

*Bills***VOLUNTARY ASSISTED DYING BILL***Committee Stage*

In committee.

(Continued from 31 March 2021.)

Clause 1.

The Hon. D.G.E. HOOD: During my second reading speech on 31 March on this bill, I referred to a document published by Palliative Care Victoria. This document suggested that the government funding for palliative care had decreased as a consequence of the introduction of their voluntary assisted dying bill of 2017. It has since come to my attention that this document that I used off their website contained a calculation error and has been removed from their website since.

I also acknowledge that the timing of the report is such that it does not provide any insight into the impact of the Voluntary Assisted Dying Act on palliative care funding in Victoria. I took that information off the website in good faith, assuming it to be correct; it turns out that it was not correct, and I assure members that there was nothing untoward and that I was acting in good faith.

The Hon. R.A. SIMMS: I welcome the opportunity to speak on this important reform—voluntary assisted dying legislation. I thank the Hon. Kyam Maher for putting this on the agenda and for his leadership on this issue. This has been a long-term priority for the Greens, and members will be aware that Mark Parnell moved his own bill back in 2008 and again in 2010. Of course, this is the first time that I have had the opportunity to put my support for this reform on the public record, so I want to make a few remarks about that. I will be exercising my vote in favour of this bill.

Like many in our community, my support for this reform is based on my lived experience and my family's experience. My nanna, Norma, died more than a decade ago, after a long-term battle with Alzheimer's disease. She had the disease for more than 20 years. In her final years she had no quality of life at all. Her mother, my great-grandmother, also died of Alzheimer's disease, and I know, from when my nanna was in good health, this was not a death she wanted for herself. She talked often about not wanting to face the same death that her mother faced. During her final years she was in a vegetative state. She was in obvious distress. She was unable to eat without assistance. Her death was prolonged and it was certainly one that was without dignity.

Obviously, I recognise that the bill before us will not deal with people in my grandmother's situation. She would not have been able to provide consent. But seeing her suffering, prolonged as it was over many years, has solidified my belief that as legislators we need to do what we can to give people choice in their final days.

I will be exercising my vote in favour of the bill for all those who I have loved who have not had the right to die with dignity and all those South Australians who have not only had to endure the loss of a loved one but have also seen them die in prolonged suffering. No-one should have to endure that in modern Australia. My thoughts are with them tonight. It may be too late for us to help them but we can do something to help other South Australians in the future.

I want to acknowledge all those who have shared their experiences in recent days. These matters of life and death are always difficult to talk about. In particular, I was saddened to read the news in *The Advertiser* about Ceara Rickard's health. Ceara is somebody I went to university with. I remember her from my Flinders University days. To quote Ceara:

These laws are not about choosing death, but giving people a death that works for them when they are...dying and death is near.

As Ceara says:

The choice of whether I die is not one that I get to make. But how and when I die can be a choice and it is one that I should be free to make.

Those are her words. I really hope that this parliament respects Ceara's choice and the choice of all other South Australians to end their lives with dignity.

The Hon. J.A. DARLEY: I did not make a second reading contribution because I thought my position was well known in this chamber, but I would appreciate the opportunity to make a very brief contribution now.

It is an appropriate time to point out that I have supported all the past bills and will again on this occasion. Many safeguards have been inserted and choice is provided for those who find themselves in an unacceptable end-of-life situation. Elsewhere in our health and welfare system there needs to be substantial improvements to services and their delivery and to make the options more acceptable to those needing extensive support or residential care.

Members have had some time to consider the VAD regime proposed and I will not be well disposed to support amendments that undermine its intent or structure.

The Hon. K.J. MAHER: When we last met to discuss this matter there were a number of questions that were asked and I appreciate that questions were put on notice. I think the nature of the way this debate has been conducted so far is what members of the public would expect of us as parliamentarians. It has been done in a very civil and respectful way. As we have noted before, reasonable people have come to very different views on these issues, and they are sensitive and difficult issues.

I think of the joint committee that the Hon. Mr Hood and I sat on. It was mentioned on more than one occasion that we do not discuss or deal with death in the way that we probably should as a society. I think the way that we have all conducted ourselves does us a great deal of credit. I think that started with the 18-month joint house committee on end-of-life choices. It did not start that well, with the Hon. Dennis Hood trying to roll the chair of the committee, but it has been very respectful and if there have been questions or issues to sort out I think it has been done in very good faith, not just with the Hon. Dennis Hood but with all members. I thank everybody for that.

I have quite a number of questions that were asked by the Hon. Dennis Hood and the Hon. Clare Scriven last time we met and I will go through the answers in relation to them. Some of them can be done reasonably briefly, some of them will take a few minutes more to answer, and if there is further follow-up needed I am happy to do that. The information that gives rise to the answers is probably a couple of hundred pages in total, but I shall not try to battle the Hon. Frank Pangallo for time speaking in this chamber and read them all out.

The first question from the Hon. Dennis Hood was in relation to medical associations opposed to voluntary assisted dying. I addressed that largely when I responded to that question previously in the first reading of clause 1, but I can get further information to supplement my previous answer. As stated by the Hon. Dennis Hood in his question, the Australian Medical Association has a stance of opposition to voluntary assisted dying; however, it should be noted that is not in line with its membership, a majority of whom said, in the AMA's own 2016 survey, that VAD should be provided by doctors if and when it is legalised.

Palliative Care Australia is now neutral towards VAD reform. The Royal Australian College of GPs, whose membership is larger than the AMA's, supports lawful VAD choice, as does the Australian Psychological Society and the Australian Nursing and Midwifery Federation, whose South Australian branch has directly made comment and recommended legislation to be passed in South Australia.

The Hon. Dennis Hood's second question raised the prospect that voluntary assisted dying will negatively impact on palliative care. The Hon. Dennis Hood had this question and a related question about palliative care funding, and he and I have spoken about this in recent days. I completely accept that he was relying on information that was put on a palliative care website in Victoria that was not correct, because we found the same information and were able to come to the same conclusion that it was reasonable to rely on that information, except that the source of the information was not correct.

I think it is important to acknowledge that, while the quality of palliative care services in Australia is world leading, even the two peak palliative care bodies, Palliative Care Australia and the Australian and New Zealand Society of Palliative Care Medicine, acknowledge that palliative care cannot address all intolerable suffering. A quote from them is:

While pain and other symptoms can be helped, complete relief of suffering is not always possible, even with optimum palliative care. It is simplistic to argue that palliative care can remove all suffering at the end of life.

Palliative Care Australia commissioned research into the impact of legal VAD on palliative care funding. The report focused particularly on European jurisdictions and Canada and found:

...no evidence to suggest that the palliative care sectors were adversely impacted by the introduction of legislation. If anything, in jurisdictions where assisted dying is available the palliative care sector has further advanced.

Emeritus Professor Ian Maddocks AM, foundation chair of palliative care at Flinders Uni and a resident in South Australia, wrote in the *Medical Journal of Australia* in 2018:

In countries where assisted dying has been introduced, palliative care has continued to flourish and grow.

The US states of Oregon and Washington, the first US states with voluntary assisted dying laws, are two of eight states across the US awarded the A grade in the 2011 national review of palliative care services and quality.

In Victoria, the Victorian government increased the funding of palliative care by \$62 million and a further \$17 million in 2017-18, the year in which the voluntary assisted dying legislation was passed in that state. I am informed there was an additional \$23 million in 2018-19, and in the 2019-20 budget they allocated an additional \$75 million over four years.

The third question the Hon. Dennis Hood asked was about a claim that people chose voluntary assisted dying to avoid being a burden to others in the state of Washington in the US. There are a number of questions that follow from the Hon. Dennis Hood's question, which uses examples from

either the North American or European jurisdictions. The legislation that we are debating here today is substantially different from overseas schemes.

I think a useful summary of the very general, broad differences is provided in the final report of the Victorian ministerial advisory panel, which characterised the North American and particularly the US model as requiring a person to qualify as having a terminal illness, while it generalised the European model as requiring a person to be enduring suffering. The Australian model effectively takes both of those things: a requirement that a person is terminally ill and is suffering. So, as a general statement, in Australia we have taken both the qualifying elements of the European and the US systems. While examples from Europe or the US may be of limited utility, I will still try, as best I can, to answer the questions the Hon. Dennis Hood has asked.

The 2013 report that I think was cited in the Hon. Dennis Hood's question is the Washington State Department of Health 2013 Death with Dignity Act Report. The years 2013 and 2012 were the years when the highest number of participants included 'burden on family and friends' as an end-of-life concern. In 2013 it was 61 per cent and in 2012 it was 63 per cent. In the other eight years, the proportion of people nominating this ranged between 23 and 56 per cent.

Up until the publication of the 2019 report, there had been 10 annual reports of the Death with Dignity Act in Washington state. The most significant end-of-life concern for respondents in those reports was loss of autonomy, with 85 to 90 per cent of participants consistently nominating that as an end-of-life concern. The 10 annual reports listed that being a burden was consistently listed as the fourth most significant end-of-life concern. So while that was a concern, the year quoted was one of the two years when it was the highest proportion. They asked a whole lot of questions, and it is consistently ranked number four in order of the concerns in those reports in Washington state.

I think the next three questions from the Hon. Dennis Hood refer to particular individual patient cases. The first one is a claim that a vulnerable older woman was not competent and subject to undue influence in a case in Oregon in the US. Again, I will preface it by saying that there are very significant differences in the way the scheme operates in the US compared with what we are proposing here. I think what is developing as the Australian model of voluntary assisted dying is consistently recognised as much more stringent and conservative.

This particular case centres around a patient named Kate Cheney. The claim is that she was not competent to make decisions and was being pressured by her daughter. I am informed and advised in relation to this case that a mental health professional thought Ms Cheney was competent and also thought that her daughter was a strong advocate but that the patient was not pressured by her daughter in considering using the law.

The doctor referred her for a second opinion to another mental health professional, who also concluded that she was capable of making the decision to use the Oregon Death with Dignity Act. I am informed that Ms Cheney's physician did not claim she was incompetent. Instead, he refused to write her a prescription, as is his right, because he does not support the act of end-of-life choices.

The medical director of Ms Cheney's health management organisation (HMO), who provides oversight on all cases where a request has been made for a hastened death, determined that Ms Cheney was competent and under no duress. I am informed that Ms Cheney held on to the prescription for the voluntary assisted dying substance for some three months before she made a decision to use it.

The fifth question the Hon. Dennis Hood asked is again about a particular individual's patient case. The allegation is that mental illness was approved for voluntary assisted dying in Oregon. I think the allegation is that according to a physician, Dr Hamilton, Michael Freeland had a history of mental

illness and was incompetent, therefore should not have qualified to receive medication under Oregon's Death with Dignity law.

I am informed that the facts are that five physicians involved in the case agreed that at the time Michael Freeland—I think he was quoted in the question as Freeman; I think the name is Freeland—received his prescription under that state's laws he was mentally competent and within six months of dying as well. I am informed that he was mentally competent when he received the medication, when he kept his medication and when he chose not to use the medication.

A particular doctor, I am informed, was apparently involved with the care of Mr Freeland for several months and never once raised an issue with authorities while he was still alive and could speak for himself about these concerns. Since the time Mr Freeland died, his family, I am informed, have been concerned that his private medical records have been used in a political campaign against voluntary assisted dying, and the family have requested for this to cease.

The sixth question the Hon. Dennis Hood asked was again about a particular case in Oregon, involving a woman called Helen. The concern or the allegation is that doctors found this patient, Helen, to be depressed, and that she then went to other doctors and that this is an example of doctor shopping—looking for someone who is prepared to write a prescription.

I am informed neither of the doctors in the Oregon system found the patient Helen to be incompetent. Instead, I am informed they simply did not support the law. One of the doctors, I am informed, said she was sad about her pending death and characterised her sadness as slight depression that did not interfere with her ability to make a rational decision. It was one of her original doctors who recommended that Helen seek further opinions, which she did.

I do note that in the Australian model being proposed by the bill before the parliament there is very significant oversight that requires every single assessment that is made by every single doctor involved to be sent to the Voluntary Assisted Dying Review Board that is proposed under the legislation for that extra oversight.

In the seventh question the Hon. Dennis Hood asked I think the question talks about the expansion of voluntary assisted dying in the Netherlands. I am informed that official data from the Netherlands showed after an initial gradual increase as the law became recognised the rate of voluntary assisted dying use in the Netherlands has levelled off and that these laws are based on establishing agreed criteria for its use, not a cap of how many people might use it.

I am informed that the Netherlands, since the introduction of the legislation in 2001, has not amended their legislation. I think the Hon. Dennis Hood asked, 'How can we ensure this bill will not be enlarged further in its scope in relation to what has happened in the Netherlands?' As I say, I am advised that the Netherlands have not increased their scope; they have not amended their law.

I know that is one of the common concerns that some who do not agree with this bill have—that slippery slope: how do we know it is not going to go further? I think quite simply the only way these laws, like any other laws, could possibly change is with the consent of both chambers of this parliament. It provides a pretty strong safeguard against concerns about the potential change of scope. It does not happen unless both houses of a parliament elected by the people of South Australia agree to it.

The experience around the globe is that once established, there is very little change that occurs with these laws. I think that mitigates the concern many have about that creeping scope. The laws change very little once they are established in a jurisdiction.

The Hon. Dennis Hood's eighth question was about the short-lived Northern Territory scheme and patients who were suffering from depression. I am informed that the NT act, while it remained operational—for that short amount of time—included many criteria which needed to be met for voluntary assisted dying. There was a claim that patients involved had symptoms of depression made by a Professor Kissane, who I am informed did not meet any of the patients who used the NT Rights of the Terminally Ill Act at the time.

I am informed three of the four patients in the NT had terminal cancer and the fourth, a Janet Mills, had mycosis fungoides—and the Hon. Denis Hood might know that better; I will give that to Hansard later, because I am sure my medical pronunciation is not correct. I think to the proposition that the Hon. Dennis Hood put—'Could that happen in the same circumstances here?'—the very simple answer is there are those 68 separate safeguards in the Victorian bill, which is what we have taken an almost carbon copy of in South Australia. In addition, it is very clear that section 13(2) makes it very clear a person is not eligible for VAD only because of a diagnosis of mental illness. It is spelt out in the bill.

The ninth question the Hon. Dennis Hood question asked is about mental competence not being addressed in the bill. In South Australia, the bill that is before us, again, as I said, does not permit VAD exclusively for the reason of mental illness in clause 13(2), and, I might add, nor for disability, as in clause 13(3). Clause 4 details the meaning of 'decision making capacity' in relation to voluntary assisted dying.

Clause 13(1)(c) expressly requires a person to have the decision-making capacity as a precondition for access to voluntary assisted dying, and it further requires both the coordinating and consulting doctors to assess and determine the person's decision-making capacity as part of the assessment process.

The 10th question Dennis Hood has asked about is, again, an expansion of voluntary assisted dying in a jurisdiction. I think he asked about an expansion in Belgium. Again, I will just restate the answer from before that the biggest safeguard we have against expansion is that two chambers of the South Australian parliament that are elected by the people of South Australia would need to agree on any possible changes, which the experience around the world shows are very few and far between.

The 11th question from the Hon. Dennis Hood is in relation to a question about whether VAD will negatively impact on the quality of palliative care. I will not restate what I said before about the experience in Victoria and the significant funding increase after palliative care was established in Victoria. I think that has been the experience in WA as well and the first two states in the US to introduce voluntary assisted dying regimes are some of the top-rated in terms of palliative care around the US.

The 12th question from the Hon. Dennis Hood is specifically about palliative care funding and the figure of a decrease of 6.3 per cent, and I do not think we need to go in to that. I think there was a reliance on information on a website that was incorrect. The 13th question by the Hon. Dennis Hood is about the use of voluntary assisted dying for minors. The question is: what would prevent that happening in the future? I will restate again: there have been very few changes once a scheme is established. I just cannot see that happening in Australia.

We have, for a very long time, held in Australia that the legal age for decision-making capacity in most areas is 18. This bill requires the person to have attained the age of majority before being eligible to access voluntary assisted dying. All those criteria have to be expressly attested to by two separate doctors. I do not mind placing on the record that I do not support voluntary assisted dying being

made eligible for minors, and I think that if I do not support it, it is going to be very unlikely we are ever going to see a majority in both houses of parliament support that.

Question 14 from the Hon. Dennis Hood was in relation to a Dutch doctor being sued for not approving VAD. This is one where I might forward the further and better particulars to the Hon. Dennis Hood about this case. My information is—and it goes over quite a number of pages—that there was a doctor who was not sued for not authorising VAD, but in the case, I think it was a Mrs Demore wanted access to VAD and I think it was an unprofessional conduct complaint that was lodged against a practitioner for, as the details have been put before me, trying to stop the person using VAD. So it was not any lawsuit to try to force someone to use VAD as it has been put before me on the basis of alleged unprofessional conduct. That one ended in quite tragic circumstances with that particular patient taking their own life in a pretty gruesome sort of way.

The 15th question from the Hon. Dennis Hood was about the loss of life years when future medical discoveries may help. I think it outlined for a young person who elects to use VAD because they meet all the criteria, and the question essentially was about the possibility of a medical breakthrough that might appear when they are in their 20s or 30s that could potentially save them and cure them from such an illness, and what is in the VAD bill to protect against that.

The fact that the time period used in our VAD bill is 'diagnosed in the last six months of your life', except for 12 months with a neurodegenerative disease, guards against that. The possibility of a miracle cure—for someone with a terminal illness that will bring about their death in the last few months of their life—is unlikely. It would be a reasonable point if the time frame was five years or 10 years that someone was diagnosed to live, I think that is a realistic possibility, but it is quite deliberately conservative and restrictive and down to the last six months.

They are the questions from the Hon. Dennis Hood. As I said, on that second to last one I am happy to get further information rather than reading pages and pages of an allegation and then the response to the particulars of the allegation into *Hansard*.

The Hon. Clare Scriven asked a few questions. The first question was about the establishment in the later clauses of the bill of the Voluntary Assisted Dying Review Board, and was it possible to get an indication of what resources would be provided for them to carry out their duties. I would like to thank the Hon. Stephen Wade, the health minister in this place, who, on a number of things, has sought comment from his department. I think all members have benefitted from some of the comments from members of his department who, as Dennis said, without supporting or not supporting the bill, have made general comment that I think has provided useful guidance.

I can quote the departmental advice that the Hon. Stephen Wade sought in relation to that question. It says simply:

If the VAD Bill was to pass into law the Department for Health and Wellbeing would undertake an assessment of the resource needs of the legal entity, the VAD review board, and fund accordingly.

I think that is what we would expect, and no less, from any legislation that we pass. It is not uncommon for us to pass legislation that establishes an office, a commissioner or an oversight function. I am grateful for that advice from the health minister that resources would be made available to implement what is required under this legislation.

I guess if this legislation did pass in South Australia the health department would not be starting from scratch and could then seek advice from Victoria, as they already have and have had in operation for close on two years a Voluntary Assisted Dying Review Board, and Western Australia, where I am

assuming they have already established their Voluntary Assisted Dying Review Board given that their scheme becomes operational—I think it is at the start of the next financial year, the start of July, or if it is not then it is soon thereafter.

The second question from the Hon. Clare Scriven was in relation to the nature of doctor training, which is a mandatory requirement for any doctor whether they are the coordinating or consulting medical practitioner under the Voluntary Assisted Dying Scheme. They cannot complete the assessment and be part of the Voluntary Assisted Dying Scheme unless they have undertaken compulsory training, a number of elements of which are set out in the act.

