PICCOLO:** I do not believe I have to. However, I would like to ask the member for Morphett what has changed his mind and why does he think it is not okay to have those other professionals involved now?

**The CHAIR:** That is a question: what has changed your mind?

**Dr McFETRIDGE:** Only dead men and fools do not change their mind.

*Members interjecting:*

**The CHAIR:** Order!

*Members interjecting:*

**The CHAIR:** Order! There is too much noise; I cannot hear.

Amendment carried; clause as further amended passed.

Clause 13—reconsidered.

**Dr McFETRIDGE:** I move:

Amendment No 2 [McFetridge–1]—

Page 11, lines 31 and 32 [clause 13(1)]—Delete 'an examination and assessment of a person' and substitute 'an examination and assessment of a person by a psychiatrist'

Amendment carried.

**Dr McFETRIDGE:** I move:

Amendment No 3 [McFetridge–1]—

Page 11, after line 32 [clause 13(1)]—Delete:

(aa) the examination and assessment must be conducted by a mental health professional;

Amendment carried; clause as further amended passed.

Title passed.

Bill reported with amendment.

## *Third Reading*

### Dr McFETRIDGE (Morphett) (04:02)

I move:

That this bill be now read a third time.

To get this piece of legislation to this stage is historic. I would like to thank all members for their vigorous debate and instruction during these last hours. I am not apologetic that it has taken this long because it is a piece of legislation that we need to make sure we do get right.

What I ask of all the members in this place is to remember what this legislation is about and particularly who it is about. It is not about us. It is about the Kylie Monaghans of this world. It is about those people out there who are in hospices, homes and hospitals who are seriously suffering and looking to control their future. They are looking to us to control their future. Our constituents put their faith in us, so let's not forget for one moment that this is an historic occasion and we need to consider this legislation and the consequences of our vote today very, very carefully.

I would like to thank each and every person who has been associated with this legislation for the last 25 years. I would like to particularly thank the nurses federation, the South Australian Voluntary Euthanasia Society, Christians Supporting Choice for Voluntary Euthanasia, lawyers for voluntary euthanasia, doctors for voluntary euthanasia and the many other advocates. It would not be at this stage if it was not for their continuing efforts over the last 25 years.

I know there are some people in this place who, fundamentally, cannot support this legislation. They still have those fundamental fears. However, I hope that we have allayed those fears with this lengthy debate because the need to be sure about it is certain. There is one person in particular who I would really like to thank for us getting this far and that is the member for Ashford.

**Honourable members:** Hear, hear!

**Dr McFETRIDGE:** The member for Ashford has put up with a serious amount of flak for many years over this—and, mate, well done.

**The Hon. J.M. RANKINE (Wright) (04:05):** In my second reading contribution I said that this legislation gives me no comfort or confidence. I would ask people, when we commit this bill to the third reading, to think long and hard about the committee process that we have just been through, the contributions that have been made and the inability of the proponent of this bill to be able to answer the most simplest of questions.

When people are concerned about safeguards, ensuring that people are not pressured, that the right processes are undertaken, that all of the safeguards are there, these are the things that the proponents of legislation like this should be able to answer and satisfy people on so that when they vote they know that they are voting for legislation that will deliver what, in their hearts, they want. What we saw tonight was the member for Morphett not being able to answer some of the very simplest, basic questions about safety provisions in this act. I would ask each and every one of you to think long and hard before you choose what side of the house you sit on this evening.

## Division for Third Reading

The house divided on the third reading:

Ayes ..... 23
Noes .....23
Majority ..... 0

**AYES**

| | | |
|---|---|---|
| Bedford, F.E. | Bignell, L.W .K. | Brock, G.G. |
| Caica, P. | Chapman, V.A. | Close, S.E. |
| Cook, N.F. | Digance, A.F.C. | Gee, J.P. |
| Hildyard, K. | Hughes, E.J. | Key, S.W. |
| Marshall, S.S. | McFetridge, D. (teller) | Mullighan, S.C. |
| Odenwalder, L.K. | Picton, C.J. | Pisoni, D.G. |
| Redmond, I.M. | Sanderson, R. | Weatherill, J.W. |
| Wingard, C. | Wortley, D. | |

**NOES**

| | | |
|---|---|---|
| Bell, T.S. | Bettison, Z.L. | Duluk, S. |
| Gardner, J.A.W. | Goldsworthy, R.M. | Griffiths, S.P. |
| Hamilton-Smith, M.L.J. | Kenyon, T.R. (teller) | Knoll, S.K. |
| Koutsantonis, A. | Pederick, A.S. | Pengilly, M.R. |
| Piccolo, A. | Rankine, J.M. | Rau, J.R. |
| Snelling, J.J. | Speirs, D. | Tarzia, V.A. |
| Treloar, P.A. | van Holst Pellekaan, | Vlahos, L.A. |
| Whetstone, T.J. | D.C. Williams, M.R. | |

**The SPEAKER:** There being 23 ayes and 23 noes, I give my casting vote with the noes. Third reading thus negatived.

At 04:12 the house adjourned until Thursday 17 November 2016 at 10:30.