PARLIAMENT OF TASMANIA

LEGISLATIVE COUNCIL

REPORT OF DEBATES

Tuesday 27 October 2020

REVISED EDITION

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The President, **Mr Farrell**, took the Chair at 9 a.m., acknowledged the Traditional People and read Prayers.

PETITION

Nonconforming Petition - White Beach Development

Ms Rattray (by leave) presented a petition not conforming with Standing Orders signed by 97 citizens who call on the state Government to intervene to prevent the proposed development at White Beach, Flinders Island as it is more than double the usual height limit, is totally out of character with existing residences and destroys the balance between the natural and built environment.

Petition received.

SPECIAL INTEREST MATTERS

Tenth Anniversary of Tim Blair Run for Kids

[9.06 a.m.]

Mr GAFFNEY (Mersey) - Mr President, I rise today to recognise the amazing achievements of one of the Mersey electorate's finest, Mr Tim Blair. Tim has selflessly worked to raise funds for local children in need, to encourage children to help others by participating in and promoting health and wellbeing events, and to increase community capital by engaging members of the community as volunteers to organise and assist with the events.

First, a little bit about Tim's history and how the Tim Blair Run for Kid's Foundation came to be. The foundation traces its origins back to 1994, when after a diagnosis of epilepsy Tim began running to become fitter and healthier. As with so many others, his love for running grew and he began to run in fun runs and other events aimed to raise money for charities.

In 2000, Tim was invited to run with friends from Deloraine to Forth - a distance of about 72 kilometres - to raise money for Giant Steps, a local organisation that caters for children with autism. For Tim this was a profound and life-changing experience, allowing him to turn his love for running into something else that also benefited others. Over the years, Tim's dedication to kids in need was realised in the rising number of fundraising events he participated in and the evolution of the foundation. He has continued to run and cycle and he has participated in many marathons, but he has had to fight his own significant health battles along the way. Incredibly, after a diagnosis of a degenerative nerve condition and later stress factors among many issues, Tim managed to bounce back a number of times and he is still going 26 years after he started his first running phase.

In November 2013, Tim ran from Devonport to Burnie and back, a distance of 120 kilometres to raise funds for a young boy suffering from cancer, who tragically had also lost his father to cancer. The run also raised funds for local cancer wards in Tasmanian hospitals. It was the first time Tim and his running partner had run a distance of over

100 kilometres. The event was also the first official fundraising event for the Tim Blair Run for Kids Foundation.

Tim and his running partner, Shane, later ran 85 kilometres through 23 schools from Penguin to Port Sorell, raising money for a young boy with extremely rare brain tumours. In the process, they set out about encouraging kids and families to step outside their comfort zones and challenge everyone to find ways to make a positive impact on other's lives. Encouraging children to be their best is something Tim is very passionate about. He worked closely with the Kids' Cancer Project and the Department of Education Tasmania on a program called Project Kids aligned with the national curriculum and launched into Tasmanian schools in 2016. The program was designed to encourage children to contribute in a positive manner and that no positive contribution is measured.

Another of Tim's noteworthy efforts, and there are many, was a 2016 run in Nepal where he ran 220 kilometres over three days. Tim ran from Pokhara to Kathmandu. The idea was to raise awareness of Nepal as a tourist destination again, and of course raise money for childhood cancer and children's education in Nepal. In September this year, somewhat closer to home, Tim recreated a run from Burnie High School to Nixon Street Primary School, that he completed 10 years ago. In 2010 he was joined by Miss Phoebe Berwick who completed a lap of the oval with him as she was fighting childhood cancer. I am thrilled to advise that Phoebe remains involved with the Tim Blair Foundation and is now studying to be a teacher.

Phoebe's reflections of Tim were glowing. She said -

> He has done so much for so many different children, including myself. He is so humble as well. He is so inspiring to so many others. It will be a full circle, celebrating 10 years.

Mr President, I could not agree more. To date, along with the help of the community, the Tim Blair Run for Kids events have raised in excess of $450 000 for sick children and childhood cancer research. Tim Blair is a wonderful asset to the Mersey electorate and the wider community. I commend him for his commitment to helping others.

Congratulations and well done, Tim.

Members - Hear, hear.

Warrane Mornington Neighbourhood Centre

[9.11 a.m.]

Ms SIEJKA (Pembroke) - Mr President, in the middle of suburban Warrane a delightful project is underway.

The vision is to create an inclusive, productive, creative and community-centred garden space for residents - and the Warrane Mornington Neighbourhood Centre, together with their many volunteers, is well on the way to achieving this.

All of us will be very aware of the good work of Neighbourhood Houses Tasmania across the state and be familiar with our own local Neighbourhood Houses. One of the strengths of

each house is that they each have their own tailored approach to responding to the needs of their community and to improving the lives of those they engage with. Every house has a significant impact on the community, all done with tight budgets, dedicated staff and the goodwill of supporters and volunteers.

My neighbourhood house is the Warrane Mornington Neighbourhood Centre. Ably run by Leanne Doherty and supported by staff members Kerryn James, Doreen Read and Leah Brightman, the house provides a range of activities, program support and assistance to empower and assist community members.

One of their most ambitious undertakings has been to create a community garden. Right in the heart of Warrane a vacant block of land is being transformed. This land is developing into a wonderful open community space guided by landscape, architectural plans, and the work of many hands.

The focus has consistently been on the engagement with the community, and this could be seen from the very first steps the Neighbourhood House has taken with a committee that included local stakeholders.

The garden's humble beginning began in April last year when members of the Tasmania Prison Service Reintegration Program helped recycle eight garden beds from the Neighbourhood House across to the garden and filled them with gravel and soil. Two weeks later, the homework group planted the first two beds and the garden was off and running.

Community ownership of the garden is obvious, with many local businesses and organisations and volunteers from all walks of life contributing to the maintenance and development of the space.

Currently a garden team, consisting of 10 local community members of varying ages and levels of gardening experience and all with an abundance of enthusiasm, work on the garden. Marie, Katie, Lily, Deborah, Sam, Emily, Ailsa, Jo and Anna make up the core of the team. They meet regularly to plan for the garden, which includes feedback from individuals and groups across the community.

Supporting the team are even more dedicated volunteers: Romina, Carolyn, Joy, John, Esperance, Sarah, Carol, Ron, Cecily, Ange and Averi. Their work and that of the centre has considerable community support seen through their many partnerships, which include local groups such as the Howrah Men's Shed, which has built celery top pine garden seating, verandahs, and plaques for the plants; cafes, such as Moto Vecchia, which has provided support and goods on community open days, as has the Howrah Garden Centre; the Australian Plant Society; Cambridge Road Play and Learn Centre, which has provided regular manpower; contributions from local Rotary and Lions, the local newsagency, pharmacy, hardware shop, supermarkets and Eat Well Tasmania. TasTAFE and UTAS have provided training and education, and the Clarence City Council has played a key role throughout. The Tasmania Prison Service Reintegration Program has also continued to be involved.

Funding has also been sought and successfully gained for more beds and fencing and to build accessible pathways and a bathroom. Efforts have been made to make the space as creative and innovative as possible with an inclusive mosaic tree stump artwork to enhance the space.

One of the initiatives of the garden has been the opportunity to sponsor a tree. Many of these were donated as memorials and reminders of special people. Others have been donated by people like myself. Such was the success of the initiative that the garden now boasts an orchard with 37 fruit trees. After a very short time the garden is already providing a huge range of fresh produce as well as communal seating and spaces to play. The garden team and volunteers have heard many stories of how the garden already has a positive impact on people's wellbeing.

The success of the garden can be seen in the huge turnout for open days. There are many plans for the garden, but most immediately they aim to employ a local garden coordinator and a market for neighbourhood makers and growers. This garden will be an incredible vision to see fully realised, but there is already much to celebrate.

Congratulations to all the staff, board members, volunteers and community members who have had the vision and provided the resources and manpower to transform a very ordinary space into extraordinary community resource.

Diverse Tassie - First Anniversary

[9.16 a.m.]

Ms WEBB (Nelson) - Mr President, today I am pleased to congratulate *Diverse Tassie* on its first anniversary. *Diverse Tassie* is a monthly newspaper serving Tasmania's diverse communities with news, views and events. It was started by three friends - Mohan Mattala, Rajat Chopra and Johnpaul Varghese. These three had a dream, a vision of introducing a community newspaper for all Tasmanians to voice their ideas for building a strong, diverse and harmonious Tasmania.

In many ways *Diverse Tassie* arose from the trio's gratitude to the Tasmanian community - a Tasmania that has embraced and accepted them irrespective of their varied backgrounds, and a Tasmania they believe has given them a better future and standard of living. Mohan wrote to me saying, 'We always wanted to give something back to the state which has given us so much.'.

The first edition of the *Diverse Tassie* community newspaper was published in October 2019. Since that first edition the newspaper has been printed monthly and distributed statewide. It also publishes regular updates on various issues through social media and on its website, and organises and promotes events and forums around the state.

Diverse Tassie's mission is to bring communities together through sharing stories and perspectives that reflect Tasmania's growing diversity. Its tag line is 'Bringing communities closer every day'. The three founders of *Diverse Tassie* identified that there was a vacuum of information for Tasmania's diverse populations and they wanted to fill that vacuum. Prior to the COVID-19 restrictions that we have experienced this year, Tasmania had seen an influx of international arrivals over the last few years. The University of Tasmania's Institute for Social Change's May 2020 Tasmanian Demographic Analysis SnapShot found that compared to 2018, 2019 saw net overseas migration to Tasmania increase by 6.8 per cent, or 2990 people, so we are on an upward trajectory, increasing our overseas migration and increasing our diversity.

The main source of overseas migrations was international higher education students, that was about a third; humanitarian entrants, which were about 17 per cent; and permanent skilled

migrants, which were also around 16 per cent. Over half of our overseas migrants were aged between 15 and 29 years of age, so in younger age brackets.

So how do we benefit from diversity in the state? When we meet and live and work with people who are different to us, we are more likely to be exposed to new ideas and new ways of thinking. It can lead us to reflect on why we do things the way we do, to examine our values and our beliefs, and this can open our eyes to the multitude of ways of doing things and can free us from the pressures to conform to a one-size-fits-all world view and approach to life. Exposure to new perspectives can lead to a better, richer, more inclusive and truly accepting community.

The team at *Diverse Tassie* is motivated to provide a positive and nurturing environment which can cater to the diversity of our rich and inclusive community. Since its inception, *Diverse Tassie* has given particular focus to stories of silent achievers who have contributed so much to the Tasmanian community with little fuss or fanfare. This has included stories of various community organisations that are working diligently within their communities. For example, in the November 2019 edition there was a story about an intercultural church hosting multicultural carols for different groups where they shared carols in their native languages, while in another example, the AFL football clinic for young women from refugee backgrounds saw players from the North Melbourne women's AFL team passing on skills and tips on playing this traditionally very Australian game.

The newspapers also covered stories about the way different community organisations and government organisations have come forward to help Tasmanians during the time of the pandemic. To highlight just a few -

- the Refugee Communities Association of Australia and Help Himalayan Youth Foundation has provided basic food items to support 40 Rohingya asylum seeker families during Ramadan this year

- Show Hope has provided curry meals and groceries to an average of 200 international students two nights a week, and

- Subbies, a home away from home community for South Asian students during the COVID-19 time, has committed to providing food and daily essentials to those in need.

These are just some of the diverse and inspiring examples of positive contributions to our community made during a time of real challenge.

In closing, I will quote the first paragraph of the first edition of the *Diverse Tassie* community newspaper. It said -

> Embracing and respecting the fact that every individual is unique and accepting him irrespective of his race, colour, ethnicity, gender, socioeconomic status, religious beliefs, political ideologies and other diverse differences is an ideal scenario for any healthy society to prosper.

We can all agree with that sentiment. I encourage all Tasmanians to grab a copy of the latest edition of *Diverse Tassie* and join me in congratulating Mohan, Raj and Johnpaul on bringing this culturally rich and diverse publication to our state.

Members - Hear, hear.

Jefferys Track Upgrade

[9.21 a.m.]

Dr SEIDEL (Huon) - Mr President, whenever decisions are difficult to make, we should go back to our communities and engage with them in a meaningful way. Community consultations are key to the best practice of evidence-based policy developments, so much so that good governance guidelines make particular reference to best practice models for all levels of government. Core to all guidelines is that the decision-making process must be transparent. Good governance implies that good decisions are promoting the interest of the community.

Good governance is participatory and inclusive. It is consensus-oriented. I like to think that governance should be with the people, not of the people. That is why appropriate community consultations are so important. However, in my electorate, the most recent government-funded consultation process - to upgrade the Jefferys Track from Crabtree in the Huon Valley to Lachlan in the Derwent Valley - has created significant angst and concerns.

The apparent aim of the consultation was to communicate and seek feedback on the possibility of the development of the Jefferys Track; to understand community and industry opinions, concerns and ideas related to the possibility of development of the track, and of certain potential traffic flows; and identify the costs and benefits of potential development. However, as local resident Jenny Cambers-Smith and many others in my electorate have pointed out to me, the community was actually presented with a scenario in which decisions already had been made by others.

For example, one scenario under consideration was a heavy vehicle industry road option costed at - wait for it - $276 million. This would, of course, require compulsory land acquisitions. Some residents have already been shown maps indicating proposed roadworks on their private properties. Imagine how residents must have felt when they saw their own properties carved up on a map without any prior communication or consultation on that matter. It really should not be like this.

The history of Jefferys Track is somewhat peculiar. It was named in honour of a an apparently wealthy and eccentric Oxford-educated Englishman, Molesworth Jeffery, who settled near Lachlan shortly after his arrival in Tasmania in 1830. The original track that connects the Derwent Valley to the Huon Valley was built in 1848. Then it was just a 4-foot bridle path using rocks and roughly packed stones. It was used to send livestock from New Norfolk to the Huon Valley markets.

Since then, upgrading the track has been a saga of broken promises. Records show New Norfolk and Huon councils first requested a better road link in the early twentieth century. In the 1960s and 1970s, further initiatives were launched to explore a sealed road. In 1984, to make a case for an upgrade, the member for Derwent, Charles Batt, and the member for Huon, Peter Hodgman, saddled their horses and rode up to the junction of their two electorates on

Jefferys Track. Those were the good days in politics. Since then we have had further reports and even a master's thesis on upgrading the Jefferys Track.

It must be the most studied gravel track in Tasmania. Essentially, the outcome of those inquiries including consultations has been the following. There are no existing circumstances under which an upgrade to the Jeffery Track to anything other than a fire trail has a social or economic case.

With regard to expensive perpetual proposals to upgrade the Jefferys Track, may I be clear, let us stop doing the same thing over and over again. Let us first and for all ensure we have an accessible fire trail. Let us focus on the tangible rather than the promises. That would make sense and is what our communities in the Huon and Derwent Valley expect. After all, as I outlined earlier, governance should be with the people.

I thank Jenny Cambers-Smith for providing me with her submission to the most recent feasibility study. The submission was written on behalf of the Smith family and other residents in the Crabtree area. It is a thorough analysis of the matter and I seek leave to table her submission.

Leave granted.

Distance Runner Stewart McSweyn

[9.26 a.m.]

Ms FORREST (Murchison) - Mr President, today I will inform members of the amazing efforts of a young King Islander who is now on his way to the Olympics.

Stewart McSweyn is a distance runner who has made a meteoric rise in these last couple of years and has qualified for the Tokyo Olympics in three events. This is rather unique and demonstrates the broad range of his talents.

Stewart, or 'Stewy' as he is known, has qualified for the 1500 metre, the 5000 metre and the 10 000 metre events, assuming they are set to go ahead in 2021. While this is still unclear, Stewart did say in an interview with *Athletics Illustrated* in September last year that he hoped the Olympics would go ahead, noting that regardless, he would still have to prepare as if they were.

Stewart grew up on a beef and sheep farm on King Island where he would appear to have had an idyllic childhood, mostly spent outdoors with his twin brother, Gus. They would do things together and although they were complete opposites, they were still best mates. They had a nearby beach and golf course, and would help on the farm chasing cattle and rounding up the sheep - they probably did not need a sheepdog - although his sister, Carmen, informs me he was not the most dedicated farm worker and preferred to spend his time running through the paddocks instead.

He first started training and racing when he was 12 years old, but did not start training consistently until he was around the age of 14 or 15. Stewart won a scholarship to attend boarding school in the strong distance running community of Ballarat, Victoria at the age of 13.

Being away from home at such a young age helped him to build some resilience which now enables him to cope with being overseas for up to five months a year.

Stewart has always had a love of sport, either watching or participating. He played cricket, tennis and AFL up to 14 years old, before deciding to concentrate on athletics. He is a fanatical St Kilda supporter. He was so excited they made it to the finals this year, he spent the last few months in London waking up at odd hours just to cheer them on.

His sister, Carmen, says he attributes his passion for sport to his father, Scott, who was an Australian weightlifting representative. Stewart also has some strong athletic influences and role models in Ballarat such as his coach, Rod Griffin, and other distance greats Collis Birmingham and Brett Robinson.

During his teenage years he qualified for nationals and occasionally won a medal. He represented Australia at the World Cross Country Championships in the junior race and then again two years later at the World University Games in the 5000 metre race.

In 2015, Stewart was focused on university studies and almost retired from running. He took some time off but missed the sport and after some encouragement from his coach, Nic Bideau, he returned and has been dedicated to it ever since. Now 25 years of age, Stewart is currently studying a Bachelor of Secondary Education specialising in PE via distance learning. He is in his final year.

In recent months, Stewart has had some amazing successes internationally. Originally, the steeplechase was his best event, but he has since dropped that and now holds all the 1500 metre, 3000 metre, 5000 metre and 10 000 metre national records, becoming the first Australian to achieve that feat. In September, he set a new Australian record in a 3000 metre event at the athletics competition in Rome. His time of 7 minutes and 28 seconds was 4 seconds faster that Craig Mottram's previous record set in Greece 14 years ago. This is a huge achievement for a King Islander, a Tasmanian.

Amazingly, Stewart's brilliant season continued when he broke his second Australian record just over a week later in the Diamond League meet in Doha on 25 September. In front of empty stands, he produced what can be described as one of the best and greatest runs of his career so far, to win the men's 1500 in 3 minutes, 30.51 seconds - I cannot even imagine running that fast - breaking Ryan Gregson's record of 3 minutes, 31.06 seconds which has stood for 10 years. Selemon Berega from Ethiopia was a distant second, in 3 minutes, 32.92 seconds.

He attributes his recent success to being able to train hard consistently, and to having a good coach in Nic Bideau, whose style he describes as tough but fair and encouraging developing athletes to be mentally tough as well as physically tough. I am sure you need that mental toughness to keep up the training regime.

Stewart will soon be returning to Australia where he lives with his sister in Melbourne. I am sure we all wish Stewart all the best in his future. He truly is a champion, and first and foremost, a King Islander, a Tasmanian and an Australian who I have little doubt will do the state and the country proud whenever he sets out to run.

Congratulations, Stewart.

Members - Hear, hear.

Richie Porte

[9.32 a.m.]

Ms ARMITAGE - Mr President, today I speak about an extraordinary homegrown hero, Richie Porte, who has very recently taken out a podium finish at the 2020 Tour de France, an incredible achievement and only the second Australian rider to do so, following the victory of Cadel Evans in 2011.

Richie was born in Launceston in 1985 and is well and truly a local boy. He grew up in Hadspen, attending Hagley Farm Primary School and St Patrick's College where now a sport's award at the Croagh Patrick Campus is named in Richie's honour, being annually awarded to the best athlete in year 9.

A well-rounded sportsman and athlete, Richie was a triathlete until the age of 21 when he switched his focus to cycling and spent two successful seasons racing at amateur level in Europe. In 2010, Richie signed with Team Saxo Bank, a professional cycling team, during which time he made a big splash in the world of professional cycling, featuring prominently in a number of stages of the Giro d'Italia, Paris-Nice and Tour de Romandie races and wining stage 5 of the Tour of Denmark.

In 2012, it all kicked up a gear when Richie was signed to Team Sky, playing a key role in the victory of fellow teammate Chris Froome in the 2013 Tour de France, which was rewarded by being given the opportunity to lead Team Sky in the Giro d'Italia in 2014. Tragically, however, a recurrent chest infection marred his ability to compete to his best ability and he was forced to sit out for the rest of the year following the Giro d'Italia so that he could rest up for the 2015 season.

In 2016, Richie joined BMC Racing and in the 2017 season won the Tour de Romandie and the Tour Down Under among other achievements and a number of European races. In 2018, Richie won the Tour de Suisse, finished second in the Tour Down Under and took out third place at the Tour de Romandie but, unfortunately, he crashed out of the Tour de France suffering a fractured collarbone and hip and was ruled out of the latter stages of the season.

Following his recovery, Richie moved on to the Trek-Segafredo team in 2019 with which he rode in the 2020 Tour de France, an especially unusual year for the race given the coronavirus pandemic. Nonetheless, and not being a favourite to make a podium finish, Richie found himself in ninth place overall by the end of the second week. By stage 17 he was in fourth place, which is where he remained going into the decisive and only individual time trial of the tour. Thanks to his strong performance, he finished the stage in third place, also finishing the tour third overall, making his first podium finish and his best result to date in a grand tour event. Richie's determination was all the more reinforced when his second child, a daughter named Eloise, was born during the final stages of the event, and he raced home so that he could meet his little two-week-old girl and little brother Luca, aged two.

In fact, knowing Richie was likely still going to be racing when Eloise would be born, Richie's wife Gemma said, 'Go do it, but I don't want to see you loafing at the back of the peloton' - advice that Richie, as a dutiful husband and father and rider, obviously took on board.

It was announced last month that Richie was to move to INEOS Grenadiers with a two-year contract from 2021 onwards - a testament to an extraordinarily impressive career to date. A true Launceston local, and I think I speak for all Launcestonians and indeed all

members of this place when I say that Richie is an extraordinary young Tasmanian and we are all so very proud of his achievements to date.

We should also congratulate Richie's mum and dad, Penny and Ian Porte, as we all know the amount of training, discipline, time and effort Richie's parents must have put in over many years to provide him with the opportunity to go for his dreams.

I am sure all members here join me in wishing Richie all the very best for the upcoming events in the next riding season. Well done Richie Porte, a true local hero.

RECOGNITION OF VISITOR

Hilde Nilsson - Dying with Dignity Tasmania

Mr PRESIDENT - Honourable members, I welcome Hilde Nilsson, President of Dying with Dignity, to the Chamber today to witness our debate. Welcome to the Chamber.

END-OF-LIFE CHOICES (VOLUNTARY ASSISTED DYING) BILL 2020 (No. 30)

In Committee

Resumed from 13 October (page 134).

Madam CHAIR - Honourable members, before we start, I will go through some of the procedural matters again to remind you of them. I wish to reiterate some of the information regarding the process to progress this bill, to remind and assist us through the consideration of the bill.

As of 13 October, a number of clauses and amendments are still to be dealt with. The Deputy Clerk will continue to call each clause separately and slowly to ensure progress in an orderly manner. We have some postponed clauses to return to, which we will do in due course.

As members will recall, several amendments to various clauses, some new clauses and some proposed amendments to amendments are to be dealt with if the main amendment is supported.

As a reminder regarding moving of amendments, each member who proposes an amendment must do so in their three speaks on the question that the clause be agreed to. All members will have three speaks on the question that the amendment be agreed to.

The member for Mersey, as the member in charge of the bill, has unlimited calls on each clause and any proposed amendments.

When a member speaks to their proposed amendment, they will read the amendment and then speak to provide the rationale for the amendment. Members will have three speaks on each question proposed by the Chair.

It is important to remember that when directing questions to members, the member proposing the amendment, particularly if it is not the member for Mersey, is to do so in a manner that allows the member proposing the change an opportunity to respond to any issues raised in the debate without having exhausted all their calls. Just a reminder to try to do that.

To reiterate the process to dealing with amendments to amendments, the main amendment will be proposed by a member. The question before the committee is that the amendment to the clause be agreed to. At this point, another member may propose an amendment to the main proposed amendment and the question will then be that the amendment to the proposed amendment be agreed. Members who are proposing an amendment to an amendment will have three speaks on the proposed amendment to the main amendment, as will other members. Again, the member for Mersey does not have any limits on his call.

Once the question that the amendment to the main proposed amendment be agreed to has been disposed of either by support or negatived, the main proposed amendment, as amended or not, will be considered. At that point, one of two questions will be that the main proposed amendment as amended be agreed to, or diverting back, that the proposed amendment be agreed to.

Once that is dealt with there will be a final question that the clause as amended stand part of the bill, or the clause as read stand part of the bill.

The Chair, either myself, or the Deputy Chair, will keep a close tally on the number of calls on each question to ensure everyone has a fair opportunity to speak on the clauses and proposed amendments.

I reiterate: amendments are all to be within the scope of the bill and in writing, and debate focused on prosecuting the case for an amendment or a rebuttal of the arguments concerning the operation of the clause or the proposed amendment. While some latitude may be extended where necessary, it is important that members keep in mind this is not an opportunity to debate broad policy issues, introduce matters outside the scope of the bill, or repeat arguments on questions before the Chair.

I encourage members to try be succinct to enable progress. This is assisted partly through the avoidance of repetition.

As at our previous sitting in the Committee stage, at times I will seek to move in and out of the Chair with the Deputy Chairs in order to speak to clauses and proposed amendments. Just to remind members, the order of precedence of Deputy Chairs is as follows -

- the member for McIntyre
- the member for Hobart, and
- the member for Launceston who I am not sure is able to if she needs to now, but she is more mobile than she was.

If members wish to clarify any issues as we go along, please do not hesitate to do so by raising a point of clarification or a point of order. We will now continue.

Clause 14 -
When person's communication under Act may be made by another person

Ms WEBB - Just to start off with a little curly one, a proposed amendment to an amendment.

We discussed this when we were finishing up last time, but to recap: it relates to clause 14, which is on assistance with communication. Members will recall the member for Rumney had moved to include after paragraph (b)(ba), and that specified if assistance were to be given with communication, a range of things could not occur. It could not be a family member; it must be someone accredited as a translator if they were translating; it was not going to be anyone who would benefit directly or indirectly from the person's death; and it was not going to be a residential care provider or someone directly involved in providing health services. That was the amendment or the additional subclauses being put forward.

Then the member for Murchison was adding to this to allow for the fact special circumstances could be taken into account. On applying to the commissioner, somebody could receive assistance with communication by somebody who fitted into one of those excluded categories if there were exceptional circumstances as to why that could occur. The safeguard was it had to be considered by the commissioner and that would be quite a formal process which could recognise, at times, that there may well be quite exceptional circumstances under which that assistance with the communication could happen from somebody in one of those categories.

What the member for Murchison proposed was that in those sorts of exceptional circumstances, consideration by the commissioner could occur only in relation to subparagraphs (i) and (ii) in (ba), in relation to the person being a family member and whether the person was an accredited translator. It only allowed for -

Madam CHAIR - Order. Can I ask the member to read her amendment to the amendment? We have the *Hansard* from last sitting, so could you focus on the actual amendment and proceed with that? This is an amendment to the amendment.

Ms WEBB - Madam Chair, I move that clause 14(4A) be amended by -

Leave out 'subparagraph (i) or (ii), or both, of that subsection do'.

Insert instead 'a subparagraph of that subsection does'.

To pick up my explanation, this amendment simply seeks to allow for these exceptional circumstances to be considered by the commissioner in relation to communication assistance not just if the person is a family member or not an accredited translator, but in circumstances where they may fit those other three categories - someone who may benefit directly or indirectly from the death of the person, someone who may be a residential care provider, or someone who may be involved directly in the health services, providing health services or professional care to the voluntary assisted dying - VAD - person.

The proposed amendment recognises that if we are going to allow for the consideration of exceptional circumstances, it makes sense to allow for the consideration of exceptional circumstances relating to any of those categories. I particularly had in mind circumstances in

which somebody may not have family members who assist them with communication, but may have others involved in their life, who, in a very ongoing and intimate way, provide them with care and are the ones who give them the greatest assistance with communication. In this circumstance it would be appropriate for them to be provided with assistance with communication if that were deemed to be an exceptional circumstance. I am thinking about people potentially with particular disabilities or circumstances where they have carers, maybe of very long standing, who facilitate that function for them.

I do not think this removes any safeguards. I think constraining it in the way presented by the member for Murchison's amendments really allows only for a small category of exceptional circumstances, but does not recognise we could conceptualise all those categories as exceptional circumstances potentially and allow for that. It may not be that this is applicable in virtually any circumstances, but if we were to exclude somebody through this and through their consideration of an exceptional circumstance by constraining it to only (i) and (ii), instead of all those elements under that clause, I think that would put us at risk of setting up a barrier for someone who might genuinely be eligible and appropriate to access this service.

Mr GAFFNEY - I thank the member for Nelson for bringing forward this amendment. We are supportive of it. We think it strengthens the bill and will allow for those circumstances so the bill remains person-focused. I am very supportive of this.

Amendment to amendment agreed to.

Clause 14, as amended, agreed to.

Clause 15 -
Person may withdraw from voluntary assisted dying process at any time.

Ms LOVELL - Madam Chair, I move that clause 15 be amended as follows -

First amendment

Clause 15(4)(d) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Second amendment

Clause 15(5)(c) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Members will recall these are subsequent amendments to the debate we had around a Commission of Voluntary Assisted Dying being inserted into the bill. This is continuing with those amendments.

Amendments agreed to.

Clause 15, as amended, agreed to.

Clause 16 -
Person may make first request to access voluntary assisted dying.

Dr SEIDEL - Madam Chair, I move that clause 16 be amended by -

First amendment

Clause 16(2)(a) -

Leave out 'and not by way of'.

Insert instead ', or by way of'.

Second amendment

Clause 16(2)(b) -

Leave out 'and not by way of'.

Insert instead ', or by way of'.

Honourable members, while my amendment represents a minute change in wording, it actually has quite significant implications. In line with my previously proposed other amendments to this bill, this amendment is designed to improve access to care without compromising quality of care. Broadly speaking, it allows telehealth via an audio and visual link to be an option for the whole consultation process between a qualified medical practitioner and a patient. That is actually not revolutionary and it really should not be controversial either.

The intent of the proposed amendment is to align the consultation process with regard to VAD with the existing regulations and standards of good medical practice as outlined in the Health Practitioner Regulation National Law (Tasmania) Act 2010. The amendment will also improve access to care, in particular, for patients and practitioners who live in remote areas of Tasmania without compromising the quality and the integrity of the medical consultation.

From March to June this year alone almost one million telehealth consultations were conducted in Australia via an audio and visual link. Although the uptake has increased substantially due to COVID-19, we actually have had Medicare-funded telehealth consultation in Australia since 2011, so it has been around for quite some time. I am very pleased - it was a privilege to be involved in the very early days of telehealth, developing the standards and conducting the second-ever Medicare-funded telehealth consultation in Australia.

The 2012 guidelines from the Medical Board of Australia really say all registered health practitioners can use telehealth as long as telehealth is safe and clinically appropriate for the health service being provided and suitable for the patient or client. The Medical Board of Australia states that telehealth is health care delivery or related activities that use any form of technology as an alternative to face-to face-consultation. It includes, but is not restricted to

videoconferencing, internet and telephone. It does not refer to the use of technology during a face-to-face consultation. I want to be quite clear that I am just referring to telehealth that includes an audio and visual link. It is video consultations; it is not telephone consultations. So very clearly I am referring to audiovisual links as part of the consultation - it cannot be just a telephone consultation.

The 2012 guidelines were developed by the Medical Board of Australia under section 39 of the Health Practitioner Regulation National Law Act as enforced in each state and territory, which came into force here in 2009. These guidelines aim to inform registered medical practitioners and the community about the board's expectation of medical practitioners who participate in technology-based consultations. I am going to be quite specific now.

Medical practitioners who advise or treat patients in technology-based patient consultation should -

(1) Apply the usual principles for obtaining their patients' informed consent, protecting their patients' privacy, and protecting their patients' right to confidentiality.

(2) Make a judgment about the appropriateness of the technology-based consultation and in particular whether a direct physical examination is necessary.

(3) Make their identity known to the patient.

(4) Confirm to their satisfaction the identity of the patient in each consultation. Doctors should be aware that it may be difficult to ensure unequivocal verification of the identity of the patient in these circumstances.

(5) Provide an explanation to the patient of the particular process involved in technology-based patient consultation.

(6) Assess the patient's condition based on the history and clinical science and appropriate examination.

(7) Ensure they communicate with the patient to -

    (a) Establish the patient's current medical condition and past medical history and current or recent use of medications, including non-prescription medications;

    (b) Identify the likely cause of the patient's condition;

    (c) Ensure that there is sufficient clinical justification for the proposed treatment.

    (d) Ensure that the proposed treatment is not contraindicated. This particularly applies to technology-based consultations when the practitioner has no prior knowledge or understanding of the

patient's conditions and medical history or access to their medical records.

(8) Accept ultimate responsibility for evaluating information used in assessment and treatment, irrespective of its source. This applies to information gathered by a third party who may have taken history from or examined the patient.

(9) Make appropriate arrangements to follow the progress of the patient and inform the patient's general practitioner or other relevant practitioners.

(10) Keep an appropriate record of the consultation.

(11) Keep colleagues well informed when sharing the care of patients.

Members, I am saying that because it is what I have been doing for over 10 years. We have a national law, we have regulations, we have guidelines. The medical profession has developed standards as early as 2011 that stipulates how to conduct a video consultation. It is not revolutionary. It should not be controversial and it should be part of how we can deliver VAD care for patients, in particular, in rural and remote areas. It is the process. It should be between the qualified medical practitioner and the patient. We already have the law in place. We do not have to restrict the use of video consultations in this bill even further.

That is why I believe we should be opening this up.

I commend the amendments to members.

Ms RATTRAY - Madam Chair, in regard to the member's proposed amendments, I reiterate: this is when a person is making the first request to access voluntary assisted dying.

I am not sure who has been through the teleconference process in the last six months, but I can assure you at times, members, they are not very effective. They drop out; they have breakdowns, and you have to try to ring back in. It is not necessarily the most efficient system I have seen so far. I know this bill will not be enacted tomorrow and there may well be some advances in technology - and I hope there is - but I am going to make my decision on what I feel is the best. When we look at the first request to access voluntary assisted dying, my preference would be that it is in person with your medical practitioner.

Thank you, member, for giving us those details, but at this time I am not going to support your amendment.

Mrs HISCUTT - Madam Chair, looking through the bill, the other two requests are either/or: you can have audiovisual consultation with the other two requests - the second request and the final request. It is also my belief at least one of those requests should be an eyeball appointment where you should be able to look into the person's eyes to make sure you know exactly what they are doing.

I understand where the member for Huon is coming from, but I believe at least one of those requests should be face to face. Unfortunately, I will not be able to support the amendment either.

Mr VALENTINE - Madam Chair, I was in the ICT area of the Department of Health when telehealth was being developed; it has been around a long time.

The telehealth facilities are far more superior to what some of our experiences may have been over time. I have to say I am not entirely sure of what it might be like, say, on Flinders or King islands.

Ms Rattray - And the north-east.

Mr VALENTINE - It is a system that has been around a long while. If a doctor found themselves in a circumstance where they were not able to hear the patient properly, the doctor's ethics would come into play here. They would not allow a person to say yes, they wanted to access this or that or go through certain processes unless they were absolutely sure that is what the patient was telling them. We are in a modern world, and things will improve. Systems will break down at times, but I am sure at the next opportunity when the system is working again, the conversation will continue, just the same as we have all experienced over this pretty interesting time with COVID-19. This matter of access is important for people in isolated places, especially where they may not have the necessary medical practitioners otherwise available.

We really have to think carefully about this - it is important for everybody to have access. If this bill becomes an act, everybody has to have access to those options under the law. You cannot have access to it simply because the telehealth system does not happen to be operating on that particular day. You keep trying and eventually it works, or you get something that the doctor is satisfied the patient understands fully - that is, what it is they are going to do and what their wishes are.

All sorts of people can have problems communicating. We have already heard from the member for Nelson about why she has moved her amendment. There are circumstances where people cannot communicate properly - they might have a disability - and it does not have to be a telehealth issue. There are all sorts of circumstances where people cannot communicate properly. I really feel this amendment should be supported and I thank the member for bringing it forward.

Ms ARMITAGE - I am inclined not to support this amendment only because, as was said by the member for Montgomery and member for McIntyre, that there is a second part that people can do by video link. The other concern when they are both by video link is that a doctor does not know who is in the room with the person. We are being very careful to make sure people are not being coerced. If it is only by video link there is a remote chance, but still a chance, that someone else could be in the room with that person that the doctor is not aware is there. I believe it is good as it is; I support it as it is the first discussion with regard to it being in person and then after that, obviously, we have the audiovisual link. Unless I can be convinced otherwise, at the moment I am not inclined to support it and am quite content with the way it is written in the bill.

Ms WEBB - Madam Deputy Chair, initially, I was relatively comfortable with the way it was written in the bill, but we have already made some amendments that cast this in a different light and lead me to support this amendment. The amendments I am referring to are where we have introduced a prognosis of six months or 12 months for neurological conditions. By introducing that, and we have already passed that amendment, we have shortened the time,

potentially, within which people can access this process, because they have to have had a prognosis that their death is expected within six months for most conditions.

In our discussions we have heard that when people get to that stage there can be quite a quick trajectory towards the end. What we have done is to put on people who may wish to access VAD a potentially very short time frame that occurs at the time of their most unwell, imminent death period. That potentially puts barriers in place for people to have face-to-face consultations, who may be in remote areas and may not be near where they can travel, or the health practitioner can travel to them.

That puts this in a different light, and requires us to consider the accessibility barrier that is there if we retain what is in the bill and say it must be a face-to-face consultation, this initial one.

I would like members to consider this alongside what we have already done with amendments - putting that prognosis in place, putting that shorter time line in place, making it that people cannot even initiate this process with this first request at an earlier stage of their disease when they are well enough to potentially travel and attend in person, or have someone attend them, and think of it being an appropriate way to balance the constraint that we have put there with the prognosis, to ensure we have not inappropriately and unfortunately constrained people's access even further by requiring face-to-face consultation.

Ms FORREST - Madam Deputy Chair, I do not support this amendment. I listened carefully to what the member for Huon said in terms of the guidelines that are used to facilitate telehealth. I am a big supporter of telehealth. It has had a really important role to play in delivery of health services. It is not for every application and it is quite clear that is the case. It can be used to good effect for a number of assessments of the clinical condition of a person, as the member for Huon said, where it is clinically appropriate.

I believe, in this case, it is clinically appropriate to be with the patient at this point because they are in the care of a medical team already. They have been diagnosed with a life-limiting condition with an expected life expectancy that is limited to six months or 12 months depending on the nature of their condition. They are in the care of medical person anyway.

I note the concerns around the reliability of telehealth links at times. It is a problem in our rural areas at times. The other main concern for me - and this is with all points of contact where you are making really important decisions about the ending of a person's life at a particular point - is that it is difficult to assess coercion when you cannot see who else is in the room.

Looking at the 'clinically appropriate', going through the consent, making sure the patient is giving consent, as the member Huon referred to - of course, a doctor will do that all the time. If you have a case where a person is maybe feeling they are a burden, or they are feeling that 'this is better for everybody, because I am obviously dying' - whatever their rationale is - then it is difficult to assess coercion if there is someone in the room and you cannot see them. That person may look the doctor straight in the eye and say, 'No, I am here on my own', because the person on the screen is looking at them, eyeballing them, and we do not know what is going on.

That is why I have concerns about telehealth and I have mentioned that previously. I supported the way this was drafted to start with. You are already in the care of a medical practitioner. We put a time frame around it, which is a really important step, but the person still is actively considering their options at this point. This is the point where they first make the decision to go down this pathway. It is the point where they may still continue other forms of treatment at this point. I assume many people would continue to take pain relief, continue to take other palliative care, whether it is medicines or other care. They will still be receiving care. It is not like you make a decision for VAD and the care stops. That is a completely ridiculous notion. The people involved in this will receive care right up to the moment and beyond the actual administration of the substance. It does not stop because you made a decision; you are still in the care of health professionals. I believe this is drafted the appropriate way here.

Also, in further support of my opposition of the amendment and staying with the current drafting, is that when we heard from the Victorian doctors who participate in this, they said that if they have any concerns at all, and in a lot of cases, they actually decide to meet with the person because they could not be sure of some of the aspects. I do not believe they were confused about the patient's medical condition, it was the fact that, 'Am I really sure this is this patient's wish; am I really sure that there are no other forms of coercion, there is nothing else going on?'. I believe it is important in this particular case because it is the initial one where you are making the decision to move from active treatment to potentially curative treatment - or there is no cure perhaps for a lot of these things, but they are deciding this is the pathway they want to enter on. They were already in the care of a health professional and it is appropriate this one particularly be done face to face.

