

VOLUNTARY ASSISTED DYING BILL

Committee Stage

In committee.

(Continued from 26 May 2021.)

Clause 1.

The CHAIR: I am going to stipulate that we do our best to comply with the standing orders; that is my job tonight, but I ask people to be conscious of that.

Dr CLOSE: I would like to make a contribution on clause 1 by way of clarification about various amendments that have been presented and filed in recent times, one of mine which initiates very soon after clause 1. I deeply appreciate and respect the complexity and the moral challenge represented by this piece of legislation. I also understand and respect that we will not all reach the same position on what we want to see happen with voluntary assisted dying.

Nonetheless, I have been heartened by the willingness across a broad range of people to work through the best practical way of addressing a complex piece of legislation in a way that does the most good and the least harm. In that context, I have had what one might call a meeting of minds with the member for Davenport in discussion about the various amendments that have been filed to date. The Chair will be aware that there is a set 2 standing in my name, and I will be advancing with set 2 and not advancing with set 1.

In order to respect the complexity of recognising that there are people in institutions in our society who operate in health care and aged care who do not support, and in fact believe to be wrong, the concept and action of voluntary assisted dying, recognising the reality of the experience of people in Victoria in hospitals and hospices and the intentions of private organisations that run hospitals and hospices here not to facilitate something they regard as wrong, I am prepared to accept the amendment that stands in the member for Davenport's name as it relates to those short stay situations.

However, in my second set of amendments I will be looking for support for a way in which we can protect the rights of people for whom their aged-care residence is their home, where they may have lived for months or years, where they may have put in their own money. Irrespective, they regard that place as the place of their permanent residence.

I will seek the support of all members to allow, even within a facility that is owned by an institution that does not wish to participate actively in voluntary assisted dying, that the rights of those people will have a pathway to be respected, without infringing on the conscientious objection of individuals and by fully respecting the desire of those organisations to not actively participate.

I appreciate that I have been able to describe that at clause 1, but I think it may assist the chamber to indicate that I will not be proceeding with my initial set of amendments but will be proceeding with my second set of amendments for those reasons.

The CHAIR: Thank you, deputy leader. For the purpose of the committee, the deputy leader has carriage of this bill tonight. Set 2 that the deputy leader was referring to actually appears here as schedule (6). I just clarify that.

Mr MURRAY: I, too, rise to, in particular, cover the issues of institutional conscientious objection. In doing so I specifically endorse the comments of the member for Port Adelaide, and thank her for the very civil and constructive dialogue we have had over what seems to have been a long time but what is, in truth, literally only a matter of days.

For the sake of clarity, I, too, have submitted a revised set of amendments that varies in one major way from the initial set of amendments I submitted. I am very grateful for the stated support of the member for Port Adelaide for my amendment that, if successful, will see the insertion of clause 10A which will effectively enshrine the ability of short stays—that is, predominantly hospitals—who have a conscientious objection to voluntary assisted dying, to not only express that view but also act upon it whilst at the same time ensuring they make others aware of it and, where others wish to avail themselves of it, that they act in a way that is stipulated.

In so doing, and for the sake of clarity, I will be supporting the amendments moved by the member for Port Adelaide, in particular the amendments which, as we have just been advised, are amendments in schedule (6), clauses 13A through to 13L exclusive of 13C. Again, I thank the member for Port Adelaide for her very constructive assistance. I hope that, as a consequence, that sets the template for what is a very vexed and complex discussion as we set off down the path of seeking to resolve this matter.

The CHAIR: I thank the member for Davenport and the deputy leader for that preamble, pre-empting what is about to occur in relation to amendments, but we will, of course, deal with those amendments when they come due.

Mr PEDERICK: I first want to make the comment that I think we had a very respectful discussion a fortnight ago in this place. Everyone knows my position on the Voluntary Assisted Dying Bill 2020. At the finish, I will not be supporting it, but I will be supporting any amendments that seek to improve the bill along the way, and I appreciate the work done by the deputy leader and the member for Davenport in coming to agreement on those amendments. It shows what can be done in this place.

I do have a couple of concerns on clause 1, the title, and I will raise them separately. I have a concern about unintended consequences because, obviously, with voluntary assisted dying there is no turning back. Deputy leader, do you think there are enough protections in the bill so that we will not have any unintended deaths? That is one concern I have.

Dr CLOSE: I really appreciate the opportunity to answer that question, and it is a very well articulated question. This piece of legislation is amongst the most conservative in the world. It is modelled very closely on the Victorian legislation, which the Premier at the time claimed to be the most conservative. If you think of the continuum of different forms of voluntary assisted dying legislation that exist, Australia is very much crumming in at one end, and that is to say that it is extremely difficult to obtain a permit to have voluntary assisted dying.

Some people will be disappointed by that, but that is very clearly what Australians have an appetite for and what Australian members of parliament and parliaments generally have an appetite for. What does that mean? It means that someone who wishes to have access to voluntary assisted dying has to go through some 70 hurdles that are placed in this legislation in order to be very certain that that is the right and legal thing to allow to happen.

There are criteria that are established that two doctors must say are to be found to be true. One is the very sincere desire by the person to obtain voluntary assisted dying, and that desire cannot be expressed just once but must be expressed in an enduring way over a period of time and through the different stages. The person must also be, sadly, dying. They must have a terminal illness and one that (other than neurodegenerative) will kill them within six months and, for a neurodegenerative disease, will kill them within 12 months.

They cannot have access to it simply because they do not wish to live. They will have access to it because they are dying and they have proven that and had it tested by at least two doctors, the coordinating medical practitioner and the consulting medical practitioner. There are further tests that are required for each stage of the process to ascertain that that eligibility is indeed fulfilled, and that the desire to undertake the process of voluntary assisted dying remains an enduring wish.

In Victoria, where this has been in place for some time now, there has been found to be by the review board no example of what the member might regard as an unwarranted or unintended death. In fact, the only criticism that that board has really found is that it takes a while, that it is hard to get and that sometimes, because of the difficulty in obtaining access to a practitioner who is prepared to engage in the process, people have died before they have been able to gain the relief they have sought. That means that they have experienced the kind of suffering they had hoped to avoid and have ended their lives in greater pain and in greater suffering than they had intended.

However, what that means is that we can be assured there is a very serious ring of protection around people so that they are unable to obtain it if they are not fully eligible. The eligibility is, again, that they must be dying within six months, or 12 months for a neurodegenerative disease; that they not only must be capable of saying they desire that but that that be an enduring desire; and also that they must be experiencing suffering they find unbearable to tolerate for which there is no tolerable remedy. I do not know of any legislation around the world that is as tight and as strict as that. So, if ever we are going to do this as a state and as a nation, it is going to be in this form.

I will add the additional reason that we can be more confident that this is the appropriate path, and that is that it is becoming the emerging Australian model, where we have seen, with very minor variations, Victoria, Western Australia, Tasmania and now our upper house consider this legislation, and not at any point weakened safeguards but ensured that they are tight and that people can continue to have confidence in them.

I would for that same reason argue against any additional amendments to add still further tests. We are at a point where it is difficult for someone who is suffering to obtain the relief that they are voluntarily choosing to seek. I believe that any additional barriers put in place to the capacity of doctors, the kind of consideration doctors have to undertake, are moving away from the model and also creating the kind of barrier that we know will cause suffering to people who are then unable to obtain the relief that they and their loved ones are seeking for them.

Mr PEDERICK: Thank you very much for that fulsome answer. The other point that concerns me is coercion. I know there are some parts of the bill later that talk about coercion and coercive control. I absolutely understand the time lines on the two different terminal illness trajectories—six months or 12 months. The one thing in light of that is that some people can live significantly longer than those forecast time lines. I guess that is something no-one can really forecast, but it is a reality and a lot of people (and, thankfully, I have not had to put up with it) can handle the treatments, whether it be chemotherapy, etc., and some choose not to have that sort of treatment.

It is similar to my first question. I get concerned that some people will believe that they are a burden to society and a burden to their family, even with these regimes of either the six-month forecast time line or the 12-month forecast time line, depending on the illness. My concern is that someone will think, 'Let's just get it over and done with.' They could be a parent, an aunty, an uncle or caregivers, but they do not want them to be burdened, so to speak.

I guess the short version is: do you believe there are enough controls around the potential for coercion? I am sure it is human nature that some people, if they really want to do something, might bluff their way through it. I know this is very serious and that it is not just about bluff; I am not saying that or trying to degrade the conversation. However, people may think, as I have already indicated, that for the greater good they will go out earlier than perhaps they needed to.

Dr CLOSE: I thank the member for Hammond for raising these issues because they are issues raised in the community about this, and it is absolutely right that we should address them in the course of this debate. The two issues you have raised, member for Hammond, are prognosis being inaccurate and the question of whether a person who is dying considers themselves to be a burden and therefore there could be an element of coercion.

To deal with the prognosis to start with, yes, prognosis is not an exact science. I have just consulted with my adviser, Dr Roger Hunt, who is an expert in palliative care, to confirm my understanding. Of course it is not an exact science; it is, however, the job of people dealing with dying, people with terminal illnesses. The experience across the world is that the length of time people are given tends to be optimistic rather than pessimistic.

So, although there will be cases in which someone lives longer than was expected, the likelihood is that the doctor thinks that they will live slightly longer than they end up living, and in any case we are talking about a fairly narrow window of time because the level of experience and expertise that oncologists have in particular, when we are talking about cancer, means that they are pretty good at determining how long and certainly at determining that the person has a terminal illness and is in that last stage of terminal decline.

On the question of the sense in which someone might consider themselves to be a burden and/or experience coercion, the difficulty is that you cannot off your relative through this.

Mr Pederick: No.

Dr CLOSE: And I do not mean to make light, as I know you did not either. If we bring in the mental health question as well, which also comes up, this is not about someone who is depressed or mentally ill, it is not about someone who feels that they might be a burden to their family through living and it is not for someone who has a coercive partner or child who wants to be rid of them. The person must have a terminal illness.

The person must see doctors and the person must, in the course of seeing the doctors with their terminal illness, express that they are experiencing unbearable suffering and that they have an enduring desire to enter the process of voluntary assisted dying. For someone to be afforded that permit on the basis of being a burden, there would have to be some sort of conspiracy at play, and I am sure none of us believe that would be possible with doctors.

There is evidence when assessment is done, when surveys are done, of people in Oregon, for example, which has had this for a very long time (since the nineties), that people include feeling a burden on their list of reasons that they would like to access voluntary assisted dying. It is not the reason; it is an understandable feeling that one has when one is not only dying but becoming helpless, often incontinent, paralysed, unable to speak.

When you are in those circumstances, when you have been an autonomous adult in control of your life for a long time, it is not unnatural to feel that you are a burden and to not want to be. The loss of autonomy appears higher on the survey list than does a burden, but they both do and that is because the features of having a terminal illness are very unpleasant, but that is not the reason that you get to go on the list of wanting voluntary assisted dying.

The member asked me at the beginning if I believe that these eligibility criteria and safeguards are sufficient—I absolutely do. As much as the Hon. Kyam Maher is a very dear friend, I would not be taking this bill into this chamber if I had not explored deeply, to my comfort, that this is not about a nice old lady feeling that she is in the way, that it is not about an abused partner or an abused older parent being made to go down a path they do not want to.

When we have looked at the experience in Victoria and the review board, they have not found coercion. As chair of the board, Justice Betty King, said, she has looked for it. She has looked for that because we all worry about the vulnerable and we all know that elder abuse exists, but there is absolutely no evidence in Victoria that, with this level of safeguards and this level of medical scrutiny on the process, that is something that has happened nor that anyone believes could happen.

The Hon. A. PICCOLO: I would like to make a few comments, if I could, to start off and perhaps end with a question. Like the member for Port Adelaide, I agree that fair-minded people can reach different conclusions on this issue, both having goodwill in their hearts. Tonight, we will probably find a number of different views and we may or may not come to different conclusions.

I should say that I do accept that this model is probably one of the safest models. If we were to progress this in the parliament this way, this is probably the safest model, so I am not going to nitpick about different parts of the bill because I think it is probably the best you can get at this time, and I accept that.

One thing I am concerned about is changes in our society over time. Changes we make in laws do change the way we think about things and the way we think about things is very important because how we think today is not how we are going to think in 20 years' time because we have changes in laws.

The member for Port Adelaide raised the issue of the Oregon scheme, which is probably one of the longest schemes of physician-assisted suicide, which I think they call it or words to that effect, in America. One of the concerns I have here is very much about the trends. If we are to pass this today, we all think this today but what are we going to think about it tomorrow? It is important because laws reflect public opinion but also influence public opinion both ways. It is important.

I will read from a piece of research from a journal of oncology which deals with the Oregon scheme and also talks about the impact of the Oregon scheme. I will quote verbatim from this article which is about the changes in those factors and why people apply for, in this case, voluntary assisted dying—I will use the language of the bill. It states:

Notwithstanding the overall trends between 1998 and 2011, from 2010 to 2011, concerns over loss of autonomy and lessened ability to participate in enjoyable activities both decreased: to 88.7% from 93.8% and to 90.1% from 93.8% respectively. Conversely, concern about burden on family, friends, or caregivers increased to 42.3% in 2011 from 26.2% in 2010. Inadequate pain control or concern about pain control also increased to 32.4% in 2011 from 15.4% in 2010.

The issue I have here is that over the time of the scheme the changes in that particular state are that people's view of life, death and a whole range of other social issues has changed. What this research shows about the Oregon scheme is that people who have applied to be part of the scheme in Oregon have

increased in terms of reasons they give. One of the key reasons is an increased concern about burden on family.

I accept what the member for Port Adelaide has said. It is not a case of conspiracy, etc. People are not going to be in a very overt way coerced into taking this up. My concern is about the covert behaviour: the things that change in our society, how we view things and how we actually make sure, as this bill says in one of the clauses words to the effect, that each life has equal value which I think is a really good principle.

So what is in this bill to ensure that people do not feel that sense of burden? We heard earlier today about elder abuse where people were saying, 'You have to do this.' It is a case where people feel they have to behave in a certain way or do certain things. How do we stop that social trend because I think that would be a dangerous step?

Dr CLOSE: Again, an excellent question, not least because it is allowing us to ventilate some of the comments that are made about this legislation outside parliament. It is important in making this decision that we address those issues that are raised. The difficulty in drawing evidence from a survey of people who are participating in physician-assisted suicide, as you say, in Oregon is that you are dealing with a relatively small number of people filling out a survey and ticking as many boxes as they want. So I think, simply on that, it would be very dangerous to assume that you are able to read trends.

If we look at the legislation, in the US and obviously specifically in Oregon, you can only have access to voluntary assisted dying if you are terminally ill. So no-one who considers themselves a burden and is not terminally ill is able to have access. The question is: even amongst the people who are terminally ill—and the prognosis must be that you are within six months of dying—are there some people who would have clung on longer had they not normalised the idea that this was an option? It is, of course, conceivable that that would be true, but the percentage of deaths has not gone up.

It is less than 2 per cent of reportable deaths and has not increased over that period. So although the reasons might bounce around in a survey of input considerations, I do not think that we have any evidence there that the existence of voluntary assisted dying has in any way opened up a worrying trend.

The truth is, though, of course, that when you bring in a piece of legislation that allows an option, some people will want to take it. At the moment, people are taking it occasionally through suicide, often in a violent way or way that is unpleasant for other people, such as train drivers, who are the recipients of someone committing suicide by stepping in front of a train. Families are coming home and finding dead and mutilated bodies as a result of suicide attempts. It is one of the reasons SAPOL has indicated their support for this legislation. So at the moment there is that kind of option, but it is an extreme one.

More commonly, I imagine, the option is that you suffer. What this does is say—and normalise—that if you are in those circumstances you may be able to choose to end that suffering at a point of your own choosing and do it with your family and your loved ones in a way that you choose. So that normalisation I am comfortable with. I would like to see a society where people in those circumstances were empowered to do that.

But there is not any evidence that in places that have this legislation, particularly where it relates to terminal illness, as does ours, that that has changed attitudes to how awful death is. People who undertake voluntary assisted dying do not want to die. They are dying, and this is their pathway to do so in a way that gives them the most dignity and avoidance of some degree of suffering that is possible. For that reason I do not think the argument of a slippery slope in that sense, of normalisation in the community, is one that we should be concerned about.

The Hon. A. PICCOLO: I thank the member for Port Adelaide for her response to my question. I agree with her: there is a danger in using one piece of research to support that. I do take that on board. I looked at another piece of research, which actually was an international literature review. It was of all the various studies right across the world, rather than just of Oregon; it has considered a number of countries. One of the findings these researchers found, when they actually studied all these studies from right across the world, was, to quote verbatim from their review, as follows:

Our findings revealed that unbearable suffering relating to psycho-emotional factors such as hopelessness, feeling a burden, loss of interest or pleasure and loneliness were at least as significant as pain and other physical symptoms in motivating people to consider assisted dying.

So this international study—and I agree with you about using just one study—looks at all the factors and at all the studies of all the schemes right across the world and at what the reality is. I accept what the member for Port Adelaide has said, which is that the people in these studies are all dying, and some people wish to die with dignity from their point of view; I accept that. What I am finding hard to understand or agree with is that there are a number of issues which do not need voluntary assisted dying to address. There are issues which are social issues, which are issues of resources and which relate to a whole range of social policies which could address some of those issues.

My concern is that this bill does not address those issues—and in a second I will come to the issue of autonomy, which has been raised by the member for Hammond. The assumption is that we cannot address these issues; therefore, we need to give people a more dignified way out. I understand that, but when you look more deeply into the research a lot of it is around inadequate social policies in those countries—inadequate policies in health care, inadequate policies in a whole range of areas—which actually lead people to opt for voluntary assisted dying, to use the Australian language. I accept that all the people in the studies are dying; I accept that. I am not sure I am convinced yet that people are motivated purely by those physical matters, which I can understand why they want to exit earlier.

Dr CLOSE: I think one thing that might be useful to set the scene when we talk about the experience of other nations is to talk about the different models that exist elsewhere. Europe is essentially based on the concept of suffering, that if you are suffering then you have a right to be able to relieve that suffering through voluntary assisted dying. In the US, it is about having a terminal illness, as we discussed with Oregon. All the people who answered that survey have a terminal illness and are within six months, by prognosis, of dying.