I am grateful for some advice from Victoria, which has been able to give a little bit of information about the detailed training modules that the Victorian government established prior to the commencement of the Voluntary Assisted Dying Act and its scheme in 2019. I am informed that the modules are studied by a doctor prior to undertaking a VAD assessment. The VAD modules take approximately eight hours to complete and are able to be undertaken by the doctor at the doctor's own pace. Content knowledge is examined using approximately 30 multiple choice questions. I am informed that a candidate must score over 90 per cent to pass, and if they fail twice they must wait a prescribed period of time before being retested.

I am informed a detailed manual is available for doctors to remind them and ensure that a VAD case is conducted to the highest standard and meets every requirement. I think that has been reflected in the very strict compliance that the reporting on the operation of the VAD scheme in Victoria so far has found.

In Victoria, the state has funded a Care Navigator Service, which helps people, patients and, I think, doctors navigate the VAD system in Victoria. I am informed the Western Australian government has been developing similar modules prior to commencement of their act in July of this year. Again, I suspect it would be very similar. If a bill was successful in South Australia, for much of the training that doctors undertake, we would seek guidance and probably look to implement, I suspect, some of the Victorian and Western Australian modules, given that we both have very similar schemes, based on what I think the health minister has correctly described as the Australian model of voluntary assisted dying.

The final question from the Hon. Clare Scriven relates to advance care directives. I think the question was whether in South Australia advance care directives were considered. Section 23(1) of the act refers to information to be provided by the coordinating medical practitioner. I think the question Hon. Clare Scriven asked was why it is not in that section of the act. Was it because this is essentially a carbon copy of the Victorian legislation and in Victoria they do not have the advance care directive legislation that we have, or was it deliberately and specifically excluded from this act?

I am able to inform the chamber that in Victoria they do have advance care directives under their Medical Treatment Planning and Decisions Act 2016, so they have a very similar regime for the availability of advance care directives. The Victorian scheme has chosen not to include advance care directives as one of those items of information that must be provided.

As I said, we are following quite strictly the Victorian model and what is emerging as the Australian model of voluntary assisted dying. Palliative care is one of the options. I think clause 23(1)(c) states one of the matters to be provided is:

(c) palliative care options available to the person and the likely outcomes of that care;

I appreciate the Hon. Clare Scriven asked me a couple more questions just before we started today. Advance care directives could be one of the items in there but also, equally, there are probably a whole lot of other possible end-of-life choices that could be in there. You could have a requirement that the doctor must inform the patient of the possibility that they can refuse medical treatment towards the end of their life.

You could also possibly include a doctor having to inform a patient about what the Hon. Stephen Wade talks about as the 'double effect' rule, that under the Consent to Medical Treatment and Palliative Care Act the patient can have a medical intervention that the doctor knows hastens their death, as long the primary intention of that is to bring about relief and comfort.

These are all things that could be included in there, but I think in terms of care options, the palliative care option is probably the one that is most relevant there. I suspect that was the motivation for the drafting in Victoria, given that they do have the same availability of palliative care options.

They are the answers to the questions that already have been put on notice. Again, I want to reiterate my gratitude to members for the respectful way this has been conducted and for those sorts of general questions to be put on notice to allow a full consideration and a response that helps understand the issues, rather than having a debate where things are brought up to test someone's knowledge on their feet about a specific thing in the bill or where a comma is. As I said, I think this does us a great deal of credit, as we are conducting this debate in a respectful way.

The Hon. D.G.E. HOOD: I will be quite brief initially. I thank the Hon. Mr Maher for his response to my multiple questions that I put on notice to him last time we met to debate this bill. He has obviously put in a good deal of work to compile those answers and I understand there is more detail to come, so I thank him for that.

This is not a love-in, but I think it is appropriate to acknowledge the Hon. Mr Maher's comments about the respectful way in which this debate has been conducted thus far. I think it is very important. I think, frankly, that is what people would expect of us and I am pleased that that is how it has ensued.

It would be remiss of me not to acknowledge that the voluntary assisted dying committee that sprang from this bill looked at all sorts of issues around end-of-life care, including palliative care. That was a productive committee, chaired by the Hon. Mr Maher. Whilst there were very strongly differing opinions on both sides of that debate, it was conducted in a way that I think was befitting of this place and of what we are trying to achieve.

I have a number of amendments, as people know, which I will move, I guess, after dinner now and other members will too. In my discussions with the Hon. Mr Maher, he suggested to me that he may not support any of them. I wish it were otherwise, but that is my expectation. If they will not get up, I do intend to move them anyway because I think the debate is worth having. I will proceed in that direction later this evening when we return after dinner.

The Hon. C.M. SCRIVEN: I would also like to thank the Hon. Mr Maher for providing those answers. I would just note that, in the previous contributions when those questions were put on notice, he had undertaken to come back to me in the break in regard to my question about advance care directives so that I could decide whether or not to move an amendment.

I would like to place on the record that I think it is concerning that, in the bill as proposed, information will be provided about voluntary assisted dying and palliative care but not about the right to refuse care, for example, or indeed the double effect, as the Hon. Mr Maher suggested, could be an extra item that would be important to a person nearing the end of their life. I certainly would have prepared

an amendment had I had that answer in the time frame. However, obviously, if the bill passes tonight there is an opportunity between the houses for others to prepare such an amendment.

I would like to just very briefly also place on the record the fact that, in my previous contribution, there have been some public comments saying that the information that I have provided, because it related to the 1990s situation in the Netherlands and the very extensive reviews there, was not relevant because the legislation did not change until the early 2000s. Perhaps those making those comments were unaware that there is a judge-made law, which happened in the Netherlands, whereby euthanasia was able to be accessed, and that is why the Attorney-General in the Netherlands was able to do such an extensive investigation over a number of years.

My points were that the law may not change but the practice does with safeguards ignored, which is the main drawback of any voluntary assisted dying law. Also, in the first years of new legislation there tends to be strict adherence, but culture changes over time and therefore practice changes over time, which is why the less than two years' experience of Victoria is insufficient to form an informed view about whether that legislation is indeed working in the way that it was intended or the way that is appropriate.

Sitting suspended from 17:59 to 19:45.

Clause passed.

Clause 2.

The Hon. D.G.E. HOOD: I state very briefly at the outset of my questions and amendments that none of this is intended to delay—I do not think it will delay—just so that the mover knows. I have a question at clause 2, and I have half a dozen questions roughly, and people are aware of the amendments I have filed. On clause 2, it may be a difficult one for the mover to answer, and perhaps is even a question for the government or the Attorney at some stage, but when would it be proclaimed? Obviously in Victoria there was an 18-month or thereabouts lead-in, and I understand they are doing similar elsewhere. What is the member's intention?

The Hon. K.J. MAHER: The health minister, the Hon. Stephen Wade, I am sure will supplement my answer. The honourable member is correct: it was about an 18-month lead-in time to get all the administrative things needed in place in Victoria. The appointment and the setting up of the Voluntary Assisted Dying Review Board, the training modules required under the act, the Care Navigator Service—there was quite a lot, as the member would appreciate, that went into setting it up. I think the Western Australian scheme comes into operation at the start of July this year, and I think off the top of my head that it may be around a 12-month, or maybe a tiny bit more, time frame.

It might be that it is somewhere around that 12-month time frame. I suspect the Victorian scheme probably will be the longest to do all those things necessary to become operational. My best guess would be 12 months up to 18 months, based on previous experience in other jurisdictions that have already passed this. Of course, we will not be reinventing the wheel, as the health minister pointed out in his second reading contribution. There is a developing Australian model for voluntary assisted dying, which Western Australia, Tasmania and certainly we are implementing very closely. There will be similarities, and my best guess is that it is a 12 to 18-month time frame.

The Hon. S.G. WADE: Thank you, Mr Maher, for suggesting that I might like to add to this. Certainly SA Health does not want to move too quickly. We get dizzy when we move too quickly. The advice from SA Health is that there be significant lead times involved—perhaps 18 to 24 months. Of course, first of all the government needs to decide where the act would be committed, if it passes the

parliament, and whether it is committed to the health minister. My understanding is that in other jurisdictions it is, so my expectation is that South Australia would follow course.

Whilst I agree with the comments of the Hon. Kyam Maher that we do benefit from a number of jurisdictions having already implemented this or similar bills, there is always something unique. One of my amendments addresses the consent to medical treatment and palliative care legislation, which is unique to South Australia. That will impact on implementation if the bill is passed.

I think it is also really important to understand the operational issues that our clinicians will need to work through. SA Health convened a clinicians' forum to discuss the bill, and a lot of the issues that were discussed were the sorts of issues that will need to be discussed by clinical networks and not by parliamentarians. The people were talking about: if we are providing palliative care to somebody in a palliative care ward, how does that interact with any other clinicians who might be offering the same person voluntary assisted dying?

To be frank, it has been an issue in Victoria. Perhaps we have less consultation to do or less work to do because legislatively we follow in the footsteps of other jurisdictions, but their experience raises issues that are best discussed and worked through. I suspect we have less work to do legislatively and administratively but we have more work to do in terms of clinical consultation. SA Health is suggesting 18 to 24 months, but that would be very much the responsibility of the government to make an assessment about what are reasonable time frames and to make a proclamation at an appropriate time.

Clause passed.

Clause 3.

The CHAIR: We now come to the first of the amendments on clause 3. It is amendment No. 1 [Hood-1], clause 3, page 10, after line 22.

The Hon. D.G.E. HOOD: This is very much a test amendment and, with your agreement, sir, I will explain what I mean by that. Really, this amendment just inserts the term 'palliative care specialist' into the bill. There is no need to insert that term if my subsequent amendment, that is, amendment No. 6, actually fails.

So with your agreement, sir, it would be my proposal to have the substantive debate on amendment No. 6 now, although I will move the first amendment. If that fails, there will be no need to move amendment No. 6 when I get to it. Is that understandable and acceptable? There being no objection to that in the chamber, I draw members' attention to amendment No. 6 [Hood-1] which, as I said, is the substantive amendment upon which amendment No. 1 [Hood-1] is based.

To further complicate things, I have moved a subsequent amendment to replace amendment No. 6 [Hood-1], which is amendment No. 1 [Hood-2], just to make that clear, and they are very similar. The only difference is that the first amendment called for two palliative care specialists to be involved, but the second amendment, that is, amendment No. 1 [Hood-2], reduces the number of two palliative care specialists to just a single palliative care specialist. It is as simple as that. I move:

Amendment No 1 [Hood-1]—

Page 10, after line 22—Insert:

palliative care specialist means a medical practitioner with expertise in the area of palliative care;

As I said, I will debate the substantive issue and that will determine where we go from there. What is the intention of this amendment? The intention of this amendment is to insert paragraph (e) in clause 13. Clause 13 is a very central clause to the bill that deals with the criteria for access to voluntary assisted dying; so how one qualifies, essentially, for this scheme or program or whatever it is.

It goes through what you might consider a very reasonable list of criteria. That is, they have to be over 18 at least, they must be an Australian citizen ordinarily resident in South Australia, when they make their first request they have lived in South Australia for at least 12 months and they must have decision-making capacity in relation to this issue. Paragraph (d) is the paragraph that I am seeking to amend. I will read it verbatim. It says:

(d) the person must be diagnosed with a disease, illness or medical condition that—

(i) is incurable; and

(ii) is advanced, progressive and will cause death; and

(iii) is expected to cause death within weeks or months, not exceeding 6 months; and

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

I am seeking to put in paragraph (e), which provides:

(e) [and] a palliative care specialist must have certified, in accordance with any requirements set out in the regulations, that such palliative care as may be reasonably available to the person would not be of therapeutic benefit.

In simple terms, this amendment requires a person seeking euthanasia or voluntary assisted dying to be consulted by a palliative care specialist to ensure that their pain cannot be treated using palliative care. I would argue that that is entirely reasonable. In fact, clause 13(1)(d)(iv) of the bill says that the medical condition 'is causing suffering to the person that cannot be relieved in a manner that the person considers tolerable'. How can we possibly know that it cannot be relieved if that individual has not seen the most qualified type of person in pain management available in order to see if they can relieve their pain?

It is my contention that we cannot know that that pain cannot be relieved if they have not seen a person who has the most tools in their armoury or the most capacity to treat that particular type of pain. As I said, the bill says if the suffering of that person 'cannot be relieved in a manner that the person considers tolerable' but we cannot know that until they have seen somebody qualified to make that decision. I refer to the AMA position statement on euthanasia and physician assisted suicide. Section 1.3 states:

1.3 For most patients at the end of life, pain and other causes of suffering can be alleviated through the provision of good quality end of life care, including palliative care that focuses on symptom relief, the prevention of suffering and improvement of quality of life...

So the AMA is quite clear. They believe that not all but—their word is—'most' patients and most pain can be relieved. I am saying that if the intention of this bill is to allow for those who are at the extreme end—that is, as it says here, they have suffering that cannot be relieved, an incurable disease, etc.—then to really be sure of that we need to put them in front of a palliative care specialist so that they can make that decision. The World Health Organization has stated, and I quote directly:

Palliative care affirms life and regards dying as a normal process. When palliative care of the highest quality is made available to every patient it improves the chances of pain being managed, thus reducing the desire to be euthanased.

The World Health Organization is quite explicit in that, and I will just repeat that last part:

When palliative care of the highest quality is made available to every patient it improves the chances of pain being managed, thus reducing the desire to be euthanased.

I contend that we should give these individuals who are in this precarious situation the opportunity for their pain to be relieved before they take what might be the ultimate solution, and that is to accept assisted suicide. My amendment requires them to have a consultation with a palliative care specialist and then, if the palliative care specialist is of the view that he or she cannot adequately treat that pain, then so be it. The criteria has then been satisfied and the person has satisfied this part of the criteria for physician assisted suicide. That is essentially my position.

The Hon. K.J. MAHER: I thank the mover for his amendment. I have had the benefit—and I think it has been of benefit to both of us—to spend some time this week with the Hon. Dennis Hood discussing his amendments, and I appreciate the ability to have done that. For the benefit of the committee considering this tonight, I will outline that I am intending to oppose all the Hon. Dennis Hood's amendments. I think that comes as no surprise to the Hon. Mr Hood.

One of the overarching reasons, and I will reflect again on the second reading contribution from the health minister, is that I think the amendments the Hon. Dennis Hood is moving, however well intentioned, bring us to departing, and quite often in a quite substantial manner, from the Australian model that Victoria first enacted, that we have seen WA and Tasmania enact and that we are now looking at. I think there is great benefit in having a scheme or schemes around Australia that share substantial similarities. I am not keen to depart greatly from those, and I think this does possibly in a very major way.

There are a few reasons I disagree, and I will go through them briefly. The first one is, as the Hon. Dennis Hood has gone through, those qualifying criteria, if you like. They talk about suffering in a manner that the person does not consider tolerable. I think it is a feature that wherever suffering is required for voluntary assisted dying—as I talked about earlier, the differences in the models in Europe and in the US do not always require that, but I will look further into it later—in all the models that have suffering that is not considered tolerable it is up to the patient to decide that.

It is not something where an outside specialist comes in and tells a patient, 'Your suffering is tolerable.' I think it is reflected in all the Australian models, and I suspect the overseas ones, that it is subjective, that it is up to the patient to determine whether or not that suffering is tolerable. Suffering does not always necessarily mean, although it often does, immediate physical pain.

The substance of the amendment requires the involvement of a palliative care specialist; it was two and I appreciate that it has been refined back to just one. I oppose that insertion, but I oppose even more the idea that they must assert that no palliative care would be of therapeutic benefit. To the first part of that, we already have the coordinating medical practitioner and the consultant medical practitioner, one of whom must be a specialist in the disease, illness or medical condition that affects the patient. There are qualifications that both those medical people involved must have.

I think it is a very significant departure from the Australian model to require another health practitioner as a third person to be involved. For a couple of reasons, I do not think it is a good idea. Firstly, a palliative care specialist might not be the most appropriate person to give that diagnosis about the condition of the person.

The ministerial expert panel in Victoria talks in a number of places about palliative care specialists often being someone who can assist, whether it is in determining a patient's ability to understand, their mental capacity to enter into a voluntary assisted dying scheme or the pain of their condition, but there are a whole lot of others who could also assist, like gerontologists. By having only palliative care specialists, it narrows it down from any other form of medical practitioner or specialist who may be even more appropriate than only a palliative care specialist.

Even more concerning than just that—and we checked this morning—according to the Medical Board of Australia's registrant data for the reporting period of the last quarter of 2020, which was published on 10 February 2021, in South Australia there were 2,185 general practitioners, 4,589 general and specialist practitioners and 27 palliative care doctors. If we are limiting it down to palliative care specialists, which I think is a bad idea to start with, it also means you are quite likely going to have to find one of only 27 people. It would almost certainly deny nearly everyone in a regional area from accessing VAD, to get to that third person, the palliative care specialist, and I think it would substantially and to my view unacceptably limit the number of people who might be able to avail themselves of the scheme.

I appreciate the intention of the amendment but on that part I fundamentally disagree. I even more fundamentally disagree with the second part, that is, the palliative care specialist has to certify that for the person who has the treatment there would be a therapeutic benefit, that is, that there is nothing else that can be done. That even more fundamentally breaches a patient's right to refuse treatment.

The Consent to Medical Treatment and Palliative Care Act very specifically makes it clear that any person can refuse treatment and they can refuse treatment even if that treatment might be life saving. What this amendment would in effect do (if the bill passes) is create a legal option for a person to get a medical intervention, that is, voluntary assisted dying, but only if they have tried everything else.

A person has a right not to try something. I think it is an exceptionally fundamental right of a person to refuse medical treatment. What this would have the effect of doing is to say, 'You have to try this medical treatment if you want to be involved in what would be (if this bill passes) a legal medical intervention.' So, for a range of cascading reasons, I disagree a bit, I disagree quite a lot and I disagree very strongly with things in there. I understand where the Hon. Dennis Hood is coming from but on this one we have a different viewpoint.

The Hon. S.G. WADE: I would like to indicate that I also join the Hon. Kyam Maher in not supporting this amendment. I do agree with the Hon. Kyam Maher that the issue of being able to find medical practitioners in this legislation would be problematic with this amendment if it passed. The proposed amendment would seek to have palliative care specialists certify that the voluntary assisted dying applicant would not benefit from palliative care.

This additional criteria creates a significant barrier to access, requiring the approval of multiple different medical practitioners: one coordinating medical practitioner, one consulting medical practitioner, one specialist medical practitioner (if deemed necessary), in addition to the proposed palliative care specialist. From an implementation perspective, and given the dearth of medical practitioners willing to provide voluntary assisted dying, this proposed amendment I fear would render the bill inoperable in practice.

The amendment, though, raises a key issue for me. My amendment, which we will be discussing later—and I assure the Chair that I will not be dwelling on it—the key purpose of the amendment that I will be moving later is to try to avoid the conflation of palliative care and voluntary assisted dying, and this amendment does exactly that.

It not only, shall we say, does not avoid the conflation that I think is already in the current bill, it actually doubles it. It says, 'Not only are we not clear about the difference between voluntary assisted dying and palliative care, we actually want a palliative care specialist interposed in a voluntary assisted dying process.'

I was very fortunate to be an observer at a clinical forum for SA Health clinicians to discuss this bill. Let's be clear, the Department for Health and Wellbeing and SA Health does not have a view on this bill. There were people in that room who vehemently opposed voluntary assisted dying and there were people who actively supported it, but the overwhelming consensus was that we do not want conflation.

We do not want medical practitioners going into a treatment context and muddying the waters about whether they are providing palliative care or voluntary assisted dying. That forum emphasised that VAD and palliative care should not be conflated. Though most people who seek voluntary assisted dying would also be supported by palliative care and end-of-life services, it is important to clarify that voluntary assisted dying and palliative care are not the same.

Palliative care does not include the practice of voluntary assisted dying, nor is voluntary assisted dying intended to be an alternative to palliative care. Both are part of a range of end-of-life choices. The reason I oppose this amendment is because we need to have that distinction codified in law, and I believe that supporting this amendment would go in the opposite direction.