Ms LOVELL - I support this amendment. I have listened carefully to the arguments put forward by members, both opposing and supporting the amendment, and I believe this is appropriate. This is about making this option for people more available and accessible. I hear the member for McIntyre's concerns on the reliability around telehealth facilities. I hear the concerns the member for Murchison has about coercion and whether doctors have any doubts. What I keep coming back to is that this is about choice - about providing an additional option - and I am confident if there were any doubts at all about coercion, as the doctors in Victoria do, or any issues with the facilities available or whether they are working reliably, the doctor and the patient can still elect to meet face to face. I am confident doctors would insist on a face-to-face appointment if they had any concerns or any doubts at all, as they do in Victoria, as we have heard from those doctors.

References have been made to whether it is clinically appropriate and I agree a determination needs to be made, but I believe that determination should be made by the doctor. As the member for Murchison pointed out, in many cases, in most cases, patients who are seeking to access voluntary assisted dying are in an ongoing relationship with the medical team; they have established trust with those medical professionals. It goes both ways - in the vast majority of cases we are not asking people to come in cold and make a determination purely based on a telehealth consultation the first time they have seen that patient. These people will have ongoing relationships with their medical team. Given this is about providing choice, it is about making it more available and more accessible to more people. Given we have a level of trust in our medical professionals to make those appropriate decisions, I am really comfortable with this and I will be supporting the amendment.

Mr WILLIE - I will address some of the points made by members. This reflects on modern practices now - there are concerns around telehealth technology, but it is going to continue to improve. This legislation will hopefully be around for a long time and we have to trust the professionalism of the medical profession. They are still bound by the act and will still have to assess eligibility. We should trust they can do that and that they will have the appropriate training. We heard in the briefings on the questions that will be asked to assess coercion and other issues discussed on this amendment, so this is a sensible amendment that will last the test of time.

Mr DEAN - Madam Chair, at this time I am not able to support the amendment. When I spoke on this bill during the second reading, my position was that the bill needed to be robust, strong and done in such a way that it could resist, in the best way possible, any corruption or abuse of it. That is my position on this bill. In my view, this amendment would weaken that position considerably at this time. We have heard about, and I am not going to repeat what has been said about where we are with technology today, but I have been involved in many instances of where these systems have broken down, have been interrupted - where people talk for a while and it breaks down and comes back on. I accept what the member for Hobart says about living in a modern world, but this modern world still has a long way to go with much of the technology we are currently using.

As members might recall, Sir William Cox in an email written to us said that not only does legislation have to be strong and be able to resist abuse and corruption as best it possibly can, it must also be capable of being policed. I am not quite sure how it could be in this instance.

I heard the member for Rumney's comment about a doctor or person probably knowing if something was wrong during one of these audiovisual discussions. I am not sure how a doctor could determine that unless the person on the other end of this process broke down and was able to say, 'There is somebody in the room next door to me who has made certain statements and threats to me', and so on. I am not quite sure how that could work.

Ms Lovell - That is not what I said. If the doctor had any doubts, they would have a face-to-face consultation.

Mr DEAN - That is what I am saying. I am not sure how a doctor could have any doubts if they are on an audiovisual system, with the person seeking voluntary assisted dying information and wanting to go down that process. This is the most important stage of this whole process.

Where does the member moving this bill stand on this? Quite obviously the bill has a review period written into it. I am not saying this will not be an acceptable amendment in due course. It probably will be when things are much more refined. The gremlins in the bill will be sorted out. That is what the review period is all about. It is about looking at the legislation to see how well it is working, to see if further changes need to be made. I am confident that the member's proposed amendment in this instance would certainly be considered in those circumstances.

At this stage the proposed amendment would weaken the bill - in my view, considerably and I am not quite sure I could then support the bill.

Ms PALMER - One of my big concerns around this amendment is that we have already heard that a medical practitioner could have an issue with voluntary assisted dying. We could have patients going to a medical professional for the first time to make the first request and therefore it is not someone who is familiar with the patient - it is not someone who may be familiar with their circumstances or their family. I believe this is a really vital time where there is that face-to-face contact and a relationship can be established. It could very well be the first time a relationship is established.

I think it is fine if it is your regular health professional, but we already know that there are bound to be cases where it is not going to be your regular health professional because they may take issue with this. They have every right not to go down the path of voluntary assisted dying with their patient.

I think this takes away that safeguard when it is a new person coming onto the 'team,' for the want of a better word, who does not have that opportunity for a face-to-face meeting. I agree with what the member for Launceston said - you do not know who is in the room. Believe me, I spent 20 years in a tiny little news studio. You would have no idea how many people could be in that room, giving you directions, talking in your ear, motioning to you what they want you to do. That is an absolute reality. The only thing the camera sees is what the camera wants to see. I think it puts medical practitioners in a really difficult position. I cannot support this amendment.

Ms WEBB - Madam Chair, I have some points that might be able to be clarified by the member for Mersey if he is going to be responding to this.

I want to be really clear: what we are talking about in this clause is somebody making a first request. Absolutely nothing gets decided at this point by the medical practitioner involved. This is about a first request being made and about providing the option for that to be done via telehealth.

It is not until we get to clause 24 where the medical practitioner who has accepted the first request then makes a determination about eligibility and going forward with things. A whole range of things will be covered in intervening clauses that inform that decision, that determination made at that later point, up to seven days later, I believe.

At this point what we are talking about is not the medical practitioner having to make a decision and take everything into account and on the spot arrive at a decision about whether this person is eligible and whether they are being coerced as part of that eligibility. It is about accepting a request. I think that is fairly important.

Regarding technology dropping out or being 'iffy', there is not an underlying expectation that this process barrels on and continues if, for instance, a connection drops out and therefore the interaction has to be had again at a different time when the connection is there. If the connection drops out, the connection drops out, and it has to be revisited. It is not that somehow that means by default everything continues and a decision is made.

We need to set out what each of these steps are. This particular one is about the making of a first request and the accepting of a first request. That is not a determination about the person's eligibility. It is not about pressing 'Go' on the first stage; it is accepting the request to then make a determination. In fact, the bill in relation to that determination, later, allows for

the medical practitioner who has accepted the first request to go into all sorts of different examinations, or gathering of information and advice, second opinions, all sorts of things that the practitioner might do to inform their actual determination of the first request. That is the decision that the person is eligible, which involves a decision without coercion.

Let us take a breath and be quite clear and not get too het up about what this stage is, and what it is not, because it is not the be-all and end-all of whether that person is going to be able to go ahead and access VAD. This bill is designed to have multiple stages, multiple steps, multiple points of determining somebody's eligibility, and things like coercion.

I encourage people, and would like comment potentially from the member for Mersey, to help us understand what this step is, and what it is not.

Ms RATTRAY - I have listened intently to the arguments for supporting this amendment. I was working through that and thinking 'Is there some justification around this?' because, as you do, Madam Chair, we represent a lot areas where people have to travel to see a medical practitioner. Is it unreasonable to ask them to travel for the first request for voluntary assisted dying? I do not think it is unreasonable, but then I look at clause 17 where it says 'Medical practitioner must accept or refuse to accept first request' - it says here 'must' -

> A medical practitioner to whom a first request is made by a person must, within 48 hours -

So they have to be really clear on their decision within 48 hours because they 'must' either accept or reject that request. I do not think it is unreasonable for them to see that person to make that first request because this is starting on the journey - and I agree that it is starting on the journey - but is not the first step on that journey the most important step? I believe it is and I do not believe this is unreasonable. People will support that person who is going to make that request, to get to where they need to be for that first request to take place. That is what I believe and at this time I am still not convinced we need to have that first request at least in person.

Mr GAFFNEY - To clarify, this bill was first drafted and proposed pre-COVID-19, and so things have changed in that space. I suggest it is a different world. My preference would be face to face. I think doctors have said that as well, but, in the space we are now playing in, that is not always possible so I will add a few comments to help to people think about it.

The member for McIntyre, the practitioner is not actually being asked to determine the condition or the illness of the person - they have to make the determination on whether they want to be involved with them -

Ms Rattray - They still 'must' either say yes or no within 48 hours.

Mr GAFFNEY - What they are agreeing with in saying yes is, 'I will be involved with it' or 'No', I will not be involved with it.'.

Ms Rattray - I understand that.

Mr GAFFNEY - I actually am quite supportive of what the member for Huon has put forward. I think there needs to be a face to face at one stage, if possible though, or during the first part or the first request. However, when you go to the Australian College of Rural and Remote Medicines, telehealth is seen as an essential component of effective rural and remote

practice. I noticed the member for Launceston asked about what would happen if there was some coercion among the people concerned. The guidelines cover that - the guide to providing telephone or video consultations in general practice and when not to use a telephone or video consultation. In situations where there is any doubt about the clinical appropriateness of a telephone or video consultation in these instances, attending the practice in person for a face-to face consultation is preferable. What they are saying is that a face-to-face would need to occur -

Ms Armitage - We are talking about the rural health; they are not talking about a VAD bill, they are talking about a general consultation. My comment, which they do not even mention, is the fact, as was mentioned by the member for Rosevears, that no-one else knows who is in that room. That was my concern: no-one else knows who is in that room with that person.

Mr GAFFNEY - I will address that because it was addressed by Dr McLaren during one of his briefings with us. I think we need to be careful about using the word 'coercion' in this space so frequently. There is no justification or evidence that coercion has occurred in any jurisdiction over the past so many years. There is no evidence of that and yet that word has come up quite often in this space. We need to be really careful. Dr McLaren said -

> I do believe that these assessments are better done face-to-face, and should be done this way if at all possible, but this allowance will mean that no matter if you live in Hobart, Launceston, or any other corner of the state, your Bill will protect those of you who are suffering from terminal diseases having to travel to see yet another specialist.

I remember Dr McLaren stating in the briefing that there was one case he was concerned about, and he visited that family or that person because of that instance and had three or four meetings with them. I do not think that has occurred many times.

It is important to know that telehealth is an acceptable part of the way we provide services now. It is much further advanced than it was at the beginning of this year. I think we would all know that in our space because we have been having more Zoom meetings and webinars, and we have never ever heard of that because of the reliability -

Ms Rattray - They are not that reliable at times, with all due respect.

Mr GAFFNEY - That is a good point because a GP or a doctor is not allowed to make a determination unless they are 100 per cent certain of the situation. If the audiovisual link was not working properly or if they thought there was not a true and reflective conversation, they would not be able to make a determination. They are not allowed to. That is the safeguard here. The doctor has to be 100 per cent certain of what they are determining and if there was any breakdown in communication flow, as there would be in any doctor/patient relationship, they would not be able to make a determination.

While the bill originally had that the first request would have to be face to face, I am not so concerned that the first request for information could not be done during a video link. For example, a person from Flinders Island - do they really want to fly to Launceston to get the relevant facts from the doctor or can they be given that the first time they meet together when they make a determination of that, and that when he has accepted the request that is when they

can give the determination? I would be more than comfortable as long as somewhere during the process there is some face-to-face conversation, whether it be here or at the first determination.

Ms Rattray - I thank the member in charge of the bill for that clarification. I find it somewhat interesting this was put in the original bill for us to consider some months ago and now the member is saying, 'Well, it does not really matter where you have your first.'. Are we expecting there is an amendment to another clause, because somewhere there needs to be a face-to-face? My view is it has to be somewhere. I am confused about why we are moving away from the first time a patient or person makes a request and will put it somewhere, but I am not sure where we are going to put it now. That possibly confuses the process even further. It would be my preference, if the member wants my support for this bill, that we stay with where we are now and people know there will be a face-to-face requirement somewhere. Why not have it here when it is the bill we have been working with for some time now? I appreciate amendments come forward, but the member in charge of the bill says his preference would be to have a face-to-face, so where do we have it? I believe we have it at the first step.

Dr SEIDEL - I will respond to a few of the comments made. I did not expect it to be that controversial, but I am sort of biased because I have done telehealth consultations for over 10 years. I was involved in developing the standards and was pushing the case for video consultations in Tasmania, so much so that when I referred patients to the Royal Hobart Hospital using a fax machine, I had a stamp where I put down, 'Please consider this patient for a telehealth consultation.'. Interestingly enough, I did not really get much positive feedback - in fact, over an eight-year period, there were zero positive responses from Royal Hobart Hospital, because the clinicians on the other side felt, 'No, it would not be appropriate' because they felt that it did not fit into their workflow. The doctors there made a decision - 'No, the patient needs to attend.'. It was still a decision between the doctor and the patient, and that is what it is all about. We are dealing with highly trained professional general practitioners - specialist GPs, medical specialists - who have been trained with regard to the appropriate consultation models for their patients, so much so that we have a health practitioner regulation national law that does not actually mandate at all how particular consultations have to occur. There is no mandate; it is not mandated for a cardiologist to see patients onsite. It is up to the medical doctor to decide if it is appropriate or not. That is why we are dealing with professional people who are trained through their undergraduate training and now in parts of their postgraduate training. We have the national law informing that. We not only have guidelines, we actually have standards - and if you are not meeting those standards, you would practice outside those standards and you would be subject to medical negligence, for example.

It is interesting the language we are using is often 'eyeballing', 'can't see', 'should be part of seeing' - yes, an audiovisual link means you are seeing the patient; it does not necessarily mean it is onsite, but you are still seeing and hearing the patient. We have a national law, we have medical board regulations and we have the standards - not only guidelines - that are enforced by the medical societies. In no other aspect of health care do we mandate whether a consultation has to occur onsite. We do not have that. The national law is very clear.

The comments made included, 'How can we be sure nobody else is in the room?', for example, and the concerns about coercion. Again, the standards stipulate it is on the doctor to ensure documentation of who is in the room. It is in the standards - I need to write down; I need to be satisfied that I know who is in the room; I need to ensure the room is screened; I need to document who is in the room. That is audited, when I am getting accredited, when the

practice gets accredited. If I, as the doctor, am not satisfied that I can practice within the given standards, I might have to say 'I am very sorry, I do not think a video consultation is appropriate here'. It is up to me as a professional who is subject to national laws and regulations and standards to decide that. That is why any professional is involved in the first place. It is the whole point of having highly trained individuals involved there.

Yes, with regard to comments from the member for Rosevears, we medical doctors are working on the standards. I have to ensure I know who is in the room. It is my job to do that and if I am not satisfied that I know who is in the room, if I am not satisfied that the video quality is good enough, then, yes, it might not be appropriate. I have to say 'I am very sorry under those circumstances I cannot go ahead with the video consultation'. Sometimes the link is just poor, the quality of the video is not good, you cannot hear - the person on the other side just drops out. Yes, that happens, but, again, there are standards that inform mitigation strategies to ensure we can still practice safely. Again, it is for the doctor to demonstrate and they have been doing this now for years in Australia and in Tasmania. Why do we need to mandate what is already legislated and regulated on a national level?

Ms Rattray - But why would you want to put a person through the fact that they may have to reschedule an appointment? With all due respect, doctors are not that easy to get in to.

Dr SEIDEL - It is a very good argument. On the other hand, you could argue, without disrespect, if I am the practitioner who is out to do a home visit and my car breaks down, that can happen as well, or have an accident on the way.

Ms Rattray - Do people still do home visits?

Dr SEIDEL -Yes. That is the counterargument, or I am stuck in a traffic jam and it takes me an hour longer to arrive to the patient.

Ms FORREST - Not many traffic jams in rural Tasmania.

Dr SEIDEL - I am based in Huonville. We do clinics on Bruny Island and home visits there. It just takes a while. Again it is up to the doctor to decide - if you are running late, if you have an accident, what is your fallback position? It is on the doctor to ensure follow-up care is being arranged, whether that is a phone call or somebody else goes out. Do we need to legislate for that? We do not legislate what type and form of communication we use when we submit forms from a practice to the Commission of Voluntary Assisted Dying. We do not regulate that it has to be encrypted email or registered mail or whether it can be a fax. We do not do that because we already have standards in place to a certain extent but we are not going to that level of detail.

For this particular part of the End-of-Life Choices (Voluntary Assisted Dying) Bill 2020 and the consultation process, we also do not have to do that. Trust the highly trained medical practitioners to do the right thing, to work within their scope of practice and to adhere to the good standards of care. If we look at the evidence, if we speak to medical indemnity insurers, if we look at the complaints, if we look at the lawsuits, it turns out that Australian doctors are actually practising very safely within that framework, within the law.

Yes, there are issues with regard to connectivity and there might be issues like people cannot use Skype or Webex or Zoom - but, again, we routinely ask patients 'Do you think we

can do a video consultation?' You would ask the patient, 'What do you prefer? How can we make it work?'. If it does not work, it does not work. That is fair enough. But again, it is between the doctor and the patient to decide. It is tested and tried. It is not recent; we have done this for years. We have the laws in place. Those laws have not changed because they are actually working. The national laws have been in place since 2009. There has been no need to amend them because they are working. That is why not just medical practitioners are involved - we also have highly trained medical specialists, GP specialists, physician specialists. They all know what they are doing and they can decide. Yes, we are eyeballing; yes, we can see. The only difference is it may not need to be onsite.

Think about the patients we are really concerned about. They are patients who have a terminal medical condition now. They are people who are expected to die within six to 12 months.

If a doctor and a patient agree in that context to conduct a video consultation, are we forcing them to travel to a nursing home, from a nursing home, from Bruny Island to Huonville, from Flinders Island to somewhere else? Why are we forcing them when a doctor says, 'No, we can safely do a video consultation', and the patient says, 'Yes, I can safely do a video consultation'. If the doctor and the patient meet each and every standard of the national law, why are we, as legislators, forcing them to say, 'No, we cannot do it because I do not like it'? Again, we have the laws in place, they are working and we do not need to change them, and we do not need to restrict them.

The member for Nelson is right. Because we have restricted the access as regards eligibility, it is essential to improve access when it comes to access practitioners. When we look at the Victorian report, the lack of the telehealth option is a significant barrier. In fact, it is the most significant barrier - the lack of access to video consultations because they are not allowing it. It is the number one barrier in Victoria, so let us do what doctors in Tasmania have already safely, effectively and efficiently done for almost 10 years. We do not need to regulate what does not need to be regulated and we do not need legislation for something that is already legislated - it should be between the doctor and the patient.

Mr GAFFNEY - This is a really interesting one; it is what we could call a 'lineball'. I hear the member's concerns. I always said it was my preference to have face to face where possible. My consideration of this was that it was consistent perhaps for the person. But with COVID-19, there have been exceptional circumstances. As the member for Huon said, is this not a more compassionate process for a person who is very ill and cannot travel? Is telehealth the way?

It is interesting to hear the Victorian board's assessment of the 12 months - it has 'Please don't forget about telehealth - I just drove a two-hour round trip to approve a woman I could have approved with a telehealth appointment.'. The evidence of coercion is not sufficient to justify this and it is disastrous to the real world application of this process.

But I can also hear members saying to me that we put it in the first bill. We wanted to have safeguards and checks on the process, so we put it in so that there was that real contact with the doctors first up. That is why it was there, but COVID-19 then came along. The rules are already consistent within the RACGP; it is already there where they can do so. It is a bit of a conundrum. I hear the member for Huon and he has presented a good case, but at this stage I am concerned that other members - and this is where you have to make some balances

- will be very concerned if this gets passed. I am inclined not to support it because it is important for us to continue with the integrity of the bill as written. After listening to the debate, I am not going to be able to support the member for Huon.

Ms FORREST - I would like to make a couple of points after listening to the debate on this. I appreciate the comments just made by the member for Mersey. He sort of retracted a little of what he said previously - that there should be a face-to-face consultation. I agree. At least one point throughout this process there needs to be a face-to-face. My expectation is there will be probably more than one in practice. I am pleased to see the member believes this is the most appropriate time, because this is where the first discussions are had - the first meaningful, 'This is an option I want to pursue as a patient' - with their doctor at that point.

I listened to the member for Huon's comments. You can argue we should not be specifying at all how a consultation occurs because it is dealt under the Australian Health Practitioner Regulation Agency - AHPRA - and the guidelines and regulations. Clearly, it was the member for Mersey's intention to put a framework in around this, and I believe it is because of the things he has mentioned, like the rigour around the process. I do not believe we should allow COVID to change the way good practice occurs. Not that I am suggesting that is what anyone was suggesting. It is COVID now, but it could be whatever virus comes along in a few years time, or something else that changes the way we operate.

The fundamental principle the member for Mersey put into this bill was that at a critical point when a person needs to make a decision about whether they seek to actively end their life as a result of their condition, there should be some face-to-face contact with a person who is going to effectively ensure they have the information they need. Then they can make a determination later, after they have had that first request meeting, or appointment, to make that determination about whether the doctor will continue down that path with them.

That is the underlying principle. COVID does not change the underlying principle. Any other virus should not change the underlying principle here. As the member for Mersey said, it is about safeguards, it is about checks. Me talking to my community and doctors in my community - I have talked to members of the community who are not medical professionals; I have talked to members of my community who are health professionals as well as ones from other jurisdictions and other parts of the state. For them, this level of rigour is important in such an important area. It is not like deciding whether you should have your gall bladder out because you are getting regular attacks of cholecystitis or something like that. This is a very different consultation that needs to be had. It is a really sensitive ethically charged and difficult conversation to have. Having a discussion with a patient at any time about them dying is difficult. Giving bad news to a patient is always difficult. It always needs follow-up. If you give a person bad news, you have to make another appointment for them to come back and discuss what the options are. It is too much for people to take in at that time.

In practice, that is what will happen but there needs to be a face-to-face component in this. The person has already had the bad news, so they will know what is happening for them, which is a tragic outcome. But we need at least one point of face-to-face. I agree with the standard principle. It is at a time when the person is least unwell in the process. Clearly, they are dying. We have already established this, but it is a time when you can be sure it is the person acting of their own free will. It is what they want. It is what they are seeking, and I think the best way to do that is with an appointment. I have GPs in my electorate who do home visits too, not just down the Huon; it does cost more, obviously, as it should, but there are

provisions for that. I do not know how many medical specialists do home visits, but I know GPs certainly do. I will not support the amendment for those reasons.

Mr GAFFNEY - Perhaps the tipping point in this one, as the member for Windemere said, is that within a relatively short time the bill will be reviewed, but as a starting point, this is how the bill has been written, so I am quite comfortable with that. I will not be supporting the amendment.

Mr VALENTINE - We have to bear in mind that this is not mandatory. It is providing an option that the doctor may choose to take, or the patient may want, and they would both have to agree that this is the way they want to do it. We have to understand that. My only question to the member for Mersey would be: Does he know of any Commonwealth law that prevents telehealth from being used? Can he provide any information in regards to that? I would be interested in that.

Mr DEAN - We have much discussion on this matter. I do not want to go over old ground at all, but this bill is a huge move forward for the state. We need a bill that will be acceptable to most people, and this bill has a great deal of support. I would not like to see anything occur with this bill that could weaken it in any way and as I have said, I think the amendment would do that at this time. I am not saying this is an amendment I would not support at a later stage, but I just want to make comment that the member for Nelson says it is not a matter we should get 'het up' about.

Ms Webb - No, I did not say that.

Mr DEAN - I thought you used the words 'het up'.

Ms Webb - In the debate just now?

Mr DEAN - On this amendment.

Ms Webb - Today?

Mr DEAN - Today, but I will look at the *Hansard* to make sure I am right on that, and if I am wrong, I will apologise, and hope that you will apologise to me if you are wrong.

This is an important part of the whole process. This is about informing the person of their position as to whether they are able to access voluntary assisted dying and medication. This is a critical part of the whole process as I see it. This is the beginning of it, to satisfy these people that, yes, they do meet all the criteria to move forward. It is the beginning of it, so it is a critical part of it, in my view. I had considered looking at the position of where a personal contact would not be possible, and I am trying to think of situations where that could happen. Will a terminally ill person suffering intolerably be in a position where, if they cannot have the audiovisual contact, they are likely to miss out on this whole process?

This is not something I would think that the person would make a determination on at a second's notice. They would be contemplating this position over a period of time, I would have thought. I would not think that a person today would be not thinking about it and then within a few minutes say 'Yes, I want to go down this path'. It is something that would have crept up on them, that the pain, the terminal illness, all of that, would be impacting on their livelihood, their quality of life, reaching a stage of where they do want to go down this path. It would be

something where there has been sufficient time available - I would have thought - to have considered all of this and to get a position in place of where they could have a face-to-face contact.

There is no doubt the member for Huon puts forward a strong argument. He has been involved in this sort of process - telehealth and so on. He understands it well, but I am saying at this time I do not think it is the right time for this amendment to proceed. I am not, at this stage, unless there is some further stronger evidence, able to support the amendment.

Mr GAFFNEY - To answer the question from the member for Hobart regarding telehealth. On 29 March 2020, the federal minister for Health announced telehealth services would be expanded to all Australians in response to the COVID-19 pandemic. Whole-of-population telehealth services were introduced on 30 March 2020. While the new COVID-19 items were initially available only to patients and providers with or at risk of the virus, this requirement has now been lifted and that service is available to all Medicare-eligible persons for the treatment of any condition and can be provided by any practitioner qualified to provide the service in line with normal circumstances, and the changes that would promote patients receiving continuous care from a patient's regular GP or medical practice took effect on 20 July 2020. The telehealth component is comfortable.

Dr SEIDEL - I thank the member for Mersey for saying that, but it is actually only about the Medicare funding of the telehealth consultation. That is just the medical component.

In answer to the question from the member for Hobart, no, there is no Commonwealth law that would restrict in any way or form the use of telehealth in Australia. The reference given by the member for Mersey was just where there is funding for it through Medicare for that. There is no Commonwealth law.

I would like members to consider whether the bill as it stands now includes an unnecessary barrier, if you take into consideration what the national law allows medical practitioners to do with regard to consulting with patients. I have tried to give argument and to provide evidence there is no need for this artificial barrier. I have tried to give arguments that when we look at Victoria where there is a state restriction, this is a significant barrier when it comes to access to health care.

Currently, we are using telehealth services for very complicated and complex interactions. Patients with multiple sclerosis, who cannot walk and cannot drive, who need to be assessed for specific and specialised medical care are using telehealth services in the vast majority of cases, as are patients who are in palliative care, in nursing homes or in rural areas who need input by pain specialists or palliative care specialists. Those specialists are not coming out; it is done by telehealth services when appropriate. Patients who have dementia who need to be assessed whether they qualify by particular treatment -

Madam CHAIR - They will not qualify under this. I do not know that we should include dementia.

Dr SEIDEL - I am talking how we are using it in general terms. We already use telehealth. If appropriate, those people can be assessed. Psychologists are using telehealth as a way of consulting with people who have significant mental health concerns. Psychiatrists are

using telehealth services when they do mental health assessments for patients when appropriate. The appropriateness is determined by the medical practitioner.

I cannot understand why we are accepting an unnecessary barrier in this bill that can now be easily overcome. It is really important we stick to what is really important for this bill. It is not about the integrity of the bill as it is written; it really is meant to be supporting patients who have an incurable terminal condition who do not find an answer in contemporary care. I thought that was what this bill was all about.

If there are clauses in the bill that could be amended to focus absolutely on supporting patients who do not find answers in contemporary care, surely members would consider my amendment? We have the laws in place, we have the regulations in place, we have the standards in place. It has been done. It is not recent. It has been done since 2012 in Australia. I urge the member to think about what we can accomplish by supporting my proposed amendment. We are reducing unnecessary barriers for patients who have to find answers in contemporary care in Tasmania.

Ms WEBB - For clarification, I could not recall saying 'het up'. Quite possibly I did, but, so I am not represented incorrectly, I think it was in relation to the fact that at the point in time this clause relates to, which is making of a request and accepting a request, this is not a decision point about the person's eligibility, necessarily, and that, therefore, matters around coercion are not being assessed in that moment.

I suspect that is when I might have used the phrase 'het up', if in fact I did - that we do not have to feel there is pressure on this point of interaction to assess coercion as part of eligibility. That is not what happens at this stage of the process. I do not believe I used the phrase getting 'het up' about this as a general concept, but it was about clarifying what happens and does not happen at this point in the process.

Madam CHAIR - The question is that the amendments be agreed to.

The Committee divided -

AYES 6	**NOES** 8
Ms Lovell	Ms Armitage
Dr Seidel	Mr Dean
Ms Siejka	Ms Forrest
Mr Valentine	Mr Gaffney
Ms Webb	Mrs Hiscutt (Teller)
Mr Willie (Teller)	Ms Howlett
	Ms Palmer
	Ms Rattray

Amendments negatived.

Clause 16 agreed to.

Clauses 17 to 19 agreed to.

Clause 20 -
Medical practitioner who accepts first request becomes PMP

Mrs HISCUTT - I have a short question -

> A medical practitioner who accepts under section 17(a) a first request from a person under section 16(1) becomes the person's primary medical practitioner (the person's ***PMP***)

Does the member for Mersey anticipate that person being a GP or a specialist, or does it not matter?

Mr GAFFNEY - It does not matter. More than likely it will be a GP, but it is not dictated in the legislation.

Clause 20 agreed to.

Clause 21 -
Notification of acceptance of first request

Ms LOVELL - Madam Chair, I move that clause 21(c) be amended as follows -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Mrs HISCUTT - I think I know the answer - it is like developing regulations. But, clause 21(c) talks about 'in the approved form'. I assume 'approved form' is at the discretion of the commissioner and the commission that now is there. Is that correct? Do you have an approved form developed or have you thought about it yet?

Mr GAFFNEY - It would be determined by the commission as regards the powers of the commissioner, and it would be in the regulations.

Mrs Hiscutt - Do you anticipate it will be a written form or in a verbal form? You do not know, okay.

Mr GAFFNEY - No, it would be my understanding that it would have to be in a written form.

Amendment agreed to.

Clause 21, as amended, agreed to.

Clause 22 -
Person who makes first request is to be provided with relevant information about eligibility

Ms WEBB - I will deal with my first two amendments together because it is the same issue. I move that clause 22(2)(d) and (e) be amended as follows -

First amendment

Clause 22(2)(d) -

Before 'reasonably available treatment'.

Insert 'information as to'.

Second amendment

Clause 22(2)(e) -

Before 'palliative care'.

Insert 'information as to'.

This is straightforwardly a matter of consistency within this clause. If you look at the language used, subclause (2)(a) starts with 'information as to' and then a list of items, while (2)(b) has 'information as to', and then we have (2)(c), which is 'the prognosis in relation to'. We return to something that should also have 'information as to' at the beginning of it in (2)(d) and then over the page in (2)(e). These proposed amendments will insert consistency in the language and in each part of that clause.

Mr GAFFNEY - We support this amendment from the member for Nelson. Clause 22(2)(d) ensures that the person making the first request is provided with all the relevant information in a detailed confidential discussion about eligibility, the holistic key options and all possible treatment and key options and outcomes by their PMP, a fully qualified medical practitioner who meets experience in VAD. I thank the member for Nelson for bringing on this amendment.

Mr VALENTINE - A very small comment in that it does not make sense without the information to be honest. It is not a matter of just consistency.

Amendments agreed to.

Ms LOVELL - Madam Chair, I move that clause 22 as amended be amended by -

Clause 22(3) -

Leave out 'Commissioner'.

Insert 'Commission'.

Amendment agreed to.

Clause 22, as amended, agreed to.

Clauses 23 to 24 agreed to.

Clause 25 -
Requirements in relation to determination of first request

Ms FORREST - Madam Deputy Chair, I move that clause 25 be amended by -

First amendment

Clause 25(1)(a) -

Leave out 'or by way of audio-visual link'.

Second amendment

Clause 25(1)(b) -

Leave out 'or by way of audio-visual link'.

Insert instead 'and not by way of audio-visual link'.

I questioned this when I was looking at drafting amendments as to the application of it, because you have to follow it back through the process. To talk it through, this is when a person's primary medical practitioner cannot make a determination about the person's eligibility - to finalise that first request, if you like - which is made under clause 24. I am happy to be corrected if I have made an inaccurate assessment of this, but we have clause 24 which talks about the PMP determining whether the person is eligible or not eligible to access voluntary assisted dying. Subclause (a) then says that the PMP after accepting under section 17, which follows the clause 16 consultation where the first request is made - the first request is made then, and as it stands in the bill, that first request appointment cannot be done by way of audiovisual link. So, section 17, it is 48 hours later, the medical practitioner who has considered that first request either accepts or refuses under section 17. We get to clause 25 - the section 17 process is referred to here - and section 17 refers to an appointment that cannot be done by an audiovisual link, so I think this refers to that appointment. It refers to the PMP accepting or refusing the request that followed face-to-face appointment.

I did question this when I asked for the drafting to be done and the amendment came back taking it out because, to me, there was no other explanation that it was separate appointments. It does not appear to be a separate appointment, it is referring to the assessment that is done in clause 17 that refers to the appointment in clause 16.

I think it is contrary and contradictory if we do not take it out, because it is referring to that same appointment that occurs in clause 16. In my view, it is a tidying up, taking out an inconsistency and a conflicting position because clause 16 says it cannot be done by an audiovisual link, this refers to that appointment under clause 16 and the subsequent doctor's assessment under clause 17 and, then further, clause 24, and then to clause 25, which is what we are looking at.

Ms WEBB - I would like some clarity about that, too. That is not how I had read that. I had read that as potentially two separate interactions and that is why it is worded as it is in clause 17 -

A medical practitioner to whom a first request is made by a person must, within 48 hours -

(a) accept the request; or

(b) refuse to accept the request.

The PMP has, after accepting under clause 17, in clause 24 - a person's PMP is to determine a first request from the person - met with the person in person or by way of audiovisual link, and then the bits that are covered in (b), and that is the process for making the determination, that decision about eligibility or not. The decision about eligibility does not happen in that first interaction around accepting the request. It happens as a separate process subsequent to that. I read it is as two separate interactions potentially. I am not sure we need to adjust the wording, but I am happy to have that further clarified.

Mr GAFFNEY - That is correct. That is the way we had it written and it has been interpreted. The acceptance might not come for 48 hours, but that is the way we have had it determined. I do not agree with this amendment as written. I am not sure if the member for Murchison is comfortable with the interpretation she has given to me. I do not agree. I think it is written correctly. I will sit down and we can move on, or I will give you more background information about this.

Ms Forrest - I think we need more background. I saw the information about this. I am happy to take a second call on this perhaps.

It does beg the question that if it is a separate appointment, it needs to be clear that it is a second appointment. It does not seem to be clear because it refers to that first appointment - we need some clarity around that appointment. The doctor does not need to see the person to accept the request. They have had the consultation with them. The accepting is something they can do in their office without the person there.

There is no reference here that this is a subsequent follow-up appointment, if you like, to discuss it further. Either way I think it needs some clarity around it. If this is the appointment then that requires the PMP when we go over to clause 12 and determining their eligibility - which is like assessing their eligibility against the criteria established in the bill in terms of the diagnosis, their prognosis, their decision-making capacity and all those sort of things. That is then a separate appointment. You could argue that should be face to face too, because that is a really crucial point as well when you are actually making that assessment. Or is that expected to occur at the first request? It is not clear to me that this is a second appointment. It is something that could occur with a doctor having met with a person under clause 16 and received their first request, provided the relevant information and all the other requirements, and determined that they are happy to proceed. Then they are going to determine that person's eligibility to continue.

It is not clear to me. I have read through it, I do not know how many times, to understand whether this is a second appointment. It is not clear. It seems to me it is a decision-making process that can happen almost remotely to the person, depending on what occurs at the first request appointment, which is clearly an appointment or a physical interaction, if you like, between the patient and the doctor. It just does not seem clear. It seems to me confusing because it does refer specifically back to that first appointment, which is face to face.

Mr GAFFNEY - This is a really important juncture for the bill. I remember speaking at some length with the Office of Parliamentary Counsel about the wording of this and they were very comfortable with the wording and intent as reflected by the member for Nelson. I would like to report progress or postpone this clause to seek further advice from OPC to clarify the intention of this amendment, as the member for Nelson said. If the member can withdraw, we will seek leave.

Ms FORREST - The trouble is I have two speaks already down on this.

Mr GAFFNEY - It is the intent, as the member for Nelson said, that once -

Madam DEPUTY CHAIR - The member is just getting his words together.

Ms Forrest - When you read clause 25(1) -

> A person's PMP must not make a determination under section 24 of a first request made by the person …

That refers to that first request which is the clause 16 request.

Ms Webb - The determination is different from accepting, so clause 17 is accepting the first request which just says, 'I will be your PMP.'.

Mr VALENTINE - It is very clear this is about determination. A person's PMP must not make a determination. So, the subject is determination, under clause 24, of a first request made by the person, unless conditions. You cannot make a determination unless 'the PMP has, after accepting under clause 17'. It is referring to a previous meeting, the first request from the person. Next consideration, met the person; then third, in person or by way of audiovisual link to clarify how they are to meet them.

It is not actually saying it is at the same time as the first meeting took place; it is a second meeting or it is a second occurrence, but it is about the doctor having to go away and do some research or consider other matters that have been raised in that first meeting, which now cannot take place by audiovisual link. That is why I thought it was really important that should be there because they can just take the request and they might then go and meet the person. We have had that argument and it is not there now.

Quite clearly, this is about the doctor determining, it is not about at the same time as having met the person the first time because it mentions specifically -

> A person's PMP must not make a determination under section 24 of a first request made by the person unless -

It gives the conditions. It is quite clear by the way it is written, therefore, that meeting the person in this clause could be by audiovisual link.

Ms LOVELL - Madam Deputy Chair, I stand with some reluctance because I do not want to complicate matters further, but I agree with the member for Hobart - this is clear and the member for Murchison and I have had conversations about this prior to today. I was hoping there would be some further clarity and we could discuss that, because I anticipated this one

might become somewhat confusing, because it can be interpreted a couple of different ways and I can see how that can happen. To me it quite clear that clause 16, Person may make first request to access voluntary assisted dying, and reading the two clauses together, there is a requirement for there to have been a face-to-face meeting. As the member for Hobart said, we have had the debate about whether that should be a requirement. It is a requirement.

When the first request is made, it does not necessarily happen at the same time that that face-to-face may have happened. So, the patient has a face-to-face meeting; as an example, hypothetically, the patient meets with their GP, discusses voluntary assisted dying and other treatment options and expresses an interest in finding out more about it. Gets the information. I expect it is likely that person is going to go away and think about it. They may not make that first formal request at that same time, but they have had a face-to-face meeting with their GP or their specialist or their primary medical practitioner, where they have discussed it and they have had that opportunity to make the determination around their decision-making capacity and all of those things that are required by the bill.

That patient can then come back and make that formal request, and at that stage that can be done by way of audiovisual link. There is no need for there to be a second face-to-face meeting as long as there has been a previous face-to-face appointment where they have been given the information. They can come back later and make a first formal request by way of audiovisual link.

If they had not had that first face-to-face meeting, at that point they would need to have a face-to-face meeting. But as long there has been one face-to-face appointment, they can make the formal first request by way of audiovisual link as the bill currently stands. That is my understanding of it.

While I am on my feet, I will say I am perfectly comfortable with that process. I would not be supporting the amendment.

Ms Forrest - Before you sit down, can I ask if in (1)(a) you put 'subsequently met the person in person or by way of audio-visual link', would that suffice? To me, the first request is the first request. It might be done then and it might be done another time. The first request is the first request and we have dealt with that under clause 16. That stands as it is in the bill.

This is now making it a determination of that first request. They are still linked, but I think it really is a separate appointment where this determination is made. Maybe it needs to have another word in there like 'subsequently' or something, to ensure there is a separate point of contact where the determination is made?

Ms LOVELL - Does the 'after' suffice for that?

Ms Forrest - It could be done in the doctor's office.

Ms LOVELL - This is where I anticipate that this clause might be one that gets a little complicated in the debate because I think there are a number of ways you could possibly do it.

I am very comfortable with what is currently in the bill. It might be that when they have the face-to-face appointment, they discuss it. The person goes away to think about it. Their

condition deteriorates. It is at that point they decide, yes, I do want to go through with this, I want to make the first formal request.

Ms Forrest - That would have to be a face-to-face meeting then. We have required that.

Ms LOVELL - Yes, but then the determination, we do not want them to then have to travel again necessarily.

Ms Forrest - That is what I am saying. If it is a separate appointment, it is a separate appointment.

Ms LOVELL - Yes, okay, I understand. To me it is clear, so I am comfortable with it. But it would be perhaps enough to have that on record rather than having to delay the passage of the bill. I would be comfortable with that. I am not speaking on behalf of other members.

Mr GAFFNEY - We spent some time with OPC and they were very comfortable with the wording of this. The issue here for me is, 'and not by way of audio-visual link'. I encourage people to vote against that amendment. It is not about the clarification, to me it about how this process works in the time line. It is about taking out the audiovisual link which I am against - the amendment. There is nothing there that talks about 'subsequent', or 'after'. I have to go back to OPC's judgment that they felt this was worded in such a way it would address the concerns raised by the member and was a proper process. Unless, we were to ask for further clarification from OPC, I urge members to vote against the amendment.

Ms FORREST - To clarify, my point is not opposing an audiovisual link meeting at this point because to me it was referring to an appointment that has to occur face to face.

The drafting has made it clear that this is obviously a separate appointment; otherwise, it would not say this potentially unless it was an oversight. That is what I am trying to clarify. If it is a second appointment, and you as in charge of the bill, member for Mersey, you could clarify it is a second appointment. I am not saying it should not occur via an audiovisual link. That is not the purpose of the amendment. The amendment is to make it consistent with clause 16 where it has to be face to face because this refers to that first request.