Australia, in this very conservative model, requires both, and I think that ought to give all of us some comfort that we are not talking about a passing sense of loneliness. When someone says that they are feeling lonely when they are dying and incapable of communication, that is understandable and is not to be used as a reason to deny them access to voluntary assisted dying.

This legislation, because of its conservativeness, has a requirement that the two physicians must agree that the person is dying, that they are suffering in a way that is not bearable to that person, in a variety of forms, all of which are understandable in the context of a terminal illness or a terminal neurodegenerative illness, and that that person has expressed an enduring wish to take that pathway.

If I were in those circumstances, I would probably tick all the boxes of my unhappiness with my life in that way because I enjoy being autonomous and active and social, and that is no longer the opportunity for people who are in those last stages of a terminal illness. However, I also think the member is making a very good point about palliative care and while I will not be supporting his desire to see this legislation, should it pass, await a review of palliative care, I think everyone who is involved in voluntary assisted dying in Australia—and I am sitting next to one of the foremost experts in palliative care—recognises the crucial role that palliative care can and does play.

I do not think you would find a single advocate for voluntary assisted dying who does not want to see us do our very best in funding and support for palliative care and all the other kinds of supports that people have when they are experiencing a terminal illness, but that is not going to be enough. It is necessary, but not sufficient for everyone who is in that circumstance. What this does is say that if it is unbearable and you are close to death, you have a right to go down the pathway to choose how that ends.

The Hon. A. PICCOLO: I agree with most of what the member for Port Adelaide has said. She raised the issue of palliative care, which I think is relevant. My concern is the evidence provided to the committee that looked at end-of-life choices by a whole range of witnesses, including people who support voluntary assisted dying, said that we have an inadequate palliative care system in this country now.

If we are all committed to palliative care, why are the resources not there today to ensure that people can actually have a real free choice? In other words, the choice is, if I choose palliative care I get A and if I choose voluntary assisted dying I get B. My concern is that all the sentiments are nice but the reality, from all the experts, is that we have inadequate resources in palliative care today. That has not changed. That has not changed since we have had VAD in Victoria or what is proposed in Western Australia, etc.

My concern is that this bill is actually silent on palliative care. It says nothing about palliative care. If there were some assurances or some link to palliative care in this bill to acknowledge the importance of that, I would feel much more comfortable about the bill. The bill has certain principles in it, which I will come to

later and which I think are really important, but I cannot see how they would ensure that we have appropriate palliative care.

That gets to the point I would also like to raise, the issue of autonomy, which was raised by the member for Hammond. I draw the house's attention to some research undertaken by Katrina George, based on Australian schemes. She is a researcher in the University of Western Sydney, and I quote from her research work: 'Research confirms the significance of autonomy for patients at the end of their lives.' I think we agree on that. People want autonomy, which is very important. The quote continues:

The strongest determinants of the desire among patients for assisted death stem not from unrelieved pain, but from anxieties about autonomy: losing control, being a burden, being dependent and losing dignity.

She goes on to assert:

...for an action to qualify as autonomous it must...be sufficiently free from internal and external constraints.

In other words, the person must not be fearful or anxious about where they are going—that is, we need a system in place to make sure that they will not feel pain or feel a whole range of things. Some of those things are social and some of them are medical. Secondly, there can be external constraints, such as strong family and cultural influences or internal constraints, such as mental health issues, drug and alcohol abuse, etc. She concludes:

...there is reason to be concerned that some populations are vulnerable to controlling influences that undermine the autonomy of their choices for assisted death. A patient's physical and psychological vulnerability at the end of life might be compounded by features of his or her context that belie the rhetoric of choice: economic disadvantage, social marginalisation or oppressive cultural stereotypes.

What I am trying to draw on here is that often the lack of autonomy would not be obvious. Because of a whole range of factors, people lose autonomy. There will be some groups in our society where they have full autonomy because of their wealth, their education, their cultural background—a whole range of things—and some people will not. My concern is that some of these other things are not being addressed.

Dr CLOSE: I heartily agree that the range of socio-economic disadvantage in our society does lead to different outcomes in a number of ways, but I think that takes us a little distance away from this legislation. There is no argument in my mind about the importance of palliative care, but also in its limit to do everything that perhaps some people wish it could do in relieving the kind of suffering experienced by people with a terminal illness who then choose to undertake the process of voluntary assisted dying.

Although people have raised the question of the quality of palliative care in Australia, it is important to note that we do have one of the best healthcare systems in the world, and we are recognised to have one of the best palliative care systems in the world. It does not mean that it cannot be improved and that it is perfect, but we ought not downplay the significant contribution palliative care specialists make in relieving much of the suffering of many people who are dying.

However, it is interesting to note that in the states that have passed this legislation—not, I suspect, because of the import of the legislation specifically but because of the discussion that occurs about the experience of dying when you are having this kind of debate, just as we are discussing now—the amount of expenditure on palliative care has gone up. In Victoria, it has gone up, in Western Australia it has gone up.

Is it because of voluntary assisted dying? I do not think it is because of any features of the bill, but I do think it is because we have said, 'There are all these people who are in this awful circumstance, and we need to do everything we can to make that as least unpleasant as possible.' I do not think there is a reason to think that bringing in voluntary assisted dying does harm to palliative care; in fact, I think it probably does the reverse.

As a final point on autonomy, one of the great virtues in my view of voluntary assisted dying is the autonomy that it gives people. It is interesting that some 30 per cent of people who are given a permit for voluntary assisted dying in Victoria have not taken it.

The palliative effect of having the right to go when you want to, even if you choose not to, should not be underestimated. When I was listening to the Denton podcast, I heard people talking about how that desire to know that they could go if they needed to made it that bit easier to manage the suffering that they were experiencing in their terminal illness. In that sense, peculiarly perhaps, given the exchange we are having, this is a contribution to palliative care rather than anathema to palliative care.

Clause passed.

Clause 2.

The Hon. A. PICCOLO: I move:

Amendment No 1 [Piccolo-1]—

Page 6, lines 5 and 6—Delete clause 2 and substitute:

2—Commencement

- (1) Subject to this section, this Act comes into operation on the day on which it is assented to by the Governor.
- (2) Sections 3 to 116 (inclusive) and Schedule 1 come into operation on a day to be fixed by proclamation.
- (3) A day fixed by proclamation for the purposes of subsection (2) must not be a day falling before the completion of the inquiry under section 2A.
- (4) Section 7(5) of the *Acts Interpretation Act 1915* does not apply to a provision of this Act.

2A—Inquiry by South Australian Productivity Commission into palliative care in South Australia

- (1) The South Australian Productivity Commission must, as soon as is reasonably practicable after the commencement of this section, undertake an inquiry into palliative care in South Australia.
- (2) The terms of reference for the inquiry are as set out in the regulations and must, without limiting the matters that may be considered in the course of the inquiry, include consideration of—
 - (a) the effect, if any, that the operation of this Act is likely to have on the funding, availability and provision of palliative care in South Australia; and
 - (b) the amount of additional funding (if any) from all sources and services that would be reasonably necessary to ensure a world class palliative care system in South Australia.
- (3) The South Australian Productivity Commission must, on completing the inquiry, prepare and deliver to the Minister a report on the inquiry (including details of any recommendations made in respect of the inquiry and containing any information required by the regulations).
- (4) For the purposes of section 2(3), the inquiry under this section will be taken to have been completed on the day on which the report is received by the Minister.
- (5) The Minister must, within 6 sitting days after receiving a report under subsection (3), cause a copy of the report to be laid before both Houses of Parliament.

The reason I have moved this amendment is that I have had some constructive feedback that does not delay the actual start of the practical application of this bill. My understanding, from what I have heard and read of what the proponents of the bill have said, is it will take 12 to 24 months for the scheme to be in place based on what happened in Victoria and other places. If passed, the provision in this amendment, once this bill is passed, would come into effect and the Productivity Commission would be required to undertake an inquiry as soon as practical to ensure that we do have the best palliative care options available.

I say that for a very important reason. If we are talking about choice and consent, which I think are the two words I have heard the most in this debate—giving people choice and their having to give consent—choice must come from actually having a choice. In my view, we need to have the best palliative care system available.

The member for Port Adelaide has acknowledged that we have a good system, but it could be improved. I do not know because I am not an expert in this field, but all the evidence to the committee, from both people who are opposed to voluntary assisted dying and those people who support it, indicated that our palliative care system had a whole range of difficulties, and particularly between states in the quality of palliative care, as some states put more money in than others, and particularly between rural and metropolitan communities. There are a whole range of different factors.

All this amendment does is say that, once this bill has passed, this inquiry will take place. I would be surprised if it could not be done within the 12-month period. Importantly, it does not delay the implementation regulations, so the bill or the regulations required under the bill can still go ahead. That provision has been deliberately missed out so that the bill can still be put into practice.

Palliative care is very important and we should seek to ensure that we have the best scheme available when this bill comes into practice if we are going to say to the community that all lives are equal, as this bill

does. I draw your attention to the bill itself and the principles behind this bill, which are very good principles that I concur with. Clause 8(1) provides:

- (a) every human life has equal value;
- (b) a person's autonomy should be respected;

Paragraph (d) provides:

- (d) every person approaching the end of life should be provided with quality care to minimise the person's suffering and maximise the person's quality of life;

Paragraph (h) provides:

- (h) individuals are entitled to genuine choices regarding their treatment and care;

Paragraph (j) provides:

- (j) all persons, including health practitioners, have the right to be shown respect for their culture, beliefs, values and personal characteristics.

These are great principles, amongst others. My view would be that the only way these principles can be put into effect—in other words, as the bill requires, that 'individuals are entitled to genuine choices'—is that the genuine choices must be genuine, in the sense that we must have a scheme of palliative care that actually supports those choices.

Dr CLOSE: I might make a comment that might be taken as a question for the purpose of the process. I do not support this, although I would be perfectly happy if the South Australian Productivity Commission chose to or was directed by the government to undertake an inquiry. The commission should undertake inquiries into things that we would like to understand if they are going as well as they could and if there are ways to make them better.

The reason I do not support this is that, although I accept the member does not intend for it to delay the implementation of this act, I have no way of knowing if that would, in fact, occur and it seems a tangential addition to an act. It does not need to sit in here because the Productivity Commission inquiry can occur by directive by the government or indeed a separate bill or motion by the parliament. To put it in here implies, as I said earlier, that somehow palliative care and voluntary assisted dying are antithetical, and that is not the case, in my view. It also risks some form of delay outside the control of this parliament and outside the control of the health minister, who will oversee the implementation of this bill, and that concerns me.

We have so many hundreds of thousands of South Australians who know about tonight, who want to know that we are going to get this through and who want to know that it will be dealt with appropriately but expeditiously in order to enable that possibility to exist for them and their loved ones in the future, and I cannot support something that even risks a tangential delay.

I would always support any government undertaking this action separately to this piece of legislation. If there are people on the government side until March who are sincere about their desire to seek improved or different palliative care, they are absolutely free to ensure that occurs. We on our side, should we win the next election, are in the same position, but I do not want to see that in what ought to be as close as possible to an Australian model of voluntary assisted dying. It does not need to have a review of palliative care put into it to improve it as a piece of legislation and therefore I believe it should not.

The Hon. A. PICCOLO: On this occasion, I have to disagree with the member for Port Adelaide. I think it is important. I think if the parliament thinks this is important to pass tonight and the parliament thinks they have some concerns, it is appropriate for the parliament to direct the government to do so. Parliaments direct governments every day and this is no different from any other issue this house has considered where we direct the government to do so, so I disagree. I do not think it is unimportant. I think it is very important.

Secondly, I do not believe—and certainly the member for Port Adelaide has not demonstrated how—this would delay the bill. If this clause were passed, the bill could still go through tonight and still be enacted. What it means is that this provision would have to be enacted fairly quickly and the government—the health minister, etc.—could undertake the rest of the bill without any delay. There is nothing in here to prevent the appropriate regulations being made, which require, if you like, putting the bill into practice.

I agree that there are a lot of people in South Australia waiting for the passage of this bill. This provision does not stop that. What it does do is provide some comfort to those people who are not supportive of voluntary assisted dying that we have done the best we can to make sure there are real choices. On that, I would like to make the point that there has been an assumption in the emails I have received in my inbox—I am sure the same emails everyone else has had—that we all have to vote the same way tonight, that that is what we are supposed to do.

I would have thought that in a democracy all voices should be heard. They might be minority voices, but sometimes minority voices are very important. I am sure the member for Port Adelaide agrees with me that they need to be heard as well. To suggest that tonight we have to pass a bill unamended in some way, because that is what people are expecting, I think would be a dereliction of our duty.

Mr PICTON: Firstly, I will start my contribution by acknowledging that I think the member for Light, my good friend, has a very strong commitment to palliative care, and that is what is being borne out through him moving this amendment. Certainly, in my second reading contribution I did make the point that each time we have these debates—and maybe this will be the last time we have this debate, but I suspect, even if it passes, it will not be—there is always a commitment from all sides that we need to improve palliative care, but that does not necessarily quite get followed through to the extent that I think we all would like.

However, I do have a couple of concerns with the amendment that has been proposed. The first concern is that this has been predicated on everything stopping until this inquiry happens. It is not that we are passing the bill or the legislation would proceed and also this inquiry would happen; it is that the legislation cannot happen until after this inquiry. That certainly does give me concern. I would be much more comfortable if we were looking at an amendment that simply raised an inquiry into palliative care as part of the legislation, without holding up the legislation for that to happen.

The second concern I have is that the group proposed to be tasked with undertaking this work is the South Australian Productivity Commission. From what I can see, the Productivity Commission in its legislation, in its functions as described on its website and in its membership is formed looking at business, productivity, red-tape reduction; it is not focused on health and wellbeing outcomes. There are other bodies. There is the Health Performance Council and there are others that potentially could look into this, but I think we might be fitting a square peg into a round hole by asking the Productivity Commission to do this work.

The federal Productivity Commission certainly has done work in social areas before. It has different legislation, and it has a long history of bringing in different members for a range of different purposes to look at non-business and non-red-tape functions. We certainly have not had that here in South Australia, so I guess I am concerned about why we are choosing that to be the vehicle for such a review. They are my two concerns, member for Light.

The Hon. A. PICCOLO: I thank my colleague, and I think they are two important questions. What I can say on the first question is that I cannot see how the amendment has been structured in a way that would actually delay the implementation of the bill. What it says is that people cannot sign up for it—you are quite right, people cannot sign up for voluntary assisted dying—until that inquiry is completed, but it does not in any way hinder the scheme from being established.

This amendment does not in any way hinder the machinery required to establish the scheme, and that is quite deliberate. Clause 117 has been deliberately excluded, which are the regulations that give effect to the machinery to establish the scheme. So I do not agree that the scheme would be delayed at all. Secondly, the Productivity Commission is not actually enacted by legislation; from memory, it is actually established by the government.

An honourable member interjecting:

The Hon. A. PICCOLO: That is correct. The government withdrew the legislation. It is actually a government instrumentality; therefore, there are no inhibitors from undertaking this inquiry, and the commission does from time to time co-opt members to the commission to do work outside a narrow area. So the commission has both the capacity and the ability to undertake this inquiry and to do it very quickly.

The parliament is directing the government to direct the commission to undertake this research. Putting those two bits together, I think that addresses the quite legitimate concerns raised by the member for Karna, but I do not agree with those concerns.

The Hon. D.G. PISONI: Could the member advise the house as to how his amendment will satisfy the terms of reference described on the first page of the Productivity Commission's website that states:

The South Australian Productivity Commission has been established to examine and make recommendations on matters referred to it by the government that facilitate productivity growth, unlock new economic opportunities, support job creation and remove existing regulatory barriers.

The Hon. A. PICCOLO: As I just said, and I will repeat it because the Productivity Commission is not by statute, it is a government instrumentality under the government's direction. I think it might be the Treasurer or the Premier who directs it, and it is a matter of government policy. That policy could be altered tomorrow to undertake this inquiry. There is no legislative barrier to this. It is different from the federal Productivity Commission which, again, not too dissimilar in purpose, has undertaken studies in disability care, health care and a whole range of other areas. I am also advised that the inquiries undertaken by the Productivity Commission to date have, on average, taken six months to conclude.

The Hon. D.G. PISONI: Can the member explain why it is the Productivity Commission and not the parliament's Social Development Committee? Why have you chosen the Productivity Commission?

The Hon. A. PICCOLO: That is a very good question and I did think about that very matter, member for Unley. I thought, 'Do we have a parliamentary inquiry, etc.?' We have been through the parliamentary process and we have been through the political process. I thought another political process would not necessarily be helpful. We have an independent body which would look through this inquiry and actually come up with all the hard evidence one way or the other.

There are a whole range of committees in parliament which could be utilised—I accept that—but I deliberately chose not to use a parliamentary committee. The end-of-life committee could not come to an agreement on this matter and that shows the difficulty with this issue. What you need to do is have experts in the field, outside of the political process, to come up with relevant data and information and advise the government of the day.

The Hon. V.A. CHAPMAN: Just on those matters, if I could clarify with the member because the proposed amendment is to mandate that the SA Productivity Commission must undertake this inquiry, and my concern is in relation to that obligation in this statute. Firstly, has the member received any advice whether this parliament has any power to actually mandate this to the SA Productivity Commission when that is an instrument subject to an agreement between the Premier and the members of the Productivity Commission and subject to the terms of that agreement? It does not have any direct relationship with the parliament.

The Hon. A. PICCOLO: My understanding is that if this amendment was passed and the bill was passed there would be a direction to the government, as the member has quite correctly hinted, a direction to parliament, and the government through either the Treasurer or the Premier—I am not sure who actually directs the Productivity Commission—would provide that direction to them.

The Hon. V.A. CHAPMAN: In obtaining that advice, if he has, why then does this amendment not direct that the Premier and/or government undertake this, as distinct from the Productivity Commission? There is no direct relationship between the Productivity Commission and its charter by agreement with the Premier to undertake the work of the parliament. Entities can exist but it does not necessarily mean that they are subject to the direction of this parliament.