Respectfully, I disagree with the Hon. Dennis Hood in relying, as he did, on a policy statement of the AMA in support of this amendment. I refer honourable members to the letter sent to me on 3 May by the South Australian President of the Australian Medical Association together with the Chair of the Board of Management of Palliative Care SA, Professor Gregory Crawford. On page 2 of their letter—and I will, in due course, table this so that it might be to the benefit of the parliament going forward—there are two particular paragraphs that are relevant on this point. They refer to the same forum I was present at, and they say:

The forum held on 10 February revealed major practical difference problems in the Victorian experience stemming from confusion between what constitutes voluntary assisted dying and palliative care. For example, a failure to have a clear, common understanding of the difference between these two concepts might cause confusion at the level of governance, transparency of funding and practical provision of care and the functioning of a palliative care service which might also provide VAD services, and this might then flow to a confusion for patients and their families.

This would be especially problematic if health practitioners working within such a service had a conscientious objection to providing voluntary assisted dying. In addition, any confusion in the minds of doctors between palliative care and voluntary assisted dying could have the effect of undermining the provision of good palliative care, with the potential for some doctors then becoming fearful of providing adequate analgesia to terminally ill patients for fear of being accused of actively ending a patient's life without their consent. That is, euthanising their patient.

I would argue, with the support of that letter, that it is very important this bill maintains a clear distinction between palliative care and voluntary assisted dying. With all due respect, I believe the Hon. Dennis Hood's amendment increases the conflation rather than reduces it, so I cannot support this amendment.

The Hon. J.A. DARLEY: For the record, and for the reasons already given by the Minister for Health and the Leader of the Opposition, I indicate I will not be supporting any of the Hon. Mr Hood's amendments.

The Hon. D.G.E. HOOD: I will just make a couple of comments if I may. As I said, I do not want to prolong this. Just to be absolutely crystal clear, I was not at all claiming that the AMA position statement supported my amendment. What I was saying was that section 1.3 clearly states:

For most patients at the end of life, pain and other causes of suffering can be alleviated through the provision of good quality end of life care, including palliative care that focuses on symptom relief, the prevention of suffering and the improvement of quality of life.

I make no further claim than that; merely that that is their position as outlined in their statement.

Clearly, there are differences of opinion in the room, and I think you might expect that with something like this. I make no apology, I guess is the way of putting it, for creating a further barrier. I think physician assisted suicide is something that should be an absolute last resort. We are literally talking about people ending their life, and it literally is the last resort. What may drive someone to making such a request—and what drives many people, we are told—is that they have this unbearable pain. So to give them the opportunity to consult with a palliative care specialist would, in my mind at least, be very helpful.

With respect to the availability of palliative care services around South Australia, I understand there are 26 such centres around the state. I will not read them all—it would take too long—but they do cover many regional areas, including the Adelaide Hills, Ceduna, the Murray Mallee, Port Augusta, Port Lincoln, Whyalla. They are in the Barossa, Clare, Port Pirie, Wallaroo—all of which, I am told, if required have access to a palliative care specialist. Of course, that does not include all the ones in the metropolitan area. That may be a concern that could be dealt with. Certainly, in my conversations with people in palliative care, they maintain that that would be possible, but that is yet to be seen.

The Hon. S.G. WADE: Because I have had a good go I might leave some other comments I was going to make until after the Hon. Clare Scriven. On the point that the honourable member just made, I think we need to appreciate that the commonwealth legislation in relation to telecommunications does not allow communication—I cannot remember the detail, but basically telehealth cannot be used for euthanasia consultations. That being the case, the access that a lot of country services would have to palliative care specialists would not be possible under the honourable member's amendment.

The Hon. C.M. SCRIVEN: I think the objections to this amendment really go to a couple of very pertinent points. The first is that the majority of the discussion, certainly in the public domain outside of this parliament but also inside this parliament, about the reasons we need voluntary assisted dying is because of unrelievable pain.

We all know of and/or have heard of people who have had terminal illnesses that have resulted in a great deal of pain. Palliative care can relieve most of those symptoms, but we are told that it cannot relieve all. If we are saying that it is not essential to actually investigate the benefits of palliative care, it really does cause us to question whether those extreme examples that are being used as the major support for this type of legislation are really what the intention is.

However, I would move on to an even more important point. Being someone from a regional area, if this amendment were to pass it would force investment in palliative care in regional areas as well as elsewhere. We have heard that there are not enough palliative doctors or palliative care services, yet we have also heard that, where voluntary assisted dying legislation is in place, supposedly investment in palliative care increases.

If it is in fact a requirement before someone can access voluntary assisted dying that they do have consultation with a palliative care specialist, that means we will have to provide palliative care

specialists. That surely is a good thing. Surely that is consistent with what most of the debate has said, which is that palliative care is an important part of end-of-life choices and, according to the proponents of the bill, is side by side with voluntary assisted dying. I think anything that would force investment in palliative care would be a very positive thing. I also challenge what the Hon. Mr Maher stated. He talked about paragraph (d)(iv):

(d) the person must be diagnosed with a disease, illness or medical condition that...

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

He then said that this amendment would mean that someone else would decide what is tolerable. That would be true if this amendment was replacing subparagraph (iv), but it is not; it would be in addition to it. So the person would still be deciding whether their suffering would be relieved in a way that is tolerable, but they would also have the benefit of understanding what palliative care can and cannot do.

I think that comes to the crux of the matter, that while people do not have access to a good understanding of what palliative care can do they are not making an informed choice. This amendment would ensure those two things: that palliative care is available and that people are then making an informed choice.

The Hon. F. PANGALLO: I will be supporting the Hon. Dennis Hood's amendment. Interestingly, with regard to this argument, I would like to draw to the attention of members a very interesting article in the current *Medical Journal of Australia*, where the Victorians are actually grappling with a number of issues as a result of VAD.

I will go further into the aspect that will affect my amendment later on about conscientious objection, but in relation to this I want to read out this section which goes to show that palliative care, according to this Victorian working group, actually needs to work hand in hand with VAD. The section states:

Perhaps the largest challenge was fulfilling the responsibility of a Pathway A public health service to provide VAD as an option while respecting the staff member's decision to conscientiously object to facilitating or being involved in VAD. The need to consider each case individually was highlighted...

It then goes on to give some examples in relation to deaths that occurred under VAD:

Without comparable local evidence, the expected demand for VAD was inferred from international evidence, which predicted that a low number of people would request VAD...

But:

Over a 14-month period (June 2019 to September 2020), the health service received 42 patient requests for VAD, with four patients progressing to a prescription of VAD medications and dying as a result. Three of these four patients died after receiving VAD as inpatients and one died at home after being discharged from the health service.

Here is where it gets interesting. The section continues:

Patients who requested VAD were cared for across a number of services and received concurrent palliative care as part of appropriate end-of-life care management. The patients who died after receiving VAD were cared for in the ward that was most familiar and suited to their needs; palliative care was provided by the treating team, with specialist input as required.

Most VAD requests were from patients in the final weeks of their lives, who therefore did not survive the full length of the VAD assessment process. This observation made it imperative that VAD processes complemented end-of-life care,

thus not denying the patient and their loved ones appropriate palliative and bereavement care respectively. Indeed, a core tenet of staff education was that progression of VAD may occur during end-of-life care; therefore, palliative and comfort care must continue concurrently with VAD processes.

Implementing VAD in a hospital setting demanded sensitive, honest and respectful communication between multiple health professional groups and the community, particularly between individuals with opposing views.

So this working group is currently going through some issues that have arisen as a result of the Victorian legislation and, no doubt, if this legislation passes in South Australia, it may well be that South Australia will also need to have a working group looking into the legislation to see how it applies. It seems to support what the Hon. Dennis Hood is saying: that they need to work together and that we need stronger emphasis and input into ensuring there is more palliative care when we introduce this type of legislation. So I will be supporting the amendment.

The Hon. S.G. WADE: With all due respect to the Hon. Frank Pangallo, I strongly support the fact that voluntary assisted dying and palliative care need to work together, but the lessons you were relaying from Victoria actually support the view of trying to avoid conflation. Sure, there are two distinct treatment modalities: palliative care treatments and the voluntary assisted dying treatments. Both of those treatments may be provided in the same facility, the same institution; they need to learn to work together. Yes, they are complementary, but it is very dangerous for them to be conflated.

To further seek to rely on the letter from the AMA and Palliative Care SA about why that is so important, if the committee could indulge me I would like to read another three paragraphs from the letter. The heading is Informed Consent and the letter says:

To be clear about the nature of a treatment, and in this case the intention of the treatment, is an important central tenet of health care and absolutely vital to respect the autonomy of a patient. As in all medical practice, a doctor must clearly explain the nature of a particular treatment and why it is being provided. To obtain informed consent from a patient, it is essential that both the doctor and the patient are absolutely clear whether they are being provided palliative care or voluntary assisted dying. A doctor's responsibility is to offer treatment options and to be clear in their own mind in explaining to a patient why the treatments are being offered. It is not the role of a doctor to unilaterally declare the fate of a patient based on their own values or because they themselves fail to properly understand the difference between treatment options. That is, it is not a doctor's role to play God.

So, while arguments for voluntary assisted dying include patient autonomy and the prevention of others imposing their values onto a patient, the same holds true in reverse. For some patients who do not want voluntary assisted dying or euthanasia, it is important that both the patient and the treating doctor genuinely understand and accept the boundary between palliative care and voluntary assisted dying so that the patient's autonomy can be properly respected in the provision of their care.

On the other hand, clearly defining palliative care and voluntary assisted dying will not undermine the ability of a patient who was waiting for or contemplating voluntary assisted dying to be provided with palliative care. The nature and timing of the two treatments would just need to be clearly explained to the patient.

The two treatments are complementary, but it is really important they are not conflated. If I can be self-indulgent, I am a Christian and I do not believe that voluntary assisted dying is an option that I feel morally able to take up. The conflation would actually make it more difficult for me to get involved with palliative care because the parliament is giving a lack of clarity to the medical practitioners who might be attending to me about what the difference is between the two.

I would strongly urge people who want to stand up for people who do not support voluntary assisted dying as a personal treatment option for them: you are doing them a service if you have clear legislative distinction between voluntary assisted dying and palliative care because, if they will not tolerate voluntary assisted dying, they will still have the moral comfort to be able to engage with palliative care.

The CHAIR: The Hon. Ms Scriven and then I will go to the Hon. Ms Bonaros. We have canvassed this amendment pretty well. We will be approaching a vote, but I will go to the Hon. Ms Scriven.

The Hon. C.M. SCRIVEN: Thank you. My question is to the Hon. Mr Wade. How does ensuring that a patient understands what palliative care can or cannot do, whether it can or cannot be of therapeutic benefit, how does that conflate palliative care with VAD?

The Hon. S.G. WADE: With all due respect, clearly the Hon. Mr Hood's amendment conflates it because it requires the approval team to be blended with palliative care specialists and people involved in the VAD treatment program. They are two separate pathways. People can have a consultation with palliative care specialists about whether palliative care can provide assistance to them in their journey. They can have conversations with the voluntary assisted dying team. It may well be that, within the particular institution, that is being offered by the same practitioners. But in the voluntary assisted dying journey, they are not compelled to have their patient choices determined by clinicians.

I completely agree with the Hon. Kyam Maher's position. I would like to know where else we are going to say that medical practitioners can determine an individual patient's treatment regime. But I think it is extremely important that we avoid conflation. Having mixed teams is clearly conflating.

The Hon. C. BONAROS: For the record, I am seeking to indicate that I will not be supporting the amendments. I agree with the arguments that have been put forward by the Leader of the Opposition and the Minister for Health. While I am on my feet, I want to make an additional observation at this stage of the debate, which I think is very important, and that relates to the use of language during this debate because I think language in this debate is very important.

I think the language in this bill has been very deliberately chosen and I think it is incumbent on all of us here tonight to be mindful of the language we use when speaking about voluntary assisted dying. There have been references to voluntary assisted suicide and to my knowledge that term has not been used in any Australian jurisdiction, but more importantly it does not appear anywhere in this bill. Indeed, clause 5 of the bill addresses this issue specifically when it refers to voluntary assisted dying not being suicide.

I think that is very important for a number of reasons, but first and foremost I think it is very important from a mental health perspective because language does matter and it matters very much in this context. So I am respectfully asking for members to bear that in mind when reflecting on voluntary assisted suicide as opposed to voluntary assisted dying, which is the terminology that we have accepted and has been drafted in the bill before us.

The Hon. I. PNEVMATIKOS: I indicate that I will not be supporting the amendments by the Hon. Mr Hood.

The Hon. N.J. CENTOFANTI: I rise to indicate that I will be supporting the Hon. Mr Hood's amendment. I think it goes to the heart of this bill, which is the voluntary assistance of dying to therefore relieve suffering. The Hon. Kyam Maher spoke about the fact that the patient should be able to determine what is tolerable in terms of suffering, and I do not disagree; I completely agree with the Hon. Kyam Maher that the patient should have that decision.

But I struggle to see how they can make that decision if they have not accessed or at least been informed of any potential form of palliative care that may relieve them of their suffering. If there is potential for the relief of suffering by palliative care, then to ensure that this is realised a palliative care specialist really needs to be involved in this process. Therefore, I support this amendment.

The Hon. I.K. HUNTER: Sir, to assist you in your deliberation, I indicate that I will not be supporting the amendment.

The Hon. E.S. BOURKE: I would also like to put on the record that I will not be supporting this amendment or any other amendments from the Hon. Dennis Hood.

The Hon. D.G.E. HOOD: Just to round it off if I may, Mr Chairman, and then we can move to a vote.

The Hon. K.J. Maher: Are you going to be supporting it?

The Hon. D.G.E. HOOD: I will be supporting the amendment, yes, there is a shock. I want to make a few final comments. I want to be absolutely clear about this: there is nothing in my amendment that takes away a patient's right to refuse palliative care. Simply, that they would be consulted and the options explained that are easily available to those persons is what the amendment does. Specifically, it says:

(e) a palliative care specialist must have certified, in accordance with any requirements set out in the regulations, that such palliative care as may be reasonably available to the person would not be of therapeutic benefit.

That is all. So the specialist has to have a view and then the patient decides what is appropriate for them.

With respect to the comment made by the Hon. Ms Bonaros, I mean no disrespect calling this anything other than voluntary assisted dying. I do not mind what term we use. The reason I have been using those terms is because those are the terms—that is, 'euthanasia' and 'physician assisted suicide'—on the Australian Medical Association's position statement on this issue, so it seems that they are satisfied that it is an acceptable term.

The CHAIR: We have canvassed this very largely, but I will allow the honourable—

The Hon. F. PANGALLO: It will be very brief, and it is just about the language. My honourable colleague raised the issue about suicide and I know that word tends to be quite sensitive to those who are supportive of this legislation, but I will just remind members what the actual definition of suicide is: suicide is the act of intentionally causing one's own death.

The committee divided on the amendment:

Ayes 7

Noes 14

Majority 7

AYES

Centofanti, NJ
CMStephens, TJ

Hood, DGE

Lucas, RI

Ngo, TT

Pangallo, F

Scriven,

NOES

Bonaros, C
IKLee, JS
Wade, SG

Bourke, ES,
Lensink, JMA
Wortley, RP

Darley, JA,
Maher, KJ

Franks, TA
Pnevmatikos, I

Hanson, JE
Ridgway, DW

Hunter,
Simms, RA

Amendment thus negatived; clause passed.

Clause 4.

The CHAIR: We come to clause 4, amendment No. 3 [Hood-1].

The Hon. D.G.E. HOOD: I have a question for the mover of the bill before I determine whether I will move this amendment or not. It deals with clause 4, as you rightly said, sir, and the issue I am particularly interested in is in subclause (1)(d), which reads:

(d) communicate the decision and the person's views and needs as to the decision in some way, including by speech, gestures or other means.

I wonder: what constitutes other means? What gestures are envisaged by this particular clause?

The Hon. K.J. MAHER: I thank the honourable member for his question. It is consistent with other pieces of legislation in South Australia that allow these sorts of wishes to be made known, for example, the Consent to Medical Treatment and Palliative Care Act 1995, regarding determining impaired decision-making capacity, takes into account in section 4(2)(a)(iv) 'communicating his or her decision in any manner'.

The Mental Health Act has a similar provision, communicated decision in any manner, not just 'a manner'. It is a good and reasonable question. It is certainly one that in the many, many hours that I have spent going through this bill and talking to clinicians in South Australia and around other parts of Australia I was interested in, as well.

For example, someone who communicates via an Auslan interpreter cannot use speech so that is a form of communicating. A different example and probably one of the most well-known examples was that of the late Professor Stephen Hawking who could communicate very well about very sophisticated concepts, but who was not able to speak and used a machine. There are people who use electronic aids, who use thumb movements to communicate—there is a whole range of very well-established means of communicating that are used outside of written or spoken communication, and they are used in South Australia, I suspect, every single day by medical practitioners in the treatment of people to understand their needs.

The Hon. D.G.E. HOOD: Yes, in fact, in the discussions I have had subsequent to filing my amendment, one of what I would call a usual supporter of my position actually took issue with this amendment because his view was that in his practice he had had experience of patients blinking for yes and no—blink once for yes and blink two for no. That being the case and I think given the response from the mover I am not inclined to move my amendment.

Clause passed.

New clause 4A.

The CHAIR: We now come to amendment No. 1 [Wade-2] which is the insertion of a new clause on page 12 after line 9. I call the Hon. Mr Wade.

The Hon. S.G. WADE: Thank you, Mr Chair, and I should thank you for referring to me as the Hon. Mr Wade and not the Minister for Health and Wellbeing because it reminds me to restate that this is a conscience vote for Liberal members. This is a private member's bill and I speak only for myself.

In some ways we have already started this conversation. I indicated in response to the Hon. Mr Hood's earlier amendment the importance that I see in avoiding the conflation of palliative care and voluntary assisted dying. Section 17(1) of the Consent to Medical Treatment and Palliative Care Act provides that a—

The CHAIR: The Hon. Mr Wade, this is replacing your original amendment.

The Hon. S.G. WADE: I am moving Wade 1 [Wade-2]—set 2.

The CHAIR: Right, but it replaces set 1.

The Hon. S.G. WADE: Yes, I am moving amendment No. 1 in [Wade-2], and I formally move:

Amendment No 1 [Wade-2]—

Page 12, after line 9—Insert:

4A—Voluntary assisted dying is not palliative care

(1) For the purposes of the law of the State, the administration of a voluntary assisted dying substance to a person in accordance with, or purportedly in accordance with, this Act will be taken not to constitute palliative care of the person.

(2) To avoid doubt, nothing in subsection (1) prevents a person who is providing, or who has provided, palliative care to a person, or an institution at which palliative care is provided to a person, from performing functions or otherwise being involved in the operation of this Act (whether as a coordinating medical practitioner, a consulting medical practitioner or otherwise).

(3) Nothing in this Act limits Part 3 Division 2 of the *Consent to Medical Treatment and Palliative Care Act 1995* (and, for the purposes of section 17(1) of that Division, a reference to administering medical treatment in that subsection will be taken not to include a reference to administering a voluntary assisted dying substance to a person in accordance with, or purportedly in accordance with, this Act).

Note—

Section 17 of the *Consent to Medical Treatment and Palliative Care Act 1995* provides that a medical practitioner does not incur liability where certain medical treatment incidentally, rather than intentionally, hastens the death of a patient.

The amendment would add an explicit statement in the Voluntary Assisted Dying bill that voluntary assisted dying is not palliative care. Section 17(1) of the Consent to Medical Treatment and Palliative Care Act provides that a medical practitioner responsible for the treatment or care of a patient in the terminal phase of a terminal illness under the Medical Practitioners Division incurs no criminal liability by administering medical treatment with the intention of relieving pain or stress.

A specific and direct reference to section 17(1) in the Voluntary Assisted Dying Bill in my view highlights the difference between the medical practitioner's intention in two situations: firstly, under the Consent to Medical Treatment and Palliative Care Act the intention is to relieve pain or distress, and under the Voluntary Assisted Dying Act the intention is to facilitate death.

Again, I seek the indulgence of the council to read three paragraphs from a letter sent to me and provided to honourable members from the president of the Australian Medical Association and the

chairman of the board of management of Palliative Care SA. It starts in Dr Moy's voice where he states:

I write to you alongside clinical academic palliative care medicine physician Professor Greg Crawford who, as its current chair, is representing Palliative Care SA in support of this amendment.

Together we write to you reinforcing the need for your proposed amendment which requires an insertion of a new clause 4A making it clear that voluntary assisted dying is not palliative care.

In doing so, this clause clearly sets out that voluntary assisted dying and palliative care are defined and distinguished by the intention of treatment, with the intention of palliative care and the concept of double effect being solely and directly aimed at treatment and relief of a patient's distressing symptoms, while the intention of voluntary assisted dying is to end an individual's life.

The addition of this amendment would enhance the legislation in creating an explicit reference to section 17(1) of the SA Consent to Medical Treatment and Palliative Care Act 1995, which remains the gold standard of legislation in Australia in setting out the protections for medical practitioners providing treatment under the framework of palliative care and the widely accepted principle of double effect (that is, while providing treatment aimed at the relief of symptoms, the medical practitioner does not incur liability where the treatment incidentally, rather than intentionally, hastens the death of a patient).

In conclusion, because I think I have made the point under two clauses now, I stress the point that I believe that the passage of this legislation, with the greater clarity of the scope of palliative care and the scope of voluntary assisted dying, will actually enhance the practice of palliative care in South Australia.

I have real concerns that there are some medical practitioners under the current Consent to Medical Treatment and Palliative Care Act who do not have clarity about the operation of the act. By having these complementary references in the legislation to stress the distinction, I think we will have better medical practice, because we will have practitioners having more clarity about what medical treatment they are offering and what informed consent they need to obtain. I think that will lead to better palliative care practice in South Australia.

The Hon. C.M. SCRIVEN: The Hon. Mr Wade refers to clarity, which raises a question that perhaps I should have asked at clause 1, but since he was not the mover of the bill I did not do so. Earlier on in the debate and in emails to members of parliament, the Hon. Mr Wade indicated that he might move an amendment in terms of death certificates. This comes to the point of transparency and clarity around how things are described in this case, voluntary assisted dying not being palliative care. Could the Hon. Mr Wade indicate why he has not gone forward with that amendment and any other relevant matters he might think would be useful for transparency?

The Hon. S.G. WADE: With all due respect, the honourable member is misstating what I wrote to members. I think the honourable member is referring to a letter that I sent two months ago, where I conveyed, merely as a messenger, six suggested amendments from the clinicians' forum on 10 February. I indicated that I might move some or none of those amendments and that other members were free to move them if they wished.

I think in that same correspondence I provided questions and answers—'frequently asked questions', as SA Health is inclined to call them—from the Department for Health and Wellbeing, and I did stress that the Department for Health and Wellbeing is agnostic as to whether or not this legislation should be passed. Unlike the termination of pregnancy legislation, which SA Health did support, the department in this context merely seeks to support an informed public discussion. I sent those six suggested amendments. At that stage I did not indicate that I would be moving any of them.

In my second reading contribution, I think I indicated that I would be moving two of those six amendments. Why it was so limited was because of what I also said in my second reading contribution, that I think it is really important that we maximise consistency. I know it can be somewhat galling when ministers quote themselves, but let me explain again by quoting my speech as to why I think consistency is important:

I think it is helpful for patients, for clinicians and for regulatory bodies if the laws in an area of law such as this are similar across Australian jurisdictions. Consistency would support access, it would support quality and safe practice and it would reduce the pressure for what is sometimes called medical tourism.

I support South Australia joining our sister states in enacting the Australian model of voluntary assisted dying. In that context, I want to be clear on my general stance in relation to amendments. I think that the basic framework of the bill is sound and should be supported. I think there is significant value in national consistency of voluntary assisted dying legislation.

Accordingly, I indicate to the council that I will only support amendments to the bill that do not undermine close national consistency, and I will not support the third reading of the bill if the bill is amended in committee in a way that does not maintain close national consistency.

I went on. In the end, I had to ask myself which matters were so important to me that I thought I should move an amendment. I was tempted not to indulge myself with unnecessary amendments, so let me explain why I chose those two. The first one is the importance of maintaining what the AMA describes as the gold standard in palliative care.

We do not want to do anything in this legislation that would undermine an excellent piece of legislation that this parliament has already had the wisdom to pass. We need to make sure that palliative care and voluntary assisted dying are complementary treatments, but they are not conflated. It is in the interests of medical practitioners and their patients that we have clarity in terms of the two treatment modes.

The second and following amendments, because they are all related to the same issue, are to not allow a medical practitioner to be one of the relevant practitioners if a family member is involved or if they would benefit financially. I would argue that that is not a diversion from the Australian model because, whilst Victoria does not have it, Western Australia does have it. I think that it is also not a matter that would disrupt, if you like, the consistency across the regimes. With all due respect to the honourable member, I never proposed that I was going to do an amendment on death certificates.

The Hon. C.M. SCRIVEN: I appreciate the clarification. Certainly, I was simply going from memory. It was not my intention to misrepresent what the Hon. Mr Wade might have said, but one of his comments in regard to transparency just prompted me to remember somewhat vaguely that piece of correspondence. I agree with the Hon. Mr Wade that it is important that clinicians do have protections in terms of the double effect not being conflated with voluntary assisted dying, and therefore I will be supporting this amendment.

The Hon. K.J. MAHER: I rise to indicate that I will be supporting the amendment in the amended form that the Hon. Mr Wade is putting forward. For the sake of the smooth operation of this committee, I will also indicate that I will be supporting the rest of the Hon. Stephen Wade's amendments.

I agree with the Hon. Stephen Wade that neither amendment, and particularly the further amendments that we will come to later on, departs in any significant way from the Australian scheme of voluntary assisted dying. The minister is quite right: the second group of amendments appear in the WA scheme. A lot of those may be obligations that registered medical practitioners would have

under a code of ethics and things that govern the way that they practice, but it is in here, and I do not oppose those.

I thank the minister for his discussions about the amendments that he has put forward. I think it has worked well with this slightly amended form. Most people who practise in this area are reasonably comfortable. I will indicate that, whilst I have appreciated those discussions with the minister, I will not get into the habit of engaging in a text message conversation with him at about 4:26 in the morning all that often in the future.

The Hon. S.G. WADE: The honourable member nudges me to properly acknowledge that the second version of the amendments was enhanced by the contribution of the Hon. Kyam Maher, so I thank him for that. I am disappointed that you are not willing to get up early, because that is my habit.

The Hon. R.I. LUCAS: The Hon. Mr Wade refers to the fact that the AMA has referred to Consent to Medical Treatment and Palliative Care Act, in particular clause 17, as the gold standard of palliative care. Given that, can the Hon. Mr Wade indicate whether any group representing palliative care doctors, palliative care society or any other medical association has made a submission either to him or indeed to the mover of the bill that the bill, as currently proposed, will undermine the gold standard?

The Hon. S.G. WADE: With all due respect, the honourable member is asking a broad question that relates to the bill as a package. Those are matters that should be asked of the Hon. Kyam Maher as the sponsor of the bill. I am only moving one amendment, and I would confidently say that, whether or not an individual clinician supports voluntary assisted dying, my expectation would be that this amendment would be welcomed because there are so many palliative care specialists who oppose voluntary assisted dying and are very disturbed about conflation.

As I said earlier, with the lack of clarity between the informed consent that is required and obtained for palliative care, there is concern that, because of that, there are administrations of palliative care that look more like assisted dying. Without a framework like voluntary assisted dying, you cannot be confident that it is voluntary.

The Hon. R.I. LUCAS: I did introduce my question by saying 'either to the mover of the amendment or the mover of the bill'. Given that Mr Wade defers the question to the Hon. Mr Maher, my question is to Mr Maher. Has he received submissions from people representing palliative care doctors who argue that the bill as he has drafted it would undermine the gold standard of the Consent to Medical Treatment Bill?

Parliamentary Procedure

VISITORS

The CHAIR: Before calling the Hon. Mr Maher, I acknowledge the presence in the gallery of the Hon. Sandra Kanck, former member of this chamber.

Bills

VOLUNTARY ASSISTED DYING BILL

Committee Stage

Debate resumed.

The Hon. K.J. MAHER: I thank the Hon. Rob Lucas for his question. I do not think I can remember exactly the nature of submissions that were put forward, but certainly one path we followed that differed from many of the other times this bill has been introduced is that, prior to the bill being introduced in parliament, we had a joint house select committee that spent some 18 months taking evidence. From memory there were about 130 written submissions and dozens of witnesses, both here and in Victoria, as the committee went to look at the operation of the scheme there, who put forward their views.

Certainly, bodies representing palliative care put forward their view. The consultation was over 18 months and ended some time ago. I cannot remember exactly the nature of the submissions, but I think it is fair to say—and as representatives of this chamber, the Hon. Dennis Hood served on that committee, as did the Hon. Mark Parnell, who up until recently was a member of this chamber—that we took a range of views, from very supportive to very unsupportive and everything in between.

It is some time since that committee did its thorough work and took submissions from all those stakeholders. I am sure there would have been some clinicians who probably expressed those views, but I cannot remember the exact details of all of them.

The Hon. J.A. DARLEY: For the record, I indicate that I will support the Hon. Stephen Wade's amendment and all other amendments of the member.

The Hon. C. BONAROS: I rise to indicate that I will be supporting the Hon. Mr Wade's amendment. I indicated at the outset during my second reading contribution that I will not support any substantive amendments that depart from the Australian scheme, as has been explained by the Hon. Kyam Maher and the Hon. Stephen Wade. In any event, I think for the reasons the Hon. Mr Wade has outlined in relation to the conflation of voluntary assisted dying and palliative care, this is an important amendment and as such we will be supporting it.

The Hon. I. PNEVMATIKOS: I also indicate that I will support the amendments of the Hon. Mr Wade because the bill needs to draw a distinction between the two processes but also acknowledge they can be complementary. I think the amendment does that.

The Hon. R.P. WORTLEY: I indicate that I will be supporting the amendment of Mr Wade and all his other amendments.

New clause inserted.

Clause 5.

The CHAIR: We now move to clause 5, amendment No. 3 [Hood-1]. You are just opposing this clause? You are not moving an amendment as such?

The Hon. D.G.E. HOOD: Correct, Mr Chairman, although I have a question before I proceed with that because I may not proceed. This intrigues me a little bit because you do hear this issue in these debates around the world. Some places around the world choose to consider that voluntary assisted dying—assisted suicide—is not considered to be suicide in a legal sense. I ask the question: why did the member choose to include this in the bill? I note that my understanding is that it is not in the Victorian act. I think that is right, so what was it that made the member include this in his bill?

The Hon. K.J. MAHER: I thank the member for the question. I think the Hon. Connie Bonaros has talked about language and the importance of the language we use. Much of the life's work of the Chair of the committee today in this chamber has been in suicide prevention. I think it is very important to recognise the difference between the two. The expert ministerial panel in Victoria discussed this at some length. Around page 145 to 150 in their report was the distinction between the two.

In a very practical sense, there are legal ramifications. In terms of potential superannuation or annuities, there are very real practical considerations. Should this bill pass and should this scheme operate in South Australia, someone who is availing themselves of a perfectly legal medical intervention might be penalised if it was suicide, in terms of some of those legal ramifications.

From a very practical sense, someone who is admitted and given approval under this scheme is going to die. They are suffering a terminal disease that two medical practitioners, one of them a specialist in that area, have determined a prognosis of less than six months to live, or 12 months for a neurodegenerative disease.

According to medical expertise, they are going to die from the condition they suffer from. They would not be able to be part of the scheme unless that was the case. It is necessarily the case that the considered view is that they are going to die. The fact of the matter that there is an intervention that, in my view, helps alleviate that suffering and with dignity does not take away from the fact that, if it were not but for that condition, they are going to die.

Andrew Denton, who many people would be familiar with, who is a very persuasive advocate in this area, describes the difference between these two in a very easy to understand way, with reference to New York in 2001 when the World Trade Centres had planes fly into them—the fall or the fire. The chief medical officer of New York did not record those people who elected to jump out of the building that was to collapse as suicides. He recorded them as homicides due to terrorism.

The very act of jumping out, if you accept that argument is suicide, ignores the fact that, faced with the choice of fire or fall, some people chose fall knowing full well that they would die from the natural consequence of the fire in the building. I think that is an apt analogy. You would be dying and succumb to your condition by the very nature of being involved in this scheme and the fact that there is an intervention that hastens your death should not detract from that.

Similarly, also under our Consent to Medical Treatment and Palliative Care Act, if you refuse medical intervention you are not committing an act of suicide by refusing intervention, even though it might have the effect of saving your life. I think they are two really important distinctions and that is why I think it is important that this clause is in the bill.

The Hon. S.G. WADE: I indicate that I support what the Hon. Kyam Maher has just said. I am also advised that it might have relevance in terms of medical codes. This clause ensures that a person who performs an act or omission in relation to a person will not be in breach of professional standards or codes of conduct.

The Hon. D.G.E. HOOD: I do not intend to move this amendment anyway.

Clause passed.

Clauses 6 to 8 passed.

New clause 8A.

The Hon. F. PANGALLO: I move:

Amendment No 1 [Pangallo-1]—

Page 13, after line 34—After clause 8 insert:

8A—Conscientious objection of entities providing health care

(1) A relevant service provider has the right to refuse to authorise or permit the carrying out, at a health service establishment operated by the relevant service provider, of any part of the voluntary assisted dying process in relation to any patient at the establishment (including any request or assessment process under this Act).

(2) A relevant service provider may include in the terms and conditions of acceptance of any patient into the health service establishment an acknowledgment by the patient that the patient—

(a) understands and accepts that the relevant service provider will not permit the establishment to be used for purposes of, or incidental to, voluntary assisted dying; and

(b) agrees, as a condition of entry, that they will not seek or demand access to voluntary assisted dying at the establishment.

(3) Subsection (4) applies in relation to a patient at a health service establishment if the patient advises a person employed or engaged by the relevant service provider at that health service establishment that they wish to access voluntary assisted dying.

(4) If this subsection applies in relation to a patient at a health service establishment, the relevant service provider who operates the establishment must ensure that—

(a) the patient is advised of the relevant service provider's refusal to authorise or permit the carrying out at the health service establishment of any part of the voluntary assisted dying process; and

(b) arrangements are in place whereby the patient may be transferred to another health service establishment or prescribed health facility at which, in the opinion of the relevant service provider, a registered health practitioner who does not have a conscientious objection to voluntary assisted dying is likely to be able to participate in a voluntary assisted dying process in relation to the patient; and

(c) reasonable steps are taken to facilitate the transfer referred to in paragraph (b) if requested by the patient.

(5) In this section—

health service establishment means each of the following:

(a) a private hospital within the meaning of the *Health Care Act 2008* or other private health facility of a kind prescribed by the regulations;

(b) premises owned or operated by a residential care provider as defined in section 41-3 of the *Aged Care Act 1997* of the Commonwealth;

relevant service provider means a person or body that operates a health service establishment.

I would hope that members on both sides, particularly those who will be supporting the bill, will see that this is actually a fair and reasonable amendment that dovetails with clause 9 regarding conscientious objection of registered health practitioners.

Basically, this amendment covers the providers, the entities that actually provide health care—those that will have a conscientious objection because of who they are and who they represent. An example of that would be Calvary, which is of course through the Catholic Church. As members would know, they are opposed to VAD. They have told me, and health practitioners in that system have said, that while there is that conscientious objection for the health practitioners overall, it does not actually cover the entities that they work for.

I think it is only fair that if the service provider does have a conscientious objection to VAD they would not allow VAD to be carried out in their premises. Essentially, this amendment covers the health practitioners who work in there. I will go into what it does now. The relevant service provider could be a hospital—as I mentioned, it could be Calvary—an aged-care facility that may well be under the auspices of the Catholic Church or a Christian organisation that does not support VAD. It would also encompass aged-care facilities that would either have operators or staff who would be opposed to VAD.

It would work in such a way that the terms and conditions of accepting any patient into the hospital would be such that when the patient comes into the hospital, they understand and accept that that establishment would not permit it to be used for purposes of or incidental to voluntary assisted dying, and the patient agrees upon entry that they will not seek or demand access to voluntary assisted dying at that establishment. I think that is quite reasonable.

Furthermore, through this amendment the establishment would advise the patient of the service provider's refusal. They could also make arrangements whereby the patient may be transferred to another health service establishment or prescribed health facility where, in the opinion of the relevant service provider, a registered health practitioner who does not have a conscientious objection to voluntary assisted dying is likely to be able to participate in a voluntary assisted dying process in relation to the patient.

In other words, if a patient wants to be admitted into a hospital like the Calvary, perhaps with a view to voluntary assisted dying as the end result, the Calvary would inform that patient that VAD is not to be carried out on those premises because they have a conscientious objection to that. If they wish to be admitted, they must understand those conditions. In the event that while they are there they do want to access VAD, the provider will enable that patient to go to a premises where it is carried out—it could be the Royal Adelaide Hospital, for instance.

I just want to go back to the article I was quoting from earlier in the current edition of the *Medical Journal of Australia*. As I pointed out, under their act, the Victorians have been required to review and have a look at the workings of their VAD laws. In mid-2018, they established a VAD working group with senior professional executive representation, which included the Chief Medical Officer, the General Counsel, the Executive Director of Nursing and Midwifery, relevant medical heads of units, senior nurses, allied health representatives and a senior clinical communications adviser. They looked at various issues that have arisen since that.

The clinical communications adviser conducted consultations with 25 working group members to explore the impact of VAD legislation on their professional group and clinical practice between September and December 2018. The outcomes of these consultations highlighted the systemic and ethical complexities inherent in implementing VAD and informed the next steps, including the need to engage with a range of appropriately skilled and experienced clinicians throughout the implementation phase.

A key consideration during the implementation phase was balancing staff members' right to conscientiously object to supporting patients when the assistance was related to VAD, with the

expectation that health professionals would continue to provide care unrelated to VAD. Capacity for moral injury for staff whose beliefs and values were at odds with the employing organisation's approach to VAD needed to be recognised and addressed throughout the implementation process.

The article then goes on to say that a survey of medical professionals was undertaken in 2019. They were invited to complete an anonymous survey asking them to indicate their willingness to participate in VAD. The survey achieved 208 responses, which was a 17 per cent response rate, with 106 of those from senior medical staff and 72 per cent of respondents supporting a patient's access to VAD at the health service. In addition, eight senior medical staff members expressed a willingness to be involved in the facilitation of VAD. The survey results guided the health service's management to determine pathway A as the appropriate model of care for this health service.

In parallel with the survey, training for VAD was provided by the DHHS-led Voluntary Assisted Dying Implementation Taskforce. During these sessions, the need for local VAD procedures were identified as staff members required further guidance to navigate patients' requests for VAD and to ensure the health service adhered to legislative requirements. Importantly, the procedures need to support the right of staff to conscientiously object to VAD while fulfilling lawful access to care.

While the Hon. Kyam Maher's bill addresses the conscientious objection to health practitioners, I think it is just that it also covers the service providers who provide a similar service to public hospitals or aged-care facilities and that those providers do have a right to express their own conscientious objection to VAD. After all, if that is their approach and their policy against VAD, they should have the right to have that conscientious objection. VAD does present quite a moral and ethical dilemma for these organisations. I hope the Hon. Kyam Maher recognises that and agrees to this amendment.

Parliamentary Procedure

VISITORS

The CHAIR: Before calling the Hon. Mr Maher, I recognise the presence in the gallery of His Grace Bishop Silouan of Sinope. Welcome to you, sir.

Bills

VOLUNTARY ASSISTED DYING BILL

Committee Stage

Debate resumed.

The Hon. K.J. MAHER: I am not going to be supporting this amendment. I fundamentally disagree with it. I think this represents a significant and very fundamental departure from what we have talked about as the Australian model. This issue has been considered and rejected in other states that have implemented voluntary assisted dying, and I think there are very good reasons why the Victorian expert panel, in their deliberations and in their report, and parliaments around Australia have rejected this idea.

Take, for example, residential aged care, which is included in this amendment. There are around 16,000 South Australians who live in residential aged care. It is their home. People who live in residential aged care pay a refundable accommodation deposit, also known as a bond. Almost always

they sell their house to essentially move into residential aged care, which becomes their home. It averages \$440,000 and ranges up to \$1 million to buy into their new home in residential aged care.

Particularly if a couple moves into residential aged care, a surviving partner in that couple after one passes away can live for years, even decades in residential aged care. It becomes their home as much as any other home that you or I might live in. To say that someone should be denied the possibility, if this bill passes, of legal medical intervention in their own home I think is a pretty fundamental departure from what we would consider reasonable.

People would find themselves in their own home unable to access their choice of care and would effectively be told, 'If you want to pursue this, move out of your own home.' In many areas that might not be financially possible. Particularly in areas of limited choice in regional South Australia, that might not even be a possibility to find other suitable care.

The wording of this amendment states that premises in both retirement villages and residential aged care are potentially captured because it refers to premises that are owned or operated by residential aged-care providers, which could be retirement villages, which I think would be even more problematic. But just on the residential aged care, I think it is a significant and fundamental departure from the Australian model. It appears in none of the other jurisdictions in Australia.

I will not go into all of them, but particularly in the Tasmanian debate, this occupied quite a deal of time for Tasmanian parliamentarians, who talked about that not just in aged care but in other hospital services it would be a perverse outcome if someone who had already been accepted and issued a permit in a VAD scheme was then denied other sorts of treatment by a hospital or residential aged-care facility by virtue of availing themselves, if this passed, to what would be a legal intervention. I cannot support something that is such a fundamental departure from what is the Australian model.

The Hon. J.A. DARLEY: For the record, and for the reasons given by the Leader of the Opposition, I will not be supporting this amendment.

The Hon. R.P. WORTLEY: I find this amendment quite appalling, to the fact that we are being asked to support an amendment which would in effect deny someone a service from a service provider for the simple reason that they may choose a process which is legal under the law. If I go to hospital, if I wanted to go to the Calvary hospital and wanted to indicate that I may want to use this legislation to assist my voluntary death, I would find it appalling that they would refuse me entry to that hospital. It is discriminatory; it is an appalling piece of discrimination.

It was not long ago when religious schools would not hire gays. They were very discriminatory, because it was against their religious principles. I fundamentally disagree with this amendment, and I hope it does not get up in this chamber.

The Hon. T.A. FRANKS: I indicate that I will also be quite strongly opposing this amendment. Not only was there a time—and there still is, unfortunately—when religious schools discriminated against both staff and students, there have also been times when hospices have refused to treat those with HIV/AIDS because of their sexuality. I certainly do not believe they should be in receipt of government funding should they do that.

I am also not of the belief that we can fool ourselves that this will not be used to diminish this legislation, and people in their own homes is the example the Hon. Kyam Maher has put quite profoundly and powerfully. It would be far more pervasive than that, but the fact that people in their own homes would not be given the choice to die with dignity is fundamental as to why this amendment should be defeated.

The Hon. D.G.E. HOOD: I will be supporting the amendment. The reason I will be supporting the amendment is encapsulated well by an opinion piece I think members would have seen. It was published in *The Advertiser* yesterday, I think. It was written by Jim Birch, the chairman of Calvary Health Care in South Australia. In part, he says:

This is why Calvary cannot—and will not participate—in VAD. We do not believe assisting a suffering person to end their own life actually addresses and responds to their suffering. Rather, it ignores and fails to address the complex physical, psychosocial and spiritual causes of a person's suffering at end of life.

If VAD is to be voluntary for the public, then it should be voluntary for clinical staff and medical officers and for the organisations that they work for.

I do not want to overstate this, so I am careful and genuinely do not want to be alarmist about this, but my concern is that if we compel these organisations to do things they do not want to do, ultimately they are going to stop existing—full stop.

These are not-for-profit organisations. They do not exist to make money; they exist to fulfil what they consider to be their mission. In fact, Calvary has a mission statement around its reasons for being, essentially. Something like voluntary assisted dying is so fundamentally against their mission statement that I worry about pushing these organisations into corners they do not want to be in, with the possibility of them just saying, 'Well then, we're not going to do it.'

I urge members to consider that. I think it is a real risk. Here we have the chairman of Calvary coming out and quite emphatically saying that they cannot and will not perform these tasks. So you do wonder what would happen if push comes to shove, and that concerns me.

The Hon. C.M. SCRIVEN: Another aspect to consider is that this amendment, if it were to pass, actually provides those who support voluntary euthanasia and who may want to avail themselves of it with real transparency. They know that if they may want to consider VAD in the future, then they do not go to an organisation such as Calvary.

It may be that organisations such as Calvary lose some of the market share, if I can use that term. Well, so be it. That is the opportunity for people to know; 'Okay, I will choose this organisation's hospital or aged-care facilities because their values align with mine in regard to voluntary assisted dying,' or, 'I will choose that one.'

It will ensure that people know what they are getting into, because they will know that if they go to an organisation such as Calvary and then want access to VAD there will be huge problems. They will not be able to do it, and it is likely to be full of conflict, which I am sure is not something we would want anybody to be experiencing as they are nearing the end of life. They will have transparency knowing this organisation will not provide those services; therefore, they can choose a different organisation. I would have thought that that kind of transparency, that kind of visibility, over what an organisation will or will not provide would only be of benefit to those who are nearing the end of their life.

The Hon. F. PANGALLO: I will point out to the Hon. Russell Wortley as well as the mover of the bill that their comments seem to be at odds with clause 9—Conscientious objection of registered health practitioners. Can the Hon. Kyam Maher tell me: when you refer to a registered health practitioner who has a conscientious objection to voluntary assisted dying, who would you be referring to in that case?

The Hon. K.J. MAHER: I would be referring to a registered health practitioner.

The Hon. F. PANGALLO: But who would they comprise, do you think? Who would have a conscientious objection?

The Hon. K.J. MAHER: I am just trying to find the definition of a registered health practitioner. A registered health practitioner means:

a person registered under the Health Practitioner Regulation National Law [Act 2009] to practise a health profession (other than as a student);

That national law says a registered health practitioner means an individual who:

(a) is registered under this Law to practise a health profession, other than as a student; or

(b) holds non-practising registration under this Law in a health profession.

These individuals are health practitioners who provide health services to patients. I think the Hon. Frank Pangallo said—and I agree with him—that the health practitioner at their work should be well covered, and they should be. It is the express intention and effect of the next section, clause 9 of this bill, that no individual should be compelled to be involved in any part of the voluntary assisted dying act. They should not be compelled to be a coordinating medical practitioner. They should not be compelled to be a consulting medical practitioner.

No registered health practitioner should be required to take part in what is entailed in the Voluntary Assisted Dying Bill, and that is exactly what clause 9 does. What it does not do is take away that voluntary aspect. It does not take away the ability of the health practitioner who does wish to be involved in that. It is that choice that I think is fundamentally taken away not just from health practitioners but, more importantly, from patients, from someone who, as I said, is living in their own home.

I received a message, and I think I may have accidentally misspoken when I said the number of people in aged-care facilities is 16 in South Australia. I meant to say 16,000. It is a massive number of South Australians whose choice will be taken away.

The Hon. S.G. WADE: Just to elaborate on the comment the Hon. Kyam Maher is making, I think it is important to understand that registered health practitioners here are much more than the medical practitioners who are involved in the process. The Australian Health Practitioners Regulatory Authority (AHPRA) is the body that registers health professionals in Australia. I think about 13 professions are registered. Some of them one would not expect to be involved in the end-of-life journey, but many you would.

Let me mention a few that might well be involved: Aboriginal and Torres Strait Islander health practice, medical—and medical would also include psychiatric—nursing and midwifery, occupational therapy, pharmacy, physiotherapy, psychology. The Hon. Kyam Maher's bill puts forward a provision which does not have a limited provision of conscientious objection; it is actually quite inclusive. By way of contrast, we only recently considered the Termination of Pregnancy Bill. My memory might fail me, but my recollection is that we had quite a narrow scope for those who could claim conscientious objection. In terms of registered health practitioners, it is not only medical practitioners.

The Hon. F. PANGALLO: I must be missing something here. In terms of the health practitioners, there would be those who would have some sort of ethical opposition to VAD, but would the Hon. Kyam Maher also concede that some of those health practitioners perhaps hold Christian beliefs and would want to exercise those beliefs in their conscientious objection?

The Hon. K.J. MAHER: Absolutely, and that is exactly what clause 9 does—it precisely allows that.

The Hon. F. PANGALLO: Which is what my proposed new clause does as well. It covers organisations.

The CHAIR: I cannot have more than one person standing at a time, but I will call the Hon. Mr Wade now.

The Hon. S.G. WADE: Yes, I do not think he is a member of our house.

The CHAIR: No, I am talking about the Hon. Mr Pangallo. The Hon. Mr Wade has the call now.

The Hon. S.G. WADE: Thank you, Mr Chair. Again, I do not want to delve too far into this because I have not researched it properly. I merely observe that the Termination of Pregnancy Bill has a similar conscientious objection provision as the Hon. Kyam Maher's bill before us has. It does not provide a similar organisational exemption. I might have missed something, but Catholic health services are not compelled to provide abortion services in South Australia. I do not believe that the Hon. Kyam Maher's bill would have that effect in relation to voluntary assisted dying.

The Hon. F. PANGALLO: Does the Hon. Kyam Maher see there could be a situation now, if my amendment does not flow through and his bill passes, that you could actually have these organisations then having to, before they employ somebody, get them to enter contracts where they may have to disclose whether they are opposed or supportive of it, and that may impact on their potential employment?

The Hon. K.J. MAHER: Again, I am not going to delve too deeply into this, but I suspect you are probably going to fall foul of other legislation. I do not think health services have that sort of right of discrimination based on religious beliefs, but I am happy to check that and, as this goes between the houses, come back.

The Hon. S.G. WADE: The only observation I would make that I can think of in a case in Australia is that there is a hospital in the ACT—I think it is called Calvary—which is a public hospital run by Catholic health services. My understanding is that they do not provide abortion. So again, I would make the point that termination of pregnancy legislation in this state does not provide, if you like, conscientious objection to an organisation. I am yet to hear an argument about why we need to make it different in this bill.

The Hon. R.I. LUCAS: I, too, want to refer to the article Jim Birch published in *The Advertiser* yesterday. I guess for the benefit of members, I am sure we all realise that Jim Birch AM is a highly regarded health administrator. I think he might actually be assisting the government in its endeavours in relation to the Women's and Children's Hospital, but prior to that, of course, he was a highly regarded senior health administrator in this state.

His current role and the reason he wrote this op-ed in *The Advertiser* is that he is the chair of the Little Company of Mary Health Care Limited, otherwise known as Calvary Health Care, and is therefore in charge of the Calvary hospital.

The Hon. Mr Hood, I think it was, referred to one element of his op-ed, but I am going to refer to the concluding paragraphs. In it Jim Birch says that Calvary has served the South Australian community for over 120 years. It has been able to serve its most vulnerable citizens with compassionate dedication because Calvary in itself is a community of practice. He says the mission, vision, by-laws, policies and procedures attract and bind every person called to practise in this community.

The article states that many people choose Calvary and other faith-based services precisely because there is a clear, identifiable focus of purpose. There is an articulated code of practice, a strong and clear ethical and values-based proposition and a sense of continuity of care which is grounded in mission. The services are valued by the people in its care, as well as those who choose to practice as part of the Calvary community, because of this commitment. If the South Australian parliament attempts to impose VAD on its services it would violate the consciences of most of the individuals involved, together with the institutional commitment to promoting and upholding critical, ethical and other values.

The article goes on to state that the current bill does not provide for organisational conscientious objection and this needs to be addressed. If not provided, parliament risks choice being valued only when individual autonomy aligns with that of the state. Mr Birch says that we are all strengthened when we nurture communities, including faith-based communities, where people can maintain a sense of personal integrity while making their contributions to the common good of all. Choice must be honoured if assisted dying is to be voluntary.

I accept in part the concerns expressed by the Hon. Mr Maher in relation to residential facilities where persons might be in what is tantamount to their home environment and the potential interpretation of this particular proposed amendment in relation to that. That criticism certainly cannot be directed at a hospital or an institution such as Calvary. Whilst I can understand the criticisms he directs in relation to the other elements of this particular amendment, the issue that Jim Birch has raised is quite specific.

I am sympathetic to that aspect of the amendment, but I cannot support the amendment in its current form for the reasons that the Hon. Mr Maher has raised. I am, however, hopeful and I would expect that the more refined version of an amendment like this might be moved in another place to cater for the sort of circumstances that Jim Birch has outlined in, I think, a clear and concise argument regarding Calvary. I cannot immediately think of others but there may be other hospitals in similar circumstances where a similar argument might be made.

I accept the fact that this amendment has only been circulated in the last 24 hours. The op-ed was only published yesterday. I must admit the issue in and of itself had not been raised with me before. Should this be unsuccessful, as it will appear to be in this particular chamber this evening, there is the opportunity for the issue at least again to be canvassed and further explored in the House of Assembly debate, when it gets there. I would certainly be encouraging my colleagues at least to explore this issue in a more specific and refined way.

I have huge regard for Calvary as an institution. I hold it in the highest of esteem in terms of the quality of the service it has provided to the South Australian community, as Jim Birch says, over 120 years. I also hold Jim Birch in high regard. He is a man of considerable reputation and I think he has argued a case that the parliament deserves to at least consider further, specifically, whilst removing from it some of the understandable concerns the Hon. Mr Maher has expressed in relation to its further extension into other institutions.

Again, the Hon. Mr Wade has more knowledge of the circumstances that relate to termination of pregnancies in various hospitals, where either the Catholic Church or churches might be involved but similar principles, I guess, as he has at least outlined, have certainly allowed, permitted to occur—I am not sure what the legal circumstances are in relation to the delivery of those sorts of health services. What it would appear that Jim Birch is arguing is similarly that the parliament should consider, as it relates to Calvary anyway, an amendment that caters for their situation.

I am sympathetic, the Hon. Mr Pangallo, to the amendment but because of the understandable concerns the Hon. Mr Maher has raised, I will not support the amendment in its current form this evening, but I will nevertheless argue to colleagues in the House of Assembly that a more refined amendment that at least addresses the Calvary circumstance should be addressed by members in the House of Assembly.

The Hon. C.M. SCRIVEN: I move to amend the Hon. Mr Pangallo's amendment as follows:

Delete subclause (5)(b).

Subclause (5)(b) is the part that says what a health service establishment means, saying it is a 'premises owned or operated by a residential care provider as defined', etc. This would overcome the problem that has been raised by the Hon. Mr Maher and that the Hon. Mr Lucas has said is also a problem for him in that it would only apply to a hospital or private health facility of a kind prescribed by the regulations.

That way, people will have the clarity of knowing not to choose a hospital such as Calvary if they want to avail themselves of VAD, but it would not impact on those who are already living in residential care facilities or residential facilities of any sort that might be owned by an organisation with such policies and concerns.

The CHAIR: If that was successful, there might need to be some other wording changes necessary as well, but we will work through that.

The Hon. S.G. WADE: I think the comment you just made in terms of the consequential flow-on impacts of even what seems to be a simple amendment by the Hon. Clare Scriven highlights the profound wisdom of the Leader of the Government in this place. I think these matters are best considered between the houses. Amendments on the run often look very ugly in the light of day.

The Hon. C. BONAROS: The Hon. Mr Wade almost took the words right out of my mouth. I think I indicated, again, during my second reading contribution that my biggest concern in this bill would be considering amendments on the fly and amendments being moved on the floor on the fly, and that is precisely what this is. I understand the dilemma that has been canvassed by all members, including the honourable Leader of the Government and including my colleague the Hon. Frank Pangallo, including the honourable Leader of the Opposition, but this is not the way to address this issue.

If we want to address this between the houses, then, by all means, let's do that, but simply trying to address this now, when we only had 24 hours to consider the amendment in its original form, is entirely inappropriate and not one that I will support at this stage.

I would like to make a couple of other points, generally, in relation to these amendments. I think my colleague has referred to what would happen in the hospital setting, and I appreciate that that is a concern for those who do not support this bill. I appreciate the concerns that are raised by Mr Birch. Hypothetically, I think if every doctor at a faith-based hospital or a Catholic hospital, whatever the case may be, was to conscientiously object, then voluntary assisted dying where you are relying on those doctors themselves to administer or to somehow be present for that process would be very difficult.

Of course, you are not always relying on those doctors to be present to administer, to supply the drugs or whatever the case may be. I may present to the hospital with a little box in my hands and not need any assistance from a doctor at that institution to be able to self-administer the substance that

ultimately results in my dying. There are an array of issues here that I think we need to consider in the cool light of day and certainly not on the floor and on the fly in this place.

I also have a lot of sympathy for the points just made by the Leader of the Government and, indeed, by the Hon. Mr Maher in relation to aged-care facilities and the impact this would have on long-term residents, both prospectively and of course retrospectively for those residents who have already been living in those facilities for some time.

For all those reasons, I do not think this is the appropriate way to deal with this amendment. I will not be supporting in its original form, and I will not be supporting it in its amended form. But if there is discussion between the houses and we come back with something that is a sensible and acceptable to all that does not deviate from the scheme that is before us—because I think that is the key that the Hon. Mr Maher has said all along and what I have said all along in terms of my position on this bill—provided it does not deviate from what has become the Australian standard, then there may be some merit to it, but at this stage that is certainly not the case.

The Hon. K.J. MAHER: I think I have indicated that I will not be supporting the Hon. Frank Pangallo's amendment that was filed yesterday afternoon, and I also will not be supporting the amendment to the amendment that was foreshadowed moments ago. Just to be clear, whilst I have very serious concerns and problems with the inclusion of aged-care facilities, I do not want it to be misinterpreted that I do not also have problems even if that was taken out. I do, and I do not agree with it. I was going to make the point that the Hon. Connie Bonaros has made, that even with that taken out it is still a very significant departure from the Australian model. This has been considered and rejected in other parliaments. It has been considered and rejected by expert panels leading up to this.

I might just make an observation that I always get worried when the Hon. Rob Lucas says that he agrees with me. I often feel it is a trap, but I appreciate his points. I do not want it to be misinterpreted that I only think it is a problem with aged care; I think it is a problem with the other parts of the amendment as well. But when the Hon. Rob Lucas suggests that colleagues in another place might want to look at it, I am sure they will take his advice and look at it.

The Hon. N.J. CENTOFANTI: I rise to indicate that I will be supporting the amendment to the amendment. I want to echo the sentiments put very eloquently by the Leader of the Government. In this bill, just as it is the decision of an individual to choose voluntary assisted dying, it should also be a decision of a doctor and indeed an entity, such as a private hospital, to conscientiously object to carrying out voluntary assisted dying in their facility because of their religious, moral or ethical beliefs.

The Hon. C.M. SCRIVEN: I have a question for the Hon. Mr Maher. Is it his intent with this bill that an organisation such as Calvary Care would be required to allow VAD in their hospitals if an inpatient requested it and the patient were able to have a visiting doctor?

The Hon. K.J. MAHER: Perhaps the best way to answer it is: no doctor would be required to administer it; no doctor would be required to be involved in it. But it is the Australian model that an institution or organisation cannot be a conscientious objector. It may well be that a hospital is not set up to provide that service, and I think the Hon. Stephen Wade has talked about the fact that that is the case in some settings with termination of pregnancy.

It may be that it cannot be provided in all circumstances, but I agree with every other parliament that has considered this, that an organisation or an institution should not have the ability to be a conscientious objector. I think it is right and proper that individuals can, and that is what the bill provides for and the Australian model provides for.

The Hon. C.M. SCRIVEN: I want further clarification from the Hon. Mr Maher. Is it his intent that voluntary assisted dying should be allowed in an organisation, such as Calvary Care, that is fundamentally opposed to such a practice?

The Hon. K.J. MAHER: I think I have answered that question. I do not think an organisation or an institution should be able to conscientiously object. I will give you an example that I think spells it out quite well. If someone has been approved for a scheme and then needs hospital admission, particularly if it is in a regional area where there are not many choices and it is a Catholic hospital or institution, I do not believe that the person who has had prior admission to the Voluntary Assisted Dying Scheme should be able to be refused medical treatment. I do not think that is right.

The Hon. I. PNEVMATIKOS: Can I indicate that I will not be supporting the amendment or the amendment to the amendment. The whole tenor of the amendment as proposed by the Hon. Frank Pangallo is inappropriate, inconsistent and discriminatory.

The CHAIR: The Hon. Mr Pangallo, and then I am going to put the question.

The Hon. F. PANGALLO: Yes, you can, Mr Chairman. I rise to say that I support the amendment to my amendment by the Hon. Clare Scriven. I have been in this place for three years now and I have seen many amendments done on the fly to far more complicated pieces of legislation. This is actually quite simplistic, and it goes a long way to addressing what the Hon. Rob Lucas has pointed out, and it quite simply addresses that issue with aged care. I can concede a lot of the comments that the Hon. Kyam Maher made in relation to aged-care providers. But again, as I said, it would certainly contradict what he is trying to do in clause 9 in relation to health practitioners.

The CHAIR: The first question I am going to put is that the amendment moved by the Hon. C.M. Scriven to the amendment moved by the Hon. F. Pangallo be agreed to.

Amendment to amendment negatived.

The CHAIR: The next question I put is that new clause 8A as proposed to be inserted by the Hon. F. Pangallo be so inserted.

The committee divided on the new clause:

Ayes 6

Noes 15

Majority p

AYES

Centofanti, NJ
CMStephens, TJ

Hanson, JE

Hood, DGE

Pangallo, F

Scriven,

NOES

Bonaros, C Bourke, ES, Darley, JA, Franks, TA Hunter, IK Lee, JS
Lensink, JMA Lucas, RI Maher, KJ Ngo, TT Pnevmatikos, I
Ridgway, DW Simms, RA Wade, SG Wortley, RP

New clause thus negatived.

The Hon. D.G.E. HOOD: My amendment, as members would be well aware, is very similar to the Hon. Mr Pangallo's amendment which has just failed, so I will not proceed with it.

The ACTING CHAIR (Hon. T.T. Ngo): Is that No. 5 as well?

The Hon. D.G.E. HOOD: Yes, Nos 4 and 5.

Clause 9 passed.

Clause 10.

The Hon. C.M. SCRIVEN: I have a question for the mover of the bill. Clause 10 says that voluntary assisted dying must not be initiated by a registered health practitioner and that such a practitioner must not initiate discussion with the person that is in substance about voluntary assisted dying or suggest voluntary assisted dying to that person. I am paraphrasing. Could the mover indicate how this will be monitored?

The Hon. K.J. MAHER: Like many things that have been monitored, I do not think there will be some sort of official standing in every consultation that a patient has with their doctor to make sure this does not happen. I suspect it will be, like nearly all other offences, monitored upon complaint.

The Hon. C.M. SCRIVEN: So it would be up to the person to whom VAD has been suggested, who is facing a terminal illness, to lodge a complaint while they are in their final weeks or months; is that correct?

The Hon. K.J. MAHER: It might be one person. It might be a family member. It might be anyone else. Any time that there are transgressions of standards, of regulations, of codes of conduct or indeed of laws of the state, there are not people sitting around waiting to try to catch someone out, as a general rule. It would not just be a patient in the final stages of a terminal illness who could make a complaint; it could be anyone. It could be a family member or anyone else.

Clause passed.

Clauses 11 and 12 passed.

Clause 13.

The Hon. D.G.E. HOOD: This is the substantive amendment we debated earlier at clause 3 and it was defeated. This is consequential to that amendment, so there is no point in moving it, but I do have a question on this clause. May I proceed with that?

The ACTING CHAIR (Hon. T.T. Ngo): Yes.

The Hon. D.G.E. HOOD: Thank you. My question on this clause for the mover of the bill, the Hon. Mr Maher, is with respect to subclause (1)(c). It says:

(c) the person must have decision making capacity in relation to voluntary assisted dying;

My question is: how is that to be judged?

The Hon. K.J. MAHER: I thank the honourable member for his question. Clause 4 of the bill before us delves into quite some detail in relation to the meaning of 'decision making capacity' for the purposes of this bill. It is of course a concept that is exceptionally well understood by the medical profession and medical practitioners. Every day of every week, most doctors will have to turn their mind to that.

Doctors have to turn their mind to the decision-making capacity of someone who, for example, elects to end or refuse treatment that may actually hasten or cause their death or any ordinary treatment that may have that effect. The double effect rule in the Consent to Medical Treatment and Palliative Care Act allows an intervention if it improves comfort but might have a secondary effect of hastening death. A doctor necessarily will have to turn their mind to the decision-making capacity of a patient who requests that.

It is a concept that nearly every day of practice a lot of doctors, particularly working with older people, particularly in the geriatrics area, will have to consider. It is given further clarity in clause 4 of the bill, which we have already passed, specifically in relation to voluntary assisted dying where it defines it further. A person has decision-making capacity if they can:

(a) understand the information relevant to the decision relating to access to voluntary assisted dying and the effect of the decision; and

(b) retain that information to the extent necessary to make the decision; and

(c) use or weigh that information as part of the process of making the decision; and

(d) communicate the decision and the person's views and needs as to the decision in some way, including by speech, gestures or other means.

I think it is a very well understood and well used concept by medical practitioners that is given further guidance by clause 4.

The Hon. S.G. WADE: I agree with the Hon. Kyam Maher that this will not be an unfamiliar concept to medical practitioners. Day by day, when they are providing any form of medical treatment, they need to have informed consent. To obtain informed consent to any medical treatment, you need to be confident that the person has the decision-making capacity to give you that informed consent. If they have not, then you need to go to other processes, perhaps the guardianship and administration act. So I believe that not only is this unsurprising but to not see it would be surprising.

I would like to make a comment, and this is, if you like, a comment for the future. As I have repeatedly said, I support this bill because it reflects the well-considered Australian model, which, as I have mentioned before, has its roots in Canadian legislation. I think it is really important going forward that we maintain national consistency, but I am not naive enough to think that the model is perfect and that it cannot be improved.

One issue, for example, I would flag that needs to be considered but needs a lot more consideration than this parliament could give and would need consultation with other jurisdictions is the issue of

mutual recognition or the residency provisions. The reason it is relevant to this clause is that part 2, clause 13(1)(b) provides that for a person to be eligible for access to voluntary assisted dying they must be ordinarily resident in South Australia and have been ordinarily resident in South Australia for a least 12 months.

That is the sort of provision you put in a piece of legislation to avoid medical tourism. In other words, you do not want each state or territory's legislative regimes being undermined by the capacity or, if you like, an inappropriate flow of patients in response to varying legislative regimes in adjoining states.

It becomes less and less relevant the more jurisdictions take on the Australian model. It may well be that, as a matter of national consistency, in the not too distant future clauses such as this should be removed because they serve no useful purpose. I also think it is something that should be considered, particularly in the South Australian context. It is our privilege as a South Australian health service to provide a significant amount of services to people from the Northern Territory. Many of those services are cancer services. The experience in Victoria is that the majority of people seeking voluntary assisted dying are people on the cancer journey.

The impact of this clause as it stands is that people from the Northern Territory would be coming and receiving treatment in our cancer services in South Australia, and you could have two patients alongside one another and the treatment options available to them are based on the postcode, even though it is basically the one pool of patients. The issue of medical tourism is complicated in this context because the commonwealth has limited the legislative competence of the territory legislative assemblies to deal with voluntary assisted dying. Personally, as a federalist I do not believe that that limitation is appropriate, but that is a matter for the commonwealth parliament.

In the meantime, it means that we will have people coming from the Northern Territory who will be, as I said, receiving care from our clinicians in our services and the clinicians will not be able to offer them treatment options that they will be able to offer other patients. I believe that is an example of an issue where we may well need to consider developing the Australian model going forward.

Personally, as the chair of the health ministers' meeting at the national level, I think the health ministers' meeting should take it upon itself to monitor the implementation of the Australian model and discuss possible changes going forward. I would suggest that, in a situation such as that to which I referred, if the commonwealth maintains its limitation on legislative competence in the Northern Territory, the appropriate process may well be for the Northern Territory Legislative Assembly to pass a resolution for the Northern Territory government to advise the South Australian government that it seeks access for its citizens to voluntary assisted dying in our state at an appropriate time, either as an amendment to the act or a regulation, so that people who are not ordinarily resident in South Australia but are ordinarily resident in the Northern Territory might be provided access.

That is one example, and I appreciate that lots of people have different views about whether that is an issue and whether it needs to be addressed, but I come back to the fundamental point, which is that I agree with the Hon. Kyam Maher that a strength of this bill is that it is based on an Australian model. As we go forward, as the bill evolves, I think it would be very useful to share the wisdom of different jurisdictions. To be frank, it would be perhaps a handbrake on ill-considered reform, if it goes through an appropriate national consultative arrangement.

Personally, I believe it is appropriate for us to have a set of nationally consistent laws rather than a national uniform law. I am very happy for state and territory parliaments to continue to be custodians of these bills, but it would be useful for all the parliaments if there was to be an appropriate process for the jurisdictions to discuss amendments to the Australian model going forward.

Clause passed.

Clause 14.

The Hon. C.M. SCRIVEN: I have a question to the mover of the bill. This is really around trying to understand how this will operate in practice. It refers to the coordinating medical practitioner and consulting medical practitioner and what they must be. One of the things that they can be is a vocationally registered general practitioner, a GP, who has practised for at least five years; however, in subclause (3) of clause 14, it states:

(3) Either the coordinating medical practitioner or each consulting medical practitioner must have relevant expertise and experience in the disease, illness or medical condition expected to cause the death of the person being assessed.

I am a little unclear. For example, if we are talking about cancer, what would be the relevant expertise and experience that a GP might have? I am not trying to make any judgement either way. I am just trying to better understand what would be relevant expertise or experience in cancer if we are talking about a GP.

The Hon. K.J. MAHER: I thank the honourable member for her question. To be clear, it is not a requirement that one of the two medical practitioners has to be a GP. I think it is a misreading if it is thought that the coordinating medical practitioner necessarily has to be a general practitioner. My understanding is that that is not the way that this is drafted or the way the scheme works.

What it requires is that one of the two (the coordinating medical practitioner or the consulting medical practitioner) have relevant expertise or experience in the disease—I think they are the ordinary meanings of the word—so that at least one has a more indepth understanding of what the disease is. Further on in the bill, it talks about the ability of the practitioners to refer for further specialist advice if they have questions around that. I think the requirements in here are exceptionally onerous to have both the coordinating and the consulting medical practitioners sign off on all the elements that we have canvassed a few of in clause 13. I think it puts in very strong safeguards.

The Hon. C.M. SCRIVEN: I was not suggesting what I think the honourable member thought I was suggesting. In my reading of it—and I am happy to be corrected if I am mistaken—it appears that both the coordinating medical practitioner and the consulting medical practitioner could both be GPs.

The Hon. K.J. MAHER: If each one of them has expertise or experience in the disease or medical condition, there is nothing necessarily that would prevent that, bearing in mind also that, as we go onto clause 22 and the relevant clause further on for the coordinating GP, a further specialist can be brought in. I do not think there is a limitation on them doing that.

I think that in many of these areas we place a lot of stock and trust in the expertise of our medical professionals. There are practitioners across all different fields of practice who are involved in these sorts of life and death decisions very regularly. I think there will be across the range of medical practice those who have expertise and experience in a whole range of things. I think the Australian model does not limit that range of practice where they come from as long as they have the relevant expertise or experience as the bill requires.

The CHAIR: Before I call the Hon. Ms Scriven, I respect that the Hon. Mr Maher was answering a question directly to his immediate adjacent colleague, but he should try to face me as much as he can. If he is going to turn a bit, he should angle his microphone a little bit closer to him.

The Hon. C.M. SCRIVEN: I am just trying to clarify. Thank you to the Hon. Mr Maher for confirming. Both the coordinating practitioner and the consulting practitioner can both be GPs as long as they have had five years' practice, etc. That then comes back to my question: if they are both GPs, what is the relevant expertise and experience? An example I would use is if it is ovarian cancer, for example.

The Hon. K.J. MAHER: It may well be there will be certain conditions. There may well not be a GP who has expertise, but it may be that there are.

The Hon. C.M. SCRIVEN: I place on the record my concern that that is not as robust as it should be.

Clause passed.

New clause 14A.

The Hon. S.G. WADE: I move:

Amendment No 2 [Wade-2]—

Page 16, after line 16—Insert:

14A—Certain registered medical practitioners not eligible to act as coordinating medical practitioner etc for person

A registered medical practitioner is not eligible to act as the coordinating medical practitioner or a consulting medical practitioner (as the case requires) for a person if the practitioner—

(a) is a family member of the person; or

(b) knows, or has reasonable grounds to believe, that they—

(i) may be a beneficiary under a will of the person; or

(ii) may otherwise benefit financially or in any other material way from the death of the person (other than by receiving reasonable fees for the provision of services as the coordinating practitioner or consulting practitioner for the person).

I have had positive indications of interest in this and related amendments, so I propose not to labour; I will just introduce the general point. This amendment and the following related amendments ensure that medical practitioners involved in voluntary assisted dying do not benefit, or are not family members of the person seeking assistance and they do not stand to benefit from the death. As I indicated previously, this is not an innovation on the Australian model; it is a preference for a Western Australian version or clause of the model rather than the original Victorian version. I think it is a sensible safeguard.

I do not demur from the point made by the Hon. Kyam Maher earlier that it may well substantially reinforce ethical obligations that medical practitioners already have, but I do think it is reassuring in the context of voluntary assisted dying to have this safeguard in place. It reflects Western Australia and also, as the minister responsible for elder abuse, I think it does reinforce the importance of protecting the rights of older people.

New clause inserted.

Clauses 15 and 16 passed.

Clause 17.

The Hon. S.G. WADE: I move:

Amendment No 3 [Wade-2]—

Page 17, after line 10—Insert:

or

(iv) is not eligible to act as the coordinating medical practitioner for the person.

I would suggest that this is consequential on the amendment we have just discussed.

Amendment carried; clause as amended passed.

Clauses 18 and 19 passed.

Clause 20.

The Hon. D.G.E. HOOD: My amendment to this clause is consequential on an amendment that did not proceed earlier, so I will not be moving it.

Clause passed.

Clause 21 passed.

New clause 21A.

The Hon. D.G.E. HOOD: I move:

Amendment No 8 [Hood-1]—

Page 17, after line 37—Insert:

21A—Referral to psychiatrist where person may be mentally ill

(1) If the coordinating medical practitioner believes on reasonable grounds that a person has, or may have, a mental illness, the coordinating medical practitioner must refer the person to a psychiatrist for the psychiatrist to determine whether the person's mental illness is, or is not, the primary cause of the person making a request for access to voluntary assisted dying.

(2) If the coordinating medical practitioner refers a person to a psychiatrist under this section, the coordinating medical practitioner—

(a) must adopt any determination of the psychiatrist in relation to the matter in respect of which the person was referred; and

(b) must have regard to that determination in determining whether the person meets all the eligibility criteria.

This is relatively straightforward. I will just read it out as it is almost self-explanatory. It is essentially requiring a referral to a psychiatrist when the person considering VAD may be mentally ill.

Subclause (1) states that if the coordinating medical practitioner believes on reasonable grounds that a person has, or may have, a mental illness, the coordinating medical practitioner must refer the

person to a psychiatrist for the psychiatrist to determine whether the person's mental illness is, or is not, the primary cause of the person making a request for access to voluntary assisted dying. That is the crux of it, essentially.

If that is the case, subclause (2) states that if the coordinating medical practitioner refers a person to a psychiatrist under this section, the coordinating medical practitioner (a) must adopt any determination of the psychiatrist in relation to the matter in respect of which the person was referred; and (b) must have regard to that determination in determining whether the person meets all the eligibility criteria. That is the amendment in a nutshell.

The reason for the amendment is to ensure that people who are not suffering intolerable mental illness do not turn to see assisted dying as the only way forward for them. For the record, I remind members—not that they probably need reminding—that in clause 13, where it lists the criteria for voluntary assisted dying, it specifically says that the condition from which the person is suffering must be incurable and that it cannot be relieved in a manner the person considers tolerable.

I refer again to the AMA position statement on euthanasia and physician assisted suicide—their words. In section 2.1, it states:

A patient's request to deliberately hasten their death by providing either euthanasia or physician assisted suicide should be fully explored by their doctor. Such a request may be associated with conditions such as depression or other mental disorders, dementia, reduced decision-making capacity and/or poorly controlled clinical symptoms. Understanding and addressing the reasons for such a request will allow the doctor to adjust the patient's clinical management accordingly or seek specialist assistance.

That is what this amendment will require. Again, I just stress that the criteria to qualify for voluntary assisted dying under this bill is that it be incurable, yet the World Health Organization states in their fact sheet on mental disorders, and I quote directly from their website, that 'there are effective treatments for mental disorders and ways to alleviate the suffering caused by them.'

Dr Caryl Barnes, a leading psychiatrist specialising in the diagnosis and treatment of depression and bipolar disorder, has said on an ABC news report, and I quote directly:

Euthanasia... is when people voluntarily seek to end their lives when they're faced with a terminal illness. Depression is not a terminal illness. It's a treatable mental disorder.

The Royal Australian and New Zealand College of Psychiatrists does not believe that psychiatric illness should ever be the basis for physician assisted suicide, according to the news archives on their own website. Furthermore, the former president of the Royal Australian and New Zealand College of Psychiatrists Professor Malcolm Hopwood has said, and I quote directly:

Unrelievable psychiatric suffering is rare, and ensuring that a person suffering from mental illness has the appropriate capacity to make decisions in this context poses significant challenges. Mental illnesses are treatable, and there are many ways to get help.

If we refer back to the bill itself, it requires that the condition the person is suffering from is incurable—I agree with that, by the way. I am not criticising that in any way; it is as it should be in this bill. As the Australian Medical Association has said, as senior psychiatrists have said and as the Royal Australian and New Zealand College of Psychiatrists has said, mental illness in most cases is not an incurable condition and in most cases it certainly will not result—in some cases it does—in death.

Of course, that is another criteria in this bill. Clause 13(1)(d)(i) requires that a disease, illness or medical condition be incurable, subparagraph (ii) requires that it is advanced, progressive and will cause death, and then subparagraph (iii) says it will cause death within weeks or months, not exceeding six months.

I am taking a long time to say that mental illness is a significant concern for people who are considering voluntary assisted dying. It is something that can be treated; therefore, in my mind it clearly does not qualify under this bill as a reason to be successful. In fact, the bill specifically states that if it is a standalone condition it does not qualify. I am anticipating what the Hon. Mr Maher might say. I am fully aware that the bill says that. In fact, it is in this clause that it says that, is it not? Yes, it is in clause 13(2). It says that a standalone is not a reason, but my amendment requires the treating doctor to refer the person to a psychiatrist if they suspect they have a mental illness problem. I think it is prudent and, if I have not already, I move the amendment standing in my name.

The Hon. K.J. MAHER: I thank the honourable member for his contribution and the amendment that forces us to consider these things. I think it is worth delving into, and certainly the discussion that happened around amendments in other parliaments I found very useful in better understanding many of the issues involved.

I was going to say that I agree with much if not the vast majority of what the Hon. Dennis Hood has said, that a mental illness alone should not qualify a person for voluntary assisted dying. As the honourable member pointed out at the end of his contribution, the bill specifically provides for that under clause 13(2) of the bill:

(2) A person is not eligible for access to voluntary assisted dying only because the person is diagnosed with a mental illness within the meaning of the Mental Health Act 2009.

I think the quotes read out by the Hon. Dennis Hood go to that and I agree with him, and that is indeed why this is in there, and this is a feature of the Victorian bill that this is modelled on exceptionally closely and a feature of the Western Australian bill and I think, but I will need to double-check, a feature of the Tasmanian legislation. I agree with him in that respect.

I might make two points. If that is all we were debating, then this would be entirely redundant because it is very explicitly provided for in clause 13(2). But in relation to a couple of other things I think this does, I will explain why I also disagree with other elements of this. I do not agree—and, from my discussions with practitioners who have been involved not just with this but in other areas of treatment of patients, particularly end of life, having a mental illness does not necessarily mean you lack decision-making capacity in relation to choices in your life, particularly choices for your medical treatment.

Many people in our society live with a mental illness and have decision-making capacity for most if not every part of their life. I do not think the Hon. Dennis Hood is necessarily suggesting it means you necessarily lack decision-making capacity, but I think the amendment he has moved tends to suggest that you may do, so I do not agree with that.

There is another thing I do not agree with, and this was specifically considered in the expert report for the Victoria legislation before it was enacted. It considered very closely, from page 63 onwards, that issue of decision-making capacity and mental illness. I think it included similarly that a mental illness does not necessarily mean and quite often will not mean that you lack decision-making capacity in relation to your treatment, including for voluntary assisted dying, but they canvassed who would be appropriate to assess that.

I think they made the good point that, even if you were to suggest that or that there was something like the Hon. Dennis Hood is suggesting here, limiting it just to a psychiatrist would not be an appropriate thing to do. They point out in the expert panel's report that there may be other medical practitioners and specialists who are more appropriate in the circumstances for a particular patient than a psychiatrist—for example, geriatricians, psychogeriatricians, neurologists, neuropsychologists, psycho-oncologists, psychologists and even palliative care experts may actually be in a better position to assess someone's capacity in a given circumstance.

From the reasoning the Hon. Dennis Hood gave for the amendment, I think that field is explicitly covered by clause 13(2) of the bill. However, even if all the reasons were not just in relation to that, many people living with a mental illness in our community do, in fact, have decision-making capacity in some if not all their choices in life, including choices of medical treatment and including choices of voluntary assisted dying. The fact is that by limiting it to only a psychiatrist necessarily excludes other professionals and specialists who may be more appropriate in the circumstances.

The Hon. D.G.E. HOOD: I thank the Hon. Mr Maher for his response. There is a lot of agreement here. Clearly, 13(2) is in the bill and it specifically rules out—it provides 'is not eligible for...voluntary assisted dying only because the person is diagnosed with a mental illness'. That is clear, we are not disputing that.

Where we do have a dispute is when the Hon. Mr Maher talked about other medical professionals being in a better position to judge mental illness. That is specifically what this amendment is about. Psychiatrists are the specialists who deal with mental illness, and I am not specifically saying that it is necessarily in respect of decision-making capacity, although that may be an element.

I want to talk about things like depression, for example, as I mentioned in one of the quotes I just gave. It can be very sad; depression can become an overwhelming thing for some and it drives their behaviour. It spirals downward, and some people may want to choose to just end it all through a VAD scheme as a result of depression.

It is not just depression, of course, but also personality disorders, as they are called. I actually have a case study here that might be worth quoting at this time to emphasise my point, if I have not enunciated it particularly clearly. I turn to a case from the Netherlands:

where a 36-year-old man with a history of attention-deficit hyperactivity disorder, drug abuse, psychological trauma, obsessive-compulsive personality disorder, and therapy resistant schizophrenia had been experiencing psychotic episodes with delusions and...(hearing voices) for [some] 10 years.

So quite an extensive period. It continues:

their intensity—

that is, the voices—

increased when his mood worsened and when he was in a stressful environment.

The patient was unsuccessfully treated with antipsychotics and the condition became increasingly unbearable for the patient, eventually resulting in a request for 'physician-assisted death' (those are their words). It continues:

During the initial assessment period he was referred to an academic hospital—

Sorry, that is a misprint there; it should be 'after'. What happened was that he was initially treated by his GP and unsuccessfully with antipsychotics, as I have just said. After the initial assessment period he was referred to an academic hospital under specialist care for an obligatory second opinion. During admission the patient's symptoms were carefully analysed and his condition was recognised as what is known as 'intrusive thoughts' and not psychotic phenomena.

He was given the appropriate treatment for intrusive thoughts, and within three weeks of treatment that patient had significant clinical improvement. Some time afterwards—I am not sure how long exactly, we could not find that out—cognitive behavioural therapy was added to the pharmacological treatment, and a few weeks later the patient reached full remission, leading him to withdraw his request for 'physician-assisted death'.

My contention is this: psychiatrists are the experts in mental health, and they are the people best placed to judge to what extent someone's mental health problems are driving the request for physician assisted suicide, or voluntary assisted dying. As I said before, and as I have indicated in the quotes I read out, many—not all, but many—mental health conditions are very treatable and some really substantial improvements can occur, as in the case I just read out to the chamber.

It is a simple amendment. It is another—what is the word?

An honourable member interjecting:

The Hon. D.G.E. HOOD: Safeguard, thank you. It is another safeguard in the process of making sure that people who end up qualifying and going through the process of voluntary assisted dying are genuinely those who cannot be treated in other ways that would, as in the case study I have just read out, lead to them actually completely recovering. If he had not gone to the hospital and had specialist assistance, that gentleman, 36 years old at the time, would be dead today. It is one case; I am sure there are many, many others that we are not aware of.

The Hon. S.G. WADE: With all due respect, the case studies the honourable member has just sketched for us would fail to meet three of the four criteria in section 13(1)(d). The condition that the honourable member is referring to is not incurable, the condition would not have caused death, it would not have caused death within weeks or months not exceeding six months. The only criteria that it might have met is not an 'or' criteria; it is an 'and' criteria, and that is 'causing suffering to the person that cannot be relieved in a manner that the person considers tolerable'. So under this legislation, the case the honourable member is referring to would not be eligible.

I know the Hon. Kyam Maher has alluded to this, but I think it is worth specifically highlighting clause 22(1). Clause 22 provides that where a coordinating medical practitioner is unable to determine the decision-making capacity of an individual seeking voluntary assisted dying—for example, due to a past or current mental illness of the person—the coordinating practitioner is required to refer the person seeking voluntary assisted dying to a registered health practitioner who has appropriate skills and training, such as a psychiatrist in the case of a mental illness.

That clause acknowledges the comments that the Hon. Kyam Maher made, which is that a person with a mental illness may well have the capacity to make decisions and, to the extent they are able, they should be allowed. It also recognises the point that the Hon. Dennis Hood is making, that in assessing that capacity one may well need to have specialist skills, and it specifically references psychiatric skills. I think the legitimate concern that the honourable member is raising is appropriately addressed in the bill.

The Hon. T.A. FRANKS: I have some questions for the mover. He noted that 'psychiatrists are the experts in mental health' in his contribution. Does he believe that only a psychiatrist is relevant in terms of mental health expertise? What mental health expertise did he seek to support this amendment? Who has he consulted with and who supports this amendment within the mental health sector?

The Hon. D.G.E. HOOD: Thank you for the question, the Hon. Ms Franks. I missed some of the end of it. I might ask you to repeat that. I think the start of what was: do I accept psychiatrists as a specialist in mental health? Was that the thrust of the question?

The Hon. T.A. FRANKS: I noted and reflected back to the Hon. Dennis Hood's words that were, I quote, 'psychiatrists are the experts in mental health'. I will elaborate more fully now. Why has the Hon. Dennis Hood chosen only a psychiatrist here? What consultation did he take with the mental health sector? What mental health advocacy bodies or professionals support this particular amendment that he has brought to us today?

The Hon. D.G.E. HOOD: I thank the honourable member for the question. Yes, it is my understanding. Perhaps I should have said 'in the treating of mental health problems or mental health conditions'. They treat schizophrenia, they treat psychosomatic disorders, they treat personality disorders. They are the experts we turn to when it comes to mental health problems. Yes, GPs treat these problems and some other doctors do as well, but those who require significant assistance would almost always end up in the hands of a psychiatrist.

They will be on drugs like risperidone and olanzapine and a whole lot of these medications which have been around for quite some time and which are now used by general practitioners but certainly in their origins were used exclusively by psychiatrists because they are recognised as the experts in treating mental health conditions. There are a number of medications treating mental health conditions which are still exclusively prescribed by psychiatrists in the medical field. That is why I consider them experts in treating mental health conditions. That is my answer to that part of it.

In terms of who I have consulted—I think was the next part of the questions—I have spoken to I think five psychiatrists about this particular amendment, on the condition of anonymity, so I will not name them. The general theme of my discussion with these people was that there is concern about the underdiagnosis of mental health in any potential assisted dying scheme, and they did think it appropriate on the whole, some more enthusiastically than others, that a mental health diagnosis is ruled out, basically.

Can I just go to a point the Hon. Mr Wade made just before I resume my seat; that is, I fully accept that the case study I read out would not qualify under this bill. That was not the intention. The intention of reading out that case study was simply to explain that this person had had the benefit of a specialist psychiatrist to diagnose a mental health problem which was misdiagnosed previously, and that did help in this person's recovery, so the value of the psychiatrist, I think, in treating mental health should not be undervalued. That is what my amendment attempts to do.

The Hon. T.A. FRANKS: So there have been five individual psychiatrists consulted with regard to this particular amendment. I am certainly concerned about language that has been used in discussing mental health in the promulgation of this amendment. I certainly would dispute that psychiatrists are the only experts in mental health. I heard no mention of psychologists, for example, or, indeed, other clinicians in this area.

I saw very little understanding of comorbidities. So was that consultation on comorbidities? Indeed, when one has a diagnosis of a physical condition that means one is going to be dead within six

months and one is in intolerable, insufferable pain, I imagine one probably would be able to get a diagnosis of depression and anxiety, but it would be very cold comfort indeed.

The Hon. D.G.E. HOOD: I think we are in agreement. These people are obviously in very difficult times, and they are suffering. The thing about psychologists is, psychologists are not doctors; psychologists do not prescribe medication. The intention here was to provide the capacity for an individual to see a psychiatrist and, if appropriate, to diagnose medical illness, which can be treated with medication. That was the intention.

The Hon. S.G. WADE: I would, again, commend to the house clause 22(1). It talks in general terms about decision-making capacity and, in the context of concern about decision-making capacity, that a registered health practitioner who has appropriate skills and training be engaged. I agree with the Hon. Tammy Franks in relation to the fact that the person with appropriate skills and training may not be a psychiatrist. I have it on very good authority that one of the leading disorders causing mortality, that being eating disorders, is very successfully treated in many cases by psychologists. It may well be that in section 22(1) the appropriate referral to a specialist is not to a psychiatrist; it is to a psychologist.

Likewise in the area of older persons' mental health, if somebody is experiencing BPSD—sorry, the behavioural and psychological symptoms of dementia—it may well be a geriatrician who has the appropriate skills and training. I also think it is important, and I respect the fact, that the Hon. Tammy Franks reminded us of comorbidity. Let us not forget that decision-making capacity can be affected by things other than a mental illness: a brain injury, for example, or intellectual disability. Again, a psychologist may be a more appropriate specialist to ensure that the decision-making capacity of the individual is respected.

So as I said in my earlier remarks, I am fully behind the concerns that the Hon. Dennis Hood is raising, but I believe that the bill handles the issue well and handles the issue well by keeping it general. We are not in a position to say this disorder should be dealt with by a registered health practitioner. What the bill requires is that you identify the decision-making capacity issue, and you are then in a position to identify which registered health practitioner has appropriate skills and training.

The Hon. N.J. CENTOFANTI: I rise to indicate that I will be supporting this amendment. As the Hon. Tammy Franks pointed out, I think it does become quite difficult for a number of people who are in pain, especially chronic pain. They are not necessarily suffering intolerably but they are dealing with pain, and they often do experience some form of depression due to that pain. Consequently, whilst they may or may not have a known history of a mental illness and are still mentally capable of making a decision, I think that those people are at risk of choosing voluntary assisted dying for perhaps the wrong reasons. We do talk about the importance of safeguards within this bill and I think that this is another critical safeguard.

The committee divided on the new clause:

Ayes 7

Noes 14

Majority 7

AYES

Centofanti, NJ Hood, DGE Lucas, RI Ngo, TT Pangallo, F Scriven,
CMStephens, TJ

NOES

Bonaros, C Bourke, ES, Darley, JA, Franks, TA Hanson, JE Hunter,
IKLee, JS Lensink, JMA Maher, KJ Pnevmatikos, I Ridgway, DW Simms, RA
Wade, SG Wortley, RP

New clause thus negatived.

The Hon. D.G.E. HOOD: Just very briefly, members will be pleased to know that all my remaining amendments are consequential, so I will not be moving them.

Clause 22.

The Hon. S.G. WADE: I move:

Amendment No 4 [Wade-2]—

Page 18, after line 34—Insert:

(5a) A registered health practitioner or specialist registered medical practitioner is not eligible to act in relation to the referral of a person under this section if the practitioner—

(a) is a family member of the person; or

(b) knows, or has reasonable grounds to believe, that they—

(i) may be a beneficiary under a will of the person; or

(ii) may otherwise benefit financially or in any other material way from the death of the person (other than by receiving reasonable fees for the provision of services referred to in this section).

I put that this amendment is consequential on amendments previously supported by the council.

Amendment carried; clause as amended passed.

Clauses 23 to 26 passed.

Clause 27.

The Hon. S.G. WADE: I move:

Amendment No 5 [Wade-2]—

Page 20, after line 29—Insert:

or

(iv) is not eligible to act as a consulting medical practitioner for the person.

I put it to the council that that is a consequential amendment or a related amendment to amendments previously supported by the council.

Amendment carried.

The Hon. K.J. MAHER: I move:

Amendment No 1 [Maher-1]—

Page 21, line 9 [clause 27(6)]—After 'person's' insert 'death'

I emailed members earlier in the week that after discussions with parliamentary counsel there were identified two typographical errors. This is the first one of them. I think it is apparent to members that the word 'death' is missed out. It says 'a person's' and it makes no sense without the word in there, and I thank parliamentary counsel for their very thorough due diligence to make sure every i is dotted and t is crossed.

Amendment carried; clause as amended passed.

Clauses 28 to 30 passed.

Clause 31.

The Hon. S.G. WADE: I move:

Amendment No 6 [Wade-2]—

Page 21, after line 36—Insert:

(2a) A registered health practitioner or specialist registered medical practitioner is not eligible to act in relation to the referral of a person under this section if the practitioner—

(a) is a family member of the person; or

(b) knows, or has reasonable grounds to believe, that they—

(i) may be a beneficiary under a will of the person; or

(ii) may otherwise benefit financially or in any other material way from the death of the person (other than by receiving reasonable fees for the provision of services referred to in this section).

I put it to the council that that is a consequential and related amendment to amendments previously supported by the council.

Amendment carried; clause as amended passed.

Clauses 32 to 34 passed.

Clause 35.

The Hon. N.J. CENTOFANTI: I want to ask the Hon. Kyam Maher a question in regard to clause 35—Coordinating medical practitioner may refer person assessed as ineligible for further consulting assessment. Basically, the clause provides:

If a consulting medical practitioner assesses a person requesting access to voluntary assisted dying as ineligible for access to voluntary assisted dying, the coordinating medical practitioner for the person may refer the person to another registered medical practitioner for a further consulting assessment.

My question to the honourable member is whether there is a potential for continuous further assessments until the desired outcome is achieved. In other words, what is to stop doctor shopping in this instance?

The Hon. K.J. MAHER: I thank the honourable member for that question. It is something that is raised in all jurisdictions where voluntary assisted dying is proposed. I do not think this clause necessarily would either allow or encourage that, but it is a reasonable question to ask, so I will answer it.

In terms of this clause, though, the coordinating medical practitioner also may not refer someone on, so that may be the end of it. I am not aware of any scheme around the world, particularly not a scheme that is part of the Australian model, that precludes a person from seeking other medical opinions. It would be very perverse if we cut off the ability for someone looking for this intervention to have further medical advice and opinions sought when we do not for any other sort of medical intervention.

One of the things that it does do—and it is something that I have asked, based on the experience in Victoria—is ask: what is there to monitor or guard against this? Every step of the way, each of the forms—the initial request, the consulting medical practitioner's form, the coordinating medical practitioner's form and the final written request form—have to be submitted to the Voluntary Assisted Dying Review Board as you go through the process. So, if there were a suggestion of that, the Voluntary Assisted Dying Review Board would see those forms and refusals come in.

the clause does not preclude the possibility of a patient seeking further medical opinions and nor should it, because we do not do that in any other way that a person seeks treatment. But there is that oversight because, every step of the way, including the decision of a coordinating or even a consulting medical practitioner to say someone is ineligible, such things need to be forwarded to the review board.

Clause passed.

The CHAIR: I seek some clarification from the Hon. Mr Hood. Is my judgement correct that none of your remaining amendments are going to be moved?

The Hon. D.G.E. HOOD: That is right. They are consequential on ones that have failed or have not progressed. But I would like to ask two brief questions on clauses 40 and 68.

Clauses 36 to 39 passed.

Clause 40.

The Hon. D.G.E. HOOD: There are two final questions from me, and members will be happy that that is it from me.

The Hon. D.W. Ridgway: Hear, hear!

The Hon. D.G.E. HOOD: Yes, thank you, the Hon. Mr Ridgway.

The CHAIR: The Hon. Mr Ridgway is out of order.

Members interjecting:

The Hon. D.G.E. HOOD: You wonder if it is worth pursuing, but I will ask the question for the sake of clarity. Clause 40 talks about witnesses witnessing declarations. I am particularly interested in subclauses (1)(a)(iii) and (2)(a)(iii). I will read them:

that, at the time the person signed the declaration, the person appeared to understand the nature and effect of making the declaration;

My question is a pretty simple one: how can a layperson objectively judge that? What is the experience either interstate or elsewhere?

The Hon. K.J. MAHER: I thank the Hon. Dennis Hood for his question. Again, it is probably not surprising that the things the Hon. Dennis Hood has turned his mind to are things that, as this bill was being developed and I became more familiar with it, these are the questions I asked practitioners, not just here but in Victoria.

In particular, that goes to a topic that we talked about before—that is, someone who does not necessarily have the capacity to communicate in a more traditional way by speech or writing—to make sure that the field is covered for someone who communicates in a different way, so that someone who appears to understand the nature and effect can make that communication. In those sort of situations it will often be someone who has known that person for a long time who will be best placed to do that.

The honourable member raises that it is a witness, it does not require a further medical practitioner, but before we get to section 40 we have gone through the coordinating medical practitioner and we have gone through the consulting medical practitioner and both of them have had to turn their mind to capacity issues. In fact, every step of the way the issue of capacity has to be resolved for it to continue.

This is that final step and there have been medical practitioners, or at least one, who have expertise or experience in the disease or condition who has gone before that. It intends to capture the field so that it might be those cases where someone is not speaking or writing but the witnesses say that the person appeared to understand the nature and effect of the making of the declaration—in those situations where, for example, someone cannot write.

The Hon. C.M. SCRIVEN: I am sorry, this is something that is not clear to me: is it correct that there needs to be a witness at that time, regardless of whether the person communicates by those other means or communicates verbally, and if so, is there any limit on who the witness can be other than the definition of ineligible witness?

The Hon. K.J. MAHER: In terms of the limitations, yes. The preceding clause 39(2)(a) precludes someone witnessing if they know or believe that they are a beneficiary under a will of the person making the declaration or may benefit otherwise financially in a way from the death of the person. They are precluded from being a witness.

Now that I have answered that, I think the other question was that if the person who is seeking voluntary assisted dying cannot communicate in writing, for instance, does there still have to be a witness? I think, and I will double-check to see if it is wrong later but, yes, there still needs to be that witness.

The Hon. C.M. SCRIVEN: I am sorry, that was not—

The Hon. K.J. MAHER: Was that the question?

The Hon. C.M. SCRIVEN: No, that was not my question. My question was, firstly, are witnesses required every time? At this step are witnesses always required? Is that correct?

The Hon. K.J. MAHER: According to section 40, yes, witnesses are required at this step.

The Hon. C.M. SCRIVEN: My second question was: other than the definition of ineligible witness, which is fine and understood, is there then no limit on who the witness could be? I guess my question is—

The Hon. K.J. MAHER: A family member.

The Hon. C.M. SCRIVEN: Yes, a family member, that is all under the ineligible part. My question is: if it is, I do not know, a person making a delivery of flowers at the time, can that person be a witness?

The Hon. K.J. MAHER: I think what the Hon. Clare Scriven is asking is: does it have to be someone who knows the person exceptionally well? No, it does not. Is it going to be someone who is delivering flowers at the time? I doubt it very much but I am not sure they are excluded from that, as long as they meet all the other criteria.

From my discussions with practitioners in the scheme that is operating in Victoria, witnesses will almost always be people who have known the person quite well. Often they will be friends of the person. As part of the difficult decision and the difficult progress of a voluntary assisted dying application, the witnesses are often those who are close to the person, but there is no qualification about how well the witness has to know the person.

The Hon. C.M. SCRIVEN: That really leads to the crux of my concern, which is that it can be pretty much anyone, as long as they are not precluded through one of those other criteria, and therefore their ability to assess whether the person understands the nature and effect of the declaration is not necessarily particularly meaningful at all.

I appreciate that in the current short-lived time of the Victorian legislation it might generally be someone who is well known to the person who is requesting voluntary assisted dying, but there is nothing in the legislation to ensure that it is someone who actually does know them well or has really any capacity to be able to make a judgement of whether the person understands the nature and effect of the declaration.

The Hon. K.J. MAHER: I think we just do not agree on the necessity for involving more people who have intimate knowledge of the patient in this circumstance. As I have answered the Hon. Dennis Hood, the steps that are gone through before you get to that stage are pretty rigorous and onerous safeguards.

The Hon. D.G.E. HOOD: It is good news, Mr Chairman. I just want to let the chamber know that the discussion that has just ensued here has aired my issue at clause 68, so I will not need to ask the question.

Clause passed.

Clauses 41 to 67 passed.

Clause 68.

The Hon. C.M. SCRIVEN: I have a question at clause 68. On reflection, I suspect it is actually more of a statement, which I just want to put on record, rather than a question, because I think it has been answered by the Hon. Kyam Maher already. I draw members' attention to the fact that this is where there will be a witness to the administration of the substance that will end the life of the person.

Again, it says that the witness must certify in writing that the person at the time of making the administration request appeared to have decision-making capacity in relation to voluntary assisted dying. Again, at this stage, the actual stage where the administration of the substance will occur that will end the life, it is someone who does not necessarily have any ability to assess whether the patient has capacity at all. I think that is a defect.

Clause passed.

Clause 69 passed.

Clause 70.

The Hon. C.M. SCRIVEN: Regarding division 3, Notification of cause of death, could the mover of the bill indicate whether the death certificate will record that voluntary assisted dying was the cause of death or that the underlying condition was the cause of death?

The Hon. K.J. MAHER: I thank the honourable member for her question. I think she will have noticed this does not prescribe that. What it does do is interact with clause 5, but it is not regarded as suicide. The intention here is that there is a recording of the fact that voluntary assisted dying has been used, but in practice this will be one of those ones where it is how it is done in practice rather than how it is legislated. I suspect, in practice, on the death certificate it will list the underlying cause rather than the administration of a substance according to voluntary assisted dying. For the reasons that were advocated earlier on, I think that is appropriate.

Clause passed.

Clauses 71 to 98 passed.

Clause 99.

The Hon. R.I. LUCAS: I address some comments to the functions and powers of the Voluntary Assisted Dying Review Board, but they also will relate to the constitution of that board, which is clause 93. The issue of doctor shopping was something that I addressed in the second reading. Whilst I acknowledge the response the Hon. Mr Maher gave, and I do not necessarily disagree with that, it is very difficult to address what is a significant issue in a number of areas of public policy—the issue of doctor or forum shopping.

I instanced in the second reading the clear examples in relation to workers compensation, which I am sure is evident to anyone who has been involved in the workers compensation field. In addressing comments back to clause 93, which is the constitution of the members of the board, given the time line the Minister for Health has indicated, which was a little more conservative than the time line the mover of the bill did, which was that this would all be up and going in 12 months, the health advice to the minister is that it is more likely to be 18 to 24 months.

If it is closer to the estimate of the mover of the bill, which is 12 months, given I am rapidly approaching my political demise I might have the good fortune of being in the party of the government that consults in relation to the constitution of the members of the board. If it is closer to the Department of Health's estimate, which I suspect is more likely to be the case, it will certainly be beyond my powers of limited influence.

Nevertheless, I place on the record, given this debate and the fact that the legislation is likely to pass at least the Legislative Council, it is certainly my very strong view that the membership of the Voluntary Assisted Dying Review Board should be a broad church—and I use that word with a small 'c' church; it might offend some people if I use the capital C. That is, in particular, there should be representation on the board of either a devil's advocate or an active opponent, a cynic or a sceptic—someone who is prepared to ask the hard questions in relation to the implementation of the policy.

The membership of the board should not all be card-carrying members and supporters of voluntary assisted dying, there should be at least some representation, in my view, on the board that promotes genuine review of how the policy is being implemented within the board. The reason I do that comes back to the functions and powers of the board, which are fairly broad, and I have no great opposition to them.

In relation to the issue of forum shopping, one way it has been addressed in the workers compensation field is that the board—management also but the board in particular—of ReturnToWorkSA has identified the particular concerns and has considered policies. In their case, they have the capacity to implement those policies. In this case, this board would not. It would have to recommend options to either government or ministers—they have collected statistics and identified those who, for example, appeared regularly in terms of workers compensation claims, and in this particular public policy area it would be perhaps the names of doctors who appear regularly in terms of signing off on voluntary assisted dying, etc.

A board that is capable of looking at that and, if there are particular issues, I note that under the functions and powers the board has the following functions: it can refer any issue or identify the board in relation to it to relevant persons, authorities or bodies, one being the Australian Health Practitioner Regulation Agency. That would be a pretty serious step; it would have to be a pretty serious offence to justify a reference to that particular body.

Nevertheless, I think that in terms of the functions there ought to be a regular reporting mechanism at the very least within the board in terms of evidence that might be able to be gathered on doctor shopping in relation to the issue, and then a consideration of advice to the minister in particular in relation to whether there are any options in terms of a policy response.

Again, I return to the workers compensation field, which is different because, as I said, the corporation does have the power to institute policy change themselves without reference to government or ministers, and they have done so in relation to some policy directions in terms of trying to provide greater rigour and oversight in relation to this important policy area. It is an issue that the Hon. Mr Maher has acknowledged is an ongoing debate in other jurisdictions. I raised it in the second reading and a number of members raised the issue during the committee stage of the debate as well.

I just wanted to place it on the record during the particular debate about the board, because when one looks at who might have power and authority to do anything, to monitor anything, to report on anything, in relation to this it will be the board. Therefore, the make-up of the board is important and the way they set about collecting information and reporting to the particular minister of the day will also be important in terms of at least considering whether or not there is an issue.

It may well be that there is not an issue, but if there is an issue, what if any policy response is open to the government of the day or the minister of the day in terms of seeking to address a response if sufficient evidence is gathered that doctor shopping has become much too apparent and beyond what might be deemed to be acceptable in terms of the practices of a particular doctor in relation to the legislation that has been outlined?

The Hon. S.G. WADE: Very quickly, I agree with the Hon. Rob Lucas that monitoring and the implementation of the legislation will be very important. The issues he raises, particularly in relation to doctor shopping, I think he called it, are covered by a number of the functions and I am sure the board could do that.

I would like to bang the drum again for the Australian model and national consistency, because the fact that we have a board in South Australia that will be similar to other boards operating around the country I believe will give us the opportunity of having not only nationally consistent legislation but nationally comparable data so that we can identify issues. After all, how do we know that our patterns in terms of referrals and the like are a concern if we cannot see how it compares with other jurisdictions? If you like, we can benchmark. I support the approach taken by this council tonight, which is to try to be part of an Australian model movement.

The Hon. R.I. LUCAS: I will quickly respond to those comments and indicate that I am not aware of the functions and powers of the equivalent bodies in the other jurisdictions, but certainly between the houses it would be worthwhile, and I ask one of my colleagues in the House of Assembly to pursue the issue as to whether or not there is the capacity in the legislation in other states to actually share information or whether they will be producing public information, which would throw light on it.

Whilst I completely understand the point the Hon. Mr Wade has outlined, if the legislation in and of itself is either not producing information capable of being shared or something prevents the information from being shared, we will not be able to learn from what would be an important point that the Hon. Mr Wade has made. I think it is an issue. I do not intend to delay further the debate this evening. I will just flag the issue and I will certainly pursue it with one of my colleagues in the House of Assembly to pursue the issue in the House of Assembly. It is an issue I would invite the Hon. Mr Maher, given his knowledge of the equivalent boards in the other jurisdictions, between the houses perhaps, to better inform the debate in the House of Assembly.

The Hon. K.J. MAHER: I will not comment very expansively. In relation to doctor shopping, I know that there have been reviews, particularly in the north American experience. I think one review in Oregon is that two-thirds of doctors wrote only one prescription. There has not been a lot of evidence internationally that this has been a major problem once implemented.

I do agree with the Hon. Rob Lucas. I think it is something that those who do not support and those who support a scheme would agree on. I think it meets both interests that a scheme is vigorously reviewed. I think those who support a scheme would be inclined to vigorous review to dispel myths or concerns that people have. I do agree with the Hon. Rob Lucas that a scheme is better if it is vigorously reviewed and interrogated.

I think it is not a bad idea to be able to have the powers to be able to have that ability to perhaps look between boards in different states, given that the functions of our board are almost identical to the Victorian ones. I do note clause 103 allows the board to disclose any identifying information obtained as a result of the board performing a function for the purpose of referring the matter to a range of people that includes the commissioner; the Registrar of Births, Deaths and Marriages; the chief executive and the Australian Health Practitioner Regulation Agency, which I suspect may cover the thought that the Hon. Rob Lucas had but it is something worth looking at between the houses.

The Hon. S.G. WADE: I want to comment on what the Hon. Rob Lucas said earlier. The Victorian Voluntary Assisted Dying Review Board does publish reports. On 25 February, it released its fourth report, which is public and detailed. It is available on the web.

On the honourable member's further point about the appropriateness of sharing between the boards, I note the remarks of the Hon. Kyam Maher. Again, no matter what cooperative regulatory arrangements are put in place between the jurisdictions, the health ministers do have oversight of AHPRA and it may well be that AHPRA is the repository of that information sharing arrangements with all of the privacy provisions that it has, so the oversight of the Australian model may well be supported by AHPRA.

Clause passed.

Clauses 100 to 107 passed.

Clause 108.

The Hon. K.J. MAHER: I move:

Amendment No 2 [Maher-1]—

Page 50, lines 30 and 31 [clause 108(1)]—Delete 'the rights, development and wellbeing of children and young people at a systemic level' and substitute 'voluntary assisted dying'

This is one of those typographical amendments that had a wrong cut and paste essentially in relation to this particular area. I again thank parliamentary counsel for the diligent work that they do and I commend the amendment to the chamber.

Amendment carried; clause as amended passed.

Remaining clauses (109 to 115), schedule and title passed.

Bill reported with amendment.

Third Reading

The Hon. K.J. MAHER (Leader of the Opposition) (23:25): I move:

That this bill be now read a third time.

The Hon. C.M. SCRIVEN (23:25): I want to make some final comments as a third reading contribution. We know that no-one wants to suffer themselves, and no-one wants to see someone they love suffer, but there is clear evidence, for those who care to look, that safeguards in voluntary assisted dying are ignored or diluted in practice once voluntary euthanasia becomes legal.

In jurisdictions that have had voluntary assisted dying for decades, the number of people who are euthanised without asking for it is about the same number as those who do ask, including people with disability, people with dementia and people with mental health challenges, regardless of the model in law, regardless of the safeguards in the law.

Victoria has not had its legislation in place even for two years. Culture and practices change over time. There are already calls to make changes in Victoria on the basis of equity. Doctors have already noted a change towards euthanasia instead of presenting all the options for relief of suffering. We need to ask: do we want our loved ones to feel pressured to end their life? Do we want our loved ones to feel they are a burden on society or on their family? Do we want our loved ones to feel that they have a duty to ask to die prematurely?

It does not matter what the model is in law or how many safeguards are in the law if they are ignored, and over time experience in other places in the world has showed that they are ignored. As a legislator, I have a responsibility to legislate for the safety of all citizens, so I will not be supporting this bill.

The Hon. T.A. FRANKS (23:27): I will make a brief third reading contribution because I want to put on the record that I thank all those members of the community who wrote to me and the other members of this chamber. Many of those pieces of correspondence were quite personal and deeply traumatic, and I appreciate their sharing their stories with me as an elected member. Indeed, they are very reflective of what we know now from the Australia Institute poll, that some four in five South Australians do believe we need voluntary assisted dying laws. For the Greens, 97 per cent of our membership believes that we need voluntary assisted dying laws. But it is significantly high for all members of all political parties.

This is simply the right thing to do for the wellbeing of our society, to ease the burden on those who are suffering, as well as their friends and family, their loved ones. No matter how caring or supportive palliative care staff are, there is only so much they can do to ease the suffering, and the toll that it takes on them as workers must be quite significant.

This bill is and always has been about the overall quality of life and enhancing that for these people, who are deserving of choice in the most difficult times and of that choice of how to end their time—a choice of autonomy, dignity and control, of not being forced to suffer an agonising death, of not being forced to spread the suffering to their loved ones, who are often needlessly traumatised, and that bereavement comes with its own particular pain and suffering that we can help them avert.

As an elected member of parliament, I am very proud tonight to see that we are probably going to pass this bill. I urge the other place to afford this piece of legislation, which is overwhelmingly supported by the public, the unfettered debating time that it needs to be done properly in the other place. We have seen time and time again bills prorogued, bills not getting to a final vote or bills rushed and then voted on in the very early hours of the morning, with people regretting that they were put under undue stress and time constraints and that perhaps their votes may have been different.

I believe people should be given the voice and control over their own deaths in their own way and I believe this bill is deserving of time in the other place that is reflective of the importance of this issue.

The Hon. K.J. MAHER (Leader of the Opposition) (23:30): I wish to take this opportunity to make a few brief comments. I will again reiterate, as I did when we started this before the dinner break, that I think it reflects very well on us as individual members and as a parliament that we can have a discussion with deeply held opposing views on such a sensitive issue yet maintain respect and

decorum. Contributions tonight, but particularly on the second reading debate, have been heartfelt, sincere and emotional.

I want to acknowledge all those that have come before in this parliament on the issue. I think there were 16 different bills, and if you count the reintroduction of the same bills I think the bill that was introduced in the Legislative Council and by my colleague Dr Susan Close in the lower house is now the 24th separate piece of legislation to have been introduced over 26 years.

I want to acknowledge John Quirke, way back in 1995; Anne Levy; Sandra Kanck; Bob Such, who if you count those 24 separate times was responsible for 11 of them; Lyn Such, who has been a regular communicator with me and has provided a great deal of support and advice; Mark Parnell; Steph Key; and Duncan McFetridge. I know quite a number of those ought to be referred to as honourable but I am pretty sure most of them probably prefer not to be.

There have been nine second reading votes on voluntary assisted dying and the second reading vote on this bill last month became the fifth successful one out of those nine occasions. It has been to a third reading vote three times previously, most notably on the last occasion in the lower house where it failed on a casting vote after a 23-all tie.

Unlike other attempts before in South Australia, this time our scheme, if successful, would not be the first in the country, nor the second or the third, but we will be the fourth state to implement what we have discussed and what has become known as the Australian model. I think that has given a significant degree of comfort to some members in both chambers who may not have voted for this before and may not have considered voting for it before but may this time.

I wish to sincerely thank the many people in SA who have been advocating and campaigning for these changes over many years and, in some cases, even decades. I will single out particularly Frances Coombe and Anne Bunning. If it were parliamentary to do so, I would probably acknowledge that they are in the chamber, but it may not be so I will not. I wish to thank my staff, both the current kids in the office and the ones who have been there before. It has been a rollercoaster of a journey.

I want to thank the politicians and practitioners, particularly in Victoria, who have shared their expertise and experience. I want to single out Dr Roger Hunt, whose expertise in voluntary assisted dying is probably unrivalled. I think Roger is the only person who has been on both the Victorian and the Western Australian governments' expert panels in setting up the scheme. He has provided heaps of time and advice, including a big chunk of last Sunday, to help with preparation and understanding for this bill.

It would be remiss of me not to thank Andrew Denton, who has almost become a full-time advocate for voluntary assisted dying and whose persuasiveness is well known to most politicians around Australia who have considered these end-of-life issues.

Most of all, I want to thank the many South Australians who have been in touch with me on this issue over the last six months. It has been a rare privilege indeed to share some of the most intimate and difficult moments of your lives. The traumatic last moments and days of witnessing the extreme suffering of a loved one that people have shared—I know exactly what you mean.

To the people who I have met, talked to and messaged who are themselves in the final stages of a terminal illness, the fact that you take your time in those last precious moments to try to ensure that others do not have to suffer and go through what you do is an extraordinary thing. I have shared the whole gamut of human experience and emotion with so many people: courage, distress, sadness, strength, love, loss and coping. Thank you, everybody. I commend this bill to the chamber.

The council divided on the third reading:

Ayes 14

Noes 7

Majority 7

AYES

Bonaros, C
IKLee, JS
Wade, SG

Bourke, ES,
Lensink, JMA
Wortley, RP

Darley, JA,
Maher, KJ

Franks, TA
Pnevmatikos, I

Hanson, JE
Ridgway, DW

Hunter,
Simms, RA

NOES

Centofanti, NJ
CMStephens, TJ

Hood, DGE

Lucas, RI

Ngo, TT

Pangallo, F

Scriven,