I know it is a determination of it, but if there is a second appointment here, if you can make that really clear on the record it is a second appointment because the person has to be met at this point. It says that the PMP, the doctor, needs to meet the person, 'in person or by way of audio-visual link' to determine this. If that is the case they have already had the face-to-face meeting where the first request was made. They have already made a first request. That was the process in clause 16. In clause 17 we get to the point where the PMP has agreed to take it on because that is what they have done. If it is a second appointment then if you could make that really clear in your comments here - that is the issue here. It was a consistency issue, not trying to knock out an audiovisual link opportunity for an appointment. Do you understand what I am saying?

Mr GAFFNEY - The way that this is written in clause 16 means the person gets all the relevant information and in that way makes sure they have all the information. They cannot do that by way of an audiovisual link now because we have taken that out. That means that once they get the information, the second time they go in and the doctor says, yes, I will accept that I will become your PMP, and the person then goes to make -

Ms Forrest - The doctor can just notify them of that acceptance. They do not need to see them for that.

Mr GAFFNEY - No, therefore they do not need to see them for that then.

Ms Forrest - Then the determination, they have to see them again. That is what you are saying?

Mr GAFFNEY - True, yes. That is correct.

Ms Lovell - It can be audio-visual.

Mr GAFFNEY - It can be audiovisual, yes.

Ms Lovell - It is a separate second appointment.

Ms Forrest - One would assume from this sequence then that the person makes the first request to the doctor in clause 16. The same person is then considering whether they will be their PMP or not. So it is the same person. Then we have the same person here, but when a doctor refuses to be their PMP - they have a conscientious objection or whatever - they have to start the process again.

Mr GAFFNEY - They will.

Ms Forrest - The appointment in clause 25 is with the same person they have had their face-to-face with?

Mr GAFFNEY - That is correct.

Ms Webb - After accepting.

Mr GAFFNEY - Yes.

Ms Forrest - That is all right. It is important to get this clear because there are requirements for at least two appointments here and the medical professionals need to know what the requirements are on it.

Mr GAFFNEY - That is correct.

Amendment negatived.

Mr GAFFNEY - I move the following amendment to clause 25 -

Insert the following subclause -

(4) If a person's PMP determines under section 24 a first request by the person by determining under section 24(a) that the person is eligible to access voluntary assisted dying, the PMP must, if the person consents -

(a) provide to a member of the family of the person, if any, the relevant facts in relation to accessing voluntary assisted dying; and

(b) take all reasonable steps to explain to a member of the family of the person, if any, the plan for the person to access voluntary assisted dying including, in particular, the arrangements to be made in relation to the body of the person if the person is intending to obtain a private self-administration certificate and self-administer a VAD substance without the person's AHP being present

The Government quite rightly flagged its concern for the wellbeing of families in any VAD process. Accordingly I have considered this in the context of the entire voluntary nature of the VAD process. I propose that the person consents to require the VAD process to be explained to a person's family. Whilst it is not necessary to give a power to the doctor to do this, if the doctor's patient agrees to this being done, the requirement with the doctor to do this may be helpful to the person. Additionally, it would be an aid to police who may be required to make a notification to next of kin who may not have known the person was seeking VAD.

This amendment should allow sufficient opportunity with the person's permission for a family member, if any, to be fully aware of the VAD process.

Ms RATTRAY - I understand completely why the member has chosen to bring this forward. Do they see an issue with providing the information to a member? Not very often do we have a family of one. Does the person who has given the consent and applied for VAD choose which family member is advised? You might have some family members who are quite supportive of it, and then you might have others who are quite distressed and not supportive of their loved one's request. I would like a little bit more clarification around that process. I understand it would be a very difficult process as well, but it does need the consent of the person who is applying for VAD.

Mr GAFFNEY - That is correct, it is always going to be difficult, but it always has to be the person's decision. I think that person would know which member of the family, or which members of the family, to inform if that is their choice, but it is a good question, so thank you.

Ms LOVELL - I am a little uncomfortable with this amendment and this new subclause. I am not sure which way I will vote on it, but at this stage I am leaning towards not supporting it because I am uncomfortable with the idea that we are legislating a requirement for a doctor to give a family member information. I understand it is with the person's consent, but it feels unnecessary to me because I cannot imagine a scenario where a person would request a doctor to give information to their family members, and the doctor would not do that. I feel this is unnecessary. We do not require it for any other treatment option or any other medical condition or any other reason that a person would go to a doctor. I cannot imagine a scenario where we would require this type of provision requirement for a doctor.

Putting aside that level of discomfort - a question for the member for Mersey - I would be interested to know what happens in other states and whether this is a requirement in other states' legislation. Also, why does it specify a member of the family? It could be the person does not want a family member told, they want a friend told or a partner or neighbour or

whoever. The fact we are specifying it is a family member and not just a person is peculiar to me. I am interested in what happens in other states' legislations.

I understand why the member for Mersey has proposed this and I saw this raised by the Government in correspondence we have all seen, but even at that point I was surprised the Government had identified this as an issue. I do not feel it is an issue and have not had any other stakeholder, member of the community or advocate raise this as an issue or a concern. I am uncomfortable with it. I would like some more information from the member for Mersey about what happens in other states. At this stage I am leaning towards not supporting it.

Mr GAFFNEY - It was one of the issues raised, as you rightly said, by the Government - in that it should point out that section 19(2) of the Victorian Voluntary Assisted Dying Act of 2017 requires a medical practitioner to explain the VAD process to the person's family, if the person consents, and also consideration should be given to incorporating similar provisions into our bill. That was from then, and in discussion with OPC it was felt it was a good idea to require the VAD process to be explained to a person's family if the person consents. Is it necessary to give the power to the doctor to do this if the doctor's patient agreed to this being done? Requiring the doctor do this may be helpful to the person and be agreed to on those grounds?

Mr VALENTINE - I can see the intent of the member for Mersey's amendment. If the family were not aware in some way, shape or form and indeed are responsible for conducting funerals and those sorts of things for this individual, it would come as quite a shock. Giving the power for information to be given if the person involved wants that is a good thing. There is an opportunity for it to create some angst between family members - 'They told him but why didn't they tell me?', that sort of thing. You are always going to get that with families; I do not know that you can ever avoid this. The important thing is with something as significant as this, especially if the family are involved with funerals and the like, it is an opportunity for information to be given to them so there are no surprises. I assume where it says 'family' that covers - I have not gone back to check the act - significant relationships?

Ms WEBB - I am going to speak for a moment, because I will not be supporting the amendment and want to briefly explain why. I very much agree with things the member for Rumney raised that it is legally unnecessary to add this to the bill. It does not need a power there, because it is with the agreement of the person themselves. There is really no need for us to imagine a circumstance under which a doctor would not provide this information to a family member or members, if requested and agreed to by the person. There is no legal necessity at all that is covered by this in the bill. It seems like a gesture to make somebody more comfortable, and I am not really sure who that person or people are, but it does not add to the bill. By adding things that are not legally meaningful, we weaken the legal robustness of the bill, so my preference is not to support this amendment because it will be given effect to, quite naturally in the process, without needing to be referred to in this way that is legally unnecessary.

Madam CHAIR - The question is that the amendment be agreed to.

The Committee divided -

AYES 8	**NOES 6**
Ms Armitage	Ms Forrest

Mr Dean	Ms Lovell
Mr Gaffney	Dr Seidel (Teller)
Mrs Hiscutt	Ms Siejka
Ms Howlett	Ms Webb
Ms Palmer (Teller)	Mr Willie
Ms Rattray	
Mr Valentine	

Amendment agreed to.

Clause 25, as amended, agreed to.

Clause 26 -
Determination of first request to be in writing

Ms RATTRAY - To clarify, 'under section 24 of a first request by a person is to be in writing' - can that be an email? Obviously, we are looking at upgrading technology so I am just interested. Does that suffice as writing?

Mr GAFFNEY - Yes, that is correct.

Clause 26 agreed to.

Clause 27 -
Records and notifications of determination of first request

Ms LOVELL - Madam Chair, I move that clause 27(c) be amended as follows -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Amendment agreed to.

Clause 27, as amended, agreed to.

Clause 28 -
Person may make second request

Ms HISCUTT - Madam Chair, I move that clause 28(3)(b) be amended as follows -

First amendment

After '2 adults',

Insert ', and a commissioner for declarations, within the meaning of the *Oaths Act 2001*,'.

Honourable members, after a recent AGM held at the north-west justices association, of which I am a member - of the JPs association - I was discussing this as I have done with

everybody and anybody. It was suggested then that perhaps one of the signatories on that should be a JP as a witness. Upon further consideration and looking at the member for Murchison's terrain and also the member for McIntyre's terrain, finding a JP could be difficult in those areas. I thought I would settle with a commissioner for declarations - CD.

I have also decided that, as with the face-to-face meeting of the three requests, there should be one face-to-face meeting. I think with the commissioner for declarations to witness signatures, that should happen for at least one of the requests.

A varied array of people are commissioners for declarations. The Department of Justice webpage will provide that information for you. There are people who are commissioners for declarations because of their profession, and there is quite a variety of them, including a veterinarian surgeon. There are also commissioners for declaration because of the appointments they hold. These people are around the place within the community everywhere. There is a big array of them. It could be anyone who is a member of the Department of Police, Fire and Emergency Management, and employees such as customer service officers. It could be a justice of the peace if you can find one on the west coast, or it could be a marriage celebrant.

I looked at it particularly because you could also be a member of the Australasian Institute of Mining and Meteorology. That gives coverage down the west coast areas. I am trying to say that CDs are easily accessible. It can be a member of a parliament of the Commonwealth, or a member of the state, as every member here in this room is a commissioner for declarations. Every member in the other place is a commissioner for declarations.

CDs could be employees of a post office or of a local government authority or a police officer. There is a varied array of people who can be plucked out of the community to witness these. It is my firm belief, member for Mersey, that at least one of the requests should be witnessed by a commissioner for declarations. I ask members for their support in this amendment.

Mr GAFFNEY - I appreciate the member for Montgomery's suggestion. It is a great idea to involve commissioners for declarations as an option, but not as an additional hurdle or extra-large bureaucracy. We could not find any situations where three witnesses are required. Some of our most important enduring legal documents in situations are witness-attested and sworn to, or are guaranteed, by one or two witnesses. So, a marriage is two witnesses, a passport application is one guarantor, affidavits for court proceedings is a JP and a statutory declaration is one witness or a public notary.

If the member - and I am not sure here of the process - I think I have an amendment to the amendment -

Mrs Hiscutt - Which you can move now.

Mr GAFFNEY - Yes, I think that would be appropriate.

Mrs Hiscutt - While the member is on his feet, by way of clarification, for marriages you need two witnesses and also the marriage celebrant to sign.

Mr GAFFNEY - Madam Chair, I move that the member for Montgomery's proposed amendment to clause 28(3) be amended as follows -

Amendment to first amendment -

Leave out ', and a commissioner'.

Insert instead ', or by a commissioner'.

Mrs HISCUTT - I am happy with the amendment to the amendment, because it still involves a person of repute within the community who is unrelated to the family and holds one of the roles I described earlier. It is a completely independent person.

Ms WEBB - I do not have a copy of that in front of me; I am trying to obtain one. Does your wording replace '2 adults' with the option of 'a commissioner', and that being the only witness?

Mr GAFFNEY - Yes.

Amendment to amendment agreed to.

First amendment, as amended, agreed to.

Clause 28, as amended, agreed to.

Clause 29 -
Certain persons may not witness a second request.

First amendment

Mrs HISCUTT - Madam Chair, I move that clause 29(1) be amended as follows -

After 'One of the witnesses'.

Insert ', and the commissioner for declarations, within the meaning of the *Oaths Act 2001*,'.

Amendment to first amendment

Mr GAFFNEY - Madam Chair, I move that the first amendment to clause 29(1) be amended as follows -

Leave out ', and the commissioner'.

Insert instead ', or the commissioner'.

Amendment to first amendment agreed.

First amendment, as amended, agreed to.

Second amendment

Ms FORREST - Madam Deputy Chair, I move that clause 29(1)(b) be further amended as follows -

Leave out 'receive a financial benefit as a result of the death of the person'.

Insert instead 'directly or indirectly benefit from, or receive a financial benefit, directly or indirectly, as a result of, the death of the person, other than by receiving reasonable fees for the provision of services'.

This amendment is to create some consistency. Other amendments will propose similar changes to ensure that when people are participating in this process in their professional capacity, they can receive reasonable fees - because that is a benefit. You are being paid for your job. It is a benefit when you are being paid to provide a service. People should not have to do this for nothing - which would occur without this amendment allowing for receipt of a reasonable fee for provision of services. It is unrealistic to expect health professionals, managers of estates or others who are providing a professional service to a person, whether it be a health service of other service, that they provide that service for nothing.

I know other members looked at or will be proposing other amendments further on in the bill, to ensure that people who are providing a service can be paid a reasonable fee - a normal fee, rather than participating in the process at no charge. Otherwise they cannot actually charge a fee for a reasonable service. You cannot ask people to charge a fee for signing a piece of paper, but if they are providing care in the process, then they are able to do so.

Mr GAFFNEY - I think this amendment strengthens the bill. It is a perfectly sound amendment. I congratulate the member for Murchison for suggesting it.

Amendment agreed to.

Mr GAFFNEY - Madam Chair, I move that clause 29 be amended by -

Third amendment

After subclause (1) -

Insert the following subclause -

(1A) The reference in subsection (1) to a financial benefit in relation to a witness does not include a reference to a financial benefit consisting only of the payment to the witness of reasonable fees related to the provision of services by the witness, after the death of the person, in relation to the estate of the person.

There was a concern that clauses that prohibit a person receiving direct or indirect financial benefit from a VAD death would prevent a professional acting for a person in performing the duties of a witness. It was felt there may be merit in enabling a lawyer or executor to be able to witness a document for a person for the purpose of the act, even though

they will benefit from the person's death by receiving the costs of work in relation to their client after the client's death. Put to you is an amendment that in effect will define the terms on which this may safely occur.

Ms LOVELL - I consider the amendment we have just agreed to in clause 29 covers this matter. The clause as amended will now include -

> directly or indirectly benefit from, or receive a financial benefit, directly or indirectly, as a result of, the death of the person, other than by receiving reasonable fees for the provision of services.

My understanding is that would cover the people the member for Mersey is attempting to capture in his further amendment, and it is probably a neater provision. I suggest this amendment is not required.

Ms WEBB - Now we have accepted the previous amendment it does not refer to financial benefit any more. The wording does not even quite work anymore. I agree with the member for Rumney that it is superfluous.

Mr GAFFNEY - Madam Chair, I seek leave withdraw my amendment.

Third amendment, by leave, withdrawn.

Clause 29, as amended, agreed to.

Clauses 30 to 33 agreed to.

Clause 34 -
Records and notifications of determination of second request

Ms LOVELL - Madam Chair, I move that clause 34(c) be amended as follows -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Amendment agreed to.

Clause 34, as amended, agreed to.

Clause 35 -
PMP who determines person eligible must refer person to medical practitioner for second opinion

Ms LOVELL - Madam Chair, I move that clause 35(1) be amended as follows -

Insert the following subclause after subclause (1):

> (1A) A person's PMP must not, under subsection (1), refer the person to another medical practitioner who is -

(a) a member of the family of the PMP; or

(b) employed by, contracted directly or indirectly by, or working under the supervision of, the PMP; or

(c) a person who is the employer of, has a direct or indirect contract with, or is a supervisor of, the PMP.

This amendment is about enshrining the independence of the practitioners involved in the VAD process in various roles, particularly and specifically around where there is a power relationship, where doctors have an employment or contractual arrangement that establishes a power dynamic, they would not be able to refer to each other. It is important to note it would not exclude doctors from referring to each other where they are working in the same practice in an equivalent role - where there is no employment or power dynamic, where there are two doctors working independently of each other in the same practice, they would still be able to refer to each other. This is just about ensuring that the practitioners who are involved in the role of PMP and CMP are independent of each other.

Mr GAFFNEY - I congratulate the member for Rumney for bringing that to the Table. We support this amendment.

Mr VALENTINE - With regard to the following -

(1) A person's PMP who has determined a second request from the person by determining under section 31(a) that the person is eligible to access voluntary assisted dying must, in writing, refer the person to another medical practitioner for that medical practitioner to determine whether or not the person is eligible to access voluntary assisted dying.

Is that other medical practitioner supposed to have the same level of experience as the initial medical practitioner? Is that covered in some way, or does it need something that says that the other medical practitioner having the matter referred to has to have a certain standard of experience et cetera?

Mr GAFFNEY - I think that is covered in the definition of 'medical practitioner' who would have to have a degree of capacity to be able to do that.

Mr Valentine - That was dealt with right back -

Mr GAFFNEY - Right at the beginning.

Amendment agreed to.

Clause 35, as amended, agreed to.

Clauses 36 to 47 agreed to.

Clause 48 -
CMP to keep record of determination and notify Commissioner

Ms LOVELL - I have two amendments to clause 48 that I will move together. I move that clause 48 be amended as follows -

First amendment

Clause 48(1)(b) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Second amendment

Clause 48(2)(c) -

Leave out 'Commissioner',.

Insert instead 'Commission'.

Amendments agreed to.

Clause 48, as amended, agreed to.

Clause 49 agreed to.

Clause 50 -
Where process ends under section 49 former PMP may not accept first request for 12 months

Ms LOVELL - I move that clause 50(2) be amended as follows -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Amendment agreed to.

Clause 50, as amended, agreed to.

Clause 51 -
Person may make final request to PMP

Ms LOVELL - I move that clause 51(5) be amended as follows -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Amendment agreed to.

Clause 51, as amended, agreed to.

Clauses 52 to 53 agreed to.

Clause 54 -
Requirements in relation to determination of final request

Ms FORREST - Madam Deputy Chair, I am not going to rehash all the debate we had before. I move that clause 54 be amended as follows -

First amendment

Clause 54(1)(a) -

Leave out 'or by way of audio-visual link'.

Insert instead 'and not by way of audio-visual link'.

Second amendment

Clause 54(1)(b) -

Leave out 'or by way of audio-visual link'.

Insert instead 'and not by way of audio-visual link'.

I am not going to go into all the discussion about how telehealth or audiovisual links work in the delivery of health care, other than to note they are a legitimate and appropriate form of providing care in certain circumstances.

This amendment deals with the final request. I accept at this point the person will likely be very unwell. It is not a life and death matter at this point; it is a death or death because this person is actively dying at this point, when they are seeking to access a voluntary assisted dying substance.

It is the last opportunity for a person to be met face to face with their health professional to ensure that is their will, they have not changed their mind, they are not being influenced by family members who perhaps do not want them to go.

I am not going to go back over the second reading contribution I made in regard to some of those family members who can want more and more treatment for a loved one when the person themself does not want it and just wants to die. We try way too hard to stop people dying when they are trying really hard sometimes. It does work both ways.

At this point this person will make a final request and within a very short period will have access to and potentially take the VAD substance, so there is no turning back from that point. This is the last point at which to make it a final decision about whether you wish to proceed and effectively end your life within a very short period of time or not. I believe that is better done in person, and doctors do visit.

In Victoria, for example, the pharmacist visits all the people accessing the VAD substance to ensure that it is an appropriate substance for them to use in line with their other medical condition and other drugs they may be taking, and other matters. It will create an impost, yes, I do agree, I do not deny that for a second but I do believe it is appropriate and

there are doctors who do home visits. This is a once-off. You are not going to be going back week after week after week for this. It is a once-off while that person actually makes that decision and it can be very clear from that point that it is their decision.

I acknowledge the challenges with people on the islands and places like that but if there is no doctor on the island, on Flinders or King islands, or another remote area, who is willing to participate, that is going to be a problem for the whole process, not just at this end point. For those reasons I urge members to consider support for this amendment.

Mr GAFFNEY - I appreciate the member for Murchison's intent with this amendment because it is a very serious point in a person's life but I cannot accept this amendment because I think there are going to be times when it will just be callous for us to expect a face-to-face meeting. It does not seem to need to happen. I will read a statement from a clinical psychologist who has worked with terminally ill people and their families -

> I am particularly concerned about the telehealth amendment that has been proposed for the bill. The bill as it stands requires the first request for the VAD option to be face-to-face and we have accepted that but if it is necessary and it is acceptable to the doctor involved then any others can be done through the distance option of telehealth. This gives equitable access across our state and telehealth has been proven to be a great asset for both doctors and the patients during our COVID-19 restrictions. It is difficult to believe that this amendment would require a particular final request to be face-to-face, to expect this of a person dying with intolerable suffering seems callous. I note the circumstances where the person, PMP or AHP or CMP at this time might be two or three hours away might not be necessary, so I could not accept this amendment. I would encourage other members not to accept this amendment.

Mr VALENTINE - I, too, feel that this is an option. You have to remember it is an option and if a person is very ill it may be difficult for them to organise to have their PMP in the room with them or a visit. I can appreciate the member's reasons for moving this in some ways, but I think it really needs to make sure that people who are in very isolated circumstances have equal access. It is not on the occasion; it is about determining the final request. It is not actually at the time that the substance is taken. It is about determining the final request. I cannot agree with the amendment.

Mrs HISCUTT - I am of a similar view as the member for Hobart. I am very satisfied that there is one face-to-face meeting. I am very satisfied that there is a commissioner for declarations witnessing one of the signatory events. I will not be supporting the amendment even though I understand your concern.

Mr DEAN - I am looking at it closely. I am inclined to the position of not supporting the amendment as well. As I said originally, I am concerned about the robustness of this bill and the fact that is has to be very strong legislation.

Here we have the position of the person having been through the processes and this is at the end stage of that process, which has all been verified, all been cleared and documented and articulated and everything else. At this stage the patient would be in an extremely vulnerable

position, would be ill and perhaps with only a very short time to live. In this instance I can support the position of an audiovisual link in these circumstances.

Amendments negatived.

Clause 54 agreed to.

Clause 55 agreed to.

Clause 56 -
Notification of determination

Ms LOVELL - I move that clause 56(c) be amended as follows -

Leave out 'Commissioner'.

Insert instead 'Commission'

Amendment agreed to.

Clause 56, as amended, agreed to.

Clause 57 -
Change of PMP after final request made.

Ms LOVELL - I move that clause 57 be amended as follows -

First amendment

Clause 57(1) -

Leave out the word 'Commissioner'.

Insert instead 'Commission'.

Second amendment

Clause 57(2) -

Leave out the word 'Commissioner'.

Insert instead 'Commission'.

Third amendment

Clause 57(3)

Leave out the word 'Commissioner' (twice occurring).

Insert instead 'Commission'.

Fourth amendment

Clause 57(4)

Leave out the word 'Commissioner' (twice occurring).

Insert instead 'Commission'.

Fifth amendment

Clause 57(5)

Leave out the word 'Commissioner'.

Insert instead 'Commission'.

Amendments agreed to.

Mrs HISCUTT - Can the member for Mersey give me some examples of why there would be a change to a PMP at this late stage of the game?

Mr GAFFNEY - There could be a late change, something could have happened to the livelihood of the PMP. They could die; they might not have the registration; they could be absent; something may happen within their own circumstances so that they may require a change. The VAD person still needs to access their needs and so there is a way for that to occur.

Ms WEBB - For clarification, clearly, this clause allows that in certain circumstances where the PMP is no longer able to be the PMP, the CMP can be appointed into that position by the commission. I am wondering if the CMP does not want to do that, what are other options for replacing the PMP? It is not detailed here and it might not be that it needs to be in the legislation. It might be something contemplated elsewhere in regulations or something like that. I imagine we could contemplate a situation where the CMP is also either not available or not willing to do that - is there an option for somebody else to step into the PMP role at this stage of the process, or would you have to begin the process entirely again with a new PMP from the start?

Mr GAFFNEY - The commission now would have a list of those PMPs, those medical practitioners who have done the training and therefore, in this circumstance, they would apply to the commission who would make a judgment on that. It is something that if it is not picked up in the legislation they will deal with in the regulations, because it is a valid one and how far do you keep going.

Clause 57, as amended, agreed to.

Clause 58 -
PMP to decide whether to be AHP

Ms LOVELL - Madam Chair, I move that clause 58(b) be amended as follows -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Amendment agreed to.

Clause 58, as amended, agreed to.

Clause 59 agreed to.

Clause 60 -
Appointment of AHP

Ms LOVELL - Madam Chair, I have a series of amendments to clause 60 but they are not all related, I will move the first two amendments together. I move that clause 60 be amended as follows -

First amendment

Clause 60(1) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Second amendment

Clause 60(2) -

Leave out 'Commissioner' (wherever occurring).

Insert instead 'Commission'.

Amendments agreed to.

Ms LOVELL - Madam Chair, I move clause 60(2), be amended as follows -

Third amendment

Leave out ', or a registered nurse'.

Members, this amendment would result in registered nurses, including nurse practitioners, not being able to play a role as an AHP in the VAD process. I want to be really clear from the start this not at all a reflection on the capacity of nurses or nurse practitioners. Nurses, registered nurses and nurse practitioners play a really important role in end-of-life care. I envisage they would continue to do that. Nurses and nurse practitioners are very important in the ongoing, and continuity of, care to patients, particularly when they are dealing with a chronic condition or a terminal condition. This is in no way a reflection on that.

The reason for this amendment is there have been some concerns raised the bills requires administering health practitioners or AHPs to play a role that may be outside of the normal scope of the role of a registered nurse. For example, making an assessment around the decision-

making capacity of a person, which is a requirement of the role of an AHP. That is not currently part of the training of a registered nurse and not part of their normal scope of practice.

In moving this amendment, I am not suggesting there would not be a role for nurses and nurse practitioners in the future, but feel there would need to be further consideration given to what that role would look like, and further consultation with nurses and with the bodies that represent them to determine what exactly would be required in the way of additional training and other requirements under the act in terms of what we are asking them to do.

The other point is that best practice is generally seen to be that a person accessing VAD self-administers, unless they are not able to do so. If they are unable to administer the substance to themselves then an administering health practitioner would come in. Again, ordinarily in most cases you would expect that is because there would be complications involved or significant health issues might mean the person is not able to administer the substance themselves.

My concern is that if those complications or that level of complexity is present, then again are we asking registered nurses to take on a responsibility outside of their normal scope of practice.

The other point that has come to my attention through this process is while we have the bodies that represent nurses, and we have heard from the Australian College of Nursing, the ANMF as the union representing nurses, and the College of Nurse Practitioners - they have all come forward and said they would do what is required of them under the legislation. I have no doubt that is the case. Nurses are absolute professionals and I have no doubt they would do whatever is required of them under the legislation, but what I am not hearing from those bodies or from nurses is an active desire to be part of this process. They are saying they will do it if it is required and some of them may actively want to be part of the process, but there are still too many unanswered questions for me to be comfortable with bringing them in at this stage.

I do not want this bill to be further delayed. I want the bill to get through parliament and I want it to be able to be implemented so the people we are legislating to try to assist can access this option as soon as possible. The level of consultation and further consideration to the matters raised by nurses and nurse practitioners could delay the bill further than we need to. I expect and hope this would be reviewed at a later date as part of the review process built into the bill.

As I said at the beginning, I absolutely expect registered nurses will continue to play a critical role in end-of-life care for members of the community. I do not feel this is an option that we need to include to ensure access. Given the number of people we expect to be eligible for VAD in Tasmania and the number of doctors who we expect would participate and where those doctors are located, I am confident we would have enough access in the state to start with.

I understand there are concerns about access, particularly in some regional and remote communities, but I am confident with the number of practitioners wanting to participate that we would have equitable access across the state.

I ask members to consider supporting this amendment in light of those concerns and am keen to hear members' views.

Mr GAFFNEY - This is very important. This is one of the innovative parts of the Tasmanian bill. I am going to take some time explaining this because this is a really important part of how I see this working.

This amendment seeks to remove the capacity for nurse practitioners and registered nurses to act as administrating health practitioners in the process which would be legalised by this bill. I do not accept nurses do not want to be involved. I do not accept nurses and nurse practitioners do not have the capacity to be involved. I do not accept that the inclusion of nurses can be anything but a positive for Tasmanian people.

With our nurses and health professionals working to combat the pandemic and 2020 being the International Year of the Nurse and the Midwife, it would appear there has never been a time in which the profession has been more visible and more valued. Nursing is a highly regulated and professional occupation and there are now many nurses in our hospitals who have achieved postgraduate degrees, often specialising in one or more areas such as acute or palliative care.

To hold registration as a nurse in itself is an achievement to attain and maintain. A Bachelor of Nursing degree requires the successful completion of three years of full-time university study as well as clinical placements in our hospitals. As the member for Murchison has previously described, a number of competencies, such as resuscitation, are regularly assessed and required in order to perform the role. It is indeed a career in which continual accreditation and currency in skills is expected.

It is a fact that nursing is continually identified as one of the most trusted professions and with good reason. Our dedicated nurses are with us in times of need when we feel vulnerable, when those we love or care for are unwell or injured. It is nurses who provide support, reassurance and appropriate medical responses. In our communities, in our hospitals, in medical clinics and hospices, nurses spend hours - sometimes days and weeks - supporting, educating, advocating for, and providing medical assistance to everyone from newborn babies to those who are terminally ill.

Families trust nurses. They are often the ones who provide supplementary information and support to individuals and their families after a diagnosis and/or prognosis that has been made by a specialist or a doctor. In remote or regional areas where there may be no permanent doctor, nurses perform a much-needed role in close-knit communities.

Registered nurses and nurse practitioners who choose to be involved will be professionals with substantial university-level qualifications and practical experience. They will also have undertaken voluntary assisted dying training and gained accreditation in order to be registered as an AHP.

I am informed that the Voluntary Assisted Dying Review Board recently met with the Australian College of Nurse Practitioners - ACNP - to discuss involvement of registered nurses and/or nurse practitioners in the VAD process in that state. It is clear to me from discussions I have had with Victorian doctors and health professionals working in the VAD space that, especially in the early stages, engaging adequate numbers of doctors who are willing and able, mainly due to their practice workload and commitment to their existing patients, has been difficult.

The Western Australian government recognised this issue well before its bill was granted and they have legislated to include nurse practitioners in the role equivalent to the AHP position in the Tasmanian bill. As nurse practitioners are relatively rare in Tasmania - with registration around the 40 to 45 mark, with not all currently practising and not often working in remote communities that we are concerned with ensuring are supported - it makes sense to me to consider registered nurses for the AHP role in Tasmania.

Throughout the bill's drafting, I consulted widely with, among others, nurses, nursing bodies such as the ACN, the ACNP, ANF Tasmania, and Palliative Care Tasmania. I also received feedback from nurses and ex-nurses in the form of submissions, letters and emails. I received the following email from Annie Fagan and I assume other honourable members will have received the same; however, I would like to read Annie's words into *Hansard* -

> As a nurse working mostly in the community and recently retired after a fifty five year career, I am extremely disappointed to note that one of the amendments to Mike Gaffney's VAD bill, is to exclude nurses from administering VAD medication. Nurses support the dying for many more hours than doctors and are often very much depended on and privy to confidential conversations with the patient and family.
>
> What could be more comforting to have that nurse than an unknown doctor administer the medication in the event the primary doctor is unavailable? Worse, no other doctor available - not unlikely in remote areas. [The member for Huon] states that there are enough doctors to handle the needs of Tasmania who are willing to be involved.
>
> Those nurses who support VAD would be honoured to help their dying patients who are experiencing unrelievable, intolerable suffering despite the best palliative care. In fact, I would suggest that not only should those nurses be able to administer the medication, but a doctor and that nurse should be registered together to manage this assistance from the onset, explaining, comforting, supporting, empathising, and finally administering if necessary. This is the work of nurses.

Fiona Jacobs, a registered nurse and administrator of the nurses for VAD group said -

> It is vital that if VAD is to function effectively in Tasmania and Australia, nurses be involved. Rural and remote areas in Tasmania are often overseen by nurses in the community who are most often the main advocate for the patient when negotiating the healthcare system.
>
> Often it is a nurse who knows a patient best, spending hours with both the patient and their family. Assessing decision-making capacity and possible coercion, would be within the scope of practice of an experienced registered nurse.
>
> …
>
> Nurses know their patients well and want to assist. An experienced nurse can participate in all aspects of care, including inserting intravenous cannula,

> assisting the physician, documenting medications, providing in-home care and after-death care, completing documentation, supporting the family and transferring the body to the morgue or designated funeral home.
>
> …
>
> The Voluntary Assisted Dying Board in Victoria, third review of their legislation, found people continue to find it difficult to find medical practitioners who have completed the training and are willing to assist ... I believe an experienced and trained registered nurse would be competent to participate in the administration of VAD.

I received the following comment from the branch secretary of the ANMF Tasmania, Mrs Emily Shepherd -

> The ANMF remains of the view that as long as the legislation provides appropriate mechanisms for registered nurses and nurse practitioners to participate safely and within the scope of practice in the voluntary assisted dying process, then the ANMF would leave the decision up to the individual practitioner as to whether [he or she] wished to participate or exercise their right to a conscientious objection. … As previously stated if the legislation is passed and it is inclusive of registered nurses and nurse practitioners with the appropriate mechanisms to allow nurses and nurse practitioners to participate safely and within their scope or choose not to by a conscientious objection, then the ANMF believe the decision to participate or not should rest with the individual nurse or nurse practitioner.

I am a bit concerned that somehow the ANMF did get the idea that the involvement of nurses and nurse practitioners might affect the bill's chance of passing. That was a comment that was made to me and that was of concern. I recently asked Palliative Care Tasmania for some feedback from their nurses and received a variety of comments -

> Nursing has so many different areas of practice in which we work that it is not up to any legislation to tie the hands of any nurse that chooses to work in any given space. Despite me not wishing to operate in this particular arena nurses are definitely required as part of the VAD process. Psychologically the proponent of this terminal act may need our health care professionally to give permission to say yes or no in their final decision. This is what nursing is.

I think we have to understand: do we want more AHPs available? The training package will contain modules on voluntariness and decision-making capacity. The final permission document is another safeguard. The member for Huon says that doctors, pharmacists and nurses should and could and can work together. Yes, they can in this process.

There is already a form approved by the chief psychiatrist in accordance with the Mental Health Act for determining decision-making capacities that nurses can access if they need to. I believe it is extremely important when faced with arguments that nurses are somehow incapable or unfamiliar with the process of undertaking the AHP role to note that this bill does

not require or ask nurses who have volunteered and undertaken the VAD training models to do anything beyond their usual scope of practice.

Members may remember the comment from the chief nurse during our recent briefing that these are concepts that nurses deal with in their day-to-day practice. There may be an argument that nurses cannot diagnose and this is true; however, there is no requirement for the AHP whether a doctor, specialist, nurse practitioner or registered nurse to diagnose anything. The diagnosis and prognosis have been made long before an AHP is identified and engaged.

We think about the flow of the process as written in the bill and how this will work in practice. The patient visits the initial doctor and/or specialist for diagnosis, terminality is established, the patient seeks information and receives relevant facts and decides to request access to VAD. The first request is to the doctor or the PMP. All eligibility criteria including decision-making capacity and voluntariness are determined.

The second request is to the doctor, the PMP. All eligibility including decision-making capacity and voluntariness are determined. With the CMP, who is a doctor or a specialist, all eligibility criteria including decision-making capacity and voluntariness are determined. With the final request, to the doctor or the PMP, all eligibility criteria including decision-making capacity and voluntariness are already determined.

As you can see there are many interactions with doctors and/or specialists and many determinations of all of the eligibility criteria. At the point where the AHP becomes involved there is no further requirement to diagnose and, indeed, check the five eligibility criteria for a fifth time.

At the point where a person is seeking final permission, the AHP determines decision-making capacity and voluntariness. It may be also worth noting that the AHP role is the same whether it is a specialist, doctor, nurse or nurse practitioner. There is no diagnosing only determination of decision-making capacity and voluntariness. Standard 4 of the Nursing and Midwifery Board of Australia Registered Nurse Standards for Practice document states -

> RNs accurately conduct comprehensive and systematic assessments. They analyse information and data and communicate outcomes as the basis for practice. The registered nurse -
>
> 4.1 conducts assessment that are holistic as well as culturally appropriate
>
> 4.2 uses a range of assessment techniques to systematically to collect relevant and accurate information and data to inform practice
>
> 4.3 works in partnership to determine factors that affect, or potentially affect, the health and wellbeing of people and populations to determine priorities for action and/or for referral, and
>
> 4.4 assesses the resources available to inform planning.

This perspective is from Palliative Care Tasmania following my request for feedback that addresses the scope of practice issue -

> Having spent more than 40 years as a registered nurse, I have seen a lot of which I wish I had not. For the last 7 years of my working life I had a clinical role in end-of-life management. I absolutely support voluntary assisted dying as proposed in Mike Gaffney's EOLC (VAD) bill. I also support the involvement of RNs, not even necessarily nurse practitioners in the VAD process. I should think that most reasonably experienced RNs could assess decision-making capacity in a patient.
>
> At any rate I would expect this to be covered in the VAD training course they would have to undertake. The same goes for assessing whether the person is acting voluntarily. Both these issues would have been dealt with in the 1st, 2nd and 3rd request process. I therefore see no reason for psychological referral of the person. I believe that this would be a completely futile impost on a very sick and suffering person. Not having nurses involved would disadvantage people in remote areas, especially where medical practices are staffed by a series of locums, and where the community nurse is often the only stable part of the healthcare system. As it is likely that people requesting voluntary assisted dying would already have had been receiving palliative care services from the nurse there would already be an established trusting relationship in place.

I received a letter from Leanne Boase who is the President of the Australian College of Nurse Practitioners. I will just take a section of it out. She writes -

> Registered nurses and nurse practitioners are health professionals, educated and experienced and are equally able to make a choice as other health professionals such as medical practitioners as to whether they would like to be involved or not.
>
> This bill is very clear that no one will be compelled coerced or forced to participate. As such both registered nurses and nurse practitioners have the ability to determine whether they wish to participate and the experience and education to understand VAD.
>
> Nurses are professional capable and strong health commissions. We concur with the chief nurse that these concepts are part of our day-to-day work and that there should not be barriers, aside from the need to having requisite experience and training.
>
> Whilst we understand there may be some discomfort among certain groups or some degree of turf protection occurring, we would appeal to the Tasmanian members to allow Tasmania to lead the way in Australia. We know from our high level of engagement in health at the Commonwealth level and within the states and territories that broad, sweeping change is on the way. Nurses, including registered nurses and nurse practitioners, are being supported to work to their full abilities in order to meet the needs of

Australian health care consumers and barriers are already being removed to facilitate that.

We see an opportunity here for Tasmania to be a leader in not only promoting patient choice but also supporting innovative and flexible models of health care delivery.

Kind regards
Leanne Boase,
President of the Australian College of Nurse Practitioners.

When thinking about the politics of reform, it can be tempting to only consider each safeguard or process individually. Each may have merit and advance particular policy goals. It may also be difficult potentially to argue that a specific safeguard is not needed, particularly if it appears to achieve at least some useful purposes. However, when the safeguards are aggregated the VAD system as a whole can become very complex and unwieldy and slowly take the legislation away from its policy goals. This policy is death by a thousand cuts. The incremental loss of policy focus through accumulation of individual safeguards without reference to the whole is a key issue for other states to consider when evaluating their proposed VAD reforms. As in Western Australia where they recognise that nurse practitioners can play a role, I recognise that in Tasmania our registered nurses should be able to play a role because they have the skills and ability.

It is suggested that each part of the law be evaluated both on its own and also for impacts, in particular the two key core goals are goals at the core of the design of the VAD act - safeguarding the vulnerable while respecting the autonomy of eligible persons who wish to access VAD.

I know that has taken a little longer than perhaps necessary, but to me a pivotal part of the Tasmanian VAD bill is to have our nurses involved and to have them included in this process. Those of us who have worked and have people in isolated or rural areas would understand the need to have registered nurses involved as AHPs in a role and capacity they can comfortably deal with. In fact, the training modules here in Tasmania are different to those in Victoria. Victoria has only ever used medical practitioners for their training modules. Here, we have used not only doctors but also nurses, clinical psychologists and somebody with experience within the Guardianship and Administration Act to try to make sure the modules cover the whole spectrum. In this process we are asking the nurse to be able to say, 'Does this person have decision-making capacity? Are they voluntary?' and to be there in a professional role to assist that person and perhaps their family and friends.

I encourage and urge all members not to remove from our bill the capacity for our nurses to be involved, because I consider that would be a major step backwards from what this bill has been trying to do.

Ms FORREST - There is a lot to respond to there and I will try to be succinct and brief. I think there is a bit of confusion here. What this amendment seeks to do is to remove nurses as administering health practitioners only. It does not remove the involvement of nurses at all in any other frame. Nurses will still care for patients before and during diagnosis, during their care, the palliative care, whatever care they might have. They will potentially still be there

during the administration of the substance and they will care for the body afterwards and the family of the person who has died.

Nurses will still be integrally involved regardless of whether this amendment goes through. It removes the responsibility for nurses to act as the administering health practitioner actually giving the medication to the patient that will end their life.