I am just at a complete loss as to how there is the power in this parliament to direct this body to do this. It may be a worthy inquiry—I do not challenge that at this point—but I am just concerned at the validity of even doing this. Has the member actually obtained some advice as to whether that is even lawful or can be required? It does not actually say it is a direction or request of the government to do this.

The Hon. A. PICCOLO: My understanding is that, if this clause is passed and the bill is passed, it will be a law of this land. The government, and all agencies are responsible to the government of the day—in other words, the executive—would actually undertake the necessary direction, because it has been directed by parliament to the executive and then to the commission. That would be the order.

Ayes 11

Noes 33

Majority 22

AYES

Brown, M.E.
Knoll, S.K.
Murray, S.
Power, C.

Duluk, S.
Koutsantonis, A.
Pederick, A.S.
Speirs, D.J.

Ellis, F.J.
Michaels, A.
Piccolo, A. (teller)

NOES

Basham, D.K.B.
Bettison, Z.L.
Chapman, V.A.
Coward, M.J.
Gee, J.P.
Hughes, E.J.
Marshall, S.S.
Odenwalder, L.K.
Pisoni, D.G.
Tarzia, V.A.
Whetstone, T.J.

Bedford, F.E.
Bignell, L.W.K.
Close, S.E. (teller)
Cregan, D.
Harvey, R.M.
Luethen, P.
McBride, N.
Patterson, S.J.R.
Sanderson, R.
Teague, J.B.
Wingard, C.L.

Bell, T.S.
Boyer, B.I.
Cook, N.F.
Gardner, J.A.W.
Hildyard, K.A.
Malinauskas, P.
Mullighan, S.C.
Picton, C.J.
Stinson, J.M.
van Holst Pellekaan, D.C.
Wortley, D.

PAIRS

Brock, G.G.

Szakacs, J.K.

Clause 3 passed.

Clause 4.

Mr MURRAY: I move:

Amendment No 1 [Murray-2]—

Page 11, lines 19 and 20 [clause 4(2)]—Delete subclause (2) and substitute:

(2) For the purposes of subsection (1), a person will only be taken to have decision making capacity in relation to voluntary assisted dying if the coordinating medical practitioner and the consulting medical practitioner have each certified in accordance with sections 23A or 33A (as the case requires) that, to their knowledge, there is no evidence that the person may not have decision making capacity in relation to voluntary assisted dying.

This amendment is closely related to amendments Nos 5 and 6. To the extent that I traverse, as part of my commentary, matters that may be covered by amendments Nos 5 and 6, I ask for your indulgence. This amendment essentially is directed at decision-making capacity. What it seeks to do is to ensure that a candidate for VAD does in fact have decision-making capability. Just to reiterate, the existing bill assumes that, unless there is evidence to the contrary, the candidate does have decision-making capacity.

What this amendment seeks to do, very simply, is charge the doctors in question, the consulting and the coordinating medical practitioners, with an obligation to positively inquire whether that is in fact the case. It is nothing more complicated than that. Very simply, it seeks to require a positive inquiry with one set only—I repeat: one set—at one time requirement for the involvement of a medical practitioner in the process who preferably has some treatment knowledge insofar as the candidate is concerned.

By way of an example of what is currently the case, from a practical perspective in the Victorian jurisdiction, I quote—and I am happy to ask for indulgence if I am quoting from an external document—from a Dying with Dignity Victoria article, dated 16 June 2020. In that article, largely on the first anniversary of the operation of the VAD legislation in Victoria, one doctor talks about his involvement in some 79 cases of application for voluntary assisted dying and his involvement in some 30 of those applications progressing to a death.

In round terms, during the first year of that scheme that one doctor has accounted for or been involved in somewhere in the vicinity of 20 per cent of those cases. That is not to criticise that doctor or the operation of that scheme; it is simply to point out the practical reality that, certainly to start with, it is likely that the coordinating medical practitioner and the consulting medical practitioner will tend to specialise and there will tend to be a reliance on a very finite number of people being involved.

The intention of my amendment is to at least equip them with the capacity to get some better, more detailed assessment of any underlying conditions and, in particular, to make a better informed decision utilising the resources of the treating medical practitioner—usually the general practitioner, the GP—so that they can make an informed, positive assessment of the capacity of the person in question as far as their decision-making is concerned.

As I have indicated, this particular amendment is closely related to and in fact triggers further amendments, being amendments Nos 5 and 6 standing in my name, which are reliant on and dictate that process. The key difference I am proposing from the legislation before us is to have the pre-existing processes in place but to have informed, positive inquiry by the doctors making the decision on whether there is a complete absence—or, to the best of their ability, they determine there is a complete absence—of any evidence to the contrary as far as the decision-making capacity of the person is concerned.

The pre-existing legislation has, in the event that they have otherwise ascertained, in the absence of making the inquiry I am suggesting they make, pre-existing steps, which I am not seeking to frustrate with my amendments. I am just seeking to charge those doctors with a requirement for the coordinating medical practitioner, in particular, to seek to have that information provided.

The requirement to do so is at amendment No. 5, and I would like to point out that amendment No. 5 has a hefty penalty for medical practitioners who would otherwise seek to frustrate this process in terms of time. That is very deliberately designed to ensure that is not the case. Yes, it does require further information, but the nub of this amendment is to task the GPs or the medical practitioners in question with an obligation to positively inquire about the capacity of the person involved rather than simply assume they have decision-making capacity.

Mr KNOLL: I want to thank the member for Davenport for bringing this amendment to the parliament. If I think about this legislation, a lot of the public support for it is based on a principle, an ideal that assisted suicide can help to stop the suffering of people. I think of the difference between that ideal and what we have to do in this chamber, that is, to deal with the practicalities of how you make that ideal work in an environment where we often have imperfect information, imperfect people and imperfect processes.

I have often likened this debate and the people I have spoken to on this topic as not about the ideal; it is about a competing set of ideals. On the one hand, the desire to see suffering stop for a group of people in the circumstances under which this bill prescribes this option should be available to them, but there is, and I think the member for Light has expressed the same concern, a second group of people for whom access to this legislation makes them vulnerable to it.

I remember the last time we debated this topic back in 2016 sitting down and hearing from a group of mostly women who had the technical definition of a terminal illness, who also suffered from mental illness, and who said, 'If you pass this legislation, there are points in our lives where we will consider using this option.' In my mind, that second group of vulnerable people—whether it be through coercion, whether it be through feeling like a burden, whether it be through a form of mental illness and depression which can quite understandably form out of having a terminal illness—must be protected.

In that previous debate, I think the fact that that second group was not protected in a way that they should be, gave rise to many people choosing not to support that legislation. I would agree that this legislation is far tighter and seeks to try to get a better balance to help make it available for people in a tight set of circumstances, but do what it can to protect those who should not.

Certainly in terms of coercion and in terms of what the member for Port Adelaide has said about assuring us that nobody, ever, anywhere, will be coerced into voluntary assisted suicide, putting a positive obligation upon the person this parliament can trust, that they delegate to trust to make that determination about whether or not someone is being coerced, that positive obligation, I believe, with this amendment—as somebody who, as I will detail in some of the other clauses, sits very uncomfortably with legislation like this—this is a clause and a positive obligation that would give me comfort, and I think would give many people across South Australia comfort that at the point in time when somebody is seeking to access

assisted suicide under this legislation (if it were to be passed) that there is somebody who is doing more than just taking a passive look at whether or not that person is one of those vulnerable people who should not be granted application under this bill.

We in this parliament and parliaments across the country give positive obligation in so many different areas. Certainly with the abortion legislation, we created a whole series of positive obligations upon a range of health professionals. I think at the moment positive obligation is manifesting itself in terms of employers needing to provide safe workplaces free from harassment and sexual harassment. In work health and safety legislation we provide positive obligations upon employers to do a whole series of things, but as somebody who sits here I think rightly sceptical of some of the down sides of what this bill seeks to do, having somebody in the process who has a positive obligation gives great comfort to me and to people who share my concerns.

I implore this parliament to support this as something that will help to make sure that if in the many words that have been spoken on this bill in the other chamber, and already tonight in this chamber, people do not believe that coercion is something that can happen under this bill and would not be used under this bill because it is unspeakable, then providing that positive obligation should be no threat.

In fact, if this chamber chooses to vote against this, it shows hollow the fact that, whilst people say that coercion will not happen, this measure, which would provide comfort to many that coercion cannot happen (or to a greater extent cannot happen), would be hollow. This is something that I believe helps strengthen, not frustrate, and give cause to deal with what many believe is a central flaw in this, in that vulnerable people can get access to this who otherwise should not.

I thank the member for Davenport. In terms of asking the question, can I ask him to put on record what he believes a delay, if any, would happen to the process as a result of this amendment being passed. What obligations in terms of time or process does he believe a doctor needs to undertake to satisfy themselves that there has not been coercion and to comply with this amended clause?

Mr MURRAY: I will do the best I can to address the question from the member for Schubert. The amendment I have proposed here does nothing other than set the scene for a subsequent amendment. It replaces the pre-existing assumption of decision-making capability on the part of the candidate with a requirement that the coordinating medical practitioner certify to the best of their knowledge and as a result of their seeking to derive information from a medical practitioner who has conducted treatment for the candidate, generally a GP. So in the case of the first medical practitioner, the intent is to do nothing other than to require them to derive that information so that, hopefully, they make a better informed assessment of the capacity or otherwise of the candidate insofar as their capacity to make a reasonable decision is concerned.

The question to some extent traverses a further amendment, and I would make the point that, whilst coercion is a completely separate set of proposals that I intend to move and cover, the extent to what is reasonable in this case is a suggestion, at a penalty of \$10,000, that no longer than seven days is the wait required from the GP for that information, which hopefully will help the first of the medical practitioners to make a better informed decision about decision-making capability. I hope that assists.

Dr CLOSE: If I might just try to assist the member for Schubert a little, this clause is not about coercion—that is amendment No. 4. This is about decision-making capacity, which may of course interact with coercion in some way, but is not the same amendment that we are talking about. It is entirely up to every individual member here what they choose to say, but I would ask us to consider not using the words 'assisted suicide', but to refer to the activity described in the bill as 'voluntary assisted dying'.

There are people who will be listening to this and reading it later who will find the discussion of suicide very upsetting, and it is not an appropriate term for what we are talking about. If people continue to use it, that is up to them, but I want to be on record asking for consideration of not using that expression, which can be extremely upsetting for people.

The issue that is being addressed in this amendment, amendment No. 1 by the member for Davenport, is a question of the way in which decision-making capacity is to be determined. Already in the bill, in clause 14(1)(c), one of the criteria that the doctors must assure themselves of is that the person must have decision-making capacity in relation to voluntary assisted dying. Indeed, at clause 4 there is chapter and verse about how one is able to determine that. So it is not that the capacity to make decisions has not been

countenanced by this bill; it absolutely has, and it has in Victoria and Western Australia and Tasmania and is in the piece of legislation that is awaiting debate in Queensland.

The question is whether that is sufficient or whether there needs to be another level of test. This clause that we are debating right now, amendment No. 4, an addition to clause 4, is reasonably brief. However, it refers to sections 23A and 33A, which are the amendments that are made in amendments Nos 5 and 6 in [Murray-2]. They have to be really read together because they are made reference to in this clause that we are debating right now.

What they do is confer a lengthy series of obligations, both in time and in complexity, on doctors. Is that warranted? Sometimes we require things of doctors so that we can be sure, and in fact this whole bill is full of things that we require of doctors, so is more warranted is the question. In my judgement, it is an onerous addition and an addition that risks both time and complexity. Let's remember, when a dying person is seeking this, time is everything to them because time is suffering and time is lack of autonomy in decision-making.

But also what it implies is a lack of trust that we do not extend to doctors in any other circumstance. They are making life and death decisions all the time and are required not only to satisfy themselves that a person has decision-making capacity, which they do as a matter of routine, but to then go and find a doctor who has previously treated the person, as appears in the later but related clauses and amendments, and determine whether there is anything in their medical history, and to do this in writing.

Sure, we could decide to do that. We could decide to depart from the Australian model and add another layer, but my question to the member for Davenport is: on what evidence is that necessary? On what evidence, given that we already have the most conservative, full of safeguards approach in the world and we have seen it in action in Victoria and we know that the one complaint in Victoria is how long it takes and how much suffering can occur in the course of waiting? What has prompted a desire to exhibit a lack of trust and a need for further scrutiny and what I would regard as quite onerous obligations on doctors who are choosing to participate in offering this service?

Mr MURRAY: I will address some of the points and/or assertions made by the member for Port Adelaide in the order that they were made. As the member for Port Adelaide has correctly pointed out, this first amendment cascades into amendments Nos 5 and 6. In order to provide a road map for people to make a reasoned decision about the support or otherwise of this particular amendment, I will address first of all the question of this being lengthy.

This amendment seeks to do nothing other than to move the bar from a presumption that the person in question seeking VAD has decision-making capability unless there is evidence to the contrary. What this seeks to do is to instead insist that they at least have a cursory look to assess whether in fact that is the case. Is that lengthy? Well, I would submit it is not especially lengthy because in amendment No. 5—which we will debate, but it is pertinent to the question before us and the question asked of me—the so-called lengthy prerequisite is that the coordinating medical practitioner must take reasonable steps to ascertain whether there is in fact any evidence that would indicate the person does not have decision-making capability.

The means by which it is prescribed that that coordinating medical practitioner does that is that they do so by notice in writing to a specified medical practitioner who is treating or has treated the person, and there are fairly onerous requirements in terms of the return of that information and penalties for a treating practitioner who fails to agree.

The first point to make is that this moves the prerequisite from a presumption of decision-making capability to at least an inquiry based on the history of the applicant for VAD and in particular any detail that can be provided by a specified medical practitioner, generally a GP. To the question, what is the evidence that has driven this, the evidence that has driven this is in fact the Victorian experience and in particular the fact that there is a tendency with this legislation (VAD legislation) for the consulting and the coordinating medical practitioners to be specialists in this field.

In many respects, that is a very natural and quite acceptable outcome. I have no issue with that. What it does mean, however, is that it is less likely with that degree of specialisation rather than more likely that those practitioners have access to or knowledge of the details, the treatment history, of the person in question. Therefore, in the absence of some information that indicates their treatment history, they are less

likely to be able to make an informed decision about whether or not they have decision-making capacity. More particularly, they are not required to make that decision.

What they are required to do is presume that that decision-making capability exists in the absence of any evidence to the contrary. What I am asking is that they appraise themselves of the treatment history for that person in the case of the coordinating medical practitioner, the first of the medical practitioners in the chain, and that any subsequent medical practitioner simply avails themselves of that detail that has already been applied for.

I stress that there is not a requirement for this step or this process to be subsequently revisited on every other medical practitioner in this process. It is simply a prerequisite to start the process so that, ideally, the medical practitioners who are commencing the process, particularly the coordinating medical practitioner and the responsibilities they are charged with, does so from a base of better information.

The evidence, I reiterate, is simply the fact that there is specialisation. The assertion is that that in turn leads to less detailed knowledge of the individual idiosyncrasies and/or treatment history of the person in question and that a better outcome would be for that particular coordinating medical practitioner to avail themselves of the treatment to the extent that it does exist.

So that is the rationale. As the member for Port Adelaide has pointed out, this amendment and the prerequisite for that positive step, that one-time step to derive that information, informs not only this particular amendment but subsequent amendments Nos 5 and 6 as well, given that they are designed to use the fruit of this prerequisite.

The Hon. V.A. CHAPMAN: I may have a question at the end of this, if it is not clear to me, because I have a slightly different view to the member for Port Adelaide but I am interested to hear from the member for Davenport as to how this is going to apply. The proposed amendment here, amendment No. 1, substitutes subclause (2) and introduces a new level of what I describe as inquiry by both parties—and this is an obligation on both of them in this clause. That is, the coordinating medical practitioner and the consulting medical practitioner each have certified as to their knowledge.

That relates to the inquiry that I think the member for Davenport is saying, if I could paraphrase it, to look into the history of the proposed patient and identify if there is any event or occasion or prior treatment—for example, a mental health episode or something—that might alert them to the fact that there may be some incapacity on the part of the patient at this point in time. So they have to do some historical search and certify that they have done it and then combine with the proposed amendments Nos 5 and 6. If they fail to do it, there are significant penalties, so there is a two-step process here as I understand it. I hear in the submissions to support this the need to have a positive inquiry, and I will come to that in a moment.

There seems to be some concern about the subclause as it currently stands, which is subclause (2) in clause 4, which simply sets out a presumption as to decision-making capacity. This is not unusual in lots of legislation—that is, to identify that there is a presumption. For example, if a document is a birth certificate and it is signed by the registrar, it is presumed by law to be a valid legal document unless there is evidence to the contrary. So it is not unusual to have presumption clauses in here, but it seems to be being responded to in this amendment by a concern that that somehow or other lowers the threshold of obligation.

To that extent, can I just bring the member's attention to clauses 4(1) and 4(4), because here is what I see in the current bill as a positive inquiry—not to go and find the history of a patient but actually to do a number of things they have to do. They cannot just rely on subclause (2) for the patient and say, 'Look, I presume that you have decision-making capacity unless there's evidence to the contrary,' but that is looking at it in isolation.

If one looks at clause 4(1), the decision-making capacity has to occur in four circumstances: the patient has to understand the information, they have to be able to retain that information to be able to understand the extent of the information, they have to be able to use or weigh up that information as part of that process and they have to be able to communicate that either by speech or indication, etc. I am paraphrasing that, but I think you understand.

To assess those things, there must be a positive inquiry/assessment by the coordinating party, and in doing that clause 4(4) even sets out a further prescription, which requires of that person who is having capacity assessed that 'regard must'—not 'may' or 'think about it' but 'must'—'be had to the following', and here it sets out another prescription.

Firstly, the person may have the decision-making capacity to make some decisions and not others, so that is another thing they have to have regard to. Paragraph (b) states:

(b) if a person does not have a decision making capacity to make a particular decision, it may be temporary and not permanent.

Paragraph (c) provides:

(c) it should not be assumed that a person does not have a decision making capacity to make a decision—

(i) on the basis of the person's appearance; or

(ii) because the person makes a decision that is, in the opinion of others, unwise...

And paragraph (d) states:

(d) a person has decision making capacity to make a decision if it is possible for the person to make a decision with practical and appropriate support.