I am inclined to support this for a number of reasons. One of the key ones is that the consultation around including nurses in the bill was very limited, or scant at best. When I contacted the College of Nursing, it had not had any communication at all, and it was very concerned about this particular aspect of the role - not about all the other aspects of nurses' involvement in the care of the dying patient. When I did my preliminary training many numbers of years ago, one of the first subjects was care of the dying patient. It is something nurses do all the time, whether it be babies who are dying, or older people, or everyone in between who dies. Of course, not all patients die in hospital - many die either at home or in tragic circumstances in car crashes and all sorts of other settings.

We are actually giving a medication here that is designed to end a person's life - that is its purpose. When you consider that, there are a number of other procedures where a doctor has to administer the drug. The nursing care does not stop during that period, it continues. Two instances come to me without really having to think at all: first, the doctor has to give the first dose of intravenous antibiotics in a hospital setting. That is the most likely time you will have an anaphylactic reaction and need to be resuscitated as a result. It is difficult at times getting the doctor back to the ward to give this medication when needed, if it is on a medical or surgical ward - as opposed to the emergency department, for example, where doctors tend to be all the time. Subsequently nurses can give the antibiotics, but they cannot give the first dose. Some hospitals may have different policies now, but that is the general rule.

Second, accessing medication where you might want a conscientious objection. Let us look at termination of pregnancy. There is every right for nurses and other medical professionals to conscientiously object to participate in a termination of a pregnancy, whether it be a surgical termination or a medical termination. As a nurse I can care for a woman during the time she is making the decision about whether to have a termination. I can care for her after she has taken the RU486, if that is what she is taking, or after she has had the surgical procedure. I can care for her during the surgical procedure, but I do not carry it out. I care for her. I care for her after the procedure. I care for her, potentially, during the decision to take the abortion medication and afterwards when she has aborted the baby.

There are certain roles here that sit with the medical practitioner. You could argue that nurses should be able to do all of that. Maybe that is a situation we will get to in time. There may be nurse practitioners who are able to prescribe in certain areas, but in Tasmania, as the member for Mersey rightly said, we do not have a lot of nurse practitioners. It is an area that is really deficient in Tasmania and one that needs to change. Nurses can be credentialled in a range of other areas. Resuscitation is a mandatory training requirement, it happens for everybody and is not related to credentialling. It is related to making sure you keep your registration, but it is a separate matter.

I think it is misleading to say that nurses will be taken out of this process. They will not. They will continue to be intimately involved and will still provide care, although there will be

some nurses who conscientiously object and will not want to be involved in the care around that part of the time. That is okay. We agree, or most of us agree, that is a reasonable position.

The assessment of decision-making capacity was a serious matter that was raised with me and I think other members too by the ANMF. I have an amendment proposed if this is not successful to require registered nurses who are not nurse practitioners who can assess decision-making capacity within their scope of practice to refer to someone who can, which adds another layer, because that is not within their scope. That is the problem here.

A family member who was not happy may challenge a nurse because they are registered nurse and it is not within their scope to assess the decision-making capacity of a person. This is the genuine concern that was raised by the body that represents nurses. I am aware of it, obviously as a nurse, but it was raised with me by ANMF, and I believe other members as well, and the College of Nursing in my communications with it.

The other issue - and this is referring slightly to another part of the bill - relates to where a person who is seeking VAD if they are going to - not just with self-administration, I do not believe - if for some reason the medication does not work, they make a choice before they proceed as to whether they want to be resuscitated or want to have more medication to give effect to their death. That creates some additional challenges for nurses, in that the doctors can give more medication because they are the prescribing person. A nurse cannot. They have to a have a mechanism to do it, such as a standing order. They have to make sure they have the equipment. If the person has requested resuscitation they have to have the equipment there for resuscitation. I am not sure how many people would do that, but it is in the legislation, so if it is there you have to be able to deal with that type of situation.

There is a range of issues around this. As the member for Windermere referred to the issue of audiovisual links, it may be something that can be reviewed at a later time.

Sitting suspended from 1.00 p.m. to 2.30 p.m.

QUESTIONS

TasWater - Waratah Reservoir

Ms FORREST to LEADER of the GOVERNMENT in the LEGISLATIVE COUNCIL, Mrs HISCUTT answered by DEPUTY LEADER of the GOVERNMENT in the LEGISLATIVE COUNCIL, Ms HOWLETT

[2.31 p.m.]

With regard to the answers to my questions without notice of the week of 14 October regarding the Waratah Reservoir -

(1) Please provide -

(a) evidence that permits were granted for TasWater to commence works in 2017 pursuant to the Water Management Act 1989;

(b) details of who issued the permits;

(c) why was the public not advised of these works prior to commencement; and

(d) why was the public not given the opportunity to respond within two weeks as provided for under the act?

(2) TasWater commissioned Nick Haygarth to provide a report on the historical and/or cultural significance of the Waratah Reservoir -

(a) why is this not publicly available; and

(b) will TasWater release the report to the community?

(3) Has the Government had direct dialogue with the Waratah volunteer fire service regarding the availability of water within that community and the ability to withdraw water from the Bischoff and Waratah reservoirs and the town hydrants in the case of fire?

(a) If so, when did that occur?

(b) If not, why not?

(4) Given the Government's desire for a 'carbon neutral state', is the Government aware that the proposal by the proponent under EOI by TasWater (Shaw Contracting) would result in Waratah becoming a 'carbon neutral town' and a shining example of the tourism industry in the state through the installation of a mini-hydro scheme?

(5) As decommissioning of the reservoir could lead to future costs associated with community safety, fire and flood protection as well as surety of domestic water supply -

(a) has the lost opportunity cost been assessed; and

(b) if so what is the cost?

(6) What opportunities will be lost if the Waratah Reservoir is removed?

ANSWER

Mr President, I thank the member for Murchison for her questions.

(1) This question is yet to be answered by the minister, Mr Barnett.

(2) TasWater undertook considerable work to better understand a range of important issues relating to its Waratah Dam and engaged consultants Entura to investigate the natural and heritage values of the dam and its surrounds, the dam's hydrology and the cost of building a new dam that complies with modern standards. These reports were finalised in late 2018 and shared with the community in early 2019; they have been publicly available on the TasWater website since early 2019.

(3) TasWater has had discussions with the Tasmania Fire Service in full about the options available should the dam be decommissioned. The TFS has advised that a range of options is available to supply water to the town for firefighting services and Waratah Reservoir is not required for this purpose.

The Minister for Police, Fire and Emergency Management recently revisited the question of the need for the reservoir for firefighting at the request of some community members. The response he received from the TFS was shared with the community. Advice to us from TFS is unchanged to what has previously been provided. The advice is there is an abundant supply of water resources in the area and the loss of the Waratah Reservoir would not impact on the TFS aerial firefighting capability. It notes that the Waratah Reservoir is accessible only by aerial appliance as a tanker would not be able to access the water source.

(4) TasWater worked closely with the proponent over an extended time; however, despite the best efforts of all parties, a viable outcome could not be achieved. Waratah-Wynyard Council also had discussions with the proponent and was unable to reach a satisfactory outcome.

(5) The Waratah Dam at its full capacity represents a considerable safety risk that exceeds tolerable dam safety limits. TasWater must take action to manage the risk. TasWater has had discussions with TFS about options available should the dam be decommissioned. The TFS has advised that a range of additional options is available to supply water to the town. Detailed flood modelling has been undertaken, while water levels would vary across the town in the event of a flood. The removal of the dam is likely to only see a slight increase in flood levels in Waratah, with no impact to homes.

Modelling is available on the TasWater website. Even during low flows, the Waratah River still provides approximately 10 times the amount of water required for the town.

(6) The Tasmanian Liberal Government is contributing $300 000 to the Waratah community to improve and upgrade walking tracks at the Waratah Falls and revitalising the Waratah Rail Bridge as a tourism experience. Both projects are seen as a community priority, identified in the Waratah community plan being processed by the Waratah community board. The site will return to its natural state and the river will commence in its natural flow and feed the key tourism attraction for the town, the beautiful Waratah waterfall.

Plenty River - Wastewater Spill

Mr DEAN to LEADER of the GOVERNMENT in the LEGISLATIVE COUNCIL, Mrs HISCUTT answered by DEPUTY LEADER of the GOVERNMENT in the LEGISLATIVE COUNCIL, Ms HOWLETT

[2.36 p.m.]

My question relates to the wastewater spill into the Plenty River and the biosolids development application being pursued for the property 'Dunedin' at St Leonards. There is a lot of angst in relation to this matter, particularly following the Plenty spill, so will the Leader please advise -

(1) Prior to the EPA granting the permit variation via EPN 8894-1 to permit No. 162/09 in 2014, allowing the waste processing operation at Plenty to receive, amongst other wastes, but specifically, human sewage waste biosolids, what site-specific surveys, reports or investigations did the EPA review and/or require from the operator of the site, Jenkins Hire Pty Ltd, located at 21 Salmon Ponds Road, in order for the EPA board and director to approve the change to the permitted activity for that site?

(2) In that the EPA reviewed the EPN application and subsequently approved the permit to allow human waste to be dumped onsite, there is clearly a conflict of interest for them. Who will now conduct or review the investigation into the spill?

(3) Will this consider environmental harm caused in the death of thousands of fry and fish?

(4) Given that the EPA is currently assessing a development application for an almost identical biological waste blending and on farmland disposal project on the Dunedin property located in the Launceston municipality of St Leonards, will the EPA board and director be conducting the assessment of that proposal in a manner and to the same level as that carried out by the EPA or the Plenty and Dulverton operations?

(5) What was the extent of oversight? When was approval given by the EPA director and board in regards to the dumping already of TasWater's biological waste onto the Dunedin property at St Leonards?

(6) What guarantees can the director and board of EPA give to the people of Launceston and residents of St Leonards area that a similar spill or spills will not occur in their locality and affect the drinking water of over 50 000 residents?

(7) Given that plastic, under existing environmental legislation and biosolids reuse guidelines, is defined as a contaminant, when will the director and board of EPA enforce existing legislation and require TasWater to conduct the required laboratory testing of its biosolid waste streams to test for total content contamination?

(8) Will the EPA confirm that the results of such testing will be used in order to give the correct contaminate classification to TasWater's biosolids waste, which dictates the permissible disposal method?

ANSWER

Mr President, I thank the member for Windermere for his eight questions.

(1) Prior to EPN 8894/1 being used to vary permit No. 162/09, several trials were undertaken to access the suitability of the composting operations to process biosoils.

In conjunction with permit variation to allow the receipt and processing of biosoils, several permit conditions were varied to strengthen the regulatory approach to the facility, including restricting the original permitted production capacity from 50 000 tonnes per annum to 9990 tonnes per annum.

(2) An investigation team within EPA Tasmania, with assistance from other areas of the Department of Primary Industries, Parks, Water and Environment, are undertaking an investigation into the cause of a fish kill in the Plenty River.

The business-as-usual operations of EPA Tasmania, in support of the EPA board and director, to regulate the level 2 composting facility operated by Jenkins Hire Pty Ltd will continue as normal.

(3) The investigation is examining the environmental harm which may have caused the death of fish at the Salmon Ponds facility.

(4) The EPA is currently assessing a development application by Conhur Pty Ltd for a biosolids composting facility at St Leonards. The proposal is defined as a level 2 activity under Schedule 2, clause 3(d)(i) of the Environmental Management and Pollution Control Act 1994, and is being assessed in accordance with the Environmental Impact Assessment Principles defined in section 74 of the EMPCA. The same assessment process was applied to the development application submitted for the Plenty and Dulverton operations.

The proposed Conhur Pty Ltd biosolids facility will receive only sewage sludge, previously referred as to Class 3 biosolids, and produce biosolids via a process of stabilisation. This differs from the Plenty and Dulverton operations, which may receive a variety of waste, including macerated fish waste. All facilities are

required to meet the same stabilisation requirements for on farmland disposal in accordance with the Tasmanian Biosolids Reuse Guidelines (EPA June 2020).

Mr Dean - Maybe they need looking at.

Ms HOWLETT - Answer to question (5) -

The EPA is not aware of any biosolids being delivered to the Dunedin property at St Leonards.

Mr Dean - They do now.

Ms HOWLETT - Recent data provided to the EPA by TasWater shows no biosolids were delivered to the Dunedin property in the 2019-20 financial year.

Further, EPA has not provided an approval for the deposition of biosolids on the Dunedin property in St Leonards. The Approved Management Method for the Reuse of Biosolids allows for low rate application of biosolids to agricultural land. Applications undertaken in accordance with AMM is not usually regulated by the EPA and can be undertaken with approval by the local council.

(6) The development application by Conhur Pty Ltd for a biosolids composting facility at St Leonards is being assessed by the EPA board in accordance with the Environmental Impact Assessment Principles defined in section 74 of EMPCA.

Should a permit be granted, the EPA board will impose permit conditions as necessary to ensure the facility can be managed in an environmentally acceptable manner. The main activities for the Dunedin proposal, the composting pad and leachate management dam are located outside the Distillery Creek drinking water catchment.

The Tasmanian Drinking Water Quality Guidelines 2015 issued under the Public Health Act 1997 are legally enforceable requirements imposed on TasWater for managing and controlling water so it does not pose a risk to public health. The Australian Drinking Water Guidelines 2011 set health-related and aesthetic guideline limits for safe drinking water.

(7) The Tasmanian Biosolid Reuse Guidelines prohibit significant quantities of large pieces of plastic in biosolids. Most sewage treatment plants screen sewage as it enters the treatment process. These screens typically have an aperture of 5 millimetres and so remove most large solid materials, including plastics. Small quantities of such materials may be found, but should not be in a quantity to cause harm when land-applied. If there are larger quantities of plastic and other non-biodegradable material present, the biosolids should not be land-applied, and should either be treated to remove the material or directed to an alternative disposal option.

Currently there is no routine analytical method to determine the plastic content of biosolids. A recent research paper has proposed to the use of pyrolysis gas chromatography mass spectrometry to identify the plastic present in biosolids.

However, this technique is still in the research arena and is not commercially available. While it would not be technically feasible to hand sort a sample of biosolids to identify all material contained within it, this is not a commercially available service.

(8) The Tasmanian Biosolids Reuse Guidelines (EPA 2020) require all biosolids intended for reuse to be tested and graded for a range of contaminants to determine the appropriate end use or disposal method. In addition to the list of contaminants included in the guidelines, it is expected that biosolids producers will conduct reviews of the sewer catchment to identify changes which may impact on the quality of biosolids produced.

York Park - Soccer Facilities

Ms ARMITAGE to LEADER of the GOVERNMENT in the LEGISLATIVE COUNCIL, Mrs HISCUTT answered by DEPUTY LEADER of the GOVERNMENT in the LEGISLATIVE COUNCIL, Ms HOWLETT

[2.47 p.m.]

I am assuming that both my questions are going to be answered by the minister, Ms Courtney, because I was instructed previously that she was also the minister for defence.

Regarding the upcoming assessment period by FIFA of Tasmania's soccer facilities and assets for the purposes of selecting host venues, and the capacity of the Small Business, Hospitality and Events portfolio, will the Leader please advise -

(1) The planned timeline for York Park to a rectangular configuration to accommodate soccer games, understanding that in order to adequately bid for World Cup games and provide facilities that will cater to increased local participation in soccer, this will require a more comprehensive configuration to the A League games that have been hosted in the past.

(2) If a time line cannot be provided, could the Leader please advise what work has been completed to date to prepare for the reconfiguration of York Park?

(3) What other steps are being taken to pursue proactively opportunities related to the hosting of the 2023 FIFA Women's World Cup, and what milestones have been achieved to that end?

(4) What engagement with Football Tasmania and other soccer organisations has been undertaken to take advantage of the unique opportunities offered by Australia's hosting of the 2023 FIFA Women's World Cup?

ANSWER

Mr President, I thank the member for Launceston for her question.

(1) to (4)

The Tasmanian Government congratulates Football Federation Australia for securing the bid to jointly host the FIFA Women's World Cup with the New Zealand in 2023. The Government contributed to the joint winning bid and we are excited at the potential to secure gains and potentially national team-based training camps.

The venue has publicly been associated with Tasmania's bid. UTAS Stadium, or York Park, is a facility owned and managed by the City of Launceston.

The Tasmanian Government's agreement with FIFA will provide an investment of $1 million should we secure three group stage matches and the option of two base camps training venues. Confirmation of final host cities and venues is expected to be announced in March 2021. The Government recognises there is a tight preparation time for Tasmania to secure our place in the final venue for the World Cup. It also recognises the ability to convert UTAS Stadium to rectangular configuration is a factor that is likely to be determined in whether we secure World Cup games.

The Government has convened a working group with senior leadership from the Department of State Growth, as well as Launceston City Council, to fully explore and progress this matter. We are expecting we will have more to say about this opportunity in the coming weeks.

Ms ARMITAGE - Mr President, while I thank the Deputy Leader for those answers, they are actually almost identical to the answers that I had from the Minister for Sport and Recreation. I was advised at the time that perhaps I should ask the Minister for Small Business, Hospitality and Events, Ms Courtney, the same questions. It is interesting that I have pretty well, with a few words changed, received the same answers.

Bowel Cancer Screening - Commonwealth Funding

Dr SEIDEL to LEADER of the GOVERNMENT in the LEGISLATIVE COUNCIL, Mrs HISCUTT answered by DEPUTY LEADER of the GOVERNMENT in the LEGISLATIVE COUNCIL, Ms HOWLETT

[2.50 p.m.]

Bowel cancer is the second leading cause of cancer and cancer-related deaths for men and women in Tasmania. Screening is absolutely essential to detect cancerous polyps very early. There is a national screening program funded through the Commonwealth that encourages biennial screening for people between the ages of 50 and 74 years. The Tasmanian Government receives funding from the Commonwealth to conduct diagnostic colonoscopies for patients who have a positive screening test.

Can the Government please advise -

(1) How much funding has been received from the Commonwealth per annum in the last five years?

(2) The percentage of patients who have a colonoscopy within the recommended 30 calendar days of a GP referral in the last five years?

(3) How many nurse endoscopists have been employed or trained by the Tasmanian Health Service (THS) since the introduction of the screening program in the last five years?

ANSWER

Mr President, I thank the member for Huon for his question.

(1) The National Bowel Cancer Screening Program amounts received from the Commonwealth are: 2015-16 - $150 000; 2016-17 - $197 000; 2017-18 - $245 000; 2018-19 - $257 000; and 2019-20 - $276 000.

(2) It should be noted that the latest Australian Institute of Health and Welfare National Bowel Cancer Screening Program Monitoring Report 2020 shows that in 2017-18, Tasmania's participation rate in the National Bowel Cancer Screening Program at 47.8 per cent was the highest in the country, with a national participation rate of 42.4 per cent.

The screening component of the National Bowel Cancer Screening Program is managed by the Australian Government. The Australian Government sends a home screening kit to eligible participants aged 50 to 74 at their Medicare registered address. From 2020 onwards, all eligible Australians aged 50 to 74 are invited to do the screening test every two years.

Population screening and cancer prevention staff within the THS follow up Tasmanians who have had a positive screening result and have not yet accessed colonoscopy or other follow-up tests. The THS advises that in 2019, Tasmanian participation follow-up nurses facilitated 2020 Tasmanian participants to access their next stage of investigation. For the first six months of 2020, Tasmanian participation follow-up nurses facilitated 925 Tasmanian participants.

The Government has provided additional resourcing for colonoscopy and endoscopy procedures in recent years, including $5 million in 2019-20, which has provided more than 2000 additional colonoscopies, thanks to funding from the federal government.

The following data represents a percentage of category 1 patients who received a colonoscopy within the clinical recommended time over the last five years. The percentages are: 2015-16 - 31 per cent; 2016-17 - 22 per cent; 2017-18 - 37 per cent; 2018-19 - 34 per cent; and 2019-20 - 19 per cent.

Procedures included -

- Colonoscopy (Bowel Cancer Screening Program)
- Colonoscopy (non-surgical)
- Direct Access Colonoscopy (Bowel Cancer Screening Program)
- Direct Access Colonoscopy non-surgical
- Direct Access Gastroscopy and Colonoscopy

- Gastroscopy and Colonoscopy

(3) The THS advises that there are no nurse endoscopists currently employed ,but the THS is continuing to explore this model.

COVID-19 - Race Club Funding

Ms RATTRAY to MINISTER for RACING, Ms HOWLETT

[2.56 p.m.]

Show societies around not only Tasmania but also around Australia have received funds if they have not been able to hold their show events this year.

Is the Tasmanian Government looking to support those clubs that normally hold a racing event, particularly St Mary's and perhaps the North Eastern Pacing Club and any others that might have to postpone this year's event, whether they will receive some funding to enable their clubs to continue?

They all have various numbers of commitments and without an event this year, they will not receive any funding. I am interested in whether the Minister for Racing will consider providing a small amount of money. I know the show society at Scottsdale will be receiving $15 000 for not holding its event. I am looking for something similar for the racing industry.

ANSWER

Mr President, I thank the member for McIntyre for her question.

Last week the Premier released a framework for COVID-19-safe events and activities in Tasmania, which will provide opportunities for race clubs to increase their attendance numbers, while still considering other public health measures. The events framework places events into three categories depending upon their accepted level of attendance. The 2 square metre rule and other social distancing restrictions will still apply -

Ms Rattray - It does not work around the bar very well, that is the problem.

Ms HOWLETT - It certainly does provide its challenges. I think people are so used to 'vertical drinking', it is very difficult to remember to sit down and drink.

These measures are really important and we need to adhere to those measures currently.

Further details on the framework of the application process will be made available in the coming days for the three categories. I understand some race clubs, particularly those run by volunteers, have indicated some COVID-19 restrictions will make holding their summer carnival events very difficult.

Ms Rattray - For instance, the St Mary's Pacing Club.

Ms HOWLETT - The St Mary's Pacing Club holds a New Year's Day event every year, which is scheduled this year. It is indicated that it is likely not to hold it, but I understand it is

still looking at the frameworks and waiting on a little bit more advice. The North Eastern Pacing Club's meeting is scheduled for 8 January and I understand it is having a meeting tomorrow night to discuss what it will do. If events are cancelled, it is something I will have to look into, but I hope that with the three events we currently have in place - we will release more details on Friday - they will continue to go ahead with their events.

COVID-19 - Race Club Funding

Ms RATTRAY supplementary question to MINISTER for RACING, Ms HOWLETT

[2.59 p.m.]

The North East Pacing Club will be assessing its options on Wednesday and yet the information on how you might hold an event will not be available until Friday. Will the minister consider letting the North Eastern Pacing Club in particular know what that might be before it makes its decision on Wednesday?

ANSWER

Mr President, I thank the member for McIntyre for her question.

When the framework was released on Friday, I provided the pacing clubs with the requirements. They have that information. I have had conversations with the mayor, with Graeme Wood and also with Pam. They have those requirements so they could sit down and look at them and discuss them with their committee prior to the meeting tomorrow night.

Tasmanian Land Tax - Thresholds

Ms ARMITAGE to LEADER of the GOVERNMENT in the LEGISLATIVE COUNCIL, Mrs HISCUTT, answered by the DEPUTY LEADER of the GOVERNMENT in the LEGISLATIVE COUNCIL, Ms HOWLETT

[3.00 p.m.]

Will the Leader please advise -

(1) What is the rationale for having the minimum threshold for Tasmanian land tax at $25 000?

(2) When was the value of $25 000 set as the minimum threshold to charge landowners land tax?

(3) When was the last review into calculating this minimum threshold?

(4) Has the Government considered, if not abolishing land tax, pegging it to the consumer price index - CPI - as is the case with many other charges, fees and taxes?

(5) Will the Government consider, if not abolishing the land tax, to raise this minimum threshold or lower the tax scale which is applied to taxable land as is the case in many other Australian jurisdictions?

ANSWER

Mr President, I thank the member for Launceston for her question.

(1) The threshold is intended to avoid the administration burden of applying taxation to small land of very low value which would yield minimal revenue for the government services.

(2) This threshold was set on 1 July 2005.

(3) The last review of land tax thresholds was in 2009-10 when amendments were made to the Land Taxing Rating Act 2000. At this time the thresholds within Schedule 1, Rate of land tax, were reduced from four tax brackets to three brackets. The minimum threshold remained at $25 000.

(4) Although minor taxes, fees and charges are fixed to CPI through fee units, the Government does not fix major tax lines such as land tax to CPI which is appropriately linked to the Valuer-General's assessment of market value.

(5) Land tax is an efficient tax, which means the process of charging the tax has a low administrative burden and does not distort people's decision-making and behaviour as much as other taxes. As such, a revision of land tax thresholds and tax rate is not proposed at this time.

In regards to the recent land tax notices, there have been no changes to the land tax schedule since July 2010. The increase in land tax notices reflects an increase in the value of property. Property revaluations occur every six years in Tasmania. Between revaluations, the Office of the Valuer-General applies annual valuation adjustment factors to land. The adjustment factors are based on property sales information, current rental data and a range of relevant market evidence. In times of buoyant real estate conditions, the factor generally increases. The Valuer-General's valuation adjustments therefore reflect strong property growth in some municipalities.

While the Government appreciates that some landowners are experiencing financial difficulty, adequate measures are already in place to assist landlords. Anyone experiencing difficulty paying their land tax can apply to the Commissioner of State Revenue to defer lump sum payments due to hardship, or arrange to pay their land tax by instalments.

Tasmanian Land Tax - Thresholds

Ms ARMITAGE to LEADER of the GOVERNMENT in the LEGISLATIVE COUNCIL, Mrs HISCUTT, answered by the DEPUTY LEADER of the GOVERNMENT in the LEGISLATIVE COUNCIL, Ms HOWLETT

What was the minimum threshold prior to the last review? If you are unable to answer now, I will put the question on notice.

ANSWER

Mr President, I will have to take that question on notice.

END-OF-LIFE CHOICES (VOLUNTARY ASSISTED DYING) BILL 2020(No. 30)

In Committee

Resumed from above.

Clause 60 -
Appointment of AHP

[3.05 p.m.]

Ms FORREST - I had not made the majority of points I wanted to make on my concerns about the inclusion of nurses in the bill as it is. It is a policy position, clearly, but this is a policy position and decision that has been made without consultation with key stakeholders. In this place we are normally very critical when that occurs. As I alluded to earlier, the College of Nurses had no involvement and it is the professional body; nor did the College of Nurse Practitioners.

The member for Rumney moved the amendment about the default position being self-administration, which is an amendment to come, to make that a stronger default position. If that is to be the case - and it should be that people administer the substance themselves if they can, rather than the health professional - then it is usually because a person has some limitations that would see them need the assistance of a medical practitioner or a health professional, so there are more likely to be complications as a result in regard to the ability to take the substance and have the desired effect in a timely manner.

When we broke for lunch, I was making the point that this is a matter which should be part of a review because key stakeholders have not been fully consulted. A case has not been made for the inclusion regarding whether we have enough medical practitioners to fulfil the roles. We do not know that; we do not have any clear evidence that I have been able to ascertain.

There is concern within the nursing fraternity that in some respects, this presents a dual process in relation to the management of these medications under the Poisons Act and under this act. That concern was raised by the government officials when they briefed us a couple of weeks ago.

Another point I make very strongly is that this is not a suggestion that nurses are incapable of fulfilling this role in any way. The only thing we are saying here is that nurses will not administer the substance if the person is unable to do it themselves. All other nursing care and care from nursing staff, nurse practitioners, will continue as it is - and it should, because that is what nurses do. That is the job of nurses and the job of the caring profession. It is not a suggestion by any stretch. That is the case.

There are some issues around the scope of a nurse's practice in dealing with decision-making capacity assessment and also giving a drug that is not prescribed if they need an

additional drug. A person self-administers the medication but it does not have the desired effect; they then have to have a prescription to fill to complete that task. We do not have the number of nurse practitioners in the state who have the high level of qualification that includes the decision-making capacity assessment and things like that. That is a failing in our system and we need to more fully support that.

For those reasons, I suggest this is not the time to include it. It needs further consideration at a later time, particularly after the bill has been in operation for a couple of years. We see, as we have noted, based on similar outcomes in Victoria, that there will not be a huge number of people accessing it. If we find there are not doctors willing or happy to participate, then maybe it can be considered at that point.

Any decision to include nurses must include nurses themselves in the consultation. It must include the bodies that represent nurses. It must include the bodies that represent nurse practitioners. Until we do that we are not ensuring all those matters are covered. We heard from the Chief Nurse and others involved in this area that there were some concerns about this. We have not had time to test whether those concerns are valid or not. The only way to fully test those concerns would be to send this bill to a committee to fully consider that. I do not believe there is an appetite for that. It is one specific area that needs more consultation and work. That can be done as an external approach. You can still maintain the integrity of the legislation. Nurses will still be involved in the care of patients. They will still be involved in every other aspect. The only thing they will not be doing is administering the drug or drugs to the person for the purposes of voluntary assisted dying.

For those reasons I will be supporting the amendment. It is a policy position. I do not like supporting policy positions that have not been fully consulted with the bodies they directly impact.

Mr DEAN - There are a couple of points I want to be clear on. This is where the registered nurse has done the VAD training and given certification. In this case I would have thought that the nurse would have a close relationship with the patient who is to be given the product at the end of the day. I would have thought a patient in that situation might prefer in all of the circumstances a person they know and have confidence in to be able to administer that substance to them. I would be surprised if that was not the case.

The other question I raise is what is 'administer'? Is it simply putting the fluid into a cup or a glass and it is ingested internally that way? How would the nurse administer it if that is the way? Just put the fluid into the glass and hand the glass to the patient? Or in some cases, would it be administered intravenously and obviously require the nurse or doctor or whoever to inject?

As I understand it, they can take it, ingest it, by simply having the fluid in a container or whatever it would be given to them in. I received a letter from another nurse recently retired, and guess other members did, this morning or yesterday -

Ms Forrest - The member for Mersey read that out.

Mr DEAN - The one that came yesterday? As long as it is described to *Hansard*.

I ask the question again. The member for Murchison and others raised the issue of how much consultation has taken place with the nurses and their representative body, and how widespread that has been. If it has been widespread what has the general response been from those people in this position if the amendment does not get up, if the bill stays as it is? Could they administer the product if they elected to do so? We have not forced this upon them. It is an election on their part.

At this time, I am not convinced I should accept the amendment but would like to listen to some further argument. There is not enough evidence at this stage for me to be properly informed as to the position I would like to adopt here. I am hoping there is some more information.

I am hoping the member moving the bill might be able to do some of that.

Mr GAFFNEY - I want to correct a few things. There has been quite a lot of discussion and correspondence since very early in the piece between many people involved in the nursing and medical profession. Everybody in Tasmania has known that this bill was drafted in January this year. Every organisation in Tasmania has known this has been there. Another draft was released in June, and all bodies were informed. I have met with many of those bodies on a number of occasions.

It is not fair to say that the bodies have not been consulted and were not aware of it. That is not correct, from my point of view. In fact, I met well before Christmas - this is possibly interesting for people who understand how the nurses' aspect came into being. Two instances - and I was going to leave this until later but I will do it now.

First, when I was in Canada, I had a meeting with Jocelyn Downie, one of the main crafters of the Canadian bill. I happened to spend three or four hours with her talking about the challenge she had introducing a bill across the country. I had just arrived from Zurich the night before, so I had got in early. I had a meeting with Professor Downie the next day. I went to one of the local pubs to have a drink before I went to bed; it was about 4 o'clock in the afternoon. A gentleman was sitting next to me - probably in his late 50s, quite a big Canadian fisherman sort, and obviously he could hear my accent. We got to talking. He said, 'Who have you been seeing?'. I said, 'Jocelyn Downie'; He said, 'This is incredible.'. I said, 'Why is that?'. He said, 'Because my father, eight months ago, was accepted for medical assistance in dying in Canada.'. I know that some people have been to the forums and have heard this story, what happened, but some of you have not. It is important for the record because he started talking. He said, 'My wife is Catholic so I have not been able to speak to her very much about it. My father had very bad lung cancer, but his decision-making capacity was also questionable. He was eligible for MAID.'.

What happened is that the doctor and his wife who were bringing the substance to the family's home where everyone was gathered for the Event - that is what they call it in Canada - but on the way there, they were killed in a car accident with a truck. Because this was fairly well north in Canada, away from Halifax, it was another 10 days before another doctor was able to get there with the substance. When that doctor arrived, he said to the father, 'You realise if you take this substance, it will kill you?' In the intervening period, the father had lost his decision-making capacity and was unaware of what was going to happen, therefore he was ineligible.

Over the next five weeks the father died quite a terrible death according to the son, a 50-year-old man in tears. He said, 'I have not been able to speak about this to anybody.'. He said, 'In some provinces we have nurses who are able to be the AHPs', but in this case they did not. Had that substance been there in time, it would have meant that the father would not have died a terrible, painful death - painful in a hospice with his son looking after him.

We should be able to do better than that in Tasmania in having nurses available to administer medication, a role they have anyway.

The second instance, I was talking to the previous president of the AMA. As I have stated in this place before, unfortunately, my invitation to meet with the subcommittee of the AMA looking into the bill was withdrawn. I was not able to talk to them this year about their concerns. Talking to the previous president he said - and categorically he was very good - I do not agree with doctors being involved with this at all, which is fairly much the hard-line for the World Medical Association, the WMA. But he did say that some doctors would be happy to determine whether the person was eligible. Some might even be happy to play second role, the second request and determine that with the CMP, but some of them do not want to be involved with the actual administering of the medication. At that stage, I thought here is an opportunity for us to ensure other people in our health profession are able to administer - all they are doing is the decision-making and acting voluntarily.

I go back to the issue that it is about capacity. No nurse has to do this if they do not feel as though they have had enough training or have undertaken the training. Once they have done the training, they still do not have to be involved if they do not want to. This is about professionalism of nurses. We know nurses are involved in administering Schedule 4 drugs as part of their scope of practice. In that light I think, yes. We have heard from the ANF. We have heard from the ACMPs how they believe they should be involved in this. We should leave it up to the nurse. Why would we create a framework where we are not giving those talented professionals an opportunity to be involved? Why would we not have a framework to say, yes, if you think you want to be involved, you want to volunteer because of your experience and have done the training? Why would we not let them be involved?

That they have not been aware is not a satisfactory explanation. That is not true. I met with the ANMF very early on, I think it was March/April, so they have been well aware of what has been going on. We had heard they are quite comfortable that their nurses get to choose what is within the legal framework. In this legal framework those nurses who want to be involved, can be involved. I do not see that as an issue. What I see as an issue is that we are putting our opinion into something where nurses are more than qualified and more than capable. If you go back to the submissions we received and tabled in this place, a number of those submissions were from nurses and doctors quite comfortable with nurses being involved, if they want to be. It would be wrong of this place to deny the person we are worried about having a nurse available.

My last example is, for instance, an island situation: the GP there does not want to involved, a conscientious objector, or has not done the training. The locum comes in, does the assessment work in the PMP, the locum flies out Friday because that is when the plane flies out. The community nurse who has been trained can be there, has the capacity to be the AHP and at the time of the family's choosing and can administer that medication. At the time of

their choosing, not that the locum has to fly out at 4 o'clock, so he has to do it on the Friday morning.

There are some advantages for the person choosing the VAD substance and that is what this bill should be about. It should be about the person and we protect the professionals. We are protecting the doctors, we will protect the nurses, and it is up to the commission to make sure they do their work if there is anything they feel they need to put further into this bill or within the regulations because it is part of what we do. I would encourage to allow nurses to play an important role in this process.

Mr VALENTINE - I have been listening to the reasons being put forward for the amendment. I have listened to the member for Mersey give quite a significant explanation about what he feels. I look at the bill and clause 62, just over the page dealing with the person entitled to refuse to be appointed and if it does get to that - and something the member for Mersey mentioned - they can always say no if they do not feel confident.

The important thing about the fact of a nurse being involved is that nurses, quite often, are the closest person to that individual who is going through this terrible suffering. Quite often they are the ones the individual feels comfortable with and we need to keep that in mind as well. If they want a medical professional to be involved, then there is that opportunity for them to say to the nurse, 'I would like you to do this with me or for me', or whatever it might be in relation to the way it is administered, in this case becoming the AHP.

I appreciate that consultation is important and if we were to take the consultation we have had with the Australian Medical Association, they are saying 'no'. You can do the consultation. You do not always get the full response from the whole fraternity of doctors. We have doctors writing to us saying, 'Yes, let us go ahead'. They may have concerns. It may well be the same with nurses. We see it in local government all the time; the Local Government Association comes out with a certain decision but there are councillors who contact us saying, 'We do not agree with that'. These are peak bodies.

I thought to myself, what would change? So, we have the consultation with the nursing fraternity. What sort of thing will change it that much that it will go further than a nurse being able to opt out? Probably not a lot. What it comes down to is the individual choice of the nurse.

I am inclined not to support the amendment to take nurses out because they are the ones who are quite often the closest to the people who are suffering and want to go down that path. I will listen to the rest of the opinions, as I always do, and someone may convince me otherwise, but that is my position at the moment.

Ms WEBB - This has been an interesting debate to listen to, and thank you to those who have made contributions. I appreciate the detail that has been gone into by the member for Mersey in his initial speaking on this and then the follow-up a short while ago.

The things that strike me about this amendment are considering the broader context of where this topic has been dealt with in other jurisdictions, and looking to Canada and seeing there are instances in which there is nurse involvement and instances where there is not, and that they grapple with the repercussions of that through the anecdote you shared. That was an example of that.

I look to Australia and note Victoria not having nurses involved, and then Western Australia subsequent to that choosing to include nurses in their process. I read the ministerial expert panel report in Western Australia where that expert panel was convened to look deeply into all matters relating to the issue there to inform the creation of the legislation. I note the comments that were made by that expert panel about the inclusion of nurses and the appropriateness that they saw in that.

I feel that in some senses we began a journey on VAD here in Australia in the contemporary sense in Victoria. We developed that further in Western Australia, and I see that this part of the discussion progressed. What is in our bill builds on that progression and picks up on what was observed and learnt and examined there in relation to nurses. To me it feels like a well-informed inclusion.

What is the problem we are trying to solve with this amendment? It is not clear to me that there is a problem in the bill in relation to this matter that we need to solve with this amendment. Issues have been raised such as a lack of consultation to date. We have heard there are various views on that; that there has been consultation to some extent. Others I am sure feel there has not been sufficient, but here we are. We know the limitations of a private member's bill of this complexity being brought forward and the difficulties of engaging in consultation for a start. The member for Mersey has genuinely been very open and comprehensive within his resources in doing that.

Other matters raised as issues become relevant not so much for this legislation, which is the legal framework, but they become relevant in the next stage and that is the nuts and bolts of implementation. What we have decided and what we have amended when we were here last time was that there will be an 18-month period during which implementation occurs before we actually begin doing this. During that time is when we are going to see serious consultation on the nuts and bolts, the details: what will be in the training, who will be involved in that, what is it going to look like for all the people involved, what will be in the regulations, what details do we need there - particularly the details around, for example, those issues to do with the substance itself, how the substance is dealt with, and how all that end of things work? That is all going to be captured in regulations in much more detail than this higher-level legal framework in the bill.

We know there is an 18-month period during which that is going to occur. I suggest as part of that process in a very purposeful and specific way there will be extensive consultation with nurses and with nursing bodies and with many other groups and medical bodies on the detail, should this pass. For me, acknowledging that we may be able to point to deficiencies or less-than-ideal consultation to date, we can also look to the consultation opportunity that remains when we are speaking about specific implementation details.

To pick up on a few of those things I have heard of the problem that we are trying to solve with this amendment, one of those related to training and the fact that nurses do not necessarily in their general training have training that would be needed here. That could be looked at and picked up on when it comes to VAD training. Not all nurses will be relevant to this anyway, just the ones who elect to be trained in the VAD process and make themselves available. We can pick up things like that decision-making training around assessing decision making. Those sorts of things could be captured within VAD training for nurses.

Of the other roles that nurses might undertake around this process, other than the administration and the acting as the AHP, there is no question that they will remain and are valued and are welcomed as part of this. No one is suggesting they need to disappear or be affected. What is at call here is the inclusion of nurses in that central AHP role and particularly potentially in relation to administering the substance. We know that there is no question here, there is no problem to solve here, in regard to whether nurses want to do that because, as many have pointed out already, it is a choice. It is entirely optional. Even if a nurse has undergone the VAD training and has the capacity to be involved, that nurse can still choose not to be in any given particular circumstance that might be requested of them. There is no compulsion, no requirement; it is thoroughly opt-in.

The other side of that question of what problem are we solving, is the secondary question of what do we lose if we contemplate this amendment? What do we risk in bringing in this amendment which removes nurses from that central AHP role and the administration role potentially as part of that? The significant thing we lose is potentially access and flexibility at that stage of the process when it will be highly important to try to retain as much accessibility and flexibility for the Tasmanian people, particularly those who are in more challenging circumstances, say in rural and regional areas. That is where this comes into play. I think about this issue around accessibility and flexibility particularly in its totality, so not just this amendment and this particular matter, but what else do we have in place and what else have we changed about this bill as it comes through this place, that impacts in the space of accessibility and flexibility so people can use it, so it is meaningful as a process that we offer the Tasmanian people?

I think about the cumulative effect of reductions in accessibility and flexibility and that cumulative effect we have tightened already. We have already brought in a prognosis requirement which begins to constrict access and flexibility. We have already looked at other matters that begin to constrict access and flexibility because we did not put in telehealth availability at that first request stage. We know from other jurisdictions that people in rural and regional areas may not have ready access to medical professionals who are willing and able to be involved.

To me, this is a balance. It is something that provides an opportunity, without providing an imperative, a requirement or a compulsion. Of course, there are mixed views amongst the nursing profession on this and there always will be. We are not requiring anything other than for nurses to have the option to be involved and potentially make themselves available, and for people to then be able to benefit from that in a very limited number of circumstances, but it is important.

Any particular circumstance where somebody might want to access this process, be eligible to access this process and be stopped from doing so because of practical constraints that could, without risk, have been otherwise, to me would be a real tragedy.

The member for Mersey, in his last contribution, was particularly relevant in highlighting that the person is at the centre of this. This is a legal framework that sits around the process with the person at the centre. The legal process simply sets up the opportunities and the constraints. We need to bear in mind where that person is left in relation to their genuine ability to be able to use this process if we pass this bill and offer it to the Tasmanian people.

This amendment is not necessary. There is not a problem that we need it to solve. We have arrived with this bill in a well-indicated place with the inclusion of nurses. I hope we do not add further cumulative constriction to what may be the iteration of this process and for the Tasmanian people, such that we put barriers there for people who are eligible and genuinely should and could be able to use it.

Madam DEPUTY CHAIR - Before I call the next speaker, I remind members that we have already had notice from the Chair this morning that this is not an opportunity for a second reading speech. I take on board everyone wants to get their points across, but we need to make it as concise as possible.

Dr SEIDEL - Madam Deputy Chair, I will be frank: I want to see this bill pass in the upper House, I want to see it pass in the lower House and, more importantly, I want to see it implemented.

The question has been raised: what are we losing if we are including nurses and nurse practitioners? We heard from the member for Mersey that it is the innovation aspect of this particular legislation and that is a reasonable argument. I am also mindful that the more we talk about innovation as part of legislation, there are also barriers because we are entering unchartered territory to a certain extent.

We often talk about what is the problem we want to solve here, and what is really the issue? Various suggestions and assumptions were made about access to health practitioners, when they are available, and we have heard some anecdotal evidence in case reports where access was not available at that particular time.

It is interesting that from a practical point of view we talk about registered nurses here, not enrolled nurses. We talk about nurse practitioners who are typically registered nurses who have undergone further training. They typically have a Master's degree as well. For example, we are not referring to physician assistants, who we could have incorporated in this bill. We are not referring to Aboriginal Health Workers, who also could have been incorporated in this bill. We are very particular about nurse practitioners and nurses.

We talked about precedents in other jurisdictions and other states. The point was made that access in Victoria now is perceived to be quite difficult because we are limited to a certain type of medical practitioner. I have mentioned before we have a moratorium there of five and 10 years and then some patient had to be referred to a sub-specialist and that is quite difficult. I think it has been made very clear. We also do not have the availability of telehealth services in Victoria. I believe that is the major barrier that has been documented.

The nurses or nurse practitioners are not involved in the VAD process in Victoria. It has not been raised as an issue in any of the reports that have been published since implementation.

With regard to Western Australia, the member for Nelson is right. Yes, nursing as a profession has been raised in the consultation process but reference has specifically been made to nurse practitioners, not nurses. It is nurse practitioners who are involved in the VAD process in Western Australia. It is not nurses, it is not registered nurses, it is not enrolled nurses, to be absolutely clear.

I mentioned before that context is important as well because the situation in Western Australia is completely different compared to Victoria or Tasmania. In the remote and regional areas in Western Australia the main health practitioner is often a nurse practitioner and reportedly they have 248 nurse practitioners in Western Australia. The vast majority of them work in regional and rural Western Australia, not in the metropolitan centre. The vast majority of those nurse practitioners are working for a not-for-profit organisation that is directly involved in community care and palliative care. That has still not changed. They have been in operation for well over a century now. It is the major provider of community nursing care and nurse practitioner care particularly in regional and rural Western Australia. It is the genuine workforce issue. Western Australia decided we are making nurse practitioners - not registered nurses, not enrolled nurses - part of the VAD process.

In other jurisdictions, for example Queensland, there is no mention of nurses or nurse practitioners in their draft bill. In New Zealand there is no mention of nurse practitioners in their bill. In Canada there is, but only in some provinces. We have, according to the latest MAID report, 1097 medical practitioners involved in VAD in Canada, but only 75 nurse practitioners are involved. Over 1000 medical practitioners, 75 nurse practitioners. There was some concern that quite a few of those nurse practitioners are not being paid for the services they offer because there is no insurance scheme. Many of the nurse practitioners in Canada are working for free when it comes to VAD.

I understand when the member for Mersey consulted with the AMA in the past, the argument was made that doctors should not be involved at all. It should be done by other health practitioners, but not doctors. We discussed in private that that is a personal opinion rather than based on evidence, because when I consulted with medical organisations I was convinced we have the medical workforce available in any area of the state that would be able to be involved in the VAD process. We have already made some changes. We can involve specialist GPs, specialists; we do not have a moratorium. I am very confident that we have medical practitioners here in Tasmania who would be willing to be involved in the VAD process from start to finish.

The argument that there are some areas in Tasmania where we do not have medical practitioners but nurses or nurse practitioners instead is contestable. We do not have nurse practitioners working on Bruny Island. We have remote area nurses working there. We have GPs there. To the best of my knowledge, we do not have nurse practitioners on Flinders Island. On King Island, to the best of my knowledge, we do not have nurse practitioners - but we have medical doctors there, specialist GPs. Cape Barren Island is the only island where we do not have nurse practitioners. We do not have medical doctors there, but we do have remote area nurses there.

We have already said as part of the VAD process, the patient needs to have a face-to-face onsite visit at least once with the medical practitioner to be eligible. So, for somebody who is on Cape Barren Island who typically does not have access to the medical practitioner, they have to find ways to have access to a medical practitioner now. We did not pass the amendment with regards to telehealth so we have resolved that already. You have already put a barrier up there. Yes, there was an argument to say if we had done telehealth for medical practitioners, then there would have been a role for different health practitioners to be the administrating practitioner, but we have already resolved that.

By including nurses, or nurse practitioners right now, we are not solving the problem. We do not have the nurse practitioner work for us either. We have 29 nurse practitioners working for the THS. We have 18 nurse practitioners working in private practice. The vast majority work in a very narrow specialised field - endocrinology. Only a small minority works in general practice palliative care, or community care. There are two in the Huon Valley and they are private nurse practitioners and I trained both of them. One works for the THS, as we heard earlier when I asked the question in question time.

However, the concerns are absolutely real because as said, with the exception of nurse practitioners, making a diagnosis is outside the scope of practice for nurses and midwives. Members believe the bill should clearly state where a registered nurse is taking on the role of an AHP, that the responsibility for final assessment of decision-making capacity must be referred to a medical practitioner, so whether we like it or not, they still want a medical practitioner to be involved anyway. It is not either/or. Those two health practitioners need to work together and so they should. Nurses want to work with doctors, doctors want to work with nurses. The question is whether it is a solution for a nurse to be the AHP who is the only person who can then administer the drug.

The administration of the drug is a problem as well because, as outlined before, given that section 20A of the Poisons Act does not include poisons as a substance that registered nurses can administer, members questioned what schedule the substance will be and whether the schedule can be included specially in the bill to give members further confidence. If we do have nurses involved who can administer, that substance needs to be double checked, so there needs to be another health practitioner involved to do that. Although we would like to have only one nurse, we need to have at least another health practitioner there because they have to check the drug. When the patient then dies you still need to have a doctor to sign the death certificate.

I am not convinced that including nurse practitioners and nurses is a solution to a workforce problem, because we still need to have a medical doctor to be very closely involved. The argument about the time frame, that it can take longer and doctors want to leave because they are locums, according to the bill as it stands now, the whole VAD process from start to completion could be 48 hours. Not 10 days, 48 hours.

A member - That is the shortest period.

Dr SEIDEL - The shortest one. There is no time frame as it is in Western Australia. In Victoria it is seven to nine days. It is 48 hours and is entirely appropriate.

If we include nurses and nurse practitioners we need to look at what sort of training they need. Quite frankly, it is not going to be the four-hour online training they have in Victoria where they just focus on medical practitioners. We need to do a summative assessment, formative assessment, of how capacity, for example, is assessed for nurses. It needs to be tested. It is not just a credentialling process; it is also an accreditation process. It has to go through the nursing board because we are changing the scope of practice. We need to involve medical insurers, or nursing indemnity insurers because you just changed the scope of practice.

Who is going to pay for the training? Who is going to do this? Are the nurses paying themselves? Is the government supporting that? There will be arguments about the cost of a commission, which we said was around $12 000. How much is it going to cost if we involve

nurse practitioners? Are they then expected to pay for the training themselves? Nurses too. Are we all in the same training? Do we have three different sorts of training? How is it going to work?

It is all possible. But the Department of Health has already told us it wants two years for implementation. It has already cut it down to 18 months, and now we are coming up with innovations that have raised quite a few issues. Is it all realistic? I do not think it is.

I think we can implement this bill now without nurses and nurse practitioners being involved. We can make this work now even for rural and remote Tasmania. We can review the bill in five years time to see whether we should include other practitioners, whether they be nurses, nurse practitioners, physician assistants and emergency health workers.

I support the amendment.

Ms LOVELL - I thank members for their contributions. I knew this amendment was not one everyone would agree on. To that end, that was one of the reasons we made it. I say 'we' because the member for Murchison and other members made an effort to circulate our amendments well ahead of time and certainly encouraged other members to look at and consider them before we got to this point. We are making big decisions. They are not decisions we should make on the hop, so I am encouraged by the fact that people obviously have taken the time to do their own consultation.

At the end of the day, it is a policy decision. People will have their view on what that policy should be and what would be the best model for Tasmania. I know the member for Mersey has a view; I have a view, and clearly other members have a view as well, which is absolutely fine. That is exactly right; that is democracy.

When it comes to making a policy decision, we talk about the need for it to be evidence-based. That has come up a few times throughout this debate. I remain unconvinced that there is evidence that registered nurses are required, right now, in Tasmania, to facilitate access to VAD for those people who choose and are eligible to access it. As other members have said, there is absolutely nothing to stop nurses from being involved in end-of-life care and in caring for patients who have a protracted and long illness.

The member for Mersey spoke eloquently about the importance of that role and the role that nurses play for patients and their families. I absolutely support that. The last thing I want anyone to do is think I would suggest it is not appropriate because it is.

The member for Mersey spoke about Victoria and said this was something the Victorian review had looked at. Again, as I have made this point on other matters, the Victorian review is taking place after it has had its legislation in operation for a period - they have had time to look at how it works and what else might be needed, how they can strengthen it, what refinements they can make.

I appreciate that the anecdote the member for Mersey shared about the gentleman in Canada is nothing short of tragic. It was a horrible, tragic situation, but I am still not convinced that legislating in response to that tragic but rare instance is the appropriate way forward.

The member for Hobart talked about the fact that members had spoken about consultation and whether it would be more appropriate for more consultation and more detailed consultation with those bodies and with those medical professionals to take place, and what that would change when nurses have or would have, under this bill as it is drafted, the option to opt out of participating.

I expect that what could change is that we might come up with a better process. We have a predetermined process here that has been developed by the member for Mersey through his consultations. If we consult further with those bodies and with those professionals, we might come up with a process that works better for them and for their patients, one that they can feel more comfortable with, which addresses the concerns that have been raised.

In response to the member for Nelson who asked what the problem is that we are trying to solve with this amendment, I feel like that has been well canvassed. People have put their views forward thoroughly on the concerns that have been raised and what we are trying to address.

The bottom line for me is that these professionals need more input and an opportunity to have more of a say in this process. At the moment we are talking about an option - people would have the option to opt out under this bill, but they only have the option of either opting out of or into a predetermined framework that they have not had input into.

Yes, people have been aware of the bill and people have been able to attend consultation sessions, but that is quite different from being invited to have a say in the process and in the actual drafting of the bill and what that process looks like. We talk about the importance of this being patient-centred, that this is a patient-centred process, and I agree. All aspects of health care should be patient-centred, but that should not necessarily be at the expense of the professionals we are asking to facilitate this process. We should be asking those professionals to participate in a process they may not be completely comfortable with. There is a balance and we can do both.

I am not going to talk about this amendment any further because it is a policy decision and people have their views, as we should. This will be determined by the Floor and I am happy to leave it to that and members to decide. I have put my view and concerns forward. There is a way forward; I am not saying rule nurses out altogether forever. There could well be a role for nurses to play in this process in the future, but I would like nurses and the bodies that represent them to have more opportunity to have a say in what that role is, what it looks like and means for them. I will leave it at that and leave the decision with members.

Ms FORREST - I want to comment on a few points and address a couple of matters the member for Windermere raised.

There is no guarantee if a nurse is the AHP that they will be known to the parties. The commissioner will have a register of AHPs and they can be appointed so they may be known - the same as a doctor may be known - but they may also be a doctor or a nurse the patient does not know, because their own treating doctor may have a conscientious objection. They have looked after them all through other aspects of their health, but they do not want to support them through that. It could be either; there is no guarantee there will be no more than their medical practitioner might be.

The other thing I wanted to touch on is this: as a nurse who has worked in hospitals and in other settings where you are giving medications to patients, we do not know for sure whether the medication, which is the physician-delivered or the AHP-delivered medication, will be intravenous. All the discussions we have had have been intravenous injection, whether it is schedule 8 or schedule 4. There are a couple of significant differences there, but, regardless, before a nurse can give an intravenous injection, they have to have another health professional, usually another nurse, check that medication. They cannot just draw it up and give it, whereas a doctor can because doctors are the prescribers. It is a different framework and process. This creates a position where you are asking the nurse to be the administering health professional, to have the medication, but not have anyone there necessarily who can check it before it is given. This is fraught in terms of their responsibilities under the Poisons Act and their registration requirements.

If someone were to challenge them and say, 'Well, you actually did not give the right medication', and no-one has checked it, it is a process we have to go through. In any IV administration, a nurse has to have another health professional check it, normally your nurse; if the doctor does, the doctor can go to the drug cupboard in the ward, pull out anything they like effectively, and give it to the patient. They do not need another health professional to check it because we trust doctors who have that higher level of qualification in terms of their capacity to prescribe. Effectively, by going to the cupboard they are prescribing - they are getting a medicine out of the cupboard, taking it to the bedside and administering it. The nurses have to have an order from the doctor, on the drug chart, then they go to the cupboard, get the drug, get another nurse to check the dose, the right patient, the right time, the right place and all the other things you have to do. Check the patient's arm band and all the other things and then you give that medication to the patient. So it is different. There are differences. That is why, as the member for Rumney alluded to, there may be a different way you can facilitate nurses in this process of administering as a health professional. When I contacted the College of Nurses, they had not had any communication. That is the professional body. The AMEF is the union, which has an important role to play, but the college is the professional body.

In Western Australia nurse practitioners are being included because they have so many more nurse practitioners. Nurse practitioners, as the member for Huon said, have a Master's degree. The same would apply in Tasmania: a nurse practitioner in Tasmania has to have a Master's degree. Registered nurses do not; they have a degree. They might have a number of degrees but they do not have a Master's. If they have a Master's, they can then progress to their nurse practitioner status. That involves a high level of training. They have prescribing rights within their scope. If you had a nurse practitioner who had prescribing rights within the scope of voluntary assisted dying then they would potentially be able to prescribe that medication. We do not have them at the moment. To use the story from Canada, as the member for Rumney said, it is very sad but if you look at Tasmania to think it would take 10 days to get another dose of the substance to provide to the patient is nonsensical; even on the west coast it does not take 10 days for the snow to clear.

We need to think about what we are dealing with in Tasmania. We have had our own constraints. We do not have the number of nurse practitioners. They are limited in their scope, often in diabetes education, as the member for Huon referred to, and endocrinology and some other areas. But we do not have the numbers. Registered nurses could be credentialed in different areas but there is still that complication in regard to how they are required to operate when giving intravenous drugs. This is what the AHP is to do. They are to administer the drugs which means giving them an IV injection. There are processes around that, that you have

to abide by. You are going to have another health professional there; maybe, it is another nurse. That is okay but you must have another health professional there anyway, so why would you not just use the medical practitioner and still be there as the nurse to provide the other care that goes on? That is what people are looking for. They are looking for the care of that caring professional, the nurse, who does spend way more time with the patient than the doctor. You ask a woman who labours. Who spends most time with them? That would not be the doctor; it is the midwife, isn't it?

We want to understand that there are differences in the roles. It is important that if you are going to include nurses - and I am not saying we should not; I just think we should not do it now - we should consult more fully with the bodies to make sure we are getting a framework that is appropriate for nurses to participate, that protects those who want to participate - it is a choice but they still need protection when they want to participate - and review this to see if there is a need. If there is no need when we get to the first review, it is one of those things that should definitely be included in that. By then, hopefully, we would have addressed some of these issues with the lack of nurse practitioners and the process around that.

Mr GAFFNEY - Thank you, members, for your information and your input. There have been a few speak so I will try to get around them.

To clarify something from the member for Murchison so that we are aware of the process, once the commissioner authorises PMP to issue the person's prescription, the prescription is issued to the PMP, the pharmacist applies the VAD substance to the PMP, to the doctor, and advises the commissioner. The VAD substance is given to the administering health practitioner by the PMP. The doctor gives it to the AHP and the AHP is to determine the decision-making capacity. Those checks and balances you spoke about, the doctor giving the medication to the AHP, are actually in the process.

The AHP advises a person that they are entitled to receive assistance to die. The AHP provides information to the person about the manner in which the VAD substance is to be administered. As the bill is written, there are three at the bedside. The person can be administered, helped; it can be administered by the AHP, or the AHP can be out of the room so the person can do it themselves.

Referring to a question from member for Windermere, we received information from Mr McMaugh from the pharmacy, who has been assisting us; he was a Victorian doctor. The substance used in the primary practitioner administration protocol are all administered by intravenous route. The substance used by self-administration is a solid dose powder suspended in a liquid vehicle that may be consumed by the oral route as a drink, in what we would say is private self-administration.

If we follow the Victorian model, the private self-administration one would be a Schedule 8 and the one to be administered by the AHP, who could be the PMP or the AHP, whoever is taking that role - it could be the doctor or the nurse - would be a Schedule 4. Correct me if I am wrong, but nurses now can administer Schedule 4s.

Ms Forrest - With intravenous Schedule 4 medication, you have to have another health professional check it before you give it.

Mr GAFFNEY - We have spoken with the AMF, which was involved early on because the AMF assisted us in changing clause 115(3) in the bill to include a representative of the registered nurses' body to help out with the module. Where the Victorian act has only the doctors involved - they only have the medical practitioners on that training module - our modules have a much more holistic approach.

Interestingly enough, we talk about innovation; Western Australia does start its legislation until the middle of next year - it has the nurse practitioners involved because Western Australia can see that it needed that to be able to cover the expanse and that would be helpful.

Ms Forrest - They have plenty of them.

Mr GAFFNEY - Yes, and we do not have that many, so therefore can our registered nurses undertake training to be able to facilitate administering a Schedule 4 medication and what needs to be changed? That is the role of the commission.

The commission has the capacity to do that. It may be a four-hour module in Victoria because it is doctors with doctors. That is not to say that is the training package that would be undertaken here. That would be up to the commission to make certain for all the elements. In our training package, the Guardianship and Administration Board and the Chief Psychiatrist are involved in the module, so it might be more extensive than the four-hour one, and I agree with that.

I am certain what the commission put in place will not allow any of our health professionals to act under any regulations that would put them at risk at all. Member for Rumney, I believe this is about the person - medical practitioners and nurses have a role, but this is about the person. What is the best way? Having nurses involved is a good way.

It was interesting that the member for Huon said this was not a place for innovation in legislation, yet earlier in this very bill, your innovative look at telehealth that was defeated was not what Victoria had. I do not want to verbal the member; please tell me if I have something wrong.

Dr Seidel - The legislation has been in place since 2009 and state's has been in place since 2012. There is no difference so there is no innovation. We use an accepted form that has been done and dusted over again, only a in slightly different area of health.

Mr GAFFNEY - I suppose the Victorian bill would have that same conversation. They do not have telehealth within Victoria.

Dr Seidel - No, because it is considered suicide and you are forbidden to use a carrier service, so that is the Victorian context. It is a completely different situation in Victoria.

Mr GAFFNEY - In this situation, we have a chance. We do not have enough nurse practitioners in this state, as has been identified. We do have registered nurses and those registered nurses have said to me, and said to some of you, that they are well capable and have the qualifications and yes, they will undertake training. That is what they do. They undertake training to upskill themselves to deal with the legislation.

It makes no sense to me. It is nonsensical to have a whole raft of capable, qualified people over here who can be the AHP and yet we are saying things like 'We are worried about this, we are worried about that.'. That is what the commission is for. Somehow into the whole mix, matters such insurance, costs, training and who is going to pay for it, and all those sorts of things are raised. Those things have not come into the bill at all and will come up in the regulations, because I have been able to go into those areas because those are government matters.

This is an important issue for our state. I know there will be nurses out there who will be infuriated they will not be able to undertake a piece of medical know-how they have trained for and if they want to do it, they can do further training to be involved with. It is wrong that in this place we are denying them that opportunity. If none of the nurses like the training and none of the nurses think they are qualified to do it and do not want to be involved, they do not have to be involved. In two or three years time, we will upgrade the training modules, and we do it again. Why don't we do it that way instead of putting the brakes on already and not allowing our nurses to do what they are capable of?

Mr DEAN - There has been much discussion in relation to this matter. There is a fine line here between the two positions. This is simply where a person's PMP is giving advice that they do not intend to be the person's AHP. The commission is then required, I understand, to identify a suitable medical practitioner as the bill is now written, or a registered nurse to fulfil that position. Would the PMP identify somebody to the commission? Or a medical practitioner? Or does the commission simply hunt around until they find somebody who is suitable for administering this product to this particular patient? I am not quite sure how that would happen.

Mr Gaffney - There is a process where a CMP can become the PMP if that is so desired. If the PMP for any reason cannot fulfil the AHP role because of illness or whatever, the commissioner has a list of people who have those qualifications, have done the training and are willing to be involved.

Mr DEAN - They will identify somebody from that list.

The member for Murchison would know more about this than I would, but the product would be there somewhere within the home or the hospital or wherever this is to occur. I am not quite sure whether the medical practitioner, if this amendment is supported, would be saying to the nurse or nurses who would be there, 'Go and get the product for me, please' and then watch the nurse or ask the nurse if it was being ingested as a fluid to put it into a receptacle or into a container for the person to ingest it. I guess the doctor then just picks that up and hands that to the patient. Or could the nurse, if this amendment gets up, hand it to the person where it is ingested as a fluid form? I do not know if you are following what I am saying.

That is why I come back to the position of administer. What is the definition of administer? What is to administer? You might say 'to administer is to give it to somebody'. I would suspect that technical and legal meaning of administer here would be to prepare it as well. That would qualify and would constitute administer. If I was to prepare it, get the product and put it into a glass ready for administering and the doctor takes it from me and provides it to the patient, then I am also administering, I would think, in that circumstance.

Ms Forrest - You are preparing it.

Mr DEAN - I am preparing it. I suspect preparing it would be to administer. That is why I looked in the bill for a definition of administer and there is none. If there is, I have missed it, or whether they would go to some other legal understanding of what 'to administer' is.

I am not going to go back over what has been said. I am not going to be repetitive at all. I am just not convinced at this stage that I should be supporting the amendment.

Madam CHAIR - The question is that the amendment be agreed to.

The Committee divided -

AYES 6	**NOES 8**
Ms Forrest	Ms Armitage
Ms Howlett	Mr Dean
Ms Lovell (Teller)	Mr Gaffney
Dr Seidel	Mrs Hiscutt
Ms Siejka	Ms Palmer (Teller)
Mr Willie	Ms Rattray
	Mr Valentine
	Ms Webb

Amendment negatived.

Ms LOVELL - Madam Acting Chair, I move -

Fourth amendment

After clause 60(2) -

Insert the following subsection:

(2A) A person may not be appointed under subsection (2) to become a person's AHP if the person is -

(a) a member of the family of the person's PMP or CMP; or

(b) employed by, contracted directly or indirectly by, or working under the supervision of, the person's PMP or CMP; or

(c) the employer of, has a direct or indirect contract with, or is a supervisor of, the person's PMP or CMP.

This is about preserving the independence of the practitioners in the various roles within the bill, and is the same principle as the amendment we moved to an earlier clause around the PMP and CMP. It comes back to that power dynamic relationship.

Mr GAFFNEY - I thank the member for Rumney for supporting this amendment.

Amendment agreed to.

Clause 60, as amended, agreed to.

Clause 61 -
Requirements for appointment of AHP

Ms LOVELL - Madam Deputy Chair, I move that clause 61(1) be amended by -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Amendment agreed to.

Ms LOVELL - For members' information, I will not be moving the rest of the amendment to this clause in light of the decision of the Chamber on the previous amendment.

Ms FORREST - Madam Deputy Chair, I move that clause 60(1)(b)(iii) be amended by -

Leave out 'receive a financial benefit as a result of the death of the person'.

Insert instead 'directly or indirectly benefit from, or receive a financial benefit, directly or indirectly, as a result of, the death of the person, other than by receiving reasonable fees for the provision of services as the PMP, CMP or AHP of the person'.

This amendment is to ensure those health professionals who are working within this framework can be paid their normal fee.

Mr GAFFNEY - I thank the member for Murchison. I am in total agreement with this amendment, thank you.

Amendment agreed to.

Mr DEAN - A small typo in 2A on page 75 needs to be fixed.

2A. A medical practitioner has the relevant experience as a practitioner at -

Clause 61, as amended, agreed to.

Clause 62 -
Person entitled to refuse to be appointed AHP

Ms LOVELL - Madam Chair, a point of clarification. I will not be moving these amendments. I have not had a chance to flick through and check if there are any further. Do I need to stand and notify members that I will not be moving amendments or do I not move them?

Madam CHAIR - When the call is made, do not get up if you do not intend to proceed.

Clause 62 agreed to.

Clause 63 -
PMP to be notified by appointment of AHP

Ms LOVELL - Madam Chair, I move that clause 63 be amended by -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Amendment agreed to.

Clause 63, as amended, agreed to.

Clause 64 -
PMP may request Commissioner to issue VAD substance authorisation

Ms LOVELL - Madam Chair, I move that clause 64(1) be amended by -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Amendment agreed to.

Clause 64, as amended, agreed to.

Clause 65 -
Commissioner may issue or refuse to issue VAD substance authorisation

Ms LOVELL - Madam Chair, I move the following amendments to this clause -

First amendment

Clause 65(1) -

Leave out 'Commissioner' (twice occurring).

Insert instead 'Commission'.

Second amendment

Clause 65(2) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Amendments agreed to.

Mrs HISCUTT - A question on clause 65(2) -

> A VAD substance authorisation in relation to a person is an instrument in writing …

Not being a doctor, an instrument in writing, is that the prescription, or is that an authorisation for the PMP to write the prescription?

Mr GAFFNEY - It is an authorisation. In 1968 that is when they allocated the prescription.

Clause 65, as amended, agreed to.

Clause 66 -
Refusal to issue VAD substance authorisation

Ms LOVELL - Madam Chair, I move the following amendments -

First amendment

Clause 66(1) -

Leave out 'Commissioner' (twice occurring).

Insert instead 'Commission'.

Second amendment

Clause 66(1)(a) -

Leave out 'Commissioner' (twice occurring).

Insert instead 'Commission'.

Third amendment

Clause 66(1)(a) -

Leave out 'Commissioner' (twice occurring).

Insert instead 'Commission'.

Fourth amendment

Clause 66(2) -

Leave out 'Commissioner' (twice occurring).

Insert instead 'Commission'.

Amendments agreed to.

Clause 66, as amended, agreed to.

Clause 67 -
Amendment or revocation of VAD substance authorisation

Ms LOVELL - Madam Chair, I move the following amendments -

First amendment

Clause 67(1) -

Leave out 'Commissioner' (twice occurring).

Insert instead 'Commission'.

Second amendment

Clause 67(2) -

Leave out 'Commissioner's' (twice occurring).

Insert instead 'Commission's'.

Mr DEAN - Madam Chair, where the commission is to sign these documents, will it simply be signed by the chair of the commission? Who would actually sign? Obviously, not signatures required from all of the members of the commission, so what will that entail?

Ms LOVELL - Member for Windermere, which amendment, so I can find my place in the bill?

Mr DEAN - I could have asked this many times. It is here: The Commissioner may, by notice to a person's PMP . The commission. Will that notice to the person's PMP be signed by the commissioner or is it expected all the signatures of the commission members be attached to it?

Ms LOVELL - I expect that would be signed by the executive commissioner or if there was an acting commissioner or deputy commissioner at the time, that would be determined by the commission.

Mr Dean - Other people have asked me so I am asking.

Amendments agreed to.

Mrs HISCUTT - When you talk about an amendment or a revocation, could you give me a couple of examples of why that would happen? Would the patient have changed their mind or what examples where revocation could happen?

Mr GAFFNEY - If the person no longer wanted to be involved or something happened, the PMP would be notified.

Mrs HISCUTT - Or if they died?

Mr GAFFNEY - Yes.

Clause 67, as amended, be agreed to.

Clause 68 agreed to.

Clause 69 -
What pharmacist may do on receiving VAD substance prescription

Ms LOVELL - Madam Chair, I move that clause 69(4)(b) be amended as follows -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Amendment agreed to.

Clause 69, as amended, agreed to.

Clause 70 -
PMP to destroy VAD substance in certain circumstances.

Ms LOVELL - Madam Chair, I move that clause 70 be amended as follows -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Amendment agreed to.

Clause 70, as amended, agreed to.

Clause 71 -
Duties of PMP when VD substance supplied to PMP

Ms FORREST - Madam Deputy Chair, I move that clause 71(2)(e) be amended as follows -

Leave out the paragraph.

Insert instead the following paragraph:

(e) the PMP has, under section 75(3), returned the substance to the pharmacist who supplied it to the PMP.

A series of amendments will follow this amendment, and the purpose of this amendment is following on from consultation with a range of health professionals in terms of accounting for unused substance. This will be the self-administration substance that can be kept at the person's home for a period of time. The person may die of their illness or some other event prior to actually taking medication - that is the most likely time you would have unused substance. It is unlikely they would not take the whole lot and there be some left; that could occur on a rare occasion. This is predominantly where a person has it, but does not actually use it and dies from other means.

This amendment will provide for the complete traceability of this substance. It is obviously a lethal substance - that is its purpose and its intent - and it is much better, in my view and the view of many health professionals who are struggling with this, including pharmacists, that it be returned to the pharmacist so there can be a full accountability.

It is not a return to the doctor who prescribed it who will dispose of it and there is no complete record of it. The doctor prescribes; the pharmacist dispenses. So it comes from the pharmacist to the person who is going to take it. If the person does not take it, it should be returned to the pharmacist so there can be full accountability and full tracing.

That is the purpose of this amendment and several others. I will only speak broadly on this one here because that gives effect to this policy intent.

Mr GAFFNEY - For expediency, I might provide information for amendments 71, 73, 74 and 75, which is this gambit of what has been raised by the member for Murchison. That will make it easier instead of getting up and down all the time.

I believe the suggested amendments are very important, but I received advice that while they could strengthen regulation, they may in fact stifle the system if added to the legislation. I would like to present the case for that. I will not be supporting any of these amendments. However, I will provide the following information for members to reflect on.

I can remember being at one of the information forums I presented at Riverside in February, and I was asked a question from a retired doctor, 'What substance will you be utilising to undertake this deed?' I got the impression that perhaps the doctor was not in favour. I responded with -

> I actually have no idea. For the purpose of legislation I do not need to know as I will be referring to the substance as a VAD substance. No doubt whatever they have chosen in Victoria and WA will perhaps assist the commission in making a decision regarding the actual substance to be used in Tasmania.

I do not believe, however, that the doctor was very impressed with that and felt that I should have been able to have a fully charged debate about the actuality of the substance and the security of the substance.

I was however supported by another doctor at the event who said -

> It does not need to be debated here at a public forum. Besides I see a couple of vets in the audience here who could also contribute to the discussion about security of poisons and substances they utilise.

It should also be noted for listeners that as was explained by the Office of Parliamentary Counsel, the VAD substance can comprise a number of substances which all may be part of the VAD substance and process.

I also believe it is important for people listening to put on the record some of the information provided to all members from Mr Jarrod McMaugh. Mr McMaugh is a pharmacist with 20 years experience in community practice, including 10 years in workforce development and both elected representation and subsequent employment with the Pharmaceutical Society of Australia. In January 2018, he was invited by the Victorian Department of Health and Human Services to participate in the Voluntary Assisted Dying Implementation task force where he sat on a number of subcommittees, including as chair of the medication protocol subcommittee. As you can see, Mr McMaugh is well qualified to provide comment on the pharmaceutical processes and any suggested amendments. He says -

> The medication protocol subcommittee was responsible for commissioning literature reviews for the substances most fitting for the role in the Victorian voluntary assisted dying process based on legal aspects, suitability of the substance for the purpose for which it will be used, and evidence of use from other jurisdictions. The medication protocol subcommittee also commissioned the development of the medication protocols that are used in the Victorian voluntary assisted dying process including self-administered VAD substance and practitioner-administered VAD substance protocols.

I believe this also helps the member for Windermere with his earlier questions -

> The substances that have been selected in Victoria are Schedule 8 poisons for self-administration and Schedule 4 poisons for practitioner administration. The scheduling if these medicines is determined on the level of control that has been necessary by the Therapeutic Goods Administration. The scheduling of each substance used in the Victorian VAD system has been in place for a significant period of time prior to the introduction of VAD. The scheduling of each medicine is not based on the use of the medicines in the VAD process, nor is the selection of these substances for each protocol based on their schedules. The scheduling of these substances is unrelated to their use in the Victorian VAD process and is not determined by their route of administration.

The Poison Standard is a legislative instrument for the purposes of the Legislative Instruments Act 2003. The poison standard consists of decisions regarding the classification of medicines and poisons into schedules for inclusion in the relevant legislation of the states and territories. It includes model provisions about containers and labels, and recommendations about other controls on medicines and chemicals.

The labelling and storage requirements of the voluntary assisted substance in the Victorian act are in the regulations for forms 5 and 6.

The principles of scheduling - schedules 1 to 10, but I will just do Schedule 4 and Schedule 8. Poisons are not scheduled on the basis of a universal scale of toxicity, although toxicity is one of the factors considered and is in itself a complex of factors. The decision to include a substance in a particular schedule also takes into account many other criteria such as the purpose of use, the potential for abuse, safety in use and the need for the substance. For example, Schedule 4 is prescription-only medicine, substances the use or supply of which should be by or on the order permitted by state or territory legislation to prescribe and should be available from a pharmacist on prescription.

Schedule 8 is a controlled drug - substances which should be available for use but require restriction of manufacture, supply, distribution, possession and use to reduce abuse, misuse and physical or psychological dependence.

Mr McMaugh wrote -

> the selection of each substance and protocol, self-administration or practitioner administration was determined during the regulatory development phase in Victoria.

It is recommended that the Tasmanian process replicate this approach for several reasons -

(1) Naming the substances in legislation makes the specifics of each substance a matter of public record. It is not necessary for this information to be generally known unless a person is accessing VAD. Limiting the availability of this information goes some way to protecting the privacy of individuals who access voluntary assisted dying as the specifics of the medicine used remains private. It also limits the potential for a person to attempt to access these medicines outside of the VAD process.

(2) Naming the substances in legislation limits the flexibility of Tasmania's Department of Health and Human Services to respond to any supply issues that may arise. If the substances are named in legislation and there is any subsequent unforeseen disruption in supply it will require an act of parliament to allow a second-line substance to be used. Similarly, if a new substance were to emerge that was considered to be more suitable to the role, it would also require an act of parliament to allow for this substance to be used. In both scenarios there would be a delay that may lead to an individual being unable to access the gold standard of treatment.

He says -

> The regulatory process is rigorous in determining the most suitable structure, controls and specific substances for the delivery of the VAD service, while allowing enough flexibility for the Tasmanian Department of Health and Human Services or the Health Minister to respond to emerging issues in a timely manner that best serves the Tasmanian people.
>
> The nature and scheduling of the VAD substances is not unique. As with all other scheduled medicines, a health professional may have these substances

.in their possession when their role requires them to be in possession of the scheduled substance for the performance of that role.

Ms FORREST - My amendment relates simply to the return of a substance to the pharmacist. It has nothing to do with scheduling. This is about returning an unused portion of the substance to the pharmacists who dispensed it. I think this is completely off the track of the amendment.

Madam Deputy Chair - I have also looked and it is not relating to any of the subsequent amendments the member indicated he would be speaking to. I would confine your comments back to the member's amendment, which has nothing to do with naming up the drug.

Mr GAFFNEY - Okay. I will go straight to the chase then if that is helpful -

> Dear Mr Gaffney, thank you for seeking comment from a Tasmanian pharmacist's perspective on the amendments proposed to the voluntary assisted dying legislation.
>
> By way of background, I have a PhD in pharmacy practice. I own three pharmacies here in Tasmania, in Lindisfarne, South Arm and Nubeena. I work regularly with older people in aged care and I have been a former state president and national president of the Pharmaceutical Society of Australia, the peak body for pharmacists in Australia.
>
> I believe that I am qualified to provide feedback and advice on this legislation as it pertains to pharmacists and medicines.

It is only three paragraphs so I will read it because it puts it in context. It from Dr Shane Jackson who spoke with us here recently.

Ms Forrest - I hope it does not confound the issue of returning the substance to the pharmacy if it is not used.

Mr GAFFNEY - Well -

> There should be no need to return any substance used in the VAD process to the pharmacist for destruction when laws and regulations already exist in Tasmania for the handling of scheduled poisons.
>
> There is a secondary reason to avoid legislating for the return of all substances to the dispensing pharmacies. That is, it would create a system where these substances are treated differently under the law based on the reason they were prescribed, rather than any intrinsic factor associated with that substance.
>
> Practitioners will be in a position where they will not be required to return these substances to pharmacists if they were used for most purposes, yet they would be compelled to do so for one specific purpose.

Dr Shane Jackson is saying that the substance, as described by the amendments, should not be returned to the pharmacists; it should go down the prescribed track it already has. This

is backed up by ANMF branch secretary Emily Shepherd. The ANMF has previously stated that the legislation should be consistent with current acts and standards by which registered nurses and nurse practitioners abide. This will reduce confusion and ensure consistency and confidence in the process. It is difficult to comment specifically without understanding exactly what the substance will be and therefore what the standard disposal process may be.

I encourage members to vote against the amendments put forward by the member for Murchison.

Ms FORREST - Madam Deputy Chair, that was a lot of information that is completely irrelevant to the purpose of this amendment. I will speak specifically to this amendment.

This substance is not like most other Schedule 8 drugs. The information about scheduling was helpful in terms of understanding that, but I think we all have a duty to understand it when we are dealing with this legislation. There is a requirement, even though people do not always comply with it, to return Schedule 8 drugs to the pharmacy. That is the expectation because they are drugs of addiction - they are dangerous drugs, they are controlled substances, and the member for Mersey read out the reasons why they are controlled. It is not necessarily related to their toxicity as such; it is around their safety and use and a range of other measures the member spoke about.

Mrs Hiscutt - Are you saying there is already a process around the disposal of unused drugs?

Ms FORREST - If you have Schedule-prescribed drugs, and you no longer need them, you are supposed to return them.

Mrs Hiscutt - So there is a process around -

Ms FORREST - Yes, you are supposed to do that; people often do not return them and some of them end up on the black market. You can buy a bit of Endone anywhere you like if you know which person will have it.

Mrs Hiscutt - But there is a process around that.

Ms FORREST - Yes, but that does not mean people necessarily comply with it, but that is the expectation. We are talking here about a Schedule 8 drug that is a self-administration drug. If we go down the path of Victoria and it is an Schedule 8 drug, that is the expectation. This is a drug designed to kill someone - that is its purpose. Rather than having it sitting around and then returned to a doctor - and I do not disagree, that is a reasonable process in these circumstances - it then has to be disposed of. We have still nurses in now, and if a nurse is the APH, we have to give it back to the PMP because they cannot dispose of it without having someone else check it. They still have to go back to the doctor anyway, and it actually enables a complete circuit, so it also gives some data about how many people are signing up for VAD self-administration, having a prescription provided for them to have at home, to use when it is appropriate for them - they die or decide not to take it - and it is then returned.

There is no way of tracking it otherwise, not that you necessarily have to track it but you do not want the risk of this stuff sitting around and being tipped down sinks and things like that without some sort of record. This is simply to provide for a mechanism that is required for that

substance. Most of the time I expect it would be used. Why would you go through the process if you do not intend to use it, generally? But there may be some people who do not and then that should be returned.