Again, there is a whole level of other things that have to be considered by the assessing party, if I can describe them as that. So it is not a situation of the presumption clause just suddenly leaving a clean slate and you do not have to do anything else. This bill sets out a level of inquiry which must occur and assessments which must be done.

That, I suppose, in many ways is much more prescriptive than we require of medical practitioners in other circumstances. We require them only to undertake a procedure or service medically if the patient has informed consent, and that obviously requires a certain level of interaction to be able to have that assessment. Sometimes they ask for that to be signed before they might do surgery, for example—for it to be signed off in writing. Usually their insurers require that, so that is probably not uncommon.

But if I were to use one other example of where there is quite a prescriptive process, it is in the Mental Health Act and relates to electroconvulsive therapy. There it requires a medical assessment, and again it is quite prescriptive for that to occur for that procedure. In circumstances where the consequences are very serious, like this legislation or like electroconvulsive therapy, which, of course, can have some very severe effects—hopefully, positive ones, if it is going to be administered in circumstances, but they can be in other ways—we need to be prescriptive.

I do not actually have a problem with us as a legislature identifying areas of prescription. What concerns me here is that we are considering a further obligation on behalf of the parties who do the assessment, which I still do not really quite understand the extent of, and it means they are also in the envelope of being punished penalty wise if they fail to do it.

I need to be really clear: if we are going to ask them to obtain and consider a medical history of a patient, for example—that is, make due diligent inquiry as to their prior medical treatment by, presumably, others—will it be over a very sustained period or will it be just in the last five years? I do not know, so I am asking for some indication from the member as to whether it is to be the whole of their life, which might be decades, or whether it should be confined to conduct.

I am asking the member to identify what is evidence that a person may not have a decision-making capacity. Does it go back to other aspects of their decision-making in their life: who they married, whether they bought a house wisely or not, whether they undertook certain employment, whether they did other things that were independent of a medical assessment but certainly may result in what is otherwise described in this bill as making a decision that is, in the opinion of others, unwise?

If someone looked at my history, they would probably find lots of things that I have decided to do in my life—perhaps even coming into parliament—that might be considered unwise on reflection, and I might never get past the mental incapacity test for anything. I just think we need to be clear about that, because if we are going to add another level of obligation to these assessing medical experts, and we are going to punish them if they do not do it, then I think we need to have a very clear understanding of what that is. At the moment, I am a little bit concerned that we are introducing a process that is not going to be legally enforceable in the sense of successful prosecution and, secondly, is at least vague for me at the moment as to what it actually will require.

Mr MURRAY: I thank the Deputy Premier, the member for Bragg, for her question. I will just cover very briefly some of the points that have been made. The intention is, as she has correctly pointed out, to derive on a one-time basis the history, to the extent that it is available, from a treating medical practitioner for the

person in question. The intention is to do nothing other than to perform that act as a means by which the presumption is they form a better grounded decision or assessment of the decision-making capability of the person involved.

To the member for Bragg's questions, the penalty for failure to follow is essentially directed at the medical practitioner and the GP failing to provide whatever detail they can to, in particular, the coordinating medical practitioner. The intention is not to enforce a decision about the stage or the state or the time line at which the person may or may not have had decision-making capability.

The prerequisite is very simple. It is extraordinarily simple. It is, 'Please make an assessment to the best of your ability, and please make an attempt to speak to the GP of the person in question so as to potentially better inform the decision you are making.' It is that simple. There is no additional gymnastic. It is simply a request for the person involved to go back and get the medical history for the person in question so as to make a better informed decision.

The Attorney talked about other medical procedures. I would submit that it would be unusual for medical history to not form part of some of the determinations made there. The prerequisite here is very simple, and that is to see whether in particular the coordinating medical practitioner can derive that information and therefore be better appraised so that subsequently, having derived that information, the decisions from there on are simply grounded in something other than the presumption.

There is no intention to upturn decades of established law; there is simply an intention to direct the coordinating medical practitioner to derive that information and, in particular, to do so in light of the fact that it is less and not more likely, given the specialisation that has occurred in Victoria and is reasonable to assume will happen here. There is likely to be a pre-existing knowledge of any of the medical history of the applicant. As a consequence, there is less likelihood of any evidence to the contrary being available.

There was reference to at what stage was there a clean slate. As I said, the assessment is not about making some sort of retrospective judgement as to how or when the person did or did not have decision-making capability. The intention is simply to ensure that the best available information is at hand when the assessment is being made. Unfortunately, that is as best I can explain the intention behind the amendment.

Dr CLOUSE: I think the issues have been extensively canvassed, so I want to highlight not only for the member and also for the house generally before we make a decision on this clause that there is the meaning of decision-making capacity, which is quite extensive and is in fact a positive assessment of decision-making—and of course that is a criterion for qualifying for assisted dying, that there is a decision-making capacity—but also reassure people of the thoughtfulness that sits behind this bill. Clause 24 is a referral for specialist opinion. Subclause (1) provides:

(1) If the coordinating medical practitioner is unable to determine whether the person has decision making capacity—

Therefore, that they are making a determination in this legislation—

...(for example, due to a past or current mental illness of the person), the coordinating medical practitioner must refer the person to a registered health practitioner...

So the concerns the member for Davenport has raised have been countenanced and addressed in this bill, and I believe it is unnecessary to add yet another layer on top of that. This is a recognised concern. We know that the person has a decision-making capacity, that it is enduring and it is given voluntarily, and that there are adequate provisions here to ensure that that is the case.

Mr MURRAY: I will endeavour to be brief. To be very clear, I have no issue at all with the process envisaged in the bill where the coordinating medical practitioner in particular is unable to assess or make an adverse assessment about the potential decision-making capacity of the applicant. This is simply about having a better, if possible, informed grounding for making that decision by referring back to the treatment history. That is, in essence, the sum total of what this amendment seeks to do.

Yes, the amendment does add an additional box of ticked steps to take. Given the seriousness of what we are dealing with, the intention is to ensure that the capacity is not simply assumed but that it is an informed decision. Given the importance of what is before us, that is not an unreasonable requirement in my view. In so saying, I indicate that I am happy to take other questions but I suspect we may be relitigating or furiously agreeing, as the case may be.

The committee divided on the amendment:

Ayes 19

Noes 25

Majority 6

AYES

Bell, T.S.	Brown, M.E.	Cowdrey, M.J.
Cregan, D.	Duluk, S.	Ellis, F.J.
Harvey, R.M.	Knoll, S.K.	Koutsantonis, A.
Luethen, P.	Michaels, A.	Murray, S. (teller)
Patterson, S.J.R.	Pederick, A.S.	Piccolo, A.
Power, C.	Speirs, D.J.	Tarzia, V.A.
van Holst Pellekaan, D.C.		

NOES

Basham, D.K.B.	Bedford, F.E.	Bettison, Z.L.
Bignell, L.W.K.	Boyer, B.I.	Chapman, V.A.
Close, S.E. (teller)	Cook, N.F.	Gardner, J.A.W.
Gee, J.P.	Hildyard, K.A.	Hughes, E.J.
Malinauskas, P.	Marshall, S.S.	McBride, N.
Mullighan, S.C.	Odenwalder, L.K.	Picton, C.J.
Pisoni, D.G.	Sanderson, R.	Stinson, J.M.
Teague, J.B.	Whetstone, T.J.	Wingard, C.L.
Wortley, D.		

PAIRS

Brock, G.G. Szakacs, J.K.

Amendment thus negatived; clause passed.

Clause 5 passed.

Clause 6.

The Hon. A. PICCOLO: I have a question to ask. Am I correct in assuming that clause 6(1) means that a death certificate would be issued for the pervading or underlying illness, rather than VAD?

Dr CLOSE: That is an interesting question, which is not resolved in this bill, so it is up to the Registrar for Births, Deaths and Marriages to determine, based on what the doctor who certifies the death has indicated is the cause of death. This bill is silent on that question.

The Hon. A. PICCOLO: Can I clarify this. Without trying to specify what the underlying illness is, the death certificate will not say it is a suicide though; is that correct?

Dr CLOSE: That is right. What this legislation does say is that it will not be taken to constitute suicide, which of course is important in terms of, for example, life insurance and others, so, no, it is not regarded as suicide. It is either that the person has died as a result of the underlying illness or that the person has died through a process of legal voluntary assisted dying.

The Hon. A. PICCOLO: To clarify, it says, 'For the purposes of the laws of the State'. Member for Port Adelaide, an issue that I have concern about is people's life insurance and other matters. How does that capture people who get insurance interstate or online?

Dr CLOSE: I have no answer for that. Sorry, I do not know.

The CHAIR: Sorry, what was your response, deputy leader?

Dr CLOSE: I do not know. I can have a chat to parliamentary counsel and see if there is any more advice for the chamber.

The CHAIR: You could.

Dr CLOSE: My point is that this is straying a little beyond the purview of this bill, which is to facilitate a process of voluntary assisted dying, and it is simply a statement of fact to say that that is not suicide. Suicide is in a very different category, which is why I asked earlier that people not use that term. I can seek further advice from parliamentary counsel or indeed between the houses as, given that we are likely to amend this bill, we are going to have another process in the Legislative Council. I can seek information there, but I cannot create information that I do not have in my head to answer that question.

The CHAIR: So I am clear, member for Light, your question was in regard to somebody who might be interstate?

The Hon. A. PICCOLO: No. If you live in South Australia, this law applies to you, but what if you purchase the insurance online or from a company that is interstate? To what extent does this have extraterritorial application to those states? This issue has risen before when we had franchise law reform and we had to have special provisions to cover that. I want to make sure that the law does what it intends to do. Secondly, what privacy provisions are in the bill to ensure that insurance companies do not go behind any death certificate, etc.? What privacy provisions are available?

Dr CLOSE: This clause does not refer to privacy provisions. This law is simply stating that voluntary assisted dying is not suicide.

The CHAIR: Member for Light, I might suggest that we attempt to seek an answer between the houses to that question.

The Hon. A. PICCOLO: I understand what the intention of the law is, and I support the clause, but I just want to make sure that the clause actually does what it says it does in a practical sense and does not impact on people later when they find out it actually does not do what it says it does in a whole range of commercial transactions.

The CHAIR: I do not know that we will have the answer to that here today.

The Hon. A. PICCOLO: Maybe it could be taken as questions on notice and be answered between the houses.

The CHAIR: Questions on notice or seek the answers between the houses, yes.

Clause passed.

Clause 7.

The Hon. A. KOUTSANTONIS: What is the impact of an interpreter not being able to be sourced who fits the criteria?

Dr CLOSE: The harsh reality is that if the wishes of the person are not able to be clearly understood without an interpreter it means that person is no longer eligible to be considered.

Clause passed.

Clause 8.

Mr MURRAY: I move:

Amendment No 2 [Murray-2]—

Page 13, after line 31 [clause 8(1)]—Insert:

(k) every person has the right to make decisions about medical treatment options freely and not as a consequence of the suggestion, pressure, coercion or undue influence of others.

This very simply seeks to add the clause in question as a means whereby it can be subsequently, at amendment No. 4, relied upon as a qualification. The intention with this particular amendment is to do nothing other than just stipulate that the person has a right to seek medical treatment freely and not as a consequence of any suggestion, pressure or coercion.

The intention here is to have a lack of coercion, in particular a person's right to a lack of coercion, enshrined as a principle along with the other 10 principles set out in that clause. The intention, as I said, is that this can then be the subject of a subsequent amendment but, as a general statement of principle, that is the sole intention of this particular amendment.

Amendment carried; clause as amended passed.

Clause 9.

The Hon. A. KOUTSANTONIS: In terms of making the first request, how is that made? It must be a written declaration or a verbal declaration. What level of evidence is required for a person making the initial request, that first request?

Dr CLOSE: If you turn, member for West Torrens, to page 17, clause 17—Person may make first request to registered medical practitioner, that specifies, I think, some of the information that you are seeking. The person may make the request to a registered medical practitioner for access to voluntary assisted dying, and it must be clear and unambiguous and made by the person personally, but it can be done verbally or by gestures, so not in writing for the first request. It is also the case that separately a doctor is unable, by terms of this legislation, to ever raise or suggest the idea. It has to be initiated by the person, but that is in a separate clause. Does that answer sufficiently?

The Hon. A. KOUTSANTONIS: So it does not need to be a written request?

Dr CLOSE: The first request does not. It initiates a process, and then, as we go back to the clause that we are now debating, clause 9, one of the elements that is later required is that there is a written declaration.

Clause passed.

Clause 10.

The Hon. A. KOUTSANTONIS: An employee of a prescribed organisation who is a health practitioner can conscientiously object at any facility—hospital, aged-care facility, medical practice, residential?

Dr CLOSE: That is right. Any registered health practitioner who might participate in this process, including a GP, a specialist, a pharmacist, is able to conscientiously object and not be involved.

The Hon. A. KOUTSANTONIS: Are members of a governing body, a board of a registered organisation, able to conscientiously object to their facility being used for the purposes of VAD?

Dr CLOSE: This clause does not countenance anything other than a person who is participating as a registered health practitioner. There are amendments coming further along that do address the question of whether an institution can opt out of having the service offered. We will be contemplating those subsequently, but this is about a person who is actually delivering a step in the process of voluntarily assisted dying being absolutely free to not do that.

The Hon. A. KOUTSANTONIS: So clause 10 is not the clause where institutions can conscientiously object?

Dr CLOSE: That is coming up in the amendments that are being proposed by the member for Davenport and then also by me.

Clause passed.

New clause 10A.

Mr MURRAY: I move:

Amendment No 3 [Murray-2]—

Page 14, after line 19—Insert:

10A—Conscientious objection of operators of certain health service establishments

(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 the 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) To avoid doubt, this section does not apply to, or in relation to, a patient accepted into a health service establishment before the commencement of this section.

(6) In this section—

health service establishment means—

(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; or

(b) the whole or part of any other private institution, facility, building or place that is operated or designed to provide inpatient or outpatient treatment, diagnostic or therapeutic interventions, nursing, rehabilitative, palliative, convalescent, preventative or other health services (including, to avoid doubt, places of short-term respite care); or

(c) any other health service establishment of a kind prescribed by the regulations, but does not include prescribed residential premises, or any establishment declared by the regulations not to be included in the ambit of this definition;

prescribed residential premises means—

(a) a facility (within the meaning of Part 1A);

(b) any other residential premises of a kind prescribed by the regulations;

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

This amendment inserts new clause 10A. This is the clause to which the member for Port Adelaide and I made reference at the start of this evening's proceedings. Whilst the focus has understandably been on the capacity of faith-based institutions to assert their rights in regard to conscientious objection, I simply want to make the point, without belabouring it, that it is not just simply those organisations that are minded to do so. I point out for the benefit of members that I am happy to table and/or seek leave, Chair, whichever you are happy with.

The Australian Medical Association's position statement on the subject of conscientious objection, which was issued in 2019, makes the following point regarding institutional conscientious objection:

3.1 Some health care facilities may not provide certain services...

It goes on to make the point that some facilities do not provide services due to conscientious objection:

...(for example, some...with religious affiliations will not provide termination of pregnancy, sterilisation or IVF services). In such cases, an institution should inform the public of their conscientious objection and what services they will not provide...

So there is an obligation to disclose. There are some indications as to how that might be effected, in terms of websites and patient brochures, etc. The second part of the position statement regarding institutional conscientious objection states:

3.2 At times, a patient admitted to an institution may request a treatment or procedure that the institution does not provide due to conscientious objection.

In that circumstance:

...doctors should be allowed to refer patients seeking such a service to another doctor outside the facility.

That is the basis on which the legislation of every other jurisdiction has been implemented. In all the other cases there has been a silence on this issue, and it is the position statement that I read out that has been relied on—off the books, so to speak—to facilitate these vexed issues and reconcile them.

Whether it is the Queensland Law Reform Commission or whether it is the entities themselves, the preference is to have a commensurate obligation for these entities to advise potential patients or users of their service—this is health service establishments, and their definition very clearly sets out that it is also their hospitals.

In the event that a patient wants VAD, the requirement is that they facilitate that by seeking to take care of the patient via the provision of that service at another establishment. What this clause simply seeks to do is provide certainty for those hospitals and their patients and to provide some commensurate obligations to follow what is in the AMA position statement.

As I have described, this is the subject of a commitment that the member for Port Adelaide and I have made to each other. I provide that background by way of very brief example as to the veracity thereof.

Dr CLOSE: I would like to take a brief opportunity to explain why I will be supporting this amendment. I think we talked about this a bit in the abortion debate as well, that there is often a gap between what is and what one would like there to be. In this case, the truth is that there are organisations that run health care that do not wish to be involved in voluntary assisted dying. That is the reality of the way in which we have constructed our healthcare system in Australia.

In Victoria, the silence on the subject of whether or not these services are going to be available in every institution has resulted in patients having a degree of uncertainty about their entitlement and their rights and also the organisations having a degree of uncertainty about what they are able to do to exercise what the board or the management of that institution feels is the right thing to do.

This amendment, paired with the one I will be putting shortly about people who are effectively in their home, their permanent place of residence, is about people who are in what would be regarded as short stay situations—hospitals and hospices. The example we would all be familiar with in South Australia is, of course, Calvary Hospital.

What is clear in how things are is that Calvary Hospital has an accreditation process—as do all private hospitals—where they credential doctors coming in. They do not wish to credential doctors coming in for that purpose, and I think we have to accept that is how the system is going to work, recognising that I see merit in acknowledging that because it will ensure that people are aware of it.

It may also have a requirement that the relevant health service provider will ensure the person going into that circumstance is aware of what they are and are not able to do, and therefore there is a degree of transparency about the situation, and there are reasonable steps made to facilitate the transfer of the patient elsewhere should they, even under those circumstances, nonetheless find themselves in a condition where they do wish to have access to voluntary assisted dying.

In acknowledging that there are healthcare services that would take this position, we are better off in our legislation in learning from the experience of silence in Victoria, and strengthening clarity about what is known by the patients, acknowledging the reality that there will be providers that will seek to opt out of this and that there is a requirement for reasonable steps to be taken to facilitate transfer. Even people who desperately want to see voluntary assisted dying occur in South Australia as a legislative reform could come to see that all of those strengthen this legislation over the Victorian legislation.

The Victorian legislation, in being silent, has had to push the question of how to deal with this reality into government policy. We are choosing to learn from them and place it into legislation. Paired with what I hope will be a successful amendment of mine for people who are living in institutions that are their home, it confers on them more rights, more entitlement. This is a reasonable accommodation in addressing the reality of how our healthcare system works.

The Hon. A. KOUTSANTONIS: I have a question for the member for Davenport. His amendment does not give the ability for aged care facilities to conscientiously object; is that correct?

Mr MURRAY: That is correct. By way of background, and to some extent also to cover the points that the member for Port Adelaide has made, my initial set of amendments sought to very deliberately

distinguish conscientious objection for hospitals on the one hand, and a separate amendment directed to enable conscientious objection for entities typically referred to as retirement villages, independent living units, etc., on the other.

The genesis of my decision, which I stress has not been taken lightly and which has been made in conjunction with me speaking to a wide variety of people, is very simply as follows. As the member for Port Adelaide has pointed out, this amendment reflects the reality, and the reality is that a private hospital—and to be very specific about it, in this case Calvary—does not wish to be required to authorise, facilitate or be complicit in any way with the VAD process.

As the member for Port Adelaide has pointed out or alluded to, in order for a medical practitioner to perform any service at a hospital generally, and in this case at Calvary, they need to be accredited and the accreditation process would therefore—were an alternative to be considered to force them to be participants—in turn force them to consider changing their accreditation process to embrace that which they simply do not believe in. They have made it abundantly clear that they would not be prepared to do that.

The good news is that they would not shut up shop immediately, but in the event that they were forced to become unwilling accomplices by way of court action or someone testing that, they would shut shop. The practical reality here that we are trying to address is the fact that, with the hospital service and the reality on the ground, we can still have voluntary assisted dying and we can acknowledge the very real and deeply held conscientious objections.

To the member for West Torrens' point, the practical reality—in talking to the people on the ground dealing with this in a situation where there is not a prerequisite or indeed an opportunity for the accreditation of doctors who are visiting these facilities—in other jurisdictions is that doctors come and go and the patient-doctor confidentiality provision means that the operators of the facility by their very definition have no way of ascertaining what medical service is being provided, whether it is VAD or whether it is a consultation on some other thing.

We are straying somewhat but to your question, which more accurately moves into the purview or the domain of the amendment that the member for Port Adelaide will move subsequent to this and which I have indicated I will support, the practical reality we face as legislators is that (in real life) in one case you are not going to get doctors accredited and that is why we have 10A, and in the other the practical reality is that you cannot intervene in doctor-patient confidentiality and, as a result, ascertain whether they are talking about VAD, the football, an ingrown toenail, whatever the case may be.

We are seeking to make a real-world assessment of what is going on. That is why I have removed new clause 10B, my amendment that was constructed prior to having an opportunity to talk at length with on-the-ground experts from Catholic Health Australia, Calvary and a variety of other people about the fact that, on the one hand with hospitals, recognition and enshrining the conscientious objection is possible and desirable. On the other hand, whilst it may be desirable in practice it is completely devoid of any capacity to enforce. The enforcement simply does not exist.

That is not to say that those organisations cannot stipulate that. That is not to say that they are not allowed to provide that information about their beliefs or indeed their lack of desire to participate. It simply means that what we have sought to do as a result of taking extensive and I stress extremely well-qualified evidence from the experts has informed the genesis of new clause 10A that you have before you.

The Hon. A. KOUTSANTONIS: It seems to me there is one fundamental error in the member's point, and this is not a criticism. It is that doctors in a hospital also have patient confidentiality requirements with them as well. So Calvary or Southern Cross or whatever the entity is have no line of sight to what is being talked about between a doctor and a patient in their care—none—and nor should they.

We are simply making a carve-out for hospitals on the basis of a religious objection because the proprietors of that hospital have a philosophical, moral, Christian or religious view about voluntary assisted dying, yet the same operators who operate an aged-care facility (not a retirement village, an aged-care facility) are not given that same ability to object conscientiously on the basis of those very same views that the member just outlined that a hospital can, and this is where I find the difficulty.

If the carve-out is good for one, why is not the carve-out good for the other? The reason the member gives the house is that, in practice he claims, you cannot find out why a doctor is speaking to someone in an

aged-care facility. What I would submit to the member is that Calvary cannot ask what a doctor is speaking to a patient about in one of their hospitals either, so what is the difference? I would like that answer from the member: what is the difference?

I suppose what the member is getting down to is that in retirement villages we are talking of the sense of property or ownership of a room as a home as opposed to a facility in a hospital, where you are basically in a bed. Is that the only difference you are talking about?

Mr MURRAY: The member for West Torrens asks what is the difference. The very simple answer is this: the distinction between the two is that VAD is a recognised medical service, and before any form of medical service can commence, whether it is removing an appendix or whatever it is, the doctor has to be accredited to do so at the organisation at which it is being accredited.

What is occurring in practice here is that, to paraphrase, if a VAD specialist were to wander up to, in this case Calvary, and say, 'Hello, I would like to be accredited to pop into your hospital to talk to and/or facilitate VAD,' the answer they would derive is, 'I'm terribly sorry. Our accreditation process does not cover the provision of those services,' just like it does not cover brain surgery or a whole variety of other medical services. That is the fundamental difference in the member's question.

They simply as an organisation do not accredit it and they will not accredit the provision of that medical service. So the question of doctor-patient confidentiality does not come into it; they never actually get there. They simply will not provide the service, they will not provide accreditation for the service, they will not change their processes to enable it and, as a consequence, any qualified medical practitioner who is seeking to practice or deliver that service will not be able to be accredited to do so in that hospital.

That is the framework we are working with, as opposed to the nursing home example, where all we can in practice rely on, or that we know for sure, is that when a doctor arrives at that facility to see Mr Koutsantonis in room 10—I am not suggesting his early demise, goodness me, no, may he live long and prosper, and I apologise for using Mr Koutsantonis (perhaps he is there to see you about your ingrown toenail). At the nursing home, the practical reality is that all we have is patient-doctor confidentiality and, as a consequence, whilst that organisation knows the doctor is in attendance, they have no real way of ascertaining, certainly at that initial stage, what the discussion is about and/or what service or consultation may be supplied.

To the question: what is the difference? The difference is accreditation. Calvary, to use it as an example, will not accredit the delivery of VAD in its facilities and therefore it is, by definition, not possible for a doctor to be accredited to provide that service and, as a consequence, irrespective of the discussion between a doctor and a patient at that service, it is not possible to deliver that service. In fact, it is arguably illegal to do so and the point is made that delivery of a service at an organisation which is not accredited to do so is in fact a breach of most health guidelines and certainly those that are operated by the health services.

The Hon. V.A. CHAPMAN: I indicate that I support the amendment No. 3 [Murray-2] to insert clause 10A in relation to a health service establishment and, essentially, the conscientious objection of that provider. I thank the member for Davenport for his contribution in the discussions to respect the service provider's requests in this regard. I think it is admirable and I think it is sensible that there is provision for the provider to ensure that notice is given to any party who wishes to use their private hospital services to understand what the circumstance is and, indeed, have the right to seek confirmation in writing as a condition of entry those terms.

I think the early notice of that is an important and helpful addition and I would hope that if we do ultimately look at some national recognition of the conscientious objection clauses, if I can put it as broadly as that, this will serve as a helpful model. I also thank in advance the anticipated support of the member of Davenport with the presentation of a foreshadowed clause 13A of the member for Port Adelaide to deal with other residential facilities, which are defined in the foreshadowed amendment. It is different and for the reasons that have been explained.

I am not sure I entirely understand the difference in relation to the opportunity to look behind the doctor-patient relationship, but for me the distinction is that one is a hospital and is providing a service and if it is a faith-based organisation, for example, we are respecting, with the support of this motion, that they have the right to be able to make that determination as to who they accept as patients, whereas, in relation to other premises, it is their home.

Many of us enjoy having our own independent residence, which we own or rent and we have that. But for many others who are relying on residential facilities, they have bought a space, they have bought an entitlement to live there and it is their home and that should be respected, and a different set of rules apply, as much as possible commensurate with what you or I might enjoy in living in our own individual dwelling.

The CHAIR: I will call the leader. I did make the point that members needed to be in their place, but given the circumstances I will allow you.

Mr MALINAUSKAS: In regard to the proposed amendment from the member for Davenport, I would simply like to make a couple of remarks, starting at a higher level principle rather than some of the specifics traversed in the discussion thus far. I think it is fair to say that in terms of this debate generally and in terms of the bill that is before the consideration of the house, this is something that I have put a fair degree of contemplation into over recent months, if not longer. It is a subject that, quite frankly, I personally have struggled with, as I know every member has in their contemplations, trying to rationalise what the appropriate vote to cast is on the bill, generally.

It has been something that, for me personally, has necessitated weighing up a whole suite of competing variables and many of those have been traversed by other members during the course of I think well put and well thought through and sincere second reading contributions. I do not intend to do that now; now is not the time for that.

But one of the persuasive arguments in favour of the VAD legislation generally is this idea of choice, this idea, this principle of people having the ability to choose a course of action that currently is not available to them under the law, that would be consistent with their values. I find that a persuasive argument. I think most people who live in our Liberal democracy would find that a persuasive argument and then it becomes a test of whether or not that can be rationalised with all the conditions, most of which I am satisfied are within this bill.

But in that principle of choice also comes this issue of a choice not to participate and trying to balance competing objectives of people who want to get access to VAD versus those who want to elect to have no role in the provision of VAD which results in a point of conflict, a point of tension, which necessarily needs to be resolved in the legislation.

This is something I feel quite strongly about because I find it incongruous on one hand to be persuaded by the necessity for choice for people to get access to VAD but then not be persuaded by the argument that someone should be able to choose not to participate in that process. I believe that principle of choice should extend not just to the individual—

The CHAIR: Leader, I am sorry to interrupt you mid-stride, but I am going to call those members on the government benches to cease their conversations while a contribution is being made. Thank you, leader.

Mr MALINAUSKAS: Not just to be persuaded that the issue of choosing not to participate in the provision of the service applies beyond the individual, I believe it also should apply to an institution. Then of course comes the test of what constitutes an institution and their ability to conscientiously object, and how should that test be applied? I do think this concept of ownership of land is a reasonable position to start, which has informed my view that the pursuit of conscientious objection via institutions is a legitimate course of action, notwithstanding the fact that that may ultimately result in the denial to an individual of access to a service such as VAD.

I want to commend the work that I understand has occurred throughout the course of today and no doubt yesterday evening from the member for Davenport in his discussions that I understand have taken place with the member for Port Adelaide, amongst others, who have been close to the development of this bill in their pursuit of trying to find a set of amendments that rationalises those competing objectives about getting the balance right between the interests of those who would reasonably seek to get access to this service versus those who reasonably seek to not participate in the delivery of it.

I think this amendment largely strikes that balance because it preserves the ability for a hospital to not participate in the provision of the service while also acknowledging that there is a legitimate distinction between a hospital and a home which goes to that concept of ownership informing the ability to object.

So I rise in support of this clause. I think it is the right avenue and I think it strikes that balance. I would simply ask the member for Davenport if he is satisfied that those people who have made representations to

him that institutional conscientious objection should be a tenet within the bill has been realised through this amendment.

Mr MURRAY: The short answer is yes. The shorter answer is that I have consulted a whole variety of people, as you have pointed out, in the discussions with the member for Port Adelaide as well as the operators of the facilities to which you refer. This amendment will enable them to continue to provide the sterling service that they do to the South Australian community whilst ensuring that they exercise their right to choose the medical services that they provide. It is a risk I will take nonetheless. At the risk of trivialising this debate—and it is a risk I will take nonetheless—that can be either VAD or brain surgery or IVF or any number of medical procedures.

The short answer is that this does enable them to exercise or to continue to exercise their conscience. As the member for Port Adelaide has rightly pointed out, what this amendment does that has not occurred in any other jurisdiction that has implemented VAD is that it enables clarity for both the institutions and for people going to those institutions as to what is or is not available by way of VAD procedures in this case or indeed any other procedure.

It enshrines the process that is already being used, but it elevates it such that everyone can make an informed choice about what is occurring. I think that is the nub of what we are here to discuss this evening. I reiterate again in answer to the leader's question: this enables those organisations to continue to operate and to express that conscientious objection, and I have no doubt whatsoever that therefore they are very supportive of us agreeing to embrace it.

Ms COOK: I essentially want to put my thoughts on record with respect to this, and I will ask a brief question at the end. I fundamentally believe that the population at large wants this bill to pass. We know that it is somewhere around 80 to 85 per cent of the population; in fact, in older cohorts it may well be much higher. People do not want to suffer. They make informed choices, and doctors support that daily.

I am very concerned about organisations being able to conscientiously object to participation in this. I am very worried about that, particularly from a point of view of the number of people who suffer terminal illnesses and find themselves within hospitals—private hospitals, very large, very well funded private hospitals that benefit from our population going through their doors.

I do not have an issue with individuals who have a conscientious objection and who need to be able to refer—and we had this debate during the abortion debate—their patients on to somebody who does not object to participating in such a practice. But the things central to voluntary euthanasia are ensuring adequate safeguards and protecting an individual's self-determination and their choice.

People who find themselves at this stage of life do not choose to access euthanasia because it is an easy thing to do. It worries me somewhat that somebody may find themselves suddenly at a tipping point whilst in a hospital or a hospice and then be required to vacate themselves from such a facility. I find it abhorrent, having cared for not one or two or even dozens but hundreds of people over the years in my career as a nurse who have found themselves at end of life. For none of them would I want to have to extract them and move them to another facility.

I think this is a word of warning to the hospitals that would like to make this decision—and I do think this amendment will pass. I think this will pass, and I may well be counting my own numbers and by myself; I do not know how the numbers will go. But I will not be voting for it, because I support people and their right to make those decisions at a point of life and not suffer further pain, embarrassment or indignity.

I absolutely respect the work that has been done in the negotiations by our deputy leader, who is taking the lead here, our leader in the upper house, Kyam Maher, and the member for Davenport. I thank you for doing that work and I humbly vote no based on my experiences and what I believe fundamentally is right.

I will say what I said in our briefing, that I would rather throw down the gauntlet and say to such institutions, 'I dare you. I dare you to stop Dr Hunt from practising within your walls because he avails someone of the choice to dignity at the end of their life,' because I do not think they would. I will not be voting yes for this.

My question to the member for Davenport is: can the member for Davenport guarantee that he (a) has done the research, (b) completely understands the consequences and (c) can assure us that this will not cause further pain, suffering and indignity to people who find themselves in such an institution and cannot avail themselves of the end-of-life choice that they have already perhaps got in place?

The CHAIR: There are three questions there, member for Davenport.

Mr MURRAY: I do not presume to even have a modicum of the medical expertise or whatever is required to issue any sort of guarantee in this environment. Like the member for Hurtle Vale and all of us, I am doing the best I can to navigate this issue on behalf of the people I represent.

I will reiterate that I am philosophically opposed to the notion of voluntary assisted dying on a personal level. I have tendered these amendments, which were they all to be supported I am on the record as saying I will vote for the legislation. Let's be very clear about that. I am not a dyed-in-the-wool hardcore supporter of this. I am someone who is seeking to do the best I can to navigate this and provide as much protection as possible, so that those people who unquestionably wish to access this can.

I am sorry, member for Hurtle Vale, I am not going to extend any guarantees. What I will tell you is that I have agonised about this. I have made the effort to engage with both sides of the debate and, given this is a personal decision, I have done the best I can to enshrine the protections that I think are necessary not just for me and my conscience but for the people who may otherwise access this.

I reiterate: I am determined that at the end of this, when this passes, I have done the best thing I can to ensure that the people who are accessing it are the right people and that they are supported. I hope to be in a position, notwithstanding my personal beliefs, as a representative in this place to ensure that the people who want to access this have the benefit, for what it is worth, of the compassion I think I should be extending in enabling them to do so.

You are not going to get a guarantee, other than I am giving it my best shot. My determination in this regard and indeed insofar as the other amendment is concerned that we will shortly contemplate, which I have already indicated I will support, as I have pointed out to the member for West Torrens, is that these are grounded in the practical reality of the landscape we have, both from the hospital perspective and in other environments. They are not pretty, they are not comprehensive, they are not capable, I do not think, of guarantee, other than me giving the best possible deliberation and work that I can to ensure that we have choice and we have compassion. That is all I can provide in response to your questions.

The Hon. A. KOUTSANTONIS: I have been asked by a service provider to ask the member for Davenport this question: would 10A cover some nursing home facilities?

Mr MURRAY: I suspect the answer, member for West Torrens, relies on the definitions enshrined in the clause. In particular, I point you to subclause (6), which talks about a health service establishment being 'a private hospital within the meaning of the Health Care Act 2008 or other private health facility of a kind prescribed by the regulations'. To be very clear, to the extent that that organisation does in some way fall under the purview of that, the answer is yes, with that caveat.

New clause inserted.

Clause 11.

The Hon. A. KOUTSANTONIS: What is the penalty if a registered health practitioner does initiate VAD conversations with a patient?

Dr CLOSE: The answer is in subclause (3): 'A contravention of [that] subsection,' which provides that a health practitioner cannot initiate a discussion, 'is to be regarded as unprofessional conduct within the meaning and for the purposes of the Health Practitioner Regulation National Law'. There are processes that flow from that.

Clause passed.

Clauses 12 and 13 passed.

New clauses 13A to 13K.

The CHAIR: Now we come to the member for Port Adelaide's amendment No. 1, which seeks to insert new clauses 13A to 13K. Before I call the leader, I might just speak to this for a moment. The member for Port Adelaide's amendments to insert clauses 13A to 13K inclusive is a very long and involved amendment. As such, I intend to work my way through each clause of the amendment in order to give any member wishing to ask questions at any point in the amendment that opportunity. However, having given the members that opportunity, I am not going to put the question on the amendment until the end. That is the way I am going to approach it.

The Hon. A. Koutsantonis interjecting:

The CHAIR: Member for West Torrens, the one amendment includes new clauses 13A through to 13K. I will give members the opportunity to ask questions on each of those, but I will put them as one question at the end.

Dr CLOSE: I move:

Amendment No 1 [Close-2]—

Page 15, after line 17—Insert:

Part 1A—Conscientious objection of operators of certain residential facilities

Division 1—Preliminary

13A—Interpretation

In this Part—

deciding practitioner, for a decision about the transfer of a person, means—

- (a) the coordinating medical practitioner for the person; or
- (b) if the coordinating medical practitioner for the person is not available, another medical practitioner nominated by the person;

facility means—

- (a) a nursing home, hostel or other facility at which accommodation, nursing or personal care is provided to persons on a residential basis who, because of infirmity, illness, disease, incapacity or disability, have a need for nursing or personal care; or
- (b) a residential aged care facility;

relevant entity means an entity, other than a natural person, that provides a relevant service;

relevant service means a residential aged care service or a personal care service;

residential aged care means personal care or nursing care (or both) that is provided to a person in a residential facility in which the person is also provided with accommodation that includes—

- (a) staffing to meet the nursing and personal care needs of the person; and
- (b) meals and cleaning services; and
- (c) furnishings, furniture and equipment for the provision of that care and accommodation;

residential aged care facility means a facility at which residential aged care is provided, whether or not the care is provided by an entity that is an approved provider under the *Aged Care Quality and Safety Commission Act 2018* of the Commonwealth;

residential facility does not include—

- (a) a private home; or
- (b) a hospital or psychiatric facility; or
- (c) a facility that primarily provides care to people who are not frail and aged.

13B—Meaning of permanent residents of certain facilities

(1) A person is a *permanent resident* at a facility if the facility is the person's settled and usual place of abode where the person regularly or customarily lives.

(2) A person is a *permanent resident* at a facility that is a residential aged care facility if the person has security of tenure at the facility under the *Aged Care Act 1997* of the Commonwealth or on some other basis.

(3) A person is not a permanent resident at a facility if the person resides at the facility temporarily.

Division 2—Information about voluntary assisted dying

13C—Access to information about voluntary assisted dying

(1) This section applies if—

- (a) a person is receiving relevant services from a relevant entity at a facility; and
- (b) the person asks the entity for information about voluntary assisted dying; and

(c) the entity does not provide at the facility, to persons to whom relevant services are provided, the information that has been requested.

(2) The relevant entity and any other entity that owns or occupies the facility—

(a) must not hinder the person's access at the facility to information about voluntary assisted dying; and

(b) must, on request, allow reasonable access to the person at the facility by a registered health practitioner or other person to enable the registered health practitioner or other person to personally provide the requested information about voluntary assisted dying to the person.

Division 3—Request and assessment process

13D—Application of Division

This Division applies if a person is receiving relevant services from a relevant entity at a facility.

13E—First requests and final requests

(1) This section applies if—

(a) the person or the person's agent advises the relevant entity that the person wishes to make a first request or final request (each a *relevant request*); and

(b) the entity does not provide, to persons to whom relevant services are provided at the facility, access to the request and assessment process at the facility.

(2) The relevant entity and any other entity that owns or occupies the facility must allow reasonable access to the person at the facility by a medical practitioner—

(a) whose presence is requested by the person; and

(b) who—

(i) for a first request—is eligible to act as a coordinating medical practitioner; or

(ii) for a final request—is the coordinating medical practitioner for the person.

(3) If the requested medical practitioner is not available to attend, the relevant entity must take reasonable steps to facilitate the transfer of the person to and from a place where the person's relevant request may be made to—

(a) the requested medical practitioner; or

(b) another medical practitioner who is eligible and willing to act as a coordinating medical practitioner.

13F—First assessments

(1) This section applies if—

(a) the person has made a first request; and

(b) the person or the person's agent advises the relevant entity that the person wishes to undergo a first assessment; and

(c) the entity does not provide, to persons to whom relevant services are provided at the facility, access to the request and assessment process at the facility.

(2) If the person is a permanent resident at the facility—

(a) the relevant entity and any other entity that owns or occupies the facility must allow reasonable access to the person at the facility by a relevant practitioner for the person to assess the person; and

(b) if a relevant practitioner is not available to attend—the relevant entity must take reasonable steps to facilitate the transfer of the person to and from a place where the person's assessment may be carried out by—

(i) the relevant practitioner; or

(ii) another medical practitioner who is eligible and willing to act as a relevant practitioner.

(3) If the person is not a permanent resident at the facility—

(a) the relevant entity must take reasonable steps to facilitate the transfer of the person to and from a place where the person's first assessment may be carried out by a relevant practitioner for the person; or

(b) if, in the opinion of the deciding practitioner, transfer of the person as described in paragraph (a) would not be reasonable in the circumstances, the entity and any other entity that owns or occupies the facility must allow reasonable access to the person at the facility by a relevant practitioner for the person.

(4) In making a decision referred to in subsection (3)(b), the deciding practitioner must have regard to the following:

(a) whether the transfer would be likely to cause serious harm to the person;

- (b) whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying;
- (c) whether the transfer would cause undue delay and prolonged suffering in accessing voluntary assisted dying;
- (d) whether the place to which the person is proposed to be transferred is available to receive the person;
- (e) whether the person would incur financial loss or costs because of the transfer.

(5) In this section—

relevant practitioner for a person, means—

- (a) the coordinating medical practitioner for the person; or
- (b) a registered health practitioner to whom the coordinating medical practitioner for the person has referred a matter under section 22.

13G—Consulting assessments

(1) This section applies if—

- (a) the person has undergone a first assessment; and
- (b) the person or the person's agent advises the relevant entity that the person wishes to undergo a consulting assessment; and
- (c) the entity does not provide, to persons to whom relevant services are provided at the facility, access to the request and assessment process at the facility.

(2) If the person is a permanent resident at the facility—

- (a) the relevant entity and any other entity that owns or occupies the facility must allow reasonable access to the person at the facility by a relevant practitioner for the person to assess the person; and
- (b) if a relevant practitioner is not available to attend—the relevant entity must take reasonable steps to facilitate the transfer of the person to and from a place where the person's assessment may be carried out by—
 - (i) the relevant practitioner; or
 - (ii) another medical practitioner who is eligible and willing to act as a relevant practitioner.

(3) If the person is not a permanent resident at the facility—

- (a) the relevant entity must take reasonable steps to facilitate the transfer of the person to and from a place where the person's assessment may be carried out by a relevant practitioner for the person; or
- (b) if, in the opinion of the deciding practitioner, transfer of the person as described in paragraph (a) would not be reasonable in the circumstances, the entity and any other entity that owns or occupies the facility must allow reasonable access to the person at the facility by a relevant practitioner for the person.

(4) In making a decision referred to in subsection (3)(b), the deciding practitioner must have regard to the following:

- (a) whether the transfer would be likely to cause serious harm to the person;
- (b) whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying;
- (c) whether the transfer would cause undue delay and prolonged suffering in accessing voluntary assisted dying;
- (d) whether the place to which the person is proposed to be transferred is available to receive the person;
- (e) whether the person would incur financial loss or costs because of the transfer.

(5) In this section—

relevant practitioner for a person, means—

- (a) the consulting medical practitioner for the person; or
- (b) a registered health practitioner to whom the consulting medical practitioner for the person has referred a matter under section 31.

13H—Written declarations

(1) This section applies if—

- (a) the person has been assessed as eligible for access to voluntary assisted dying; and
- (b) the person or the person's agent advises the relevant entity that the person wishes to make a written declaration ; and
- (c) the entity does not provide, to persons to whom relevant services are provided at the facility, access to the request and assessment process at the facility.

- (2) If the person is a permanent resident at the facility—
- (a) the relevant entity and any other entity that owns or occupies the facility must allow reasonable access to the person at the facility by the coordinating medical practitioner for the person and any other person lawfully participating in the person's request for access to voluntary assisted dying to enable the person to make a written declaration; and
 - (b) if the coordinating medical practitioner is not available to attend—the relevant entity must take reasonable steps to facilitate the transfer of the person to and from a place where the person may make a written declaration.
- (3) If the person is not a permanent resident at the facility—
- (a) the relevant entity must take reasonable steps to facilitate the transfer of the person to and from a place where the person may make a written declaration; or
 - (b) if, in the opinion of the deciding practitioner, transfer of the person as described in paragraph (a) would not be reasonable in the circumstances, the entity and any other entity that owns or occupies the facility must allow reasonable access to the person at the facility by a relevant practitioner for the person and any other person lawfully participating in the person's request for access to voluntary assisted dying.
- (4) In making a decision referred to in subsection (3)(b), the deciding practitioner must have regard to the following:
- (a) whether the transfer would be likely to cause serious harm to the person;
 - (b) whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying;
 - (c) whether the transfer would cause undue delay and prolonged suffering in accessing voluntary assisted dying;
 - (d) whether the place to which the person is proposed to be transferred is available to receive the person;
 - (e) whether the person would incur financial loss or costs because of the transfer.
- (5) In this section—
- relevant practitioner* for a person, means—
- (a) the coordinating medical practitioner for the person; or
 - (b) a registered health practitioner to whom the coordinating medical practitioner for the person has referred a matter under section 31.

13I—Application for voluntary assisted dying permit

- (1) This section applies if—
- (a) the person has made a final request; and
 - (b) the person or the person's agent advises the relevant entity that the person wishes to make an application for a voluntary assisted dying permit; and
 - (c) the entity does not provide, to persons to whom relevant services are provided at the facility, access to a person's coordinating medical practitioner to enable such an application to be made.
- (2) If the person is a permanent resident at the facility—
- (a) the relevant entity and any other entity that owns or occupies the facility must allow reasonable access to the person at the facility by the coordinating medical practitioner for the person to consult with and assess the person in relation to the application; and
 - (b) if the coordinating medical practitioner is not available to attend—the relevant entity must take reasonable steps to facilitate the transfer of the person to and from a place where consultation and assessment of the person can occur in relation to the application in consultation with, and on the advice of—
 - (i) the coordinating medical practitioner; or
 - (ii) another medical practitioner who is eligible and willing to act as the coordinating medical practitioner for the person.
- (3) If the person is not a permanent resident at the facility—
- (a) the relevant entity must take reasonable steps to facilitate the transfer of the person to and from a place where the coordinating medical practitioner for the person can consult with and assess the person in relation to the application; or
 - (b) if, in the opinion of the deciding practitioner, transfer of the person as described in paragraph (a) would not be reasonable in the circumstances—the relevant entity and any other entity that owns or occupies the facility must allow reasonable access to the person at the facility by the coordinating medical practitioner for the person to consult with and assess the person in relation to the application.

- (4) In making a decision referred to in subsection (3)(b), the deciding practitioner must have regard to the following—
- (a) whether the transfer would be likely to cause serious harm to the person;
 - (b) whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying;
 - (c) whether the transfer would cause undue delay and prolonged suffering in accessing voluntary assisted dying;
 - (d) whether the place to which the person is proposed to be transferred is available to receive the person;
 - (e) whether the person would incur financial loss or costs because of the transfer.

Division 4—Accessing voluntary assisted dying and death

13J—Administration of voluntary assisted dying substance

- (1) This section applies if—
- (a) an application for a voluntary assisted dying permit has been made in respect of the person and a permit issued; and
 - (b) the person or the person's agent advises the relevant entity that the person wishes to self administer a voluntary assisted dying substance or have the coordinating medical practitioner for the person administer a voluntary assisted dying substance to the person; and
 - (c) the relevant entity does not provide, to persons to whom relevant services are provided at the facility, access to the administration of a voluntary assisted dying substance at the facility.
- (2) If the person is a permanent resident at the facility, the relevant entity and any other entity that owns or occupies the facility must—
- (a) if a practitioner administration permit is issued in respect of the person—allow reasonable access to the person at the facility by the coordinating medical practitioner and any other person lawfully participating in the person's request for access to voluntary assisted dying for the person to make an administration request and for the coordinating medical practitioner to administer a voluntary assisted dying substance to the person; or
 - (b) if a self administration permit is issued in respect of the person—
 - (i) allow reasonable access to the person at the facility by a person lawfully delivering a voluntary assisted dying substance to the person, and any other person lawfully participating in the person's request for access to voluntary assisted dying; and
 - (ii) not otherwise hinder access by the person to a voluntary assisted dying substance.
- (3) If the person is not a permanent resident at the facility—
- (a) the relevant entity must take reasonable steps to facilitate the transfer of the person to a place where the person may be administered or may self administer a voluntary assisted dying substance; or
 - (b) if, in the opinion of the deciding practitioner, transfer of the person as described in paragraph (a) would not be reasonable in the circumstances, subsection (2) applies in relation to the person as if the person were a permanent resident at the facility.
- (4) In making the decision under subsection (3)(b), the deciding practitioner must have regard to the following—
- (a) whether the transfer would be likely to cause serious harm to the person;
 - (b) whether the transfer would be likely to adversely affect the person's access to voluntary assisted dying;
 - (c) whether the transfer would cause undue delay and prolonged suffering in accessing voluntary assisted dying;
 - (d) whether the place to which the person is proposed to be transferred is available to receive the person;
 - (e) whether the person would incur financial loss or costs because of the transfer.

Division 5—Information about non-availability of voluntary assisted dying at certain facilities

13K—Relevant entities to inform public of non-availability of voluntary assisted dying at facility

- (1) This section applies to a relevant entity that does not provide, at a facility at which the entity provides relevant services, services associated with voluntary assisted dying (including, without limiting this subsection, access to the request and assessment process or access to the administration of a voluntary assisted dying substance).
- (2) The relevant entity must publish information about the fact the entity does not provide any services, or services of a specified kind, associated with voluntary assisted dying at the facility.
- (3) The relevant entity must publish the information in a way in which it is likely that persons who receive the services of the entity at the facility, or may in future receive the services of the entity at the facility, become aware of the information.

I will not speak for long. Some of what is in this has been canvassed in the discussion about the previous amendment. The point of this is to recognise two realities: first, that there will be facilities under the Aged Care Act that represent the home of people that are run by organisations that are reluctant to be involved, or actively do not wish to be involved in the provision of any stage of voluntary assisted dying, and that those institutions represent the permanent home of the people living there. They are under the Aged Care Act, which has its own protections, and they have the right to choose their own doctors. They are often funded by the person and funded by the public purse through the commonwealth government, largely.

Under the Aged Care Act, not only do people have some security of tenure, because it is their own home, but they also cannot be discriminated against. In trying to balance those realities, this rather complex amendment with its series of clauses is being proposed, to go through each of the stages of the voluntary assisted dying process and to illustrate what accommodations can be made for those people. I will allow questions to guide how much detail we need to go into.

The CHAIR: I did indicate that we would go through clause by clause. Member for Davenport, do you have a question on new clause 13A or something more general?

Mr MURRAY: I have something more general. I am happy to hang this point off new clause 13A or, indeed, any part of clause 13 that takes your fancy or makes life easiest, Chair. I just simply want to make the point that, by way of follow-on from the remarks I made at the start of this committee, I will be wholly, fulsomely and completely supporting the amendments as moved. We have covered some of the potential theoretical deficiencies therein but I just want to make it clear that the amendments we have before us will be supported in their entirety by me as part of my pre-existing commitment to the member for Port Adelaide. I am happy to commend them, including new clause 13A, on that basis.

The Hon. A. KOUTSANTONIS: I have heard many people discuss VAD, in its passing around relevant state parliaments, and the 'Australian model' of VAD. My memory does not serve me very well tonight, but I imagine that these series of amendments are unique to the South Australian legislation rather than to the other interstate pieces of legislation.

Can the deputy leader explain to the house (1) why we are departing from the so-called Australian model and (2) how is the act in Victoria deficient by not having these clauses? I suppose, on top of that, is there anyone in Victoria who wishes to access or conscientiously object—I am just trying to get my ahead around what the problem you are solving here is because, if you are silent on it, the rest of the act applies.

Dr CLOSE: Yes, there is a great desire to have a consistent Australian model. The three states that have the legislation are silent on the capacity for an institution to not wish to engage in voluntary assisted dying. The only jurisdiction where that is being played out is Victoria because it is the only one where the process is now occurring.

The reality is that silence leaves some people uncertain at their most vulnerable time because they are in a location that is their home and that is owned by an institution that does not believe that voluntary assisted dying is appropriate. What has happened in Victoria is that people have found it difficult to have access to doctors. One gentleman in particular who lived in a centre developed metastatic bowel cancer some two years or so after going to the centre and making that his home. As I understand it, that is a very painful terminal illness. He wished to avail himself of voluntary assisted dying and had chosen to tell the facility about the pharmacist coming to deliver the substance, in part out of care for the staff as they ought to know this was going to happen and that he would be dead.

The facility decided that they would forward that request to the ethics committee, which took nine days to come back and say that they did not want to allow the pharmacist to go. That is nine very long days for a person in those circumstances, having received the permit, to wait to find out. A transfer was facilitated for this gentleman to go to a public facility, but he was also told at that time that he was not to tell anyone he was living with, who were fellow residents, why he was leaving. He just had to go and die.

That is an example of a less than satisfactory way to manage the awkwardness between these two realities—that this is his home and it is owned by an organisation that does not wish to participate in voluntary assisted dying. The silence is dealt with in part in Victoria through government policy and that is a way of doing it. It requires consultation and discussion with the organisations and may or may not come up with policy that would have dealt better with that gentleman's circumstances.

As a result, in Queensland a study has been done by a couple of academics on what might be a better model and what sits here comes out of the proposition that is going to be considered in the Queensland parliament. While it is a departure from the Australian model, it is filling a gap that has been deliberately, perhaps, left in Victoria. It is attempting to stay with the next state that will be considering this and no doubt that state will look at these combined amendments, should they go through, and consider whether that is a model they want to adopt or whether they want to maintain the current draft version, which includes mine but is different on the subject of hospitals.

We are slowly evolving this Australian model. As much as possible, we should keep consistency; however, when we see a gap that could be filled by something better, we should also consider that and consider it particularly in the context of the next jurisdiction that is considering exactly this way of dealing with it. I hope that answers your question. If not, ask again.

The Hon. A. KOUTSANTONIS: The compulsion on these institutions that conscientiously object is simply to allow the access of a practitioner. In practice, it is your intent to allow an organisation that conscientiously objects to say, 'We and our staff will not facilitate this procedure, but we will allow people to enter our facilities to make this procedure available to someone who is staying or residing or has property within our institution.' I understand that there is a form of compulsion about assisting in new clause 13J, where there was an act of compulsion on the organisation to assist. Could you explain to the committee how that compulsion would work on an organisation that conscientiously objects?

Dr CLOSE: Which compulsion are you referring to? Can you point to it?

The CHAIR: We are just clarifying it.

The Hon. A. KOUTSANTONIS: The organisation must coordinate a medical practitioner.

Dr CLOSE: It must facilitate the transfer.

The Hon. A. KOUTSANTONIS: Yes.

Dr CLOSE: This recognises that a person in their own home has a right to have access to something that is lawful. It creates a pathway whereby, ideally, that is able to be provided to them in their own home by the organisation not engaging with who is coming in and out. To remind you, of course, no medical practitioner involved is doing so under compulsion.

So the medical practitioners have an absolute individual right to conscientiously object. But it does provide provision if it is not possible for a practitioner to come in and see the person, possibly because of the nature of the illness, and the equipment that might be needed to assess might not be on hand, that the organisation must at least facilitate them going off and having that assessment and coming back, ordering an ambulance and ensuring that that works.

There is a degree of engagement in that sense, but it is not an engagement that relates to any of the stages of a voluntary assisted dying process first assessment, first consultation, second consultation, the final assessment, the issuing of the permit—none of those stages that are stepped out in this legislation are undertaken. It is simply a matter of transferring someone who gets to choose their own doctor, because they are living in their own home, facilitating them being able to move from one place to the other.

The Hon. A. KOUTSANTONIS: So the only compulsion that the member is imposing on these organisations is allowing people, in effect, to choose their own treating doctor and to make their own decision. There is no ability for an organisation not to authorise the entry of a facilitating doctor into their premise to talk about VAD. The only compulsion is allowing residents to access the facilities. Can VAD be administered at those facilities?

Dr CLOSE: Yes, it can. The majority of people who die having access to voluntary assisted dying do so in their own homes often, usually surrounded by their loved ones, and there is no reason for that to differ depending on where their home is. The expectation would be that the pharmacist would be able to deliver the locked box in the case of self-administered, and there would be permission for a physician who is administering to be able to be allowed to go into that person's home.

New clauses inserted.

Clause 14.

The CHAIR: At clause 14 we have an amendment standing in the name of the member for Davenport—

The Hon. A. PICCOLO: Mr Chairman, while we are waiting can I ask a question on the existing clause 14?

The CHAIR: Yes, I am happy to do that.

The Hon. A. PICCOLO: My question is to the member for Port Adelaide—I assume I am at the right place, 14, criteria for access. Under part A it says the person must be aged 18 years or more, and then there is a whole range of other criteria, to access the VAD scheme. That is my understanding. My question through the Chair to the member for Port Adelaide is that in section 6 of the Consent to Medical Treatment and Palliative Care Act 1995 it states:

Legal competence to consent to medical treatment

A person of or over 16 years of age may make decisions about his or her own medical treatment as validly and effectively as an adult.

The question is: why do we have a difference of two years in the two acts?

Dr CLOSE: I am just seeking some assistance to further inform, but the bottom line is that there is a view that there should be a higher degree of competence and maturity and understanding of the consequence of decisions when we are talking about ending a life. Therefore, there is a strong view—not a pragmatic but a strong view—by advocates and by legislators in the Legislative Council and myself here that it is only reasonable to think of a person over the age of 18 as having that degree of capacity and maturity to make such an important and unalterable decision.

There was an excellent ministerial advisory panel, which I believe my adviser was on as well, that considered this matter and talked about how important it is that voluntary assisted dying be consistent with other legislation that recognises essentially that adult decision-making comes at the age of 18 and that there was no interest or appetite or recognition of any kind of merit in according any younger age with that degree of requirement to be mature and capable and to understand fully the consequences of decisions.

Mr MURRAY: I move:

Amendment No 4 [Murray-2]—

Page 15, after line 36 [clause 14(1)]—Insert:

and

(e) the person must be acting freely and without coercion.

The amendment very simply adds an additional criterion for access to voluntary assisted dying. Clause 14 sets out a total of four broad-ranging criteria that help inform whether or not a patient seeking to access voluntary assisted dying should in fact do so. It ranges from the quite binary—whether or not they are 18 years of age or more, whether they are an Australian citizen ordinarily resident in South Australia—through to a variety of diagnoses insofar as the illness that they are suffering from.

Amendment No. 4 is very closely related to amendment No. 2, with which we as a chamber had no real issues. Amendment No. 2 sought to point out the fact that, as a general principle, a lack of coercion is, as a bare minimum, a desirable feature of this legislation. I reiterate that it is desirable that there is a lack of coercion. This amendment very simply enshrines as a further prerequisite that the person seeking to access VAD must be acting freely and without coercion. That is, in many respects, a subjective test. I am happy to concede that point.

Part of the reason for the construction we see of the bill, the process, the Australian model, is to have experts make assessment according to a set of criteria and to do so on our behalf as a community and, more particularly, with us here this evening on our behalf as legislators. I am seeking to enshrine the necessity for a lack of coercion to be a prerequisite.

More particularly, there is no intention to charge someone with conducting any particular test. It is simply a requirement that, where the medical practitioner is of the view that some form of coercion exists, that is a criteria insofar as determining whether the person should or should not move to the next stage. I reiterate that coercion is, certainly from my view, an undesirable attribute for a prospect of voluntary assisted dying.

The current bill before us does seek to provide some safeguards by way of written declaration, etc. However, I would make the point that, rather than the person self-attesting to a lack of coercion, I do not

think it is unreasonable to expect the experts we have working for us in this case to make an assessment and to act according to their perception of whether or not coercion exists. Coercion is by its very definition often subtle, covert, manipulative and not always particularly apparent.

I would leave the chamber with the point that we have just had a royal commission into aged care and safety. That royal commission took a sample, derived from 67 aged-care facilities around the country, and found that the prevalence estimate for neglect for those residents was just over 30 per cent. The prevalence estimate for emotional and psychological abuse was 22.6 per cent (one in four people) and the prevalence estimate for physical abuse was 5 per cent (one in 20 people). The reality is that we are implementing this process in an environment where those statistics should be concerning.

I would make the very strong point, for what it is worth, that it is not unreasonable for a reasonable person—the pub test, if you will—to seek to have some indication or evidence of coercion that is apparent to the experts we are charging with delivering this. I believe a reasonable person would have no hesitation, if the expert believes there is coercion, in saying that that should be a factor in whether or not the person starts the journey to the endpoint of voluntary assisted dying. It is for that reason that I have sought to add that as a criterion.

As I said, there is no complicated test, etc. It is simply that if, in the view of the medical practitioner, there is coercion then that should be a very deliberate consideration as one of the criteria for accessing voluntary assisted dying. On that basis, I commend the amendment to the house.

Dr CLOSE: I indicate that I will be voting against it on the basis of its being superfluous.

Mr PICTON: This is probably not formally allowed, but I wonder if I can direct a question to the member for Port Adelaide. If I have to, then I formally direct it to the member for Davenport, who is moving the amendment. Are there other provisions in the bill, and in the act in Victoria and in other states, that would prevent people being coerced into this provision? Are there other protections and safeguards that do make what is being proposed here superfluous?

Dr CLOSE: First of all, we have already moved an amendment that has included coercion, from a previous motion, so that each person has the right to make decisions about medical treatment options freely and not as a consequence of the suggestion, the pressure, the coercion or the undue influence of others. More importantly, as the legislation exists already, the process the two doctors go through, particularly with the focus on ensuring the enduring will of the person is being expressed, is a guard against a coercive circumstance for the person who is seeking voluntary assisted dying.

So each of those people, including not just the coordinating medical practitioner and the consulting medical practitioner but also the pharmacist who brings the locked box, are required to ask the person if this is what they want to do. They are required to form a view that that is indeed what the person wants to do.

If at any point there was a suspicion or concern that that was not what the person wanted to do, because it is voluntary assisted dying, the entire process is built around that being a reason to make that person ineligible. There is no need to add that as an additional separate criterion. It is built into the way the process is designed.

Indeed, as I mentioned earlier in the evening, Justice Betty King, the presiding officer for the Victorian review board, said that they looked for any examples where that might have happened and could not find any. They were not just wondering what issues would be raised with them; they wondered if that was a problem and went and hunted for it, but could not find anything. In fact, the stories she heard were more often of adult children of people seeking voluntary assisted dying trying to persuade them not to. That was more common. So the way it is constructed appears to be very much based on avoidance of coercion.

If you look at clause 26(1), and the outcome of the first assessment, it provides that the coordinating medical practitioner must assess the person as eligible for access to voluntary assisted dying if the coordinating medical practitioner is satisfied that eligibility criteria are met, the person understands the information, and the person is acting voluntarily and without coercion.

Mr MURRAY: I will take the opportunity to add to the very learned contribution of the member for Port Adelaide in answer to the member for Kaurna's question. Prior to this chamber passing my amendment No. 2 this evening, whereby a lack of coercion as a general principle is a desirable thing, I am not aware of any other act that covers VAD that specifically proscribes coercion, that mentions it at all.

I grant that it is possible to perceive a situation whereby some of the other controls in place could help address a situation where coercion exists. I make two points in that regard. The first is: what are we to lose if we ask people who are our agents, who are experts in this field, who, in the course of making an assessment of a person, form the view that coercion exists? I do not believe it is onerous to ask them if, in their view, that is the case. We are not asking them to conduct any tests, we are just asking them if they believe coercion exists. That, in our view, is an undesirable element insofar as the assessment process is concerned.

Regarding the member for Kaurna's question, no other jurisdiction specifically addresses that. In many cases it is perceived as an issue as a consequence. For what it is worth—and it is a little perverse—coercion can work both ways in this case. It is entirely possible to have someone seeking to access VAD who has been coerced not to.

The prescription here is a very simple one. We are comfortable with enshrining the notion of a lack of coercion as a desirable trait in the legislation. We have done that this evening. This seeks to give the evidence of that as a means whereby the medical practitioner in question can factor that into their decision as to whether or not that person should be accessing VAD.

As I said, the reasonable man in the street, the reasonable person, I would respectfully submit to the chamber, will have no problem with that. If someone is being coerced into VAD, whether that is real or perceived coercion, I do not think it is necessarily a bad thing for us to equip the people who are going to be dealing with this, if they believe there is coercion, with the capacity to have that form part of their determination. If they deem it necessary to disqualify the person because they believe the coercion exists—and presumably the coercion is to have someone amenable to accessing VAD—they can in fact refuse to provide that permission because that is one of the criteria that we have asked them to assess on our behalf.

The CHAIR: I am going to go to the member for Light because he was looking to get the call previously.

The Hon. A. PICCOLO: Thank you, Mr Chair. Again, I am not sure if I am allowed to ask this question but, if I am permitted, I would like to ask the member for Port Adelaide what harm, if any, does the member see in this amendment?

Dr CLOSE: I appreciate the opportunity to speak. The problem with the amendment is that it is putting into the criteria for access to voluntary assisted dying not being coerced, which is not a criteria for access to voluntary assisted dying in itself, so it is not in the right place in the legislation.

Where it belongs is where it is, in clauses 26(1)(c), 35(1)(c), 40(2)(a)(i) and 42(1)(a)(i), that is, at each point when the medical practitioners are assessing whether the person is able to proceed to the next stage. The question they must turn their mind to is whether this is a decision being made freely and free of coercion.

I gave the example in answer to the previous question of clause 26(1)(c), which is in the outcome of first assessment, 'the person is acting voluntarily and without coercion'. In clause 35(1)(c) we come to the outcome of the consulting assessment. So the first assessment has occurred and there is now a consulting medical practitioner. In clause 35(1)(c) 'the person is acting voluntarily and without coercion'. Clause 40(2) is when a person is reaching the end of the process and is signing a written declaration:

- (2) The written declaration must—
 - (a) specify that the person—
 - (i) makes the declaration voluntarily and without coercion;

As we can see under clause 26—Outcome of first assessment:

- (2) If the coordinating medical practitioner is not satisfied as to any matter in subsection (1)—

one of which is that the person is acting voluntarily and without coercion, 'then the request and assessment process ends.' Freedom from coercion is in all the places it needs to be in order to make sure, as I said in answer to the previous question, that this is indeed voluntary assisted dying. Not only is it throughout the legislation but it also has been tested by the Victorian board in practice and not found to be an issue.

So to include coercion in a section which is about eligibility, I think, is misplaced. The reason I expressed that it was superfluous is that the member has already been successful in having it placed early on in the principles and therefore the point has been made very clearly, I would have thought from the member's

perspective, that coercion is important and then it is already in the bill in every single point throughout, and is a reason that an assessment may be terminated if the medical practitioner does not believe the person is acting in a way that is free of coercion.

Mr MURRAY: If I can add to the answer provided, or at least address some of the points made. Yes we have enshrined as a general principle the undesirability of coercion—no-one is arguing with that. I submit that, if we do not act upon that desire, we do not give the people who will represent us in this process—the consulting medical practitioner, the coordinating medical practitioners—the right, if they believe it is necessary, to use the evidence of coercion as a criterion. We are talking about clause 14 which, notwithstanding the fact that the headings have no bearing, is for a reason described as 'criteria for access to voluntary assisted dying'. I make the point, in pointing that out, that clause 14(1)(c) talks about the fact that the person must have decision-making capacity.

We have talked at some length this evening about the desirability of having decision-making capacity. The bill before us, with which I have no problem, enshrines in this same clause I am seeking to amend that it is desirable, in fact mandatory, for decision-making capacity and an assessment of that by the medical practitioners to be a criterion as to whether or not someone can access it. I would submit that it is therefore the perfect place for us to also insert the fact that there must be an absence of coercion, and I would further submit that, if we do not insert this as a prerequisite, as a criterion, we are condemning our previous interest in or desire to have the lack of coercion enshrined as a principle. We are condemning it to be nothing more than what I term a motherhood statement. We are either fair dinkum about this or we are not.

I fully accept that it is possible that someone who is the subject of coercion may in fact, as a consequence of that perception of coercion, be excluded on the basis of some other clause. What I am seeking to do is very simply make our view that a lack of coercion is important, enshrined as a criterion for access. If decision-making capacity is important, I submit that coercion or lack thereof is just as important, just as desirable, and it is for that reason that I have inserted it.

I make the point, for what is worth, that simply being silent on this is not desirable. If we can save one person from being coerced into VAD as a result of this, then I submit that that is a worthwhile exercise. I reiterate that I am not talking about extra tests; I am talking about us giving the professionals the ability to use their view as to whether or not coercion exists as the basis to exclude someone if they see fit. It is a subjective test.

Mr PICTON: Just to clarify, that certainly has satisfied me, that in relation to the current legislation we already have a number of provisions, being 26(1)(c), where the first coordinating medical practitioner needs to assess that the person is acting voluntarily and without coercion. That is followed up in 35(1)(c), where the second consulting medical practitioner also has to do an assessment and be satisfied that the person is acting voluntarily and without coercion. Following that, in 40, the person has to make a written declaration to that effect. I thank both the member for Davenport and the member for Port Adelaide in terms of their clarification. I certainly am now of the mind that this is probably superfluous, that it is already embedded in the legislation that we have before us.

Amendment carried.

The Hon. A. KOUTSANTONIS: Can I ask the deputy leader how we came at an age of 18?

Dr Close interjecting:

The Hon. A. KOUTSANTONIS: Did you? Sorry, well, I apologise. If you have already informed the house, I will read the *Hansard*. Why are non-citizens excluded and non-permanent citizens excluded if they are suffering from the same eligibility? I understand the residency in South Australia so we do not have people shopping for this, but I imagine there will come a time when this legislation will be uniform around the country and once it is will that requirement for residency in South Australia still be required or is that just simply to stop the VAD shopping, as it were?

I just point out to members that I think this is the clause that we will come back and revisit five, 10, 15 or 20 years from now. For those who are interested—and there probably are not any—my second reading contribution in opposition to this is not so much the access to VAD or people taking up this proposition as the compromise that I see in this bill to get a law passed because the logic does not make any sense. If you are 17 and you are feeling the same pain and are eligible under every other criteria other than age, why can

you not have access to this? And the big question for us as a community, once we have passed this threshold, is dementia.

This is the clause that I would like some clarity on. It is a bit unfair on the member for Port Adelaide because this is now the Australian standard, the Australian model, I imagine. So why 18, and why are we excluding people who may be refugees who arrive here who are diagnosed with these types of illnesses and are eligible but cannot access it? What is the reasoning behind an exclusion of those people who are not Australian citizens?

Dr CLOSE: If I just briefly canvass again the age of 18—and let's be very clear, the legislation is about 18 year olds—the reason is that that is the standard Australian age at which we are expected to act as adults. It is certainly the view of every review that has been conducted that under the age of 18 the capacity to have the maturity to understand the consequences of decisions is not sufficiently well realised, and therefore 18 is the absolute minimum age.

In asking about the residency, that is a somewhat more complex issue because the member points out that there are challenges, particularly as our federal government has chosen to delay the time between when one can become a permanent resident and when one can become a citizen. It used to be a source of pride in our country that we facilitated that very quickly and I think it was one of the great bases of our multicultural society that there was a sense of belonging that was encouraged very quickly and early—but I digress. So I appreciate the reason for the asking.

A simple answer I could give now is national consistency. If that is in the other pieces of legislation, let's maintain it. I suspect there may have been initially in the contemplation the desire not to encourage people to move to somewhere to a jurisdiction in order to have access, so having got an illness that meant that this was the likely trajectory that people leave states that do not have voluntary assisted dying and arrive in Victoria.

It is one area that I think the Hon. Stephen Wade, the health minister, has contemplated. Should there be voluntary assisted dying of the same or similar nature across the country, then there may be a different view about being able to go from one jurisdiction to another. But there is simply a decision that was taken that we are matching, I think is the best answer I can give for this piece of legislation.

The Hon. A. KOUTSANTONIS: I do not wish to debate this like we debated the last clause about coercion, but I will point out that this parliament has contemplated and passed measures to treat minors as adults when they commit criminal offences. So we have already taken that jump that we will assess their judgement as being good enough to know that they will be tried as an adult if they are caught. But that is just a debating point. It is not really relevant here.

The other point I want to make is in clause 14(1)(d) that 'the person must be diagnosed with a disease, illness or medical condition'. I hate doing this, but I am going to ask a hypothetical question. The treating doctor has a different diagnosis from the authorising doctors from VAD. There is nothing in the bill that requires the treating doctor to be the doctor who authorises VAD. The patient can go to any doctor.

If you have cancer and your oncologist says, 'Actually I think it is curable. Actually I think you have more than six months to live,' but you go to another doctor who says, 'Actually my conclusion is that it is incurable and you will die within six months, so you are eligible,' how do we solve this conflict without a reference to the treating doctor, and who is the treating doctor?

I imagine people who are facing these terminal illnesses have a battery of practitioners who assist them, so it is not as clear-cut as there being one person in charge who is making all the decisions. I would imagine that there are a number of clinicians and consultants who assist. At what stage do we say, 'Yes, it is incurable,' and can the treating doctor object and say, 'I disagree with the diagnosis'? I would like some clarity around this.

I had this conversation earlier with the shadow minister for health. Like other matters here, I do not understand why there is no reference to a treating doctor when it comes to this measure. Could the member explain why we do not make reference to the treating doctor as well?

Dr CLOSE: The hypothetical is that a person is ill, has a treating doctor, the treating doctor says, 'You can live 18 months to two years,' and the person decides not to accept that and to seek another opinion—in fact, two other opinions that both agree that the illness is more terminal than that, but that the person is acting of their free will. They are not being coerced. They are capable of making the voluntary and

sustained request for the application of the voluntary assisted dying process despite having a treating doctor who says you will live longer.

That is an unusual hypothetical to sustain. But what it comes to at the heart is that a person has a right to obtain medical opinion and this legislation protects to the extent that there must be two who agree to that and not only agree to how long that person has to live but also that the person is acting voluntarily without coercion and has the capacity to make those requests. There is also the requirement for the practitioner to refer to specialist opinion if they feel that they are not able to determine completely. So it may well be more than two that are brought into place.

That is both for the decision-making capacity but also for whether the disease, illness or condition meets the eligibility criteria. So for example, if you look at page 18, division 3—First assessment, clause 24 has the stepping out process for obtaining specialist opinion. So in your hypothetical you would expect not only that someone would actively seek two doctors who will certify that the person will live less time than their treating doctor will certify but also that those two doctors will be so confident that their view is different—shorter—to the treating doctor that they do not feel the need to seek specialist advice.

I think that that hypothetical is not sufficiently coherent to require a change to legislation which has been carefully thought out and has been in practice for some time and where the board of review in Victoria has not seen any anomalies or abuse of the type you are suggesting.

Mr PICTON: Can I just add a couple of thoughts in relation to that matter, which is certainly something that has been raised by members in debate around the country and last time we debated this as well. I think there are a couple of issues to raise. One is that I think very clearly a lot of people who will be in this situation would not just have one doctor who is their treating doctor but would have a variety of different doctors who would be helping that person for a variety of different, specialised tasks.

I think the other aspect that becomes tricky is that I think we have all agreed that there is a very important role for conscientious objection—that doctors do not have to be involved in this process whatsoever—and if we are putting in the legislation that it is reliant upon that doctor who is treating you for your terminal illness to be involved in this process, then that is contradictory with that conscientious objection for that medical practitioner not being involved in that process.

This becomes a bit of a trap for that person, because they might have the best cancer doctor in the world, who might be totally opposed to VAD and want nothing to do with it. So we have then created a bit of a trap for that person, in that they cannot access what parliament is looking to engage as their rights because of their choice of their particular doctor.

The Hon. A. KOUTSANTONIS: I accept what the two members are saying, that they want to make sure that people are entitled to get a different medical opinion, because it is their choice to do so, and if that medical opinion differs, they are entitled to choose which one they like. I accept that, but I also point out the legislation currently allows someone to ignore the advice of their specialists and take the advice of two general practitioners. But, again, just debating points.

On page 16, in clauses 14(2) and 14(3), again, a hypothetical, which probably is unfair on the member: if someone has qualified for the first and second application for VAD and is found eligible but is subsequently diagnosed with a mental illness, does that then supersede the two approvals? Clause 14(3) provides:

A person is not eligible for access to voluntary assisted dying only because the person has a disability within the meaning of the Disability Inclusion Act 2018.

Does that mean that a disability could preclude someone who would normally qualify for VAD simply because they are defined as having a disability under the act?

Dr CLOSE: Just to be helpful to the member, over the page there, in clause 14(2) and 14(3), what the bill is saying is that you are not eligible only because you have a mental illness. So you are not eligible for access only because you have a mental illness; you are not eligible for access only because you have a disability.

It is perfectly possible for someone to have a terminal illness and then get a mental illness, to experience a period of mental illness. That will affect the course of what had previously been a process that was going down only if that person as a result of the mental illness is then unable to maintain capacity to make a clear

and sustained and enduring desire to have voluntary assisted dying or for some reason be in a position of being coerced through the experience of the mental illness.

It is not impossible to access voluntary assisted dying if you have a mental illness, as long as that mental illness does not interrupt all of the other eligibility criteria. What is impossible is that just because you have a mental illness you have access. You must have a terminal illness. You must be diagnosed by at least two doctors, one of whom must have expertise, just to pick up an earlier debating point that was made, in the illness that you are dying from. You must be within six months, or 12 months for neurodegenerative disease, you must have an enduring desire, you must have the capacity to express that, and you must be suffering in a way that cannot be relieved in a manner that is tolerable to you. All those criteria at no point go away, whether or not you have an episode of mental illness.

Clause as amended passed.

The CHAIR: We come to clause 15. Before I do that, I might just go to the member for Davenport. You have amendments Nos 5 and 6 standing in your name, which by my reading are consequential to your first amendment, which did not get up, so I look for your agreement that you will not be putting those when the time comes.

Mr MURRAY: Never let it be said, Chair, that I am not agreeable. I am more than happy to concur with your assessment, that as a consequence of the failure of amendment No. 1 my amendments Nos 5 and 6 have, by their very definition, also failed, and I will not put them. They are consequential, and as a consequence of them being consequential to the first amendment, which failed, there is no point in my putting them.

The CHAIR: Thank you. I think what that meant was that you will not be moving them. They are a little further on, but that is okay. In that case, we do not have any amendments now until clause 107, where we are looking to insert a new clause after that. That said, I am cognisant of the importance of this bill and the importance of each and every clause, so you will need to bear with me while we work our way through them.

Clause 15 passed.

The Hon. A. PICCOLO: I am just asking whether we could actually take them in blocks of 10, Mr Chair.

The CHAIR: I have considered this, member for Light, and as I said a moment ago, I think this bill is of such significance and each and every one of the clauses seems to be quite involved, so I will give people the opportunity, should they need it.

Clauses 16 to 22 passed.

The CHAIR: Member for Light, I am coming back to your suggestion. We have just passed clause 22, but division 3 would take us to clause 28. Thank you for your counsel, member for Light.

Clauses 23 to 28 passed.

The CHAIR: Division 4 contains clauses 29 to 39 inclusive.

Clauses 29 to 39 passed.

The CHAIR: Division 5 contains clauses 40, 41 and 42.

Clauses 40 to 42 passed.

The CHAIR: Division 6 consists of clauses 43 through to 50, which will then take us to part 4.

Clauses 43 to 50 passed.

Clause 51.

The Hon. A. KOUTSANTONIS: If someone is authorised to receive an assisted dying permit, is there any mandatory reporting requirement to the next of kin?

Dr CLOSE: Can I just check—at the point of authorisation?

The Hon. A. KOUTSANTONIS: Yes.

Dr CLOSE: No.

The Hon. A. KOUTSANTONIS: So if someone with a terminal illness has qualified and been given the permit, there is no mandatory notification of family, next kin, nothing?

Dr CLOSE: No. Through privacy considerations, that would be inappropriate, just as it would to inform next of kin that someone has a terminal illness, for example.

Clause passed.

The CHAIR: Division 1, we have passed clause 51, so I will put clause 52. Are there any questions on clause 52?

Clause 52 passed.

The CHAIR: Division 2 of part 4 contains clauses 53 through to 58. Are there any questions on clauses 53 through to 58?

Clauses 53 to 58 passed.

The CHAIR: Are there any questions on clauses 59, 60 or 61?

Clauses 59 to 61 passed.

The CHAIR: We come to part 5, division 1, which contains clauses 62 through to 68. Are there any questions on those clauses?

Clauses 62 to 68 passed.

The CHAIR: Division 2, page 35, contains clauses 69, 70 and 71. Any questions on clauses 69, 70 and 71?

Clauses 69 to 71 passed.

The CHAIR: I had better ask if there are any questions on clause 72. Are there any questions on clause 72?

Clause 72 passed.

The CHAIR: That brings us to part 6, which contains clauses 73 through to 77 inclusive. Are there any questions on clauses 73 through to 77 inclusive? Is everyone keeping up?

Clauses 73 to 77 passed.

The CHAIR: We come to part 7, division 1, which contains clauses 78 through to 81. Any questions on clauses 78 through to 81 inclusive?

Clauses 78 to 81 passed.

The CHAIR: That brings us to division 2 and clauses 82, 83, 84 and 85. Are there any questions on any of those four clauses?

Clauses 82 to 85 passed.

The CHAIR: Part 8 contains clauses 86 to 94 inclusive.

Clauses 86 to 94 passed.

The CHAIR: This brings us to part 9, division 1, which contains clauses 95 to 103.

Clauses 95 to 103 passed.

The CHAIR: Division 2 contains clauses 104, 105, 106 and 107.

Clauses 104 to 107 passed.

New clause 107A.

The CHAIR: There is an amendment on schedule (5). Amendment No. 7 seeks to insert new clause 107A.

Mr MURRAY: I move:

Amendment No 7 [Murray-2]—

Page 51, after line 18—Insert:

Division 2A—Annual examination of Board's operations etc

107A—Chief Public Health Officer to examine operations of Board

(1) The Board must, on or before 31 August in each year, cause an examination of the operations of the Board during the financial year ending on 30 June of that year to be conducted by the Chief Public Health Officer in accordance with any requirements set out in the regulations.

(2) Without limiting subsection (1), the Chief Public Health Officer must examine each request for voluntary assisted dying received by the Board, and each death of a person after being administered or self administering a voluntary assisted dying substance, during the relevant year to determine the extent to which each such request or death complied, or did not comply, with this Act.

(3) As soon as is reasonably practicable after conducting an examination under subsection (1) (but in any event not later than 30 September in each year), the Chief Public Health Officer must prepare and provide to the Board and to the Minister a report setting out the results of the examination.

(4) This section is in addition to, and does not derogate from, a provision of any other Act or law that requires or authorises the Auditor-General or any other person or body to audit the accounts of the Board.

(5) The Board must, in the annual report of the Board for the relevant financial year prepared under section 106, include—

(a) a copy of the report provided under subsection (3) for the financial year; and

(b) if requested to do so by the Minister, an explanation of the report, or a specified part of the report.

(6) In this section—

Chief Public Health Officer means the Chief Public Health Officer under the *South Australian Public Health Act 2011* and includes a person for the time being acting in that position.

The purpose of this amendment is very clear, and again I suspect in part it may well be conducted by the board. The intention of the amendment is quite simple, and that is to ensure that an audit of all voluntary assisted deaths is performed on our behalf to ensure they are compliant and that at all stages the work we have done here is in fact being followed and that, to the extent there has been no compliance with that, it is in fact audited. The key is for each and every voluntary assisted death to have an audit conducted that will satisfy the test. The test is complete compliance with the bill as passed by this house or the bill as it stands in law.

What has driven that is evidence from overseas jurisdictions and even here in Australia and I will quote, with your forbearance and the forbearance of the house, from the Queensland Law Reform Commission, report No. 79, dated May 2021. This is the legal framework for the voluntary assisted dying report's summary. In particular, I would guide people to page 22 of that report, which talks about compliance in the context of Victoria. Here we are in South Australia reading the report prepared in Queensland that assesses what has been conducted in the first year of the operation of the VAD legislation in Victoria. Under the heading of Compliance, it states:

The Board analyses forms submitted to it and takes other steps to monitor compliance. Its data show 95 per cent of cases were compliant with the Act. Between July and December 2020, six cases were identified as non-compliant. However, the Board determined that those cases were clinically appropriate, all eligibility requirements were met, and a misunderstanding had occurred that did not raise a concern about the completion of legal requirements.

I will readily concede that the pre-existing clause in the bill or clauses, or the provision for the board, may well result in the board conducting a similar analysis but there is no compulsion for that to happen.

What I am simply asking for is the pre-existing paperwork to be assessed in the case of every voluntary assisted death and that we and our successors here—for those of us who are older than others—are assured of the fact that each of these voluntary assisted deaths was conducted in a fully compliant manner. I make the point, for what it is worth, that a voluntary assisted death that is not compliant is a serious matter, obviously, and it is not something that can be, by its very definition, rectified.

It is something that I think is entirely within our purview and it is entirely reasonable for us to assess whether there are systemic differences, whether there is laziness—whatever the cause, if there is noncompliance we need to be aware of it. The intent of this amendment is to ensure that we are advised, and it is a compulsion to advise us, about whether or not the process for the preceding year is compliant or not.

I make the point, for what it is worth, that there is a variety of steps, checks and balances and definitions insofar as what needs to happen on or before a certain time each year, and the point that those results have to be put before this parliament. The intention is really to give us an opportunity to assure ourselves and the community at large that the steps that we have taken, and negotiated, enshrined and argued are, in fact, being addressed. That is in its totality the rationale behind my amendment.

Dr CLOSE: There are a few problems with this proposition. Essentially this is another layer of bureaucracy that appears to be entirely unnecessary. The kind of work that the member has just described are essentially the functions and powers of the board of review—that is why we have the board of review. It is required to provide reports to parliament on the operation of the act and any recommendation for the improvement of the process of voluntary assisted dying. It is required to promote compliance with the requirements. It is required to refer issues that they identify to appropriate bodies like the police, registrar, chief executive and so on.

I fail to see anything that is not in the functions and powers of the board in clause 101, which we have already passed, that does not do all of the kind of work that the member is seeking to have done. In fact what the member's clause does is add the Chief Public Health Officer—and I do not know why the Chief Public Health Officer because this is not a public health matter—to examine the board itself and to say whether the board is doing the right thing.

One then wonders if we might be back having a review of the Chief Public Health Officer, and the Chief Public Health Officer's review of the review board of this voluntary assisted dying. I want to resist the weighing down of this process with what I regard as an additional layer of unnecessary bureaucracy and one which, if given in to, we might fear has no end.

Mr MURRAY: Can I commend the member for Port Adelaide on her—

Dr Close: Brevity?

Mr MURRAY: —yes, her brevity as well, but her desire to have as little as possible red tape. I will just enumerate—

Mr Picton: It has all gone backwards.

Mr MURRAY: It has. It is all very weird. I just want to make the point—and these are my handwritten notes for what it is worth—that the functions of the board are to monitor, that is 101(1)(a), to review, to provide reports to parliament, to promote compliance, continuous improvement, conduct analysis, provide information, collect, use and disclose forms, consult and engage, provide advice and provide reports. There is no audit step there. There is an obligation to promote it. What I am seeking—and I am happy to concede it is as a result of my being an accountant many years ago—is an audit to be done. I do not want someone who may or may not assess it; I want an audit done of the voluntary assisted deaths. That is the sole rationale.

If the functions of the board were to conduct an audit and give us confidence that the results produced to us have in fact been assessed in their entirety, I am happy with that. I will not belabour the point at this late hour about the Chief Public Health Officer. There was some consideration and discussion about getting commercial audits done. The intention is simply to have faith in and to direct very specifically the conduct of an audit so that we can have that faith. It is no different from what every public company has to undergo insofar as their results are concerned.

Respectfully, there is no audit per se. It gets close in places, but it does not actually cover it. Given the subject matter, it is not an unreasonable requirement to ensure that the steps we set out in the act, once it becomes an act, are in fact being followed.

Mr PICTON: I am perhaps even a little bit more confused about this than before the debate started, particularly in regard to how it would be relevant to a financial company audit, which seems to have been suggested—that the Chief Public Health Officer is essentially reviewing each death of a person after this act—and how that is at all relevant to what a financial auditor would do in their practices. It seems to be two very different things, two very different roles, and two very different professions would be involved.

My question to the member for Davenport is, in seeking to put this provision in that would give the Chief Public Health Officer—the incumbent of course being Professor Nicola Spurrier—this very significant role of reviewing each death of a person after being administered a substance under this act, have there been

discussions with the Chief Public Health Officer about this? If so, what has been the feedback from the Chief Public Health Officer about the proposal that has been put forward?

Mr MURRAY: Very simply, there has been no discussion with the Chief Public Health Officer about this role. I am not fixated on who does it. I will take you up on your earlier point. I do not think it is desirable that we come out the other end of this process, and in 12 months' time we have a 95 per cent compliance rate, or 90 per cent, or 80 per cent. I do not think that is acceptable. What I am seeking to do here is have, without exception, a process where we are assured that the numbers put before us by way of some report have every single step assessed as to whether it was or was not compliant. I do not think that is particularly complex. I do not think it is unreasonable given the subject matter, and that is the rationale behind it.

I am happy, if you want to move an amendment, to have someone else perform the audit for us, or perhaps you have some other way of assuring us that the steps we put in place in this act are followed in every single case and we do not have, for example, a situation where someone is doing a tick-and-flick and, 'Oh, oops,' and it is too late.

I do not think it is unreasonable for us to try to ensure, given the amount of effort that has gone into this for all of us, regardless of our viewpoint, that we mandate that the steps taken have been followed and that that is assessed in every case. I do not think that is unreasonable. As I said, I am happy if you have an alternative suggestion as to how we go about deriving that. That is my concern. That is my best effort in assessing it. I have discussed this with a variety of health professionals, but not, to your direct question, with the Chief Public Health Officer, who I think at this stage has got far better things to do, frankly. I will leave you with that.

The CHAIR: Before I call the deputy leader, I am conscious of the time. We still have a little way to go with this—not too far but a little way to go—so we will need to extend past midnight. I might ask that the Minister for Energy and Mining report progress.

Progress reported; committee to sit again.