I have talked about the issues with nurses. The Schedule 8 drugs have special requirements above and beyond all other scheduled medications. You cannot just keep them in a pharmacy on a shelf; they have to be locked up and signed out by two people. In a hospital, they have to be in a double-locked cupboard. You have to have special keys for it that only the registered nurse can hold.

Mr Valentine - The same with destruction?

Ms FORREST - Yes, it has to be signed off by two people and recorded back in the dangerous drugs register. I do not know if it is still called that. When you took a drug out of the DD cupboard, two people signed it out. If you smash the ampule accidentally as you are drawing it up, you have to sign for that and then get another one out and two people have to witness that.

If, for some reason you got to bedside and the patient was dead, you would not give it, obviously, and you would have to go back and squirt it down the sink and sign for it, both of you. There are really strict processes around S8 drugs and that is what we are talking about here. We are not talking about the S4 drugs you give intravenously, even though they are designed to kill a person, but you do require more than one at a time and for the health professional then to administer it intravenously.

The issue will be a delay to access to a suitable substance, because this does nothing to describe, indicate or direct the nature of the product that can be used. If newer drugs become available, that will be something determined along with the regulatory process. This does nothing. It talks about returning a substance for a complete tracing of the product. If it is taken, it is taken; if it is not, it is returned to the pharmacy and that is what is expected.

The comments from ANMF were not saying that they did not support this amendment, but the fact that there are special requirements for nurses to dispose of S8 drugs. I cannot get an S8 drug and then toss it down the sink on my own without getting it checked. That is the legal requirement, that is the Poisons Act. If you do not do it right and get caught out, you could lose your registration. There are specific requirements around these drugs for good reasons.

This is simply about asking if there is an unused portion or unused bad substance, it is returned to the pharmacy, it can be recorded and disposed of by the pharmacist who does those sorts of things all the time.

Mrs HISCUTT - The member for Murchison's main concerns seem to be the poisonous drug that is still left within the community.

Ms Forrest - And the traceability and the recording of it.

Mrs HISCUTT - I am thinking of children - dishwashing liquid, cleaning fluids, bleaches, disinfectants - they are already there but if children get hold of them, it will create a

lot of damage to them. That sort of stuff is already out there in our community. I will not touch on farming chemicals so much, but they are fairly destructive.

Ms Forrest - You have an obligation to keep them safe, too.

Mrs HISCUTT - You have an obligation with chemicals, but you do not have to return them back to the manufacturer. You can put them in your shed and with dishwashing liquid, on the top shelf, that sort of stuff. You can lock them up; there is a process for it.

There already appears to be a process in place for these drugs, medically speaking, not farm chemical speaking, so I feel comfortable that the processes are in place, in light of all the other things you are talking about. I will not support this amendment. There are many I will, but not this one.

Ms WEBB - I am clarifying the piece we are looking at in clause 71(2)(e) relates to the PMP. This relates to the PMP, who is a medical practitioner. We are not about the AHP, we are not talking about potentially we are talking about a nurse, a PMP, the medical practitioner. The bill currently requires the PMP destroys the substance in accordance with 75(3) which again is also related to the PMP.

To me, that is requiring the medical practitioner, who we have had the confidence in to undertake this whole process and recognised for their qualifications to do so, treats this substance appropriately and destroys it appropriately. It does not seem like a stretch to me to ask a medical practitioner to be responsible for doing that. The member for Murchison talked about returning things to the pharmacy in other circumstances. I am not sure if it is only nurses who are required to do that or is it the medical practitioners?

Ms Forrest - No, that person is the patient.

Ms WEBB - This particular amendment is talking about the duties of the PMP, talking about what the PMP has to do.

Ms Forrest - Or the AHP.

Ms WEBB - No, this is about the PMP, if you read it -

> (e) The substance has been destroyed by the PMP in accordance with section 75 -

and section 75 is also about, under the heading, 'Duties of PMP'.

To clarify, there might be other parts where you have a similar amendment that relates to actions that are the responsibility of the AHP, but this particular one is about the duties of the PMP. I am comfortable there is an appropriate level of responsibility we are already expecting of a PMP, a medical practitioner, in this process, to undertake that destruction. If I am mistaken, I would appreciate clarification.

Mr GAFFNEY - Madam Deputy Chair, I think I said at the beginning that I would put my speaks together for proposed sections 71, 73, 74, 75, to give some background.

In respect of this being in legislation, I was informed by Mr McMaugh -

> It should be noted that in Victoria, there is a climate where all of the VAD substances are returned to the central pharmacy department for destruction, but that is not in legislation, it is in their regulation.

Ms Forrest - We do not have that; we have a different legislative framework in the legislation where you have disposal.

Mr GAFFNEY - But that is in part of regulation, which they will be involved with. Again -

> It should be noted that destruction of the VAD substance will already be subject to Division 10, section 34 of the Tasmanian Poisons Regulations. That is that you cannot just destroy an S8 medicine without cause and if you do you need to have a witness who is a health practitioner.

Throughout the bill, Mr McMaugh who looked at this with Dr Jackson from Tasmanian pharmacists, felt the amendments would be, and could be, addressed in regulations - they were not necessary in the legislation. They would actually say that it would stifle it. I am trying to say that other information is there that would help people understand, and I will just put in one -

> The nature and scheduling of the VAD substance is not unique as with all other scheduled medicines. A health professional may have these substances in their possession.
>
> As an example, a pharmacist, registered nurse, nurse practitioner or medical practitioner is able to have in their possession any Schedule 4, Schedule 8 medicine -

There are already regulations and rules about what they must do if they are going to return or dispose of those medicines, if there is another nurse person with them. The VAD substance should not be treated any differently than would be required under the act to which they are already working.

We all know, as the member for Montgomery pointed out, there are a number of chemicals and substances out there, and we want to make certain that the legislation is not compounding the issue for people working with those medications. If there needs to be something specific, that can be handled in the regulatory phase where they can talk about that with the associated bodies.

I encourage members not to support the amendments.

Ms FORREST - If that is the case, this should say, 'In accordance with the Poisons Act requirements' because what we are doing here is legislating a process that is different. In Victoria, the substance goes to the doctor who returns it to the pharmacist, in accordance with regulation. Here, we have a piece of legislation stating that a doctor will destroy it. The PMP will destroy it; the doctor will destroy it. You cannot return it to the pharmacist once it is destroyed. 'Destroyed' means 'tip it down the drain'. You cannot return it to the pharmacy, if you were basing it on the Victorian model, if it has been destroyed.

There are provisions in the bill for the substance to be kept in a secure, locked place, where only certain people have access to the key - like the dangerous drug cupboard in a hospital ward. However, now this puts in place a process that says the doctor must destroy it.

Why would we go down a path of legislating this and not putting it in the regulations? You are arguing against your own contention here, because you are saying we should not be describing this in the legislation, we should be putting it in the regulations - which is why the Victorians do it in the regulations and require that the substance is returned to the central pharmacy.

You cannot put that in regulations if you have a principal act that says the doctor has to destroy it. It is contrary, it is in conflict if you are suggesting it should be returned for complete traceability, if it is going to be destroyed. You cannot have it both ways. You cannot have something in the act to tell you that you have to do one thing, and then expect the regulation to say something else.

If you were serious about applying one regime and not having any duplication or any different method, you would have it complying with the Poisons Act. Complying with the Poisons Act provides a tried and true method that people know. There is a process for recording. As the member for Mersey read out, if it is a Schedule 8 drug it has to be accounted for, it has to be signed by two people. There is the traceability - it has to be recorded. With this, it simply gets taken back to the doctor and shot down the drain.

Mrs Hiscutt - That is recorded, though.

Ms FORREST - It is creating a different regime than in the Poisons Act.

Mrs Hiscutt - But it is recorded, though. It records destruction.

Ms FORREST - Where does it say that?

Mrs Hiscutt - That is what the PMP is doing.

Ms FORREST - If you are going to go by the Poisons Act, name up the Poisons Act.

Ms Webb - They have to notify the commissioner. There is a record of it because now the commission has to be notified of the destruction as part of this process. I am looking at clause 75.

Ms FORREST - What other drug do you have to do that with? If you are having a consistent approach, what other drug do you do that with?

Ms Webb - It is a way of recording. I am just pointing out.

Ms FORREST - You are creating by this a different approach to treating a drug in a specific way. It is legislated here. It is not regulations. It is legislated. If you want to argue the point in not supporting this amendment why are you putting in another process that is not necessarily consistent with the Poisons Act? Or is it consistent with the Poisons Act? Do we know? This is the problem.

The Victorian model is you return it to the pharmacist. There are different views on all of this. There were different views on every aspect of this bill. There were consistent views from medical practitioners that it should be returned to the pharmacist. There are drugs you are supposed to return yourself if you do not use them. Does anyone have any S8s in their cupboard they are not currently using? Give them back to the pharmacy if you have. That is the expectation. Do not keep them for a rainy day, or sell them. That is what people do - stockpile them and then sell them. That is one of the reasons why we have such strict requirements around these drugs because of the potential for misuse. You are not going to have these misused in the same way as some of the opioids are.

Regardless, we are creating a separate process. This is one of the things that was raised by the department: a process that is separate and almost parallel to the Poisons Act. Why not just apply the Poisons Act? Why legislate for something in addition to that and create confusion. That was the very point that was raised in the briefings.

I have used up my three calls. I believe the outcome is if you want to see it returned to the pharmacists, as occurs in Victoria, then you support this.

Mr GAFFNEY - The PMP must destroy, and obviously the destruction by doctors will be consistent with the Poisons Act of division 10, section 34 of the Tasmanian Poison Regulations 2008.

We did recognise that there could be some conflict within the acts. Clause 138 of the bill from OPC, relates to conflict of acts -

> If there is an inconsistency between a provision of this act and a provision of the Poisons Act 1971, or the Misuse of Drugs Act 2001, the provision of this act prevails to the extent of the inconsistency.

Ms Forrest - Why create an inconsistency?

Mr GAFFNEY - I have been informed by Victoria that there could be a situation where the supplier of the substance as used in the Schedule 8 insists that there is only one point of call and that the drug must be returned to that pharmacist. That will come through the regulations period, not through this section.

All I can say is the information I have received from Mr McMaugh, who is heavily involved with the Victorian legislation and regulations and pharmaceutical side, and from Dr Shane Jackson have both said that while the amendments have some validity, they should not be put into legislation, but into the regulation framework which will be the device of the commission.

Mr VALENTINE - I am inclined to agree with the member for Murchison in the sense we have nurses involved now as a result of the amendment not passing. It is really important it can be traced; we are talking about a product that can kill a person. You can align it to other chemicals and things on farms or wherever, but the eyes of the world are on this and it is important we are seen to close that loop. It is a simple thing for me - it is about closing the loop.

A doctor cannot be called into question about whether they put it aside for use by someone else at a later date or whatever. I know their integrity would not let them do that, but if somebody were of a mind, that is a possibility. If it is recorded and goes back to the pharmacy and is signed off as being destroyed, there is no question there. From that perspective, this being the bill it is, it is important that loop is closed, so I agree with the member for Murchison in this case.

Dr SEIDEL - I also agree with the amendment from the member for Murchison. We need to reduce the availability of drugs in the first place, in particular Class A drugs. It is always interesting that we put lots of restriction on the prescribing side, but once they are not being used, they seem to be freely available. This is certainly an issue in Tasmania. The argument 'Just flush it down the drain' is not a good idea because we actually monitor our septic system for drug use. Although strictly speaking it may not be necessary to return that particular drug to a pharmacy because we do not use other toxic substances we are returning, we should make the point because it is different. It is a VAD substance so we want a closer loop, absolutely right.

There is no harm done by being specific, there is no harm done by putting it into legislation as outlined by the member for Murchison, and therefore I support the member for Murchison's amendment.

Mr DEAN - I am not sure I can support the amendment. This amendment is about - and the member for Murchison will correct me if I am wrong - putting in place a system where this product, if it is not used or if there is any left over, will be returned to the pharmacy from where it was provided as a way of ensuring that it has been accounted for. I was given medication by a doctor and I did not want or need the medication so I took it back - I was told to leave the office because they will not, under any circumstances, take back any medication of any sort once it has been provided to you.

Ms Forrest - The doctor or pharmacist?

Mr DEAN - This was the doctor.

Ms Forrest - The doctor does not want it back.

Mr DEAN - Also pharmacies do not want to take medication back, because they said to me that they cannot be assured that what they are getting back has not been contaminated or interfered with in some way.

Ms FORREST - That is not true because they take it back and dispose of it - they do not reissue it.

Mr DEAN - Who is to say this medication was taken back to the pharmacy from which it was issued in the first place? Unless it was in a specifically sealed airtight container but then -

Mrs Hiscutt - It would not be reissued though.

Mr DEAN - It could not be reissued; you are right. This is about the doctor. The member for Nelson is right - this is the PMP, not the nurse, it is the doctor. If we cannot have faith and

trust in our doctors to dispose of this product in the way it should be disposed of, who else can we trust? We certainly cannot trust ourselves here. We are about three rungs below the bottom status ladder, whereas the member for Huon was on the top rung, and he is now about two rungs below.

If we cannot accept the position of the doctor in the circumstances, I do not think it would be any stronger position to have the doctor take it back and return it to the pharmacy from whence it came. That does not really add anything to it, to be frank.

Ms Forrest - That is what happens in Victoria.

Mr DEAN - It may well happen in Victoria. I am not sure whether other members are able to produce some further information, but I am not convinced at this stage I can support the amendment.

Mr GAFFNEY - If you have registered help for practitioners, they have to abide by the law and whatever the disposal protocols already are. A PMP, a doctor, is already working under the correct protocols to get rid of the substance and if there is already a process in place, why would you propose an amendment to send it to the pharmacist when there is already a proposal in place under the act that says they can dispose of it already as an S8?

The destruction of the VAD substance will already be subject to Division 10, section 34 of the Tasmanian Poisons Regulations 2008. There is no need for this. It is not going to impact on the bill itself; it makes it a little more confusing with what they are already operating under for dispatch.

The advice I have been given from Dr Shane Jackson, whom we have met, and Mr McMaugh is that the amendments are not necessary. I urge and encourage members not to go down this path.

Ms ARMITAGE - I will support the member for Murchison. I see no problem with this amendment, and it was very well outlined by the member for Hobart. I am surprised with the member for Windermere. No-one is casting any aspersions on the medical practitioners, and I would assume any pharmacy, unless you are actually seeking a refund, would take back drugs to destroy. It is what they do and they tell you time and again, if you have any drugs in your cupboard, to deliver those drugs to them and they will take them back. It was well described by the member for Hobart. I will support the amendment.

Mr GAFFNEY - At the end of the day, it is not going to make a huge impact on the bill and I understand that. If it is in regulations, there is a bit more flexibility with it and it can be addressed. If it is in the legislation, when the review of the act comes up in three or five years time, they can look at it then too, so either way it is not necessary. That is the advice I have been given from people who operate in that area, both in Victoria where the legislation is and from our own Dr Shane Jackson.

That is the best I can put on the Table. I encourage members to vote against the amendment because I have taken the advice from those people who work in that area who say these amendments are not necessary.

Madam DEPUTY CHAIR - The question is that the amendment be agreed to,

The Committee divided -

AYES 10	NOES 4
Ms Armitage	Mr Dean (Teller)
Ms Forrest	Mr Gaffney
Ms Howlett	Mrs Hiscutt
Ms Lovell	Ms Webb
Ms Palmer	
Ms Rattray	
Dr Seidel	
Ms Siejka	
Mr Valentine	
Mr Willie (Teller)	

Amendment agreed to.

Clause 71, as amended, agreed to.

Clause 72 agreed to.

Clause 73 -
Duties of AHP when VAD substance supplied to AHP by PMP

Ms FORREST - Madam Deputy Chair, I move that clause 73(2)(e) be amended by -

Leave out the paragraph.

Insert instead the following paragraph:

(e) the AHP has, under section 74(3), returned the substance to the pharmacist who supplied it to the PMP.

Amendment agreed to.

Clause 73, as amended, agreed to.

Clause 74 -
Duties of AHP in relation to VAD substance when VAD substance no longer required.

Ms FORREST - Madam Deputy Chair, I move that clause 74(3)(a) be amended as follows -

First amendment

Leave out 'person's PMP or is destroyed'.

Insert instead 'pharmacist who supplied the substance to the person's PMP'.

Amendment agreed to.

Ms LOVELL - Madam Deputy Chair, I move that clause 74(3)(b) be amended as follows -

Second amendment

Leave out 'Commissioner'.

Leave out 'Commission'.

Amendment agreed to.

Ms FORREST - Madam Deputy Chair, I move that clause 74(3)(b) be amended as follows -

Third amendment

Leave out 'person's PMP or destroyed, as the case may be'.

Leave out 'pharmacist who supplied the substance to the person's PMP'.

Fourth amendment

Insert the following subclause:

(4) A pharmacist to whom a VAD substance, supplied by the pharmacist, is returned under subsection (3) must destroy the substance as soon as practicable and record that the substance has been destroyed.

Amendment agreed to.

Clause 74, as amended, agreed to.

Clause 75 -
Duties of PMP in relation to VAD substance when VAD substance no longer required

Ms FORREST - Madam Deputy Chair, I move that clause 75 be amended as follows -

First amendment

Clause 75(2)(c)

Leave out the paragraph.

Second amendment

Clause 75(3)(a)

Leave out 'is destroyed'.

Insert instead 'is returned to the pharmacist who supplied the substance to the PMP'.

Amendments agreed to.

Ms LOVELL - Madam Deputy Chair, I move that clause 75(3)(b) be amended as follows -

Third amendment

Leave out 'Commissioner'.

Leave out 'Commission'.

Amendment agreed to.

Ms FORREST - Madam Deputy Chair, I move that clause 75(3)(b) be amended as follows -

Fourth amendment

Leave out 'the destruction of the VAD substance'.

Insert instead 'the return of the VAD substance to the pharmacist who supplied the substance to the PMP'.

Fifth amendment

After clause 75(3) -

Insert the following subclause:

(4) A pharmacist to whom a VAD substance, supplied by the pharmacist, is returned under subsection (3) must destroy the substance as soon as practicable and record that the substance has been destroyed.

Amendments agreed to.

Clause 75, as amended agreed to.

Clause 76 -
Final determination by AHP of decision-making capacity and voluntariness

Ms FORREST - This is not related to that same matter; this is a separate amendment. I move that clause 76 be amended by -

After 'final permission'.

Leave out all the words

.

Insert instead 'from the person -

(a) must, if the AHP is not a registered nurse or is a registered practitioner, determine whether the person has decision-making capacity and is acting voluntarily; or

(b) if the AHP is a registered nurse who is not a nurse practitioner -

(i) must refer the person to an authorised medical practitioner for the medical practitioner to determine whether the person has decision-making capacity and is acting voluntarily; and

(ii) must determine whether the person has decision-making capacity and is acting voluntarily; and

(iii) may only determine under subparagraph (ii) that the person has decision-making capacity and is acting voluntarily if the medical practitioner is of the same opinion.

I have moved this amendment because with nurses remaining in the bill now it is outside the scope of a registered nurse practice to determine decision-making capacity. Nurse practitioners have that capacity in their scope, but a registered nurse does not. I believe this was raised with all of us with the ANMF; certainly with me and others. This was a concern to them, that it puts them in an awkward position of them being asked to assess someone's decision-making capacity when it falls outside their scope and could create a problem for them. They would actually need to have the PMP or another medical practitioner, or even a nurse practitioner, who has that capacity within their scope to determine that decision-making capacity before they could participate as an AHP. It is a protection for that nurse so there can be no question about whether he or she made an accurate assessment of that person's decision-making capacity because to do so, if it outside their scope, it could put them in a precarious situation.

Mr GAFFNEY - I thank the member for Murchison. I would have thought part of an RN with VAD training, the modules they had is to actually look at this specific aspect, being able to determine a patient's competency with the decision-making process. I think that would be in the training and that the commission would say, okay this is what we need to do to upskill our nurses. It might be that if in any situation they might feel the person is not, they could ask for extra advice. It is similar to an RN having training in other areas, palliative care, acute nursing, et cetera. To me this is about upskilling registered nurses so they can cater for that.

I think nurses generally decide when they are talking with somebody or working with a person or a patient, that they can understand whether the person has decision making capacity.

Ms Forrest - They cannot make diagnoses either and it is outside the scope. It is in the same principle, it is outside the scope.

Mr GAFFNEY - No, it is not asking for a diagnosis. It is saying, is the patient competent to assess the decision-making capacity and are they acting voluntarily. There have been three or four times already that has been done by the PMP or the CMP. Also, the pharmacist would be involved. If there was any concern I would think, as part of the training package, the registered nurse would be informed, look, if you have any concerns, this is what you might do, or this is how to do it, or there are other processes around it.

I am not going to accept the amendment because I believe a registered nurse would be module trained in a whole range of things; they should be able to be competent to decide whether the person has decision-making capacity. I do not think it is necessary. As the chief nurse said in our briefing, nurses are required to do this sort of training constantly and it is a part of what they do. I would not like us to restrict this because, again, we have so few nurse practitioners, very few of them would possibly ever going to be involved in the AHP. I think we had 47 and some of those are not practising anymore, so this is an unnecessary impost.

Ms Forrest - It was requested by the ANMF though.

Mr GAFFNEY - No, not really. We were told the ANMF would be comfortable to work under any legislative framework presented. I do not believe that is correct. The branch secretary, Emily Shepherd, said -

> However, the final permission stage is similar to checking understanding or consent with patients who have surgery. The surgery is discussed with the patient along with risks etc with the surgeon and then the patient signs a consent form, as I understand will occur with the PMP and CMP. Therefore in terms of the final permission stage if a patient was having surgery the RN would present the person with the signed consent form and check it was their signature, that they wished to proceed and could explain themselves what was about to occur.

In that situation the registered nurse is determining the decision-making capacity. I do not believe this amendment is necessary and encourage members to vote against it.

Mrs HISCUTT - I cannot see this amendment is a distraction from the intent of the bill. I can see it may provide a little bit of comfort to RNs, so I do not have any particular issue with your amendment and I am happy to support it.

Dr SEIDEL -I am inclined to not support the amendment for the simple reason that we just resolved health practitioners who are now involved in the VAD process have to undergo compulsory credentialing and training. A very important part of the training is going to be having a new acquired competence that includes the capacity assessment. To then compel the trained-up practitioners to refer them anyway is an extra barrier. Because we resolved that nurses can be involved and they must undergo credentialing and further training, they will be taught a new skill. They will extend their scope of practice because as clearly stated by the ANMF, assessing capacity is not within their current scope of practice, so it is a new skill. That will complicate the training but we resolved what they are going to do. Once they have passed

the training course, it is a new competence and the competence should be applied and it would therefore make the amendment redundant.

I am not inclined to support the amendment.

Mr VALENTINE - I have a question on the wording of the amendment. I am not sure I am going to support it, but I need to ask the question just in case -

> If the AHP is not a registered nurse or is a registered practitioner …

Should that be 'registered health practitioner'? I cannot see a definition for registered practitioner - it is either health or medical. I think it is not complete. I am sorry for not picking that up earlier but I just reread it. I am not inclined to support it anyway.

Mr GAFFNEY - I thank the member for Huon for the points he made there. It was very good.

Going back to the member for Montgomery, if you look at clause 77, it says -

> 77. AHP may refer person to another person, &c.
>
> A person's AHP may, for the purpose of enabling the AHP to determine for the purposes of section 76 the decision-making capacity of the person or whether the person is acting voluntarily, do any one or more of the following …

It says they can refer the person to another medical practitioner for examination; request the person to provide to the AHP all the information. It is already contained within clause 76 where your concerns were on top of the training that was alluded to. I urge members to vote against this amendment.

Mr DEAN - I need to understand a bit more. It relates to the amendment and the other part is to how it will operate. Where it says a person's AHP must within 48 hours before the AHP - then do we leave out? - then, receives a final permission, everything then is left out and then we have got the amendment.

What I am asking is, how will that occur? It has to be 48 hours before any of this occurs, so the person must have given the indication to the AHP they were going to proceed in this way with the administration of the product 48 hours before. I am wondering how that works. A person's AHP must be notified within 48 hours before the AHP receives a final permission; and then we have the amendments.

Madam DEPUTY CHAIR - Is the question to the member who proposed the amendment?

Mr DEAN - I think it is to the mover of the bill about how that will occur. If we look at the clause as it is now before it is amended - the person's AHP must be notified within 48 hours before the AHP receives a final permission from the person. The person must be going to say to the AHP, 'Look, in 48 hours time I am going to give my permission for that product to be administered.'. I am not sure how it is going to work. Maybe the mover of the bill might be

able to explain that to me. It says specifically it must be within 48 hours before the AHP receives a final permission.

Mr GAFFNEY - I understand the intent here is that you do not want the final determination by the AHP of decision-making capacity to happen a week before. It has to happen within the 48-hour period before so it is made at the time they are considering taking the substance. It has to made within a short time frame.

Ms Forrest - They are lucid when they are making that decision.

Mr GAFFNEY - It has to be made within that period of time. You cannot have it too far out, which is why we have made it 48 hours. We think that makes sense.

Ms LOVELL - These are the types of issues I felt could be better resolved by slowing down the process of adding nurses to this role. This is a difficult one for me, having said that - given that was not the will of this place. Now that all the health practitioners, nurses, registered nurses and nurse practitioners will have to undergo the training described by the member for Mersey, and in light of the fact there is the provision for them to refer a concern to another medical practitioner, I am inclined not to support the amendment. I am concerned it adds a barrier that will be complex for people to overcome at this point in the process.

Having said that, I am pleased it is on record that these types of things will be addressed through the training module, and nurses will be involved as well.

Ms FORREST - It is important to clarify this was an amendment I had drafted at the request of the ANMF. It was quite concerned about nurses being required to work outside their scope, because it is nurses we are talking about, not nurse practitioners. I accept the point the member for Mersey has made in clause 77, that there are referral powers, and an APH - who may be a nurse - can refer to another medical practitioner. The way it is worded suggested that is a medical practitioner who is doing the referring. I will read this literally, this is clause 77A(a) 'refer the person to another medical practitioner'. A nurse is not a medical practitioner - it has to be referred to another medical practitioner. In that regard you are more or less saying that this doctor can refer to another doctor because they are another medical practitioner, but a nurse referring to another doctor - you can see the language here is a little confusing.

The power is certainly there to refer to a medical practitioner. It should say 'refer the person to'. If it is the nurse who is acting as the AHP here, the nurse is not a doctor so they cannot refer to 'another doctor'; they refer to 'a doctor'.

My amendment seeks, where a nurse needs more information because it is outside the nurse's scope to assess decision-making capacity - and I accept that the training may well and should -

Dr Seidel - It would have to.

Ms FORREST - Yes, it would. You almost need to be considered a nurse practitioner at that point because you would then be credentialled with an extra set of skills along the lines of a nurse practitioner. Maybe there needs to be a nurse practitioner course in VAD and have nurse practitioners skilled in VAD. I do not know; that is something that will be determined

by the commission. The commission has a hell of a lot of work to do and it only has 18 months to do it.

This was at the request of the ANMF which was genuinely concerned. I also ran it past the College of Nurses after I had it drafted, because it had similar concerns about the scope the nurses are operating under. It is a legal requirement. If you were to operate out of your scope, you can be deregistered. It is serious and nurses know this.

When you sign off on your competencies each year and when you renew your registration, if you lie on that, or are proven to have worked outside your capacity, you will certainly be disciplined and AHPRA can come after you. It is not pleasant if AHPRA comes after you, but that is its job - it is what it is there for and that is why we made it a law, to make sure that people were working in a way that was in their scope and their training.

If this is not supported - and I can count as easily as the next person, probably better than some in some cases - there are provisions there. However, it does not make sense in that if the AHP is a nurse, they are not a doctor referring to another doctor, they are a nurse referring to a doctor. It is semantics in some respects.

Mr Dean - You are right - 'another medical practitioner'; it is clear.

Ms FORREST - The reality is that at this point a person is making their final request, and in giving their final permission to proceed, to actually take the medication, the person who is the AHP - which may be the nurse or may be the doctor - needs to be convinced and confident the person has decision-making capacity and has acted voluntarily. They have to be convinced at that point.

Previous consents and previous assessments of decision-making capacity and voluntary participation are irrelevant at that point. They are important at the points they occurred, but at this point, it is right here, right now, that the AHP - nurse or doctor - assures themselves that this person still has decision-making capacity, because they would have it all the way through or they would not have come this far, and they are acting voluntarily. They have to convince themselves and be confident that the person is acting voluntarily and has decision-making capacity.

Yes, the training required will have to cover that, but it still is questionable whether that then still fits within the scope. Maybe it will or maybe it will not; we do not know. This sort of amendment was requested by the body that represents nurses, to ensure they were not being required or asked to work outside their scope because they are not nurse practitioners.

Nurse practitioners are treated differently in this amendment. They can make that assessment. Nurses are treated differently because it is normally outside their scope. That is the difference.

Regardless of what has happened before, the AHP at that point has to satisfy themselves. Not anybody else - not hearing from the doctor who was involved two months ago that the patient had decision-making capacity then - they need to know today when they are about to administer this substance.

Mr GAFFNEY - The important paragraph here is 'do any one or more of the following'. What the member is focusing on is the AHP in this situation may actually be a doctor, so the AHP -

Ms Forrest - No, you are on clause 77 now.

Mr GAFFNEY - Yes, but what I am saying here is if that is there they can actually do any of those, so they can actually refer that in the practice. I went on to clause 77 because in clause 77(d) they can -

> request a psychiatrist, psychologist, a registered health practitioner, or any other person who the AHP thinks fit -

It could be a doctor or a nurse who thinks fit -

> to provide to the AHP [the doctor or the nurse] with the information that the AHP [the doctor or the nurse] reasonably requires in order to make the determination.

Those options will be part of the training so if there is any concern for any of the registered nurses they have scope to approach anybody else. From that point of view, I am comfortable that the training would be fine.

Mr VALENTINE - I have a question to the member for Murchison. Is there a reason in (b) if the AHP is a registered nurse who is not a nurse practitioner must refer the person to an authorised medical practitioner and not a nurse practitioner? Is there a reason that a nurse practitioner -

Ms Forrest - Only because we don't have many nurse practitioners. They go to the doctor they have already been dealing with.

Mr VALENTINE - So it is simply a case of -

Ms Forrest - It is a practicality.

Mr VALENTINE - there are not enough in Tasmania.

Madam CHAIR - The question is that the amendment be agreed to.

The Committee divided -

AYES 4	**NOES 10**
Ms Armitage	Mr Dean
Ms Forrest	Mr Gaffney (Teller)
Mrs Hiscutt (Teller)	Ms Lovell
Ms Howlett	Ms Palmer
	Ms Rattray
	Dr Seidel

Ms Siejka
Mr Valentine
Ms Webb
Mr Willie

Amendment negatived.

Clause 76 agreed to.

Clause 77 agreed to.

Clause 78 -
Notice where AHP determines person does not have decision-making capacity or is not acting voluntarily

Ms LOVELL - Madam Deputy Chair, I move that clause 78(b) be amended by -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Amendment agreed to.

Clause 78, as amended, agreed to.

Clauses 79 to 81 agreed to.

Clause 82 -
Private self-administration certificate

Ms FORREST - Madam Deputy Chair, I move that clause 82(1)(b) be amended by -

Leave out the paragraph.

Amendment agreed to.

Clause as amended further amended -

Ms LOVELL - Madam Deputy Chair, I move that clause 82(4)(c) be amended by -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Amendment agreed to.

Clause 82, as amended, agreed to.

Clause 83 -
Referral for determination as to life expectancy

Ms FORREST - Madam Deputy Chair, I move that members -

Vote against the clause.

Motion agreed to.

Clause 83 disagreed.

Clause 84 -
Appointment of contact person

Ms LOVELL - Madam Deputy Chair, I move that clause 84(4)(b) be amended by -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Amendment agreed to.

Clause 84, as amended, agreed to.

Clause 85 -
AHP may supply, &c, VAD substance to person

Ms FORREST - Madam Deputy Chair, I move that clause 85 be amended by -

First amendment

Clause 85(2), before paragraph (a) -

Insert the following paragraph:

(aa) the AHP has issued to the person under subsection (5) an AHP administration certificate in relation to the person; and

Second amendment

Clause 85, after subclause (3) -

Insert the following subclauses:

(4) A person may apply to the person's AHP for the issue of an AHP administration certificate in relation to the person.

(5) A person's AHP may issue an AHP administration certificate in relation to the person if the AHP is satisfied that it is inappropriate for the person to self-administer a VAD substance, having regard to any of the following:

(a) the ability of the patient to self-administer the VAD substance or to digest the VAD substance;

(b) the patient's concern about self-administering the VAD substance;

(c) the method of administering the VAD substance that is suitable for the patient.

This amendment is to make a default position - self-administration. This is about a patient-centred approach. It is where the patient, or the person who has sought VAD, has gone through the process here - the first, second and third requests and are at the point where they have sought to use a VAD substance to end their life.

In my view, and the court of public opinion is with this, if the person who wants to do this has a patient- or person-led approach, they are the person who administers it - they take it themselves if they possibly can. If they cannot, it may be that they are really concerned and feel frightened about taking it; that concern is covered under (b).

If that is the case, if their condition is such they cannot swallow, or they are likely to vomit, or there is some other physical reason they cannot take the medication themselves, or there are other concerns as outlined in (b) or (c) - their concern or the method will not be suitable for them - they can request that the AHP administers the substance to them.

It does not change the nature of the process. It just makes self-administration the default position with health professional-assisted administration where that is not appropriate for a range of reasons. I hope members will support this. This is what the court of public opinion tells me is the expected approach.

Mr GAFFNEY - We support this. This is a good amendment and strengthens the bill. I thank the member for Murchison.

Amendments agreed to.

Clause 85, as amended, agreed to.

Clauses 86 to 90 agreed to.

Clause 91 -
Duties of contact person where VAD substance to be, or is, privately self-administered

Mr GAFFNEY - Madam Chair, I move that at the end of clause 91(2), the clause be amended by -

Insert 'and, if the person has not died at the person's usual place of residence, must, as soon as practicable, notify the police as to the location of the person's body.'.

This concern was raised through the heads of agencies we received and was forwarded to all members to address concern raised for the potential for a person with a private

self-administration certificate to choose a remote location in which to take the VAD substance. Therefore, I have prepared this amendment to ensure the contact person is required to notify the commissioner as to where the body of the person who has self-administered a VAD substance under the legislation may be located. It was expected to be in exceptional circumstances. The amendment may minimise any possible concerns as to the location of the deceased person. In response to the concern we received this amendment was raised.

Amendment agreed to.

Mrs HISCUTT - I was wondering if you could put on *Hansard,* on the record, clause 91(1)(b), it says -

> the contact person in relation to the person is authorised for 14 days to possess and store the unused or remaining …

Under what circumstances would you envisage there would be some unused or remainder of VAD substance? I would have thought it probably would have been prescribed volume to weight ratio, so why would there be a remainder?

Mr GAFFNEY - The person may have died before they have taken the substance, so therefore the contact person would have to return that substance.

Mrs HISCUTT - That would be unused, but why would there be a remainder? Remainder means a little bit has been used and there is a remainder.

Mr GAFFNEY - I will defer to some of the medical practitioners around here but there may be a situation where the person goes to ingest and swallows and perhaps coughs and there could be a little bit left over and it has to be returned.

Clause 91, as amended, agreed to.

Clause 92 -
Duty to notify Coroner

Ms LOVELL - Madam Chair, I move that clause 92(1)(b) be amended by -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Amendment agreed to.

Mr GAFFNEY - Madam Chair, I move -

Clause 92(2)(a), after 'required' -

Insert 'unless directed to do so by the Attorney-General or Chief Magistrate in accordance with section 24(1)(g) or (h) of that Act'.

This also came from some questions from the Government through the heads of agency. In relation to other acts, the Government has suggested that at the discretion of the Attorney-General or that of the Chief Magistrate, to allow them to direct the Coroner to investigate if they see fit.

Section 92(2) of the bill operates so it is not mandatory to hold an inquest under the Coroner's Act in relation to a death under the bill, but deliberately does not operate so as to prevent a coroner exercising their discretion to conduct such an investigation. If they have any concerns in relation to a death, that is apparently a death under the bill, there is a risk an Attorney-General or Chief Magistrate who was philosophically opposed to euthanasia may always seek an investigation of a death so, as to discourage the bill from being used or to inhibit a person's consideration of its use.

However, to assuage the Government's concerns on the issue of maintaining some of the checks and balances of the Coroners Act 1995, I put this amendment to you with the expectation it will only be utilised in good faith and with honourable intent.

Amendment agreed to.

Clause 92, as amended, agreed to.

Clause 93 -
Interpretation of Part 15

Ms LOVELL - Madam Chair, I move that clause 93(c), definition of eligible applicant, be amended by -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Amendment agreed to.

Clause 93, as amended, agreed to.

Clause 94 -
Application for review of decision

Ms LOVELL - Madam Chair, I move the amendments to clause 94, in my name -

First amendment

Clause 94(1) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Second amendment

Clause 94(3) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Amendments agreed to.

Clause 94, as amended, agreed to.

Clauses 95 and 96 agreed to.

Clause 97 -
Withdrawal and dismissal of application

Ms LOVELL - Madam Chair, I move that clause 97 be amended as follows -

First amendment

Clause 97(1) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Second amendment

Clause 97(2) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Third amendment -

Clause 97(4)

Leave out 'Commissioner' (twice occurring).

Insert instead 'Commission'.

Amendments agreed to.

Clause 97, as amended, agreed to.

Clause 98 -
Purpose of review, &c.

Ms LOVELL - Madam Chair, I move that clause 98 be amended as follows -

First amendment

Clause 98(1)(a) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Second amendment

Clause 98(1)(b) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Third amendment

Clause 98(1)(c) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Fourth amendment

Clause 98(2) -

Leave out 'Commissioner' (twice occurring).

Insert instead 'Commission'.

Amendments agreed to.

Mrs HISCUTT - Clause 98(2) reads -

> For the purposes of a review of a decision to which an application relates, the Commissioner is to …

How long do we think a review may take? Is this a matter of days or is it a matter of weeks or months?

Mr GAFFNEY - My advice is that the commission would get it done as quickly as possible because they need to get the review.

Clause 98, as amended, agreed to.

Clause 99 -
Procedure

Ms LOVELL - Madam Chair, I move that clause 99 be amended as follows -

First amendment

Clause 99(1) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Second amendment

Clause 99(2) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Third amendment

Clause 99(3) -

Leave out 'Commissioner' (first occurring).

Insert instead 'Commission'.

Fourth amendment

Clause 99(3)(a) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Fifth amendment

Clause 99(3)(b) -

Leave out 'himself or herself on any matter in the way that the Commissioner'.

Insert instead 'itself on any matter in the way that the Commission'.

Sixth amendment

Clause 99(4) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Seventh amendment

Clause 99(6) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Amendments agreed to.

Clause 99, as amended, agreed to.

Clause 100 -
Evidence

Ms LOVELL - Madam Chair, I move -

First amendment

Clause 100(1) -

Leave out 'Commissioner' (wherever occurring).

Insert instead 'Commission'.

Second amendment

Clause 100(3) -

Leave out 'Commissioner' (wherever occurring).

Insert instead 'Commission'.

Mrs HISCUTT - Point of order. Was that your third amendment?

Ms LOVELL - Second amendment.

Third amendment

Clause 100(4) -

Leave out 'Commissioner' (first occurring).

Insert instead 'Commission'.

Fourth amendment

Clause 100(4)(c) -

Leave out 'Commissioner' (twice occurring).

Insert instead 'Commission'.

Fifth amendment

Clause 100(5) -

Leave out 'Commissioner' (wherever occurring).

Insert instead 'Commission'.

Sixth amendment

Clause 100(6) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Seventh amendment

Clause 100(7) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Honourable members, while my amendment represents a minute change in wording, it actually has quite significant indications. In line with my previously proposed other amendments to this bill, this amendment is designed to improve access to care without compromising quality of care. Broadly speaking, it allows telehealth via an audio and visual link to be an option for the whole consultation process between a qualified medical practitioner and a patient. That is actually not revolutionary and it really should not be controversial either.

The intent of the proposed amendment is to align the consultation process with regards to VAD with the existing regulations and standards of good medical practice as outlined in the Health Practitioner National Law Act 2009. The amendment will also improve access to care, in particular, for patients and practitioners who live in remote areas of Tasmania without compromising the quality and the integrity of the medical consultation.

From March to June this year alone almost 1 million telehealth consultations were conducted in Australia via an audio and visual link. Although the uptake has increased substantially due to COVID-19, we have had Medicare-funded telehealth consultation in Australia since 2011, so it has been around for quite some time. I am very pleased - it was a privilege to be involved in the very early days of telehealth, developing the standards and conducting the second-ever Medicare-funded telehealth consultation in Australia.

The 2012 guidelines from the Medical Board of Australia say all registered health practitioners can use telehealth as long as telehealth is safe and clinically appropriate for the health service being provided and suitable for the patient or client. The Medical Board of Australia states -

> Telehealth is health care delivery or related activities that use any form of technology as an alternative to face-to face-consultation. It includes, but is not restricted to video conferencing, internet and telephone ...

It does not refer to the use of technology during a face-to-face consultation. I want to be quite clear that I am just referring to telehealth that includes an audio and visual link. It is video consultations; it is not telephone consultations. So very clearly I am referring to audiovisual links as part of the consultation - it cannot be just a telephone consultation.

The 2012 guidelines were developed by the Medical Board of Australia under Schedule 39 of the Health Practician Regulation National Law Act as enforced in each state and territory, which came into force here in 2009. These guidelines aim to inform registered medical practitioners and the community about the board's expectation of medical practitioners who participate in technology-based consultations. I am going to be quite specific now.

Medical practitioners who advise or treat patients in technology-based patient consultation should -

(1) Apply the usual principles for obtaining their patients' informed consent, protecting their patients' privacy, and protecting their patients' right to confidentiality

(2) Make a judgment about the appropriateness of the technology-based patient consultation and in particular, whether a direct physical examination is necessary

(3) Make their identity known to the patient

(4) Confirm to their satisfaction the identity of the patient in each consultation. Doctors should be aware that it may be difficult to ensure unequivocal verification of the identity of the patient in these circumstances

(5) Provide an explanation to the patient of the particular process involved in technology-based patient consultation

(6) Assess the patient's condition, based on the history and clinical signs and appropriate examination.

(7) Ensure they communicate with the patient to:

    (a) establish the patient's current medical condition and past medical history, and current or recent use of medications, including non-prescription medications

    (b) identify the likely cause of the patient's condition

    (c) ensure that there is sufficient clinical justification for the proposed treatment

    (d) ensure that the proposed treatment is not contra-indicated

Amendments agreed to.

Clause 100, as amended, agreed to.

Clause 101 -
Self-incrimination

Mr GAFFNEY - Madam Chair, I would like to put on the record we will have a dinner break at 6.30 p.m. I think everyone is getting tired. We have just hit clause 100 and we have only clauses to go.

Madam CHAIR - And a few clauses.

Mr GAFFNEY - A few clauses, but I was thinking we should keep our energy levels up and in 20 minutes time we will have an hour's break. I support the clause.

Ms RATTRAY - Madam Chair, I am interested in clause 101, Self-incrimination. It says -

> (1) A person is not excused from answering a question or producing a document in proceedings, or pursuant to a notice given to the person under this Part, on the ground that the answer or document might tend to incriminate the person.

Can we expand on where this might be used? Why it is here in this particular legislation? I think it is important to have it on the record.

Mr GAFFNEY - It followed discussion with the Office of Parliamentary Counsel. Clause 100 refers to the Personal Information Protection Act 2004, and I understand within that act and within that ruling there is a self-incrimination section. It was transferred over here so the process was made very clear. We took OPC's advice.

Ms Rattray - It is really in regard to the commission undertaking an inquiry and somebody says, 'I am not providing you with documents, it might self-incriminate me, I am not answering', and there will be an obligation to answer.

Mr GAFFNEY - That's correct, thank you, member for McIntyre.

Mr DEAN - So I am clear on this, in that situation, in clause 101(1), they are advised they cannot withhold the answer or the documents on the grounds it will incriminate them. I suggest they will have to be told of that situation. Further, if they did answer and it did incriminate them, that evidence could not be used against them in any future matter.

Mr GAFFNEY - That is my understanding, member for Windermere.

Clause 101 agreed to.

Clause 102 -
Determination of application

Ms LOVELL - Madam Chair, I move that clause 102 be amended by -

First amendment

Clause 102(1) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Second amendment

Clause 102(2) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Third amendment

Clause 102(3) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Fourth amendment

Clause 102(5) -

Leave out 'Commissioner' (twice occurring).

Insert instead 'Commission'.

Fifth amendment

Clause 102(6) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Sixth amendment

Clause 102(6)(a) -

Leave out 'Commissioner's'.

Insert instead 'Commission's'.

Seventh amendment

Clause 102(6)(b) -

Leave out 'Commissioner's'.

Insert instead 'Commission's'.

Amendments agreed to.

Clause 102, as amended, agreed to.

Clause 103 -
Reasons for decision

Ms LOVELL - Madam Chair, I move that clause 103 be amended as follows -

First amendment

Clause 103(1) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Second amendment

Clause 103(2) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Third amendment

Clause 103(2) -

Leave out 'Commissioner's'.

Insert instead 'Commission's'.

Amendments agreed to.

Clause 103, as amended, agreed to.

Clause 104 -
Supreme Court

Ms LOVELL - Madam Chair, I move that clause 104 be amended as follows -

First amendment

Clause 104(1) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Second amendment

Clause 104(2) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Third amendment

Clause 104(4)(a) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Fourth amendment

Clause 104(4)(b)

Leave out 'Commissioner'.

Insert instead 'Commission'.

Fifth amendment

Clause 104(4)(c) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Amendments agreed to.

Clause 104, as amended, agreed to.

Clause 105 -
When PMP ceases to be PMP

Ms LOVELL - I move my amendments to clause 105. I will move the first amendment, and then the second and third amendments separately.

First amendment

After clause 105(1)(c) -

Insert the following paragraph:

(x) the person's CMP is, or becomes -

(i) a member of the family of the relevant person; or

(ii) employed by, contracted directly or indirectly by, or works under the supervision of the relevant person; or

(iii) a person who is the employer of, has a direct or indirect contract with, or is a supervisor of, the relevant person; or

Members, this is again consistent with amendments we moved earlier in the Committee stage of this bill around the independence of the medical practitioners.

Mr GAFFNEY - I thank the member for Rumney. This amendment also strengthens the bill. I support this amendment.

Amendment agreed to.

Ms LOVELL - Madam Deputy Chair, I move my second and third amendments together -

Second amendment

Clause 105(1)(d) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Third amendment

Clause 105(2)(c) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Amendments agreed to.

Clause 105, as amended, agreed to.

Clause 106 -
Former PMP may apply to Commissioner to become PMP again

Ms LOVELL - Madam Chair, I move that clause 106 be amended as follows -

First amendment

Clause 106(2) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Second amendment

Clause 106(3) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Third amendment

Clause 106(4) -

Leave out 'Commissioner' (first occurring).

Insert instead 'Commission'.

Fourth amendment

Clause 106(4)(c) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Amendments agreed to.

Mr DEAN - Is the heading there automatically changed? Is an amendment required to that?

Ms FORREST - Yes, that happens automatically.

Clause 106, as amended, agreed to.

Clause 107 -
When CMP ceases to be CMP

Ms LOVELL - Madam Chair, I move the first amendment because it is to do with the independence of the medical practitioners. I move that clause 107 be amended as follows -

First amendment

Clause 107(1)(c) -

Insert the following paragraph:

(x) The person's PMP is, or becomes -

(i) a member of the family of the relevant person; or

(ii) employed by, contracted directly or indirectly by, or a person working under the supervision of, the relevant person; or

(iii) a person who is the employer of, has a direct or indirect contract with, or is a supervisor of, the relevant person; or

Mr GAFFNEY - Once again, it is consistent, and I think that is good for the bill to have that and well done, once again, on this amendment. Thank you.

Amendment agreed to.

Ms LOVELL - Madam Chair, I move the second, third and fourth amendments in my name together.

Second amendment

Clause 107(1)(d) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Third amendment

Clause 107(2)(b) -

Leave out 'Commissioner'.

Insert instead 'commission'.

Fourth amendment

Clause 107(6) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Amendments agreed to.

Clause 107, as amended, agreed to.

Clause 108 -
When AHP ceases to be AHP

Ms LOVELL - Madam Chair, I move that clause 108 be amended by -

First amendment

After clause 108(c) -

Insert the following paragraph -

(x) the relevant person is, or becomes -

(1) a member of the family of the person's PMP or CMP; or

(2) employed by, contracted directly or indirectly by, or works under the supervision of, the person's PMP or CMP; or

(3) a person who is the employer of, has a direct or indirect contract with, or is a supervisor of the person's PMP or CMP; or

Amendment agreed to.

Madam CHAIR - Member for Rumney, there is a second amendment there. The only issue with this one is the consistency with the benefit now. This relates to the nurses who were taken out of the bill. It is not the same wording as the other benefit clauses. There needs to be a consistency with the benefit clause there. Your amendment was to take that out. It does leave the benefit clause in.

Ms LOVELL - Yes, my amendment would no longer be required in light of the earlier decision of the Chamber. I take the point, through the Chair, that this then creates an inconsistency around the financial benefit in terms of wording. I think it is probably -

Madam CHAIR - It may be that we need to postpone the amended clause to redraft that provision.

Ms LOVELL - It is around the 'financial or other benefit'.

Madam CHAIR - It is on page 130 of the bill paper, clause 108(d).

Ms LOVELL - Sorry, for members' clarity and perhaps the member for Mersey might want to speak to this. My concern is that this paragraph now will be inconsistent with the

paragraphs earlier in the bill that refer to 'financial or other benefit' as a result of the death of the person. It can be fixed with a very simple amendment. I seek some advice whether we postpone or whether we are able to draft a quick amendment.

Mr GAFFNEY - Madam Chair, it is probably a good time to report progress and seek leave to sit again.

Mr DEAN - I am asking the question now as to how much longer we would be going through this bill and what the intention is. Is it to simply draw up this amendment, if that is what is considered, or whether you are waiting for a dinner break? It doesn't look like it is going to be that much longer.

Mr Valentine - We have all the new clauses.

Madam CHAIR - We also have other postponed clauses to come back to. I will put the question again that we report progress and seek leave to sit again at a later hour.

Progress reported; Committee to sit again.

Sitting suspended from 6.26 p.m. to 7.32 p.m.

END-OF-LIFE CHOICES (VOLUNTARY ASSISTED DYING) BILL 2020 (No. 30)

In Committee

Resumed from above.

[7.32 p.m.]

Madam CHAIR - Before we recommence, the member for Mersey had a discussion with most members, maybe all members, during the dinner break. When we get to around 10 p.m. whoever is in the Chair at the time will check in with members. If we are getting close to finishing but have not quite, either we proceed and continue or we adjourn and come back on Friday, depending on what point we are at, acknowledging we never know exactly how long any particular matter will take to deal with.

We will check in again, but for anybody watching, we may go beyond 10 p.m. if we are getting close to completing the bill, which includes the new clauses and the postponed clauses that we have to go back to. I make that point.

Clause 108 -
When AHP ceases to be AHP

Ms LOVELL - Madam Chair, I move the amendment in my name to clause 108(d) -

Second amendment

Leave out 'receive a financial benefit as a result of the death of the person'

insert instead 'benefit from, or receive a financial benefit, directly or indirectly, as a result, of the death of the person, other than by receiving reasonable fees for the provision of services as the AHP of the person'.

This is to address the pick-up earlier in the evening that there would be an inconsistency with the rest of the bill regarding the financial or other benefit, so we had that drafted and I am moving that in order to maintain that consistency.

Mr GAFFNEY - I congratulate the member for Rumney for putting in this process. It makes sense and has consistency, so I support all of it.

Amendment agreed to.

Clause 108, as amended, agreed to.

Part 17 - Heading -

Ms LOVELL - This amendment to the heading of Part 17 reflects changes agreed in principle around the appointment of a voluntary assisted dying commission as opposed to the commissioner.

Madam Chair, I move the following amendment to Part 17, Commissioner of Voluntary Assisted Dying -

Leave out the heading to the Part.

Insert instead the following heading to the part -

PART 17, VOLUNTARY ASSISTED DYING COMMISSION

Amendment agreed to.

Clause 109 -
Appointment of Commissioner of Voluntary Assisted Dying

Ms LOVELL - Now we are getting into a bit more of the nuts and bolts of the commission for voluntary assisted dying. I move that members -

Vote against the clause.

Madam Chair, I propose and urge members to vote against clause 109. Clause 109 deals with the appointment of the commissioner of voluntary assisted dying. Later in the debate I will move new clauses later that will deal with the appointment of the commission and executive commissioner of voluntary assisted dying. Given we have had a debate on the principle of the commission that has been agreed to by members, this clause will no longer be required. I urge members to vote against it,

Motion agreed to.

Clause 109 disagreed.

Clause 110 -
Deputy Commissioner of Voluntary Assisted Dying

Ms LOVELL - Just as with the previous clause, this clause will not be required with the insertion of new clauses. I urge members to vote against this clause and move that they -

Vote against the clause.

Motion agreed to.

Clause 110 disagreed.

Clause 111 -
Officers of Commissioner

Ms LOVELL - Madam Chair, I move that clause 111(1) be amended by -

Leave out 'Commissioner in the performance of his or her functions'.

insert instead 'Commission in the performance of its functions'.

Amendment agreed to.

Clause 111, as amended, agreed to.

Clause 112 -
Functions and powers of Commissioner

Ms LOVELL - For clarity, I advise that I will not be moving my second amendment because it relates to registered nurses as AHPs, so that will need to remain. I move -

First amendment

Clause 112(1) -

Leave out 'Commissioner' (twice occurring).

Insert instead 'Commission'.

Second amendment

Clause 112(2) -

Leave out 'Commissioner' (first occurring).

Insert instead 'Commission'.

Third amendment

Clause 112(2)(b) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Fourth amendment

Clause 112(2)(c) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Fifth amendment

Clause 112(3) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Sixth amendment

Clause 112(4) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Seventh amendment -

Clause 112(4) -

Leave out 'his or her'.

Insert instead 'the Commission's'.

Amendments agreed to.

Clause as amended further amended -

Ms LOVELL - Madam Chair, the next amendment has been circulated. I move the following amendment -

Eighth amendment

Clause 112(4) -

Insert the following subclauses -

(5) Except as otherwise provided for under this Act, a member of the Commission and any officer appointed under section 111 are not subject to the control and direction of the Minister in the performance or exercise of a function or power of the Commission under this Act.

(6) A member of the Commission, and any officer appointed under section 111, must not perform or exercise a power or function under this Act in relation to a person if the member, or officer, respectively-

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

(b) has a financial or other interest that may be affected, directly or indirectly, by the performance or exercise of the function or power.

Members, this amendment is about preserving the independence of the commission in its operation and the conduct of its business. The amendment, the new subclause (6), is specifically to address concerns whether there would be a potential conflict if there was a member of the commission exercising his or her role as part of the commission in relation to a member of that person's family. In Tasmania, it is not unlikely, that that might occur but given we have expanded the make-up of the commission to five persons, there would be room for that person to excuse themselves from that role if needed in relation to that person.

I urge members to support the amendment.

Mr GAFFNEY - While I was not in favour of the commission and was more in favour of the voluntary assisted dying commissioner, I support this amendment. It makes sense, it is reasonable, and it now strengthens the bill even further. I appreciate the amendments, member for Rumney.

Amendment agreed to.

Clause 112, as amended, agreed to.

Clause 113 -
Delegation by Commissioner

Ms LOVELL - Madam Chair, I move the amendment in my name to clause 113 -

Leave out 'Commissioner may delegate any of his or her functions',

Insert instead 'Commission may delegate any of its functions'.

Ms RATTRAY - I have a question. The commission may delegate any of its functions - who would the commission delegate to? If there is a panel of three, who are they going to delegate to? How might this function or work in practicality?

Ms LOVELL - Thank you, member for McIntyre, for the question. This is to remain consistent with the wording that was originally in the bill. I expect the types of powers that it may delegate would be around performing any of the roles or functions. We had the discussion earlier in the debate that there was a power of delegation. It could be things like the development of the training modules, or any number of the functions that the commission is responsible for. Hopefully that answers the question? It is hard to list them all because essentially it could be any of them.

Ms RATTRAY - I seek confirmation that the commission is not intending to delegate its functions when it comes to assessment. I understand the response by the member in regard to putting together those training modules. That is fine. I want to make sure that -

Madam CHAIR - That is a question for the member in charge of the bill about what the commissioner could have delegated.

Ms RATTRAY - As long as we get a firm commitment that none of those functions will be delegated. That is what I am looking for.

Mr DEAN - The member for McIntyre raises an interesting point. We have the commission, the supreme body, able to delegate to - and the question was, and the answer given as perhaps some of those areas that they can delegate to. This commission is not subject to the control of the minister. I would be interested to know just how the delegation will occur. Normally with a delegation it goes to somebody else within that organisation, or within that commission, or that area, to perform some of those functions, and so on.

Here we are being told that the delegation can be completely outside of the commission to any other person somewhere. That other person somewhere may well be subject and under the control of the minister, or under the control of other people as well. I have some concern here as to who the delegation is going to be to and how it will work.

Ms RATTRAY - I think the problem here is 'any' where it says -

> The Commission may delegate any of its functions.

I know you cannot possibly write down what its functions might be because possibly they do not know what some of their functions might be at this point in time, but it seems to be very widespread, as the member for Windermere said.

Madam CHAIR - We need to direct that question to the member in charge of the bill, because that is what it says in the act as drafted.

Ms WEBB - It makes sense when it was just a commissioner with a deputy. But the whole argument for a commission was based around expanding. So, it is relevant to the commission and not to the original commissioner.

Ms RATTRAY - I would appreciate the member in charge of the bill giving us some indication of the functions that will be delegated. I know we heard one which is around putting together the training modules. I seek to make sure they are not going to be delegating here

there and everywhere. They are very wide-ranging here when it says 'any' of its functions. I want to be absolutely clear on that, thank you.

Mr DEAN - The member for Nelson raises a very important matter here. It supports and backs up my original position and statement on this as it was originally written. Therefore, it is a matter for the person moving this amendment, and not the mover of this bill because the amendment removes the 'Commissioner' and replaces it with 'Commission'. The commissioner could delegate to the deputy commissioner, and may even, if there are other ranks within that area, delegate to them as well; he could well do that. But the commission stands alone. Where does the commission delegate to? If the member can answer that, I will be pleased.

Ms LOVELL - I am happy to answer the question in relation to the commission and I have been attempting to get the call for a couple of calls. I take your point.

The bill still allows for officers of the commission to be appointed. Section 111 provides for the ability for the minister to appoint officers as the minister considers necessary to assist the commission - as amended - in the performance of its functions. I imagine the commission would delegate some of its powers and functions to those officers if and when they were appointed as deemed necessary by the minister, in the way that commissions operate in practice normally.

Mr Valentine - While the member is on her feet -

Madam CHAIR - She only has one call left.

Mr Valentine - Are those officers that are reporting part of the commission,?

Ms LOVELL - No. There is the commission, which is made up of an executive commissioner, deputy executive commissioner and three members. There are officers to the commission who can be appointed. If we look at clause 112, Functions and powers of the Commission, it has a list of some functions or powers that are in addition to others. For example, I refer to clause 112(1)(b) -

> to establish and maintain a list of medical practitioners and registered nurses who have completed approved voluntary assisted dying training …

Clause 112(1)(c) is -

> to establish and maintain a list of medical practitioners who are willing to be PMPs, CMPs or AHPs ...

Some other functions and powers are also included in the clause.

I imagine these are the types of functions and powers that an officer of the commission could be delegated - to maintain a list of adequately trained practitioners. You would not convene a meeting of five commissioners to update a list; that would be the type of thing you may delegate to an officer of the commission.

Mr Valentine - It would not be outside the commission's power, is that what you are saying?

Ms LOVELL - Yes, that is right. I am reluctant to sit in case there are any further questions while I am on my feet.

Mr Valentine - I think my concern is that the way it is written could mean the commission could delegate certain things to an outside third party. There is nothing to stop that. I think that is probably what the member for Windermere might have been pointing to, or the member for Nelson. In any event, does it need tightening up to be within the operational sphere of the commission or something similar? That is, to make sure they cannot delegate outside to a third party that is not covered by the same laws that the commission itself is governed by. That is my concern. I am not sure what the solution is or which words should change, but I think that is the concern here.

Mr DEAN - My concern is probably even worse now. Clause 111 says -

> (1) The Minister may appoint such officers as the Minister considers to be necessary to assist the Commission in the performance of his or her functions.
>
> (2) A person appointed under this section -
>
> (a) is appointed subject to and in accordance with the *State Service Act 2000* …

Clause 111(2)(b) states they 'may hold the office in conjunction with State Service employment.'. How could those persons perform the functions of the commission without some control or involvement of the minister responsible for that act as well as for that area? They would also be subject to the control of senior people within the State Service organisation.

It certainly would have worked before because it was with the commissioner, but I cannot understand how it can work here because these officers are supposedly totally independent. The member is saying that the minister cannot interfere with their functions and what they are doing, but they are and will be State Service employees as the bill says -

> (a) is appointed subject to and in accordance with the State Service Act 2000; and
>
> (b) may hold the office in conjunction with State Service employment.

The member may be able to answer that.

Mr VALENTINE - The commission as a functioning unit could get officers who are working for the commission to do work without having to have anything in this bill. I wonder whether the best way forward here is to actually vote against the clause. On review, at a later time, an amendment can be brought forward. The member for Rumney might consider that.

Madam CHAIR - I wonder whether, before the member is given the call, as it is her last call, does the member for Mersey want to talk about the reason why there is a delegation power at all?

Mr Valentine - It is irrelevant.

Madam CHAIR - Not if this is defeated because we go to that clause.

Ms LOVELL - I am a little confused as to what people are suspicious that the commission will delegate and why this is a concern. I understand what the concern is, but I am confused as to why it is a concern. If, for example, we look at the Integrity Commission and the way it operates, the Integrity Commission has powers of delegation. I will read from the relevant act here, from section 16. It says -

> (1) The Board may, by resolution, delegate to a member of the Board, a member of the staff, other than the chief executive officer, of the Integrity Commission, or any other person all or any of its functions or powers under this Act or any other Act, other than this power of delegation.

This wording is actually very standard and consistent with other similar bodies such as the Integrity Commission, which is what this has essentially been based on. It is good that people are paying such close attention that it has made them stop and think about it, but we are getting a little bit caught up in the detail of this particular clause and what it might mean when there is no need to be suspicious or concerned about what powers the commission has.

I do not see a problem with the commission delegating one of its powers or functions to a third party if that is deemed appropriate by the commission. It may be that they need that expertise or that experience from a third party, from someone who is not a member of that commission, and it is appropriate that decision rests with them.

I want to reassure members that this is absolutely consistent with the way that other bodies that are very similar and appointed in the same way as this operate, and is consistent with the legislation that is in place.

I am going to proceed with this amendment. I will proceed with the amendments we have. I thank members for bringing this to our attention because it is an important conversation to have, but we need to take a step back and look at what this is based on, how it operates in other similar bills, and why that might be there. There is no cause for concern, so I will proceed with the amendment.

Mr Dean - This is different to the Integrity Commission. These officers here are appointed under the State Service Act.

Ms LOVELL - No.

Mr Dean - Well, that is what it says.

Ms LOVELL - There is some confusion then between the officers and the members of the commission. The members of the commission are appointed, not under the State Service Act. You are looking at the officers who are essentially the staff who would be appointed to support the commission. They do not have powers of delegation.

Mr Dean - Who does the commission delegate to? That is the question I am asking and you referred to clause 111 and you referred to the minister being able to appoint other persons

under this section. The only other persons that can be appointed under this section have to be appointed under the State Service Act.

Ms LOVELL - Yes, the commission can delegate powers or functions to those officers -

Mr Dean - under the State Service Act -

Ms LOVELL - Yes, but those officers cannot then delegate their powers.

Mr Dean - What we are saying here is that these officers are not subject to the control of the minister in anyway whatsoever. They are obviously subject to the control of the State Service Act because that is what they are appointed under. With the Integrity Commission officers, the other persons are not appointed under the State Service Act or some other act, only the Integrity Commission Act.

Ms LOVELL - Yes. The commission is not subject to the direction or control of the minister. Not the officers. The officers would be appointed under the State Service Act. They would be responsible to the relevant minister as employees of the State Service. The members of the commission would not be.

Mr Dean - The commission delegates its authority. Delegates its requirements and authority to these officers.

Ms LOVELL - It does not delegate its authority. It would delegate its functions or powers.

Mr Dean - Well, it delegates its functions for these people to carry out those functions.

Ms LOVELL - Something like maintaining a list of trained AHPs. I would think it would be perfectly reasonable for the commission to delegate that power to an employee of the State Service, an officer of the commission, rather than having to do that itself as a commission.

Mr Valentine - That is fine, but the difficulty is that if they delegate to somebody who is not within the State Service, what protection does the information have that is outside of the State Service? It is all of that.

Ms LOVELL - Which is consistent with what the commissioner would have been able to do under the original wording of the bill. If we were still dealing with the commissioner as opposed to a commission, that is consistent. The commissioner would have been able to delegate his or her powers to somebody outside of the State Service, to a third party, to any person they deemed appropriate. As does the Integrity Commission have the same power to do so.

Mr Dean - Not under the State Service Act, the Integrity Commission. It is different.

Ms LOVELL - I have answered the questions as best I can. I will proceed with the amendment.

Amendment agreed to.

Clause 113, as amended, agreed to.

Clause 114 -
Commissioner to determine VAD substances

Ms LOVELL - Madam Chair, I move that clause 114(1) be amended by -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Amendment agreed to.

Mr VALENTINE - Madam Chair, I move that clause 114(1) be amended by -

Leave out 'is likely to'.

Insert instead 'is expected to'.

This might not sound like a great change, but it is more consistent and it is not just something that might happen. This is something that is expected to happen, and it is simply that. I ask members to simply agree with that.

Mr GAFFNEY - I do not have any issue with this, but I have to put it on the record that according to the dictionary definition of 'expected' is to look forward to, regard as likely to happen. It does use the word, but I will not hold this august body up any longer than necessary and I will agree with the amendment.

Amendment agreed to.

Mrs HISCUTT - Just on the first line there, mover of the bill, clause 114(1) is -

> (1) The Commissioner is to determine to be VAD substances one or more substances …

Is that 'to be' correct wording, or do you think it is a style, or is it incorrect?

Madam CHAIR - I look forward to this explanation.

Mr GAFFNEY - It is quite simple actually. The initial was even more confusing and we took it to OPC and I have great regard that it is actually correct in the way it is written. I deferred to OPC's abilities there. If you drill down into it, it does read as correct.

Mrs Hiscutt - I am happy to defer to OPC.

Clause 114, as amended, agreed to.

Clause 115 -
Commissioner to approve voluntary assisted dying training courses

Ms LOVELL - Madam Chair, I move the following amendments -

First amendment

Clause 115(1) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Second amendment

Clause 115(3) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Third amendment -

Clause 115(3)

Leave out 'he or she'.

Insert instead 'the Commission'.

Amendments agreed to.

Clause 115, as amended, agreed to.

Clause 116 -
Commissioner may request authorisation of nurse practitioners to possess and supply VAD substances

Ms LOVELL - I will not move my proposed amendment to this clause, but it has just been brought to my attention that this clause will need to be amended as it stands in the bill. In clause 116(2), 'the Commissioner' will need to be amended to 'Commission'. I imagine I could table an amendment if it is a simple rewording, if members can bear with me.

Madam CHAIR - The member for Rumney can move it but it may help the Clerk if pages could be circulated after she has read it.

Ms LOVELL - Thank you, Madam Chair. I move that clause 116(2) be amended by -

Leave out 'Commissioner'.

Insert instead 'Commission'.

I will ask the Clerk to circulate that. Again, this is just for consistency. Do I need to remain on my feet while the Clerk does that?

Madam CHAIR - Yes.

Ms LOVELL - Can I seek some advice, Madam Chair; do I need to seek to table it or do I just move it?

Madam CHAIR - As it is being circulated, I will ask the member to speak briefly to it.

Ms LOVELL - This amendment is to maintain consistency with the appointment of a commission as opposed to the appointment of a commissioner.

Madam CHAIR - Would members like to check they are happy with the proposed amendment before we vote on it?

Ms LOVELL - I thank members for their patience.

Amendment agreed to.

Ms RATTRAY - This is the first time that we have seen a reference to 'Secretary'. It says -

> ***Secretary*** has the same meaning as in section 3 of the Poisons Act 1971.

On the following page of the bill paper is another reference to the secretary -

> The Commissioner may request the Secretary to authorise …

In clause 116(3) -

> The Secretary must not, without reasonable excuse, refuse a request made under subsection (2).

I do not have the Poisons Act in front of me, but I am interested in the secretary's role here, given that it relates to the authorisation of nurse practitioners to possess and supply VAD substances.

Mr GAFFNEY - It was interesting that in the working of the bill there is a relationship with the Poisons Act. Earlier in the bill it says that this legislation overrides, but in the Poisons Act 'nurse practitioners' were mentioned, not 'registered nurses'. We needed some way for the secretary to be able to change that and address that in this. That is why the use of 'secretary' is coming in this part of the bill.

Ms Rattray - I think other people would be interested in that explanation as well.

Mr GAFFNEY - In this case the secretary means the secretary of the department.

Clause 116, as amended, agreed to.

Clause 117 -
General record requirements

Ms LOVELL - I move that clause 117 be amended as follows -

First amendment

Clause 117(1) -

Leave out 'Commissioner' (twice occurring).

Insert instead 'Commission'.

Second amendment

Clause 117(2) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Third amendment

Clause 117(2)(a) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Fourth amendment

Clause 117(2)(c) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Fifth amendment

Clause 117(3) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Sixth amendment

Clause 117(4) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Seventh amendment

Clause 117(5) -

Leave out 'Commissioner' (wherever occurring).

Insert instead 'Commission'

Eighth amendment

Clause 117(6) -

Leave out 'Commissioner' (twice occurring).

Insert instead 'Commission'.

Amendments agreed to.

Clause 117, as amended, agreed to.

Clause 118 -
Annual Report

Ms LOVELL - Madam Chair, I move that clause 118(1) be amended by -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Amendment agreed to.

Clause 118, as amended, agreed to.

Clause 119 -
Person who suspects contravention of Act may notify Commissioner

Ms LOVELL - Madam Chair, I move that clause 119 be amended as follows -

First amendment

Clause 119(1) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Second amendment

Clause 119(2) -

Leave out 'Commissioner' (twice occurring).

Insert instead 'Commission'.

Third amendment -

Clause 119(2)(c)

Leave out 'he or she'.

Insert instead 'the Commission'.

Amendments agreed to.

Mrs HISCUTT - Clause 119(2)(b), where the commissioner is notified of a suspected contravention, says the commissioner 'may (but is not required to) investigate the matter'. Is that because perhaps the police might be involved at that stage, or why may they not investigate it?

Mr GAFFNEY - That is correct or the commission may determine it is a vexatious complaint and therefore should not continue with the investigation. Thank you for the question.

Clause 119, as amended, agreed to.

Clause 120 -
Commissioner may require information from persons

Ms LOVELL - Madam Chair, I move the following amendments to clause 120 -

First amendment

Clause 120(1) -

Leave out 'Commissioner' wherever occurring.

Insert instead 'Commission'.

Second amendment

Clause 120(2) -

Leave out 'Commissioner' wherever occurring,

Insert instead 'Commission'.

Amendments agreed to.

Clause 120, as amended, agreed to.

Clause 121 -
Requirement in relation to Commissioner where suspected contravention of Act

Ms LOVELL - Madam Chair, I move this clause be amended as follows -

First amendment

Leave out 'Commissioner' (twice occurring).

Insert instead 'Commission'.

Second amendment

Clause 121(b) -

Leave out 'he or she'.

Insert instead 'the Commission'.

Amendments agreed to.

Clause 121, as amended, agreed to.

Clauses 122 to 127 agreed to.

Clause 128 -
Offence to fail to provide notice to Commissioner when required.

Ms LOVELL - Madam Chair, I move clause 128 be amended by -

Leave out 'Commissioner' (twice occurring).

Insert instead 'Commission'.

Amendment agreed to.

Clause 128, as amended, agreed to.

Clauses 129 to 138 agreed to.

Clause 139 -
Giving of notices

Mr VALENTINE - Madam Chair, I move that clause 139 be amended as follows -

First amendment

Leave out 'in writing may'.

Insert instead 'in writing must'.

Second amendment

Clause 139(a) -

After 'in writing'.

Insert ', signed by the person,'.

Third amendment -

Clause 139(b)

Leave out the paragraph,

Insert instead the following paragraph -

(b) with the approval of the -

Madam CHAIR - If the member might just hold it for a second. We might just dispense with the first and second amendments first.

Mr VALENTINE - They are all connected. They are all there for the same reason, but if you wish, I can take it.

Madam CHAIR - If you move the first two and speak in broad terms, we can then deal with the third one.

Mr VALENTINE - I move the first and second amendments then -

First amendment

Leave out 'in writing may'.

Insert instead 'in writing must'.

Second amendment

Clause 139(a) -

After 'in writing'.

Insert ', signed by the person,'.

This is giving of notices. At the moment when a notice is given under this act, it says it is required to be given to another person in writing, and it may be in writing on a paper document given to the other person, or with the approval of the other person, in writing in an electronic document sent to the other person electronically.

It gives the option, as opposed to enforcing it. It really needs to be in writing 'must' because you do not want a notice being given that is not authorised by a signature. That is the reason for the series of amendments. The first amendment is about the 'must', quite simply.

The second amendment is after 'in writing signed by the person'. It is stipulating that it has to be signed by the person.

They are the first two amendments.

Ms FORREST - For the benefit of the new members, the 'may' and 'must' discussion. We have this every so often to determine whether 'may' or 'must' is the right term.

'May' is a term that gives a power. It gives a power to do one or another thing. 'Must' can often follow the power that is inserted by 'may'.

I support the bill as it stands in this case, because what we have here is giving of notices -

> A notice under this Act that is required to be given to another person in writing may be -
>
> (a) in writing on a paper document given to the other person;

A notice is given, I assume, from the commission - is this where the notices come from?

Mr Valentine - No, it is any notice.

Ms FORREST - Any notice, yes. Let us say it is from the commission, for example. It is given in writing to the person, to that person.

Or, it may be given -

> (b) with the approval of the other person, in writing in an electronic document sent to the other person electronically.

If you put 'must' there it does not make sense. It is the power-giving approach where you have two options. If there was only one option you would say 'must'. There are two options so you must say 'may'. Sorry to use both of those in the one sentence like that.

We often have this discussion. We have all done it as new members, the argument about may versus must. But in this case 'may' is the appropriate term because it is the power to do one of two or more things.

I cannot support the amendment because that actually undermines the option. You are not doing both. You are doing one or the other, so it gives that power. I will be sticking with the bill as drafted.

Mr GAFFNEY - Members might realise I sat on that one, because I thought it would take the member for Murchison three or four minutes to explain. That would have taken me about 10 minutes. So, in light of the time, I acquiesce to your longstanding understanding of what OPC have written. I concur.

Mr VALENTINE - Well, I had it on good authority but I cannot invoke anyone. I appreciate exactly what you are saying, but there are occasions in this Chamber since I have been here since 2012, where 'must' has been inserted for a very good reason. With the notice, it forces a signed notice, otherwise it is possible that 'may' can be interpreted as 'may'. You do

not have to do it in writing in a paper document or do it electronically. I had this discussion and it was agreed that for it to be sure that the notice is given, in this particular instance 'must' was considered essential. I cannot invoke someone's power and I will go with whatever the Chamber decides.

Mrs HISCUTT - Reading from the beginning, it says 'a notice under this act that is required to be given to another person in writing may be either (a) or (b).'. It says clearly it is required to be given to another person, then it tells you how to give it to the other person, one or the other. That is the way I read it.

Ms WEBB - I agree, the 'must' would have come earlier in clauses that said notices must be given, so this is just referring to the 'must' referred to earlier and giving two options, so 'may' is appropriate.

Mr VALENTINE - The point about 'is required' is certainly that somebody else might think about it as not giving an option to give the notice because it says it is required, so that does fix it. The second one, which is with regard to the signing, after 'in writing' inserts 'signed by the person', so it does not force the notice to be signed the way it is in the bill at the moment. That is making sure that the notice is signed.

Madam CHAIR - Both amendments are on the Table at the moment.

Mr VALENTINE - Yes, they are. I seek leave to withdraw the second amendment if that is appropriate.

Madam CHAIR - Can I clarify which one you are seeking to withdraw?

Mr VALENTINE - The 'must', not the second one - the first amendment.

Leave granted; first amendment withdrawn.

Mr VALENTINE - The second amendment deals with the signing of the document because at the moment, as the bill reads, no signing is required. It merely says, 'notice to be given'.

Ms WEBB - I am going to clarify that there are instances in the bill where it requires a notice to be given. Some of them we discussed earlier - for instance, notice must be given to the commission that the substance has been destroyed. I am not sure if we require a signature on all instances of that.

Mr Valentine - You would.

Ms WEBB - I am not sure about that. I would be interested to hear the member for Mersey's thoughts.

Mr GAFFNEY - There are a lot of notices where the notices are forms and are signed, but there are some circumstances when notices are given where there is no requirement for them to be signed. If we place this into the bill, it would actually limit what we should be doing. I understand the concern of the member, but it is not a concern I share and so I will not support the amendment.

Mr VALENTINE - This is a very important bill that deals with very important actions, and one hopes there is no opportunity for people to give notices that are not in accordance with the law. Indeed, because you have electronic notices too, it is possible for electronic notices to be recorded, for instance. It is important that those notices are signed by the individual who is actually giving the notice. That is what this is about - it is about verifying that this is an official notice. I hear what the member for Mersey is saying, that some notices now may not need to be signed; however, I think that they do in a bill like this.

Mr Dean - An email is an electronic -

Mr VALENTINE - That is the next one.

Ms WEBB - Perhaps the member for Mersey could clarify - other than putting it into the bill where it would lock things down a global way across all notices - would the commission, in designing the format and the forms of notices within this process across all those iterations, design which notices need to be signed and which do not need to be signed? Could that determination happen at this next phase, during implementation and design?

Mr GAFFNEY - I remember when I was speaking with OPC early in the process, we only had about 106 pages and the word 'prescription' came up 17 times already. I consider it is better to have something like this in the regulations or the forms when the commission actually sits down and goes through the notices. I am certain the commission will ensure that whatever has to be signed or given notice would fall under the legal framework that we would want in this bill. I would not like to put it into the legislation because I do not think it is warranted.

Amendment negatived.

Mr VALENTINE - Madam Chair, I move -

Third amendment

Clause 139(b) -

Leave out the paragraph.

Insert instead the following paragraph -

(b) with the approval of the approval of the other person, an electronic scan of, or electronic photograph of, a paper document containing the notice, in writing signed by the person, which scan or photograph is sent to the person electronically.

That is to stop digital fraud. However, you have voted on the second amendment that did not get through. It probably does not make much sense to put this in if it is going to be included elsewhere, but I leave it for you to consider. It might be belt and braces but at least it is there and it makes sure that there cannot be any digital fraud.

Mr GAFFNEY - I thank the member for Hobart. Many people involved in this bill and what is going to be required for the commission will go back to this transcript of *Hansard*. They will listen to the points that were raised and some of the issues and concerns that may have been mentioned, and this would be one of them. I still believe it would be better suited for regulations and for the commission to be able to decide what is most suitable for the notices to be signed and formatted. I appreciate the member for Hobart, but I will not be supporting this amendment.

Amendment negatived.

Clause 139 agreed to.

Clause 140 agreed to.

Clause 141 -
Report on initial operation of Act

Ms LOVELL - Madam Chair, I move clause 141 be amended by -

First amendment

Clause 141(1) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Second amendment

Clause 141(2) -

Leave out 'Commissioner'

Insert instead 'Commission'.

Amendments agreed to.

Clause 141, as amended, agreed to.

Clause 142 -
Review of Act

Ms FORREST - Madam Deputy Chair, I move -

First amendment

Clause 142(1) -

Leave out all words after 'conduct a review',

Insert instead 'of the operation and scope of this Act'.

This is the review clause because it is important that the legislation is reviewed. This amendment means that clause 142(1) would read -

> The Governor is to appoint a panel of persons nominated by the Minister, to conduct a review of-
>
> … the operation and scope of this Act.

It is broad in that it asks the Government to appoint a panel of persons nominated by the minister to review how the act is working and the scope of the act. Some areas we have already talked about - we have included nurses, but other areas have been considered, such as audiovisual appointments in the first request and things like that - are included in this scope and operation of the legislation. Rather than try to spell out specifically what it should be, the potential scope inherent in the scope of the act, if the scope is limiting in ways that are disadvantaging Tasmanians, that will be picked up and will be considered. If further changes need to be made, they will be recommended by the panel. This is broad, it is succinct and it actually much clearer than the way it is currently drafted.

Mr GAFFNEY - I do not think this proposed amendment is necessary, but I do not have any concerns with it and so I will support the amendment.

Mr DEAN - I am of the same view. I do not see where it makes any difference at all. 'Review' is a common word used when we look at what will happen to legislation in the future. 'Review' covers everything the member has in the amendment. It covers the whole lot in reviewing the whole act and everything it relates to and everything around it.

Ms FORREST - It simplifies it.

Mr DEAN - It does simplify it. It looks at the whole legislation, the way it is written. I am not sure we should accept and support members for the sake of changing only a couple of words that really make no difference.

Amendment agreed to.

Ms FORREST - Madam Deputy Chair, I move that review clause 142(3) be amended as follows -

Second amendment

Leave out the subclause.

This has been quite a contentious area. We have had briefings and information from the member for Mersey on the intent of this clause. Everywhere I have gone everyone - from people in the street, to health professionals, retired health professionals and currently practising health professionals - have seen this as an absolutely unnecessary review requirement.

These comments will also stand for the third amendment. I will not repeat them all then, but these sorts of reviews can be done by a body appointed separately to the review of the act

to look at any other legislative change around people under 18, in other states, territories, countries. This sort of work is done in regard to a whole manner of things. I think it is of deep concern to many members of the public and to many health professionals that this is included in the bill. Even though it is notionally a review of what else is happening around the world, you do not need it in legislation for that to occur, and you certainly do not need it linked to this bill, in my view.

That is a very clear and strong message I have got almost everywhere, even those who strongly support the principle of the bill. It does create an unnecessary distraction from the principle and intent of the bill. I urge members to support the removal of subclause (3).

Mr GAFFNEY - We are doing really well but I do need to put this on the record because if you look at subclause (3) it is linked to this bill. It says -

> (3) The Governor is to appoint a panel of persons, nominated by the Minister, to conduct a review to obtain information in relation to whether persons under the age of 18 years in other States or Territories, or other countries, are able to access processes similar to the voluntary assisted dying process under this Act.

It is clearly linked to this act.

I would like to spend a moment - and I will be dealing with subclauses (3) and (4) at the same time, because if subclause (3) fails, subclause (4) will not go. There is some information. We will come back to (5).

As I mentioned in my second reading speech, a review of the persons under the age of 18 has caused some discussion. I believe this clause is being treated unfairly by some individuals, especially those who are not aware of the legislation that exists internationally. Opponents to the VAD bill often use the phrase 'within two years the Gaffney bill will allow children to be killed', or words to that effect.

As a teacher, I have always liked the idea that students should be well informed about any issue before putting pen to paper, or nowadays fingertips to the keyboard. Being misinformed is no excuse, especially for the members in this place. All this clause is doing is asking the persons - and I am thinking in my headspace, an independent panel of experts appointed by the Governor, nominated by the minister, people of the calibre of the Commissioner of Children and Young People - to prepare a report and return to the parliament with those findings of that review.

I do not see why, as a parliament, we cannot legislate that review to take place and a report to be tabled - not only to inform future members of parliament, but also the community. As I have mentioned before, nothing in this clause indicates enthusiasm for or bias towards extending the act to include children. Nothing in this clause guarantees an outcome, or recommendation to this independent review. Nothing in this clause compels a government to act on that information collated in such review, and nothing in this clause means that the act will instantly mean people under the age of 18 will be eligible.

Whether a panel finds legislation allowing access to VAD processes or similar in other jurisdictions is deemed acceptable or required, is entirely at the panel's discretion. The reality

is that any finding or recommendation must still be adopted and actioned by the government of the day.

Whilst being mindful of recent media interest in the changes in the Netherlands for under-12 access - and for members' benefit I did forward the review of the Australian research by an academic, Mr Neil Francis. It was a 15-page research paper he compiled in September of this year because he was aware of clause 142 of the Tasmanian bill. He, as an academic Australian researcher, looked into this specific clause to help this place understand so that we are informed when we make this decision.

He titled his paper *Use of VAD by Minors is Rare - Worldwide Report*. For the benefit of *Hansard* and listeners, Mr Francis wrote -

> Differences of opinion continue to be expressed regarding law reform to permit voluntary assisted dying, or VAD, for minors, persons under the age of legal majority or adulthood, which in most jurisdictions is 18 years. Some claims are florid and ill-informed -

Unlike the member for Murchison -

> To date, no cohesive report has been published regarding the actual use of VAD by minors in jurisdictions where it is lawful. This research aims to address that shortfall.

This high quality academic researcher thought, 'Well, if the Tasmanian parliament is going to debate this, they need the correct information to be able to debate it.'. That is what we would expect in this place. As I said before, it is what I would expect in any school I taught at. I would want the people to understand.

This study examines official evidence from lawful jurisdictions regarding the extent and nature of VAD amongst minors. Its aim is to facilitate calmer public discourse and more fully-informed legislators considering VAD law reform proposals. I will put in a nutshell the findings so that the people listening can understand what this review is about.

Madam DEPUTY CHAIR - The member can always table that 15-page -

Mr GAFFNEY - No, this is a really important part, and it includes a section of our community that is not catered for at this stage, so with some indulgence - and it is probably five or six minutes, it is not forever -

> VAD is currently a lawful choice for minors in the Netherlands, Belgium, Switzerland and Colombia. Dutch and Belgian legislation and Colombian regulations stipulate additional requirements regarding minors. Available Dutch and Belgian data reveal very low rates of use, between zero and three cases per annum, with parental involvement in decision-making. There are no cases of VAD amongst minors on record in Switzerland. No official case data is available from Colombia, however, given the extremely low rate of VAD use overall, cases amongst minors are highly unlikely.

This all comes out of the reports, the findings -

> While use of VAD laws by minors is rare, a review of case records reveals as for adults, severe refractory underlying illness with extreme unrelievable suffering.

Mr Francis concluded -

> Use of VAD by minors in lawful jurisdictions is rare but nevertheless occurs with parental involvement in decision-making and otherwise, as for adults in cases of severe, refractory underlying illness with extreme unrelievable suffering.

It was worth noting that in Mr Francis' work the following information has been obtained: The Netherlands, currently just over 17 million people - from 2003 to 2019, in 17 years there have been 14 cases of people under the age of 18 accessing this legislation. In Belgium, with a current population of 11.5 million, in 17 years there has been eight cases. Switzerland, with a current population 8.5 million, since 1998 the Swiss Federal Statistical Office has stated there are no cases of VAD among minors.

Mr Francis went out, researched this information, and has brought it back so that we can make a decision about this very clause. It is more difficult to get information from Colombia; however, in 2018 the regulations for VAD were revised for an access by children and adolescents from the age of seven. Additional safeguards include, similar to Belgium's provisions, compulsory testing for decisional capacity and approval of parents. Mr Francis wrote -

> No public official documents reporting the use of VAD in Colombia were found. However, an informal report suggests that between 2015 and 2018 around 40 people in total used the law. This is a very low rate of incidence in a country with a population of nearly 50 million.

He continues by writing -

> Given the low rate of adoption prior to 2018, it is likely that there have been almost no, if any cases, of VAD use amongst minors.

If I do not include Colombia with 50 million people and no cases and only include the statistics from the Netherlands, Belgium and the Swiss, in those jurisdictions where there is some VAD legislative process for those under the age of 18, there have been a total of 22 cases in a combined population of 37 million people over a total period of time of 56 years and we are worried about having a review into the legislation when that is available, internationally.

Mr Francis also wrote to me saying that he researched and wrote the report because people were misinformed about VAD legislation for those under 18. As a researcher, Mr Francis wants people to make qualified judgements.

Mr Francis suggested to me that when opponents to this clause inevitably decry that child provisions are not required because cases are too rare, you can poke at the incoherence of your opponents' arguments against the bill by observing that 'Some of you oppose VAD law reform because you say too many people will use it, but now you oppose this clause because you say too few will use it' -

> For those 22 young people and their families, right to access this legislation must have been exceptionally stressful, but at the same time, immeasurably compassionate. Where Mr Gaffney's bill was to kill children in two years, it should have said, 'Mr Gaffney's bill is to stop the intolerable suffering of these 22 young people'.

How can we not have this review? How can we not properly assess the situation if it only means that one of our young people might not have to suffer intolerably until they can access VAD, where at the moment they have to wait until they are 18? I do not understand the reason in a compassionate society and in compassionate legislation, why we would not accept this review to take place.

Although I have met with experts in Belgium, Switzerland and the Netherlands, where young people under the age of 18 may have access to VAD, I had not planned to address the issue in this bill, although I am aware of situations where it may have been considered and I cannot fully appreciate how those families must have felt or how they must feel, listening to this debate.

Even as a parent, have you considered what you might do if your terminally ill child begged for your consent as their pain and suffering were unable to be relieved? The very least we can do in this place is get the information, and that will not be done unless we put it in this legislation. The reason for that is so clear.

It may have been easier to do what was suggested to me before the debate on the bill began - that it would be wiser simply to remove this clause before the bill was tabled because, 'Mr Gaffney, you would have less responses, less dissention about this bill.'. There would have been fewer attacks and less opposition to the bill.

It was also suggested to me by a minister of the Government that the Government could bring this clause or part of the bill back at a later time, so as not to negatively impact on the passing of the Tasmanian End-of-Life Choices (Voluntary Assisted Dying) Bill 2020. I responded by saying that because it is not popular, it will be interesting to see how the independents and party politicians vote on this amendment in this place.

The issue was not included in the Victorian and Western Australian legislation as, again, it would have created too much angst and opposition because the opponents to voluntary assisted dying would come out and say exactly what they have to me, 'Gaffney's bill to kill children within two years'.

The parliament is about dealing with difficult issues, not turning away from them or getting rid of them because they are unpopular. I reject the notion that any member in this parliament would fail to support the bill because a review on the access to people under the age of 18 was going to be undertaken. If that is the case, I believe that individual politicians are looking for any excuse not to support the bill, and if part of clause 142 were not in the bill, they would still find a clause somewhere else.

I oppose the amendment and I encourage other members to leave this quite important clause in the Tasmanian bill. The Tasmanian bill should be about access and compassion with adequate and appropriate safeguards. In this instance, we should have the knowledge, should

learn from experience overseas and inform this parliament of the legislation. I urge members to consider compassionately and objectively the importance and genuine intent of this clause. It is not to predict or assure an outcome; it simply allows a panel of qualified people to gather information and gain a deeper understanding of the issue of terminally ill young people who are suffering intolerably and whether attaining the age of 18 years should be a permanent criterion for accessing VAD in Tasmania.

In closing it is interesting that people have said to me, 'Michael, the Dutch have just come out and now they are going to look at it for under-12s.'.

Ms Forrest - Under-12s are under 18.

Mr GAFFNEY - Yes, but at the moment the legislation is from 12- to 16- or 18-year-olds. It is coming at the moment.

Are we to assume by this that the Dutch do not love their children as much as we do? Is that what we are saying? The Dutch put this is in because there is an issue with their legislation. They may have one or two - 22 under-18s in a population of 37 million people over 18 years. This is not a high end; this is not killing children - this is about stopping a legal process and framework so 22 young people of those 37 million in 18 years did not have to suffer. All we are doing is asking for an expert panel to go out and bring the information back to parliament, bring the information back here, because nobody else will do it. No party will do it and no Legislative Council committee inquiry will do it either because - what? It hurts our sensibility. What are we trying to do? We are trying to alleviate the suffering of those 22 young people.

I encourage all members in this place to support the clause and not accept the amendment proposed by the member for Murchison.

Ms ARMITAGE - I support the amendment by the member for Murchison. As the member for Murchison says it does not matter whom I spoke to, whether they were doctors in favour, whether it was doctors against, whether it was people in the community, it did not matter who it was. It was the one issue, and I believe it was a reason for people not to support the bill in effect. One doctor - and I have his email here - was concerned that this clause in the bill could be a reason for people to not support the legislation. He was hoping it would come out for the people who supported the bill, because he thought it could be a reason for people not to support it.

As he has mentioned to me, Victoria, Western Australia, Queensland and New Zealand do not mention extending legislation to allow children to access VAD. I believe it is step too far for this bill. I really do. Without fail, everyone - as I said - I cannot think of anyone I have spoken to - who has read the bill or has any understanding of it are very concerned. Obviously, not everyone read the bill and some people just commented on it.

I also heard the member for Mersey. I heard you speaking on talkback radio with regard to why. Somewhere I have a transcript of it, had I time to find it, but my understanding, and you will correct me, I am sure, if I was wrong, was that you indicated what a young chap under-18 could not access. I am just trying to remember. I know you spoke to LAFM and I heard your reason for why you put this in.

We do not review something unless we intend to do something about it. Saying it is okay, we are just going to review it, we are going to have a look and see what is happening in other countries, in other states, territories or whatever - we do not do it unless we are actually planning to look at something like that ourselves. You have said that yourself. I understand the passion you obviously feel for that. We could see it in your speech, but I cannot accept leaving this in. I wholeheartedly support the member for Murchison's amendment to take that out even though I can see that you really are passionate and believe seriously about taking away this insufferable suffering of the children. I understand that, but I feel just as passionately that I cannot support leaving it in.

I support the member for Murchison and the many constituents, medical practitioners and others who have all spoken to me saying, 'Please support taking that out because it is something that could stop the bill being supported.'. Many doctors I have spoken to are in favour of this bill, but many of them are against it. They are saying, 'We have tried to get this up so many times, please do not let that clause stop it going through.'.

I hear what the member is saying; I understand his passion. I listened to the member on LAFM with Aaron Stevens at one stage. I heard the member and I understand how deeply he feels about it, but I am sorry, I cannot support him on this. I will support the member for Murchison.

Mrs HISCUTT - I will also support the member for Murchison. I must admit I think the member for Mersey is very emotionally charged with his response there. A couple of things he said I found slightly offensive but I forgive him because, of course, we are talking about an emotionally charged subject here. I feel it is one step too far at the moment, and I will be more than ready to agree with and support the member for Murchison's amendment.

Ms HOWLETT - This is a really difficult personal situation. I have a 12-year-old and I have a 24-year-old, and I cannot support this amendment. I will certainly support the member for Murchison's amendment.

As a mother of a 12-year-old, I would do absolutely anything I possibly can to seek her treatment in order to make her better. Anything I can possibly do, whether it be take her around the world, do whatever I can, I will do so. There is a gift, a gift of life, and whatever I can do, whether it be for my state of mind, or for her to ensure positivity in her life, I will do.

It is time to exclude children from this bill. This is absolutely not fair. We need to give them hope; we need to give them everything we possibly can to ensure we try to do everything we can to make their life better, and ensure we can try to overcome their illness.

I am sorry but I support the member for Murchison's amendment.

Ms PALMER - I put on the record how irresponsible I have felt the debate has been around this particular clause. Some of the comments made and that the member for Mersey has previously expressed are really disturbing and upsetting. It is there in black and white: this is not a proposal to introduce a voluntary assisted dying bill for children under the age of 18. I think it has been really unfair that we have had some groups that have really attacked this clause unfairly. That needs to be put on the record.

In saying that, I will support the amendment. I see absolutely no reason to have a review of introducing, or exploring around the world, what is happening with VAD for children under

18. I wholeheartedly agree with the member for Launceston's comments - you do not have a review unless you intend to do something with that information.

I certainly would be vehemently opposed to that. However, it is important to put on the record that when we have debates like this, they should be factual debates. Many facts have gone out the window in this debate. It has taken a personal toll on many of us who have had to read awful emails, if we are going to support this - and indeed attacks on the member for Mersey who has done what he wholeheartedly believes in. We have seen such a passionate response from him.

The member and others in this place have had horrible attacks from people who have taken certain words out of a clause and twisted them to make them more sensational and to put fear into the hearts of people. That is an inappropriate way to lobby people; it is an inappropriate way to behave, and it is irresponsible.

I will certainly support this amendment.

Ms FORREST - Madam Chair, I note and acknowledge the comments made by the member for Rosevears - that there has been some misrepresentation of what this subclause intends to achieve. The member for Mersey has talked about the process around that.

In many respects the problem is - and I have heard the member's interviews on ABC and other interviews, and there are quite a number, because it is quite a contentious matter - that the member keeps talking about what it is being introduced in other jurisdictions. While we should look at that, there is an expectation that you are saying it will be considered for here. Therein lies the problem - that it is the natural progression, that if you put a legislative review into a particular aspect related to the bill, and that all these other jurisdictions are doing it, that it should be done. Obviously it has to go through the parliament and the parliament will decide.

As the member for Launceston said, and I said in my introductory comments on this amendment, many people who strongly support the principle - diehard supporters who have been on my case for a long time about this - when I sat down with these doctors, their first comment to me was that this clause has to go. Even though it is not advocating for extending the bill for people under 18, that is the natural progression and even the member for Mersey's comments go to that when he talks about his concern about leaving out any suffering of young people.

I am sure I speak for all of us in the Chamber, the member for Mersey included - we do care deeply about children and we do care about suffering of anybody, and we particularly find the suffering of children very difficult to bear. I have looked after dying children and dying babies. I have held mothers while they have held their babies while they have died. That does not come easily and it leaves an impression. I am sure the member for Huon has had experiences too, with dealing with dying children. It is really difficult.

As the member for Prosser said, you do everything you can to alleviate the suffering of your child, as you do your loved ones generally, whether they are under 18 or over 18. It is an unfair attack to say that the members would use inclusion of this clause, if my amendment was not successful, to fail to support the bill. We take the bill as a whole and there may be members, if my amendment is not supported, who would take that opportunity to vote against the bill in the third reading.

I do not believe that is the case because we are more grown up than that, and we will deal with the overall bill at the time. However, whilst the bill does not specifically require people under 18 to be considered for inclusion in the voluntary assisted dying process, it seeks to establish a link; even the member for Mersey's comments in the *Hansard* have created that link as something we are concerned about in the suffering of children.

He said this bill is about access to compassion with adequate safeguards.

I absolutely agree. That is what this bill is about - access and compassion. Access to this process, compassion and adequate safeguards. A review into what is happening in other jurisdictions related to children does not fit into that. It does not need to be here. The review into those other matters may not be done by a government, whatever colour the government is. It can be commissioned by the university or some other research body. There is no reason at all why it could not be commissioned by another body with the capacity and skills to do that sort of work. There are many ways to bring that to parliament. You could table a report and note it by way of a motion and debate it. There are many ways to bring that back to parliament.

I agree it would be a very difficult thing for any government party to bring it forward, but there are many ways it can be brought before the parliament. You do not need the government to bring things before parliament; we do in this place all the time.

I thank members who have made contributions already to this amendment.

Ms WEBB - I will speak very briefly on this amendment, which is a tricky one. It is a shame it has been misconstrued and misrepresented broadly and frequently in the public domain. It certainly does not require any particular change; it is simply about looking at other jurisdictions and bringing a vote to parliament.

I do not accept the assertion you do not do a review unless you expect a change to occur. As the member for Murchison rightly pointed out, parliament decides. This is just about information being brought to parliament for consideration.

I also accept and agree with the member for Murchison's point that this kind of review can happen through a range of channels and come to parliament in other ways. I understand the member for Mersey's inclination to put it into this bill to try to ensure at least that review of other jurisdictions happens. I agree with the member that it is unlikely any government of the day, of whatever stripe, will do it off their own bat. I acknowledge the intent to try to ensure it does happen.

On a very practical level, it presents a barrier to people accepting the bill broadly. It does allow an opportunity for people to vote against the bill on the basis of this one clause. There are people who may want to vote against the bill anyway and they will do so regardless of whether this clause is in or out. It does give an extra impetus.

On the practical side of things, it is not my inclination to remove it because I do not think it poses any risk at all. It just says that we will look at what is happening elsewhere at this particular time and bring that information back to parliament. There is absolutely no risk in that. The risk it might pose to the bill passing ultimately through the full parliament is certainly one weighing on my mind.

I wanted to speak about where I am at in considering this and I make it very clear what is weighing into my consideration of how I will vote on it.

Mr VALENTINE - This would have to be one of the most challenging considerations we have ever dealt when it comes to socially oriented bills. It is not easy. Quite clearly, people have used this particular aspect of the bill to try to persuade people not to pass voluntary assisted dying.

I am very much aware disease and pain are no respecter of persons. Here we are looking at a bill that gives people an option. We have young children who may indeed experience the same level of pain and agony an adult might. Do we use that defining point as to whether something like this should stay or should go? I have been very interested in listening to the offerings tonight on this particular issue. I can see some members may try to use it downstairs to rail against the bill, but they could also attempt to amend it out and then it would come back to us as a new bill, if that is the process.

We are talking about human rights here. I think of a child - what rights does a child have? I cannot imagine being a parent with a child suffering to the point where they feel the only way they could handle things is to choose this way out. I can appreciate those who have young children - I have had three of my own over time and I now have seven grandchildren. I understand how difficult it would be even to contemplate. The point is that it is happening in other places.

What are we being asked to do in the bill as opposed to the amendment?

The Governor is to appoint a panel of persons nominated by the minister to conduct a review to obtain information in relation to whether the persons under the age of 18 years in other states, territories or other countries are able to access processes similar to the voluntary assisted dying process under this bill. That is all it is asking.

People will say it is the slippery slope. Well, I have to say that if this review were to come back, it is not a foregone conclusion it will come back as a positive thing. Lots of things can happen between now and when a review might happen. It is not an easy thing for us to sit in this Chamber and approve even a review. It is going to be a different parliament at the end of the day and it will be people who have been elected by those in the community to make decisions such as this. We are not making the decision tonight that people under the of 18 years can access voluntary assisted dying: let us make it very clear - that is not what is being expected of this Chamber tonight.

It will be the will of the parliament for this bill to survive - it has to go downstairs and it will be debated down there. I hope the bill does not fail to survive because of one clause that could so easily be deleted. The member for Mersey is right: it will never ever be addressed, and those of us who might support this will be probably lambasted from here to eternity for even considering it.

I make the statement right now - this is about a review; it is not about allowing children to access voluntary assisted dying. It is a part of a process of inquiry of getting facts and information together and presenting them. We should not be constrained by the tough decisions. This is tough for many because we all know that there would be those who would be very unhappy if this survives. It is tough, but we are here to make tough decisions. While

I do not disagree with what is in the amendment, what it actually takes out is the point we are all here considering tonight. I have only ever had one person associated with my life very closely in terms of family that may have suffered, because I do not really know how much they suffered towards the end of life, and that was my mother. I certainly have not had a child in the circumstance where they were in such pain and agony, although when my daughter was nine months she nearly died with an influenza-related condition in her leg. I will never forget how I felt when they were trying to inject antibiotics into her body, but could not find a vein big enough and I had to hold her down while they did that. I understand the potential there for parents to be dealing with their children in painful situations. I cannot say I have personally experienced a high level where my child has had leukemia or whatever other condition they might have that causes such great grief and pain.

All I can imagine is if it ever did get to the point where, as a parent, you would want all the options possibly open to you, you probably would, but taking that decision would be very, very difficult.

Research is important for a proper decision to be made on this. You can say no, if now is not the time. Well, it may well not be the time, but as I said right from the start disease and pain has no respect for persons.

I will continue to listen to other contributions. I always do. They can sway my mind, my thinking, as did the member for Montgomery when she said 'if required', a simple couple of words in the thing I was trying to amend and I thought yes, well, that is right and it changed my thinking on that first amendment I moved not long ago.

That is where I stand. It is definitely about gaining information. It is not about saying people under 18 can choose voluntary assisted dying.

Mr DEAN - This is a very emotive area when you look at it. The fact that this bill is a voluntary assisted dying bill, end-of-life bill, in extreme circumstances for people to enter into in intolerable pain, terminal illness, and all of those other things, when people have read this section that we are now dealing with, they will have put their own interpretation on it. I do not think many of them who have contacted me on this section would have read it clearly, because they see this as an end-of-life bill. They see that there and they do not read into it that this is just a review to look at what is happening around the rest of the world and so on. They simply see it and read into it that this is a position, an amendment, that will shortly come into this bill. That is how a lot of people have read this. I, like others in this Chamber, have had many people who are supportive of the bill raise this clause with me, saying it should not be supported and should not be included in this legislation at this time. I am not sure they said 'at this time', but I think some inferred that. Others said it should not be there.

Nothing is mentioned about dealing with young children who are in pain and agony and who are suffering. It tears you apart - there is absolutely no doubt about that. In fact I remember my son when he was about five months old - my wife will correct me if I am wrong - who was screaming in intolerable pain. Absolutely screaming as a five-month-old. I did not think that a five- or six-month-old could do it in fact. We raced him into the hospital and we were lucky we did not waste time because his life was saved - he had a strangled bowel. He was operated on and it was fixed very quickly, but to see a child like that.

The member for Rosevears might remember the journalist who was killed at Sassafras a number of years ago. He was an acquaintance of the previous member for Rosevears. His two children were in the car with him, two young boys from memory. I was one of the first police officers on the scene. One of the boys was suffering so badly, knowing that he was going to pass away. You could see it was going to happen. It was just gut-wrenching.

Looking at this, I will certainly support the amendment. I would not say this will never happen. I am not so sure that will be the case. I think probably well down the path. This bill is will be supported because so many people are asking for it. I think it will get up and I think we will see changes happening in this bill over a period of time.

It is quite a large bill, and we see amendments made to these bills all the way through. That is what review periods are all about - looking at the bills, seeing if they can be made better, if there needs to change, if there need to be amendments to it and so on. Normally when doing that, you look at what is happening with similar legislation, not only around the world but in other Australian states and territories. You look at their legislation to see where it is going and what is happening. I am not saying this bill will not ever be touched. I would not accept that at all. I can see the member for Mersey, who moved this bill, is very passionate about this matter. It is only about a review, but that has been overlooked, as I said, by many people.

At this stage, this clause would be better removed from the bill, which would allow us to move on and move forward. Let us see how it all goes and see how it all works out. As I said, I think most people in the community would like to see the legislation move forward as well. As I said, many people, even those who support it, have said that to me - not just a few, but many.

At this stage I will certainly support the amendment.

Madam DEPUTY CHAIR - The question is that the amendment be agreed to.

The Committee divided -

AYES 11	**NOES 3**
Ms Armitage	Mr Gaffney (Teller)
Mr Dean	Mr Valentine
Ms Forrest (Teller)	Ms Webb
Mrs Hiscutt	
Ms Howlett	
Ms Lovell	
Ms Palmer	
Ms Rattray	
Dr Seidel	
Ms Siejka	
Mr Willie	

Amendment agreed to.

Ms FORREST - Madam Deputy Chair, I move that this clause 142(4) be amended as follows -

Third amendment

Leave out the subclause.

This needs to be removed because we have removed subclause (3).

Amendment agreed to.

Mr GAFFNEY - Madam Deputy Chair, I move that clause 142 should be amended as follows -

First amendment

Clause 142(5) -

After 'as to whether'.

Insert 'appropriate pain management and support services are available for'.

I will do all three amendments because they all relate to -

Madam DEPUTY CHAIR - It would be advisable if you did the first one to see if you get any support.

Mr GAFFNEY - It is wording for the whole thing. I will take some advice because it changes the review plan. I suggest we speak to all three amendments at once.

Madam DEPUTY CHAIR - Again, I will take some advice. I have been advised that would be the most appropriate and efficient way to move forward. I invite the member for Mersey to put forward the three amendments.

Mr GAFFNEY - Thank you. I have already read in the first amendment. I move the following amendments -

Second amendment

Clause 142(5) -

After 'the death of the person'.

Insert 'within 6 months, or if the disease is neurodegenerative, within 12 months,'.

Third amendment

Clause 142(5) -

Leave out 'ought'.

Insert instead 'and who, but for the fact that the person is not expected to die within whichever of the above periods is applicable to the person, may seek'.

This one will not be as long as the previous one, but it is necessary to make because of the changes we made to the prognosis last week. The clause will now read -

> The Governor is to appoint a panel of persons, nominated by the Minister, to conduct a review as to whether appropriate pain management and support services are available for persons suffering from a disease, illness, injury or medical condition, that is not expected to cause the death of the person within 6 months or, if the disease is neurodegenerative, within 12 months, but that -
>
> (a) is advanced, incurable and irreversible, and
>
> (b) causes the person suffering from pain that is in the opinion of the person, intolerable -
>
> and who, but for the fact that the person is not expected to die within whichever of the above periods is applicable to this person, may seek to have access to the voluntary assisted dying process under this Act.

I earlier sent two letters to all members: first, a letter of support from the Australian Pain Society, dated 20 August, and, second, another letter of support from the Tasmanian Pain management working group. To read in a couple of things from there -

> Given the changes in prognosis time for VAD access from our amendments to earlier clauses in the bill that excludes people outside of these, I feel it is necessary to adjust the scope of the pain review proposed in clause 142(5). This is to flag the need for essential and timely pain management programs and support services to address the specific requirements of people in intolerable suffering that may seek access to VAD process, but are ineligible under the amended bill.
>
> There have been a variety of initiatives to address the needs of people suffering from persistent pain, many of which are constrained by the availability of funding support initiatives to address the needs of people suffering from persistent pain, many of whom are constrained by the availability of funding support to ensure a continuity of service delivery. The development of the Tasmanian Pain Management Strategy began in 2019 with a specialist multidisciplinary working group, but with no indication as yet when this may reach a stage when it can be implemented. There is some hope with the development of the local pain educator program, the state-led multidisciplinary approach to addressing pain management across all services. The pain revolution team that toured Tasmania in 2019 to launch this initiative is collaborating with the Tasmanian Department of Health, and

with Health Recruitment Plus, to help build capacity in rural and regional Tasmania.

One of the issues, Madam Deputy Chair, is that the only statewide pain management service or clinic option is in Hobart, making it almost impossible for anyone outside the tolerable commuting distance of the Hobart CBD to access its services on a regular basis, assuming they can get a timely appointment after a referral from their GP.

I bring your attention to a letter from Dinah Spratt, a specialist APA pain physiotherapist with a masters in science in pain management, who lives and practices in my electorate, together with an additional supporting letter from the Australian Pain Society with their thoughts on the proposed review. I have shared these letters, but I will take out a couple of sentences out of both of them. Ms Spratt says -

> I would suggest that the review must also consider the current level of provision of pain services across the whole of Tasmania.

She goes on to say -

> Whilst I welcome the potential of the review within the Bill to highlight the need for additional support for pain management services it should not be seen as an obstacle to inhibit the debate or the enactment of the Bill. The proposed review is an opportunity to objectively examine the provision of health services for people in pain, many of whom are struggling to live their normal lives in such circumstances.

The Australian Pain Society said -

> Unfortunately, many individuals are unable to achieve effective pain relief, significantly restricting their quality of life. We believe access to effective pain treatment across all stages of life, including palliative and end of life care, is a fundamental human right.

The society wrote to express its support of the submission made by Dinah Spratt regarding the End-of-Life Choices (Voluntary Assisted Dying) Bill 2020. We have here a situation where the terms of reference of the pain review as initially suggested have been changed because the prognosis time has been changed to six months and 12 months.

This review is about how we manage pain outside that finite prognosis period for people who may not fall within that gap. This review is worthy of consideration because it will feed into our Health department and our Government and this parliament about what the actual situation is. It is appropriate it is linked with this bill because we have now limited people in the six-month and 12-month neurodegenerative group to be able to access voluntary assisted dying.

We have to make certain that people who fall outside that time frame have adequate pain resources to help them manage, and perhaps help them recover sufficiently not to have to seek VAD if that is possible. That is why I hope members will consider a review. I think this review - and it is going on to (6) and is after the third anniversary - I purposely set the third anniversary so more data could be collected to inform those looking at the review about how

many people have fallen outside or are ineligible for voluntary assisted dying access, and who are living in intolerable pain.

I hope members might support this review.

Ms FORREST - I have an amendment to this clause, as members will note. I want to talk about how this impacts on that. I suggest we remove this clause. I believe a review into the operation and scope of the bill is an appropriate process. Reviews of an act should relate to that act. The member for Mersey said this does relate to the act - well, if that is the case, you do not need it because it will be considered in the review of the act. My view is that a review of an act should relate to the act you are dealing with. Other reviews in relation to matters related to, but with some bearing on, the act are a separate matter.

Once we start legislating for reviews of matters that are not part of the act just to collect the data, we are setting an unnecessary precedent because these reviews can be set up by the government or anybody else who wants to commission a body to do it at any time. I mentioned previously on the other amendment we have just dealt with, that they can be brought to the parliament in a variety of ways. I also go back to the fact that those people who support the principle of access to voluntary assisted dying for people are actually dying. We heard so many times during the second reading debate that it is not between a matter of life and death, but is a matter between two different deaths. These people are actually dying, but this again goes outside that scope.

My proposed amendment, the fourth amendment of mine to this clause, seeks to remove that because it is not something that in my view is part of this bill at the moment.

This is about facilitating a process that shows compassion and provides access with adequate safeguards to an assisted dying process when someone has a terminal condition and is actually dying. If you want to look at areas outside of that, whether it be people under 18 which we have dealt with, or people who do not have a terminal illness but are experiencing suffering, that is a separate process. I do not think we should include reviews of extra matters in an act when you are reviewing the act.

It is a bit of a conundrum here. If the clause is to stay in, we need those changes, but I do not think the clause should be there in the first place. Even if I voted for these amendments I would still vote against the subclause when I get to my amendment because I do not think it should be there. This one is a bit of a tricky one in terms of dealing with it, but I think for those reasons, and a number of the reasons I gave in relation to the review that looked at the jurisdictions considering or that have in place measures to facilitate people under 18, I do not think it is part of the intent of this bill. That intent is being proposed and promoted, and so I think it should not be there. I will just listen to the debate around the amendment which relates to this matter.

Mr DEAN - This is the -

Madam DEPUTY CHAIR - This is the member for Mersey's amendment.

Mr DEAN - I was just wanting to, looking at this -

Madam DEPUTY CHAIR - The third amendment, honourable member.

Mr DEAN - this is the member for Mersey's -

Ms Forrest - The first, second and third amendments.

Mr DEAN - This is the amendment to clause 142(5). I take the point the member for Mersey is putting forward. Under clause 142, Review of Act, what under that review could not be done as referred to in subclause (5)? I would like to have left that because it was a review of the act but, anyway, the scope is exactly the same. I think the review would be done three years after the bill commences, as on page 154 of the current bill paper -

Ms Forrest - That is the point I was making.

Mr DEAN - Yes, which is also in (5) as well, under subclause (5), which is to commence at the third anniversary. So, you have two reviews of this bill, or this act if it is supported: why you would want that? I cannot quite work that out - the same time, same period, looking at these areas. If the member from Mersey could explain that to me I would be more comfortable.

Mr GAFFNEY - It is a good question. If you look at the original bill put forward, we had the cause of death was open-ended to a certain extent. Then it was changed by this group to six and 12. I tried to move it to two years but it was six and 12. It meant at this end where I had the pain review, the pain review then was looking at those people who may be intolerably suffering, but it would not cause death. So that is 15 per cent of the people who could not be managed appropriately and were suffering. It was to look at that and think if we study that group of people and they are not able to access VAD, what can we do? In other countries they can; sometimes it does not have to be the cause of death.

Once we determined that was the six-month and the 12-month at this end, it meant down at this end the people who do not die within six months, but could die within two years, or could be terminal - and that is the difference. They would be terminal, but they do not qualify for the six months because of the time, but they could qualify for 12 months or 18 months and they are terminal.

Ms Forrest - On point three, there is a subsequent amendment of mine we have not dealt with that gives the commissioner power to exempt that.

Mr GAFFNEY - Yes, and that is fine. In this situation, this one not only includes the ones that are terminal, this pain review would also include the people who were not terminal, because it is intolerable suffering outside that time limit.

Whilst now it is on record that we believe that could be the scope of the review in three years time, it gives me some hope. This organisation is saying it is underfunded, it is under-resourced and people on the north-west, west, south and north do not have access to it, that is an area that -

Ms Forrest - They should get access. You should not have to make this the alternative.

Mr GAFFNEY - Therefore, they should have access to appropriate pain management. So, from that point of view I can understand. It is flagging to the Government that this is an issue that needs to be addressed and this was an appropriate way of doing it.

I understand, and do appreciate, the member for Murchison's additional amendment to come back to at the end, because that is really important.

That is why I have put the change in. It was an opportunity to say okay, they do not qualify within the six- and 12-month frame limit, they still might be terminal, they still suffer in pain, what can we do? We need to review that to get it right and provide to the government better information so they can provide better services across the state to assist those people.

Madam DEPUTY CHAIR - The question is that the amendments be agreed to.

The Committee divided -

AYES 3	**NOES 11**
Mr Gaffney (Teller)	Ms Armitage
Mr Valentine	Mr Dean
Ms Webb	Ms Forrest
	Mrs Hiscutt (Teller)
	Ms Howlett
	Ms Lovell
	Ms Palmer
	Ms Rattray
	Dr Seidel
	Ms Siejka
	Mr Willie

Amendments negatived.

Ms FORREST - Madam Deputy Chair, I move -

Fourth amendment

Clause 142(5) -

Leave out the subclause.

As the member for Windermere rightly pointed out it is noticeably a mismatch if it is included considering the overall review of the bill. I have already spoken to the principle of this when I spoke to the member for Mersey's amendment so I will not repeat what I said.

Amendment agreed to.

Ms FORREST - Madam Deputy Chair, I move -

Fifth amendment

Clause 142(6) -

Leave out the subclause.

That is because we have just removed subclause (5).

Amendment agreed to.

Ms FORREST - Madam Deputy Chair, my sixth amendment relates to the periods of review and how often they should be done. I move -

Sixth amendment

Clause 142(7) -

Leave out the subclause.

Insert instead the following subclause:

7. The Governor is -

(a) after the end of the 8-year period beginning on the day on which this section commences, to appoint a panel of persons, nominated by the Minister, to conduct a review of the operation of this Act in relation to that period; and

(b) at the end of each subsequent 5-year period after the end of the 8-year period, to appoint a panel of persons nominated by the Minister, to conduct a review of the operation of this Act in relation to that 5-year period.

After the first review in three years, currently in subclause (2), this amendment will create a rolling five-year review. This amendment tidies that up because there was going to be another one-year review going on to a five-yearly review after that. That was considered to be the most appropriate. It takes a lot of work to review such a big piece of legislation and after three years, one would expect there would be enough data and evidence to do a review, then every five years after that - particularly as we would expect not to see large numbers of people accessing this. I believe that gives time for it to be properly considered and whether there are gaps or things that need tightening up or other provisions made. It is to provide the first review in three years and then every five years after that.

Mr GAFFNEY - I am quite comfortable where this amendment is now. Initially in the bill, had we had the two-year and the three-year reviews, it would have been good to have the five-year one. For young people and pain, you would then have the five-year review because you could take some of those recommendations and include them. It makes sense now to go with three and five years. I am more than comfortable with this amendment going ahead and I will support the amendment.

Amendment agreed to.

Clause 142, as amended, agreed to.

Madam CHAIR - It is now 10 o'clock, and we only have a couple of small matters left - clause 143 and the postponed clauses. Can members indicate if they are happy to continue

with the member for Mersey? I do not know how long the new clauses will take - we may need to reassess it - but if members are happy to continue at this point, we will do so.

Mr Dean - We have set aside Friday. Some people might not want to sit on Friday, but we set that day aside to continue this bill. It has been a pretty emotional sort of day, starting at 9 o'clock this morning.

Madam CHAIR - If somebody wants to get to their feet to speak to me, I am happy to listen to them.

Mr DEAN - We have had a very long day. We started at 9 o'clock this morning, then we had lunchtime meetings as well, so we did not get a break then. It is now 10 o'clock at night and we have been discussing a very emotional bill. It is not as though it has been an ordinary bill where we have been able to enjoy the day.

Madam CHAIR - Make your comments brief as we are soaking up time.

Mr DEAN - We have Friday set aside.

Madam CHAIR - Do you want to move a motion that we report progress?

Mr DEAN - I do. I move -

That the Committee reports progress and seeks leave to sit again.

Had we not set Friday aside, I could understand this, but this is an extremely emotional matter which has caught up with some members more than for other members. We need to be able to concentrate on the amendments coming forward and the parts that are now being referred to. I am confident there will be quite a lot of discussion on those parts as well.

I do not see why we should sit on. We will still be here at midnight or later, and we have briefings again in the morning at 9 o'clock. We are not machines and it is reasonable that the motion to report progress be supported. I urge members to support it, not for the fact that you do not want to come back on Friday but to look at it for all the other good reasons as to why we have done sufficient today to warrant us leaving now.

Madam CHAIR - I make the point that the honourable Leader, through her staff, has sent an amendment saying she has very generously cancelled the 9 o'clock briefing, which will not occur until 10.30 a.m. The member for Montgomery might like to refer to that.

Mrs HISCUTT - We have taken the opportunity to rearrange our 9 o'clock briefing and postpone it to 10.30 a.m. so we will not be starting until 9.30 in the morning. That is an extra half hour in bed.

I will speak against the motion, unfortunately, member for Windermere. I am quite happy to sit for another hour.

Motion negatived.

Madam CHAIR - We will review this again before it gets too late. We will not be going until midnight.

Clause 143 -
Regulations

Ms LOVELL - Madam Chair, I move that clause 143(4) be amended as follows -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Amendment agreed to.

Clause 143, as amended, agreed to.

Clause 144 agreed to.

Postponed clause 4 -
Interpretation

Ms LOVELL - Madam Chair, I move that postponed clause 4 be amended as follows -

First amendment

Definition of ***approved*** -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Second amendment

Definition of ***approved voluntary assisted dying training*** -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Third amendment

Definition of ***Commissioner*** -

Leave out the definition.

Insert instead the following definition:

'**Commission**' means the Voluntary Assisted Dying Commission established by section B(1);

Amendments agreed to.

Ms LOVELL - This is consistent with amendments that have already been agreed to in relation to the make-up of the commission.

Fourth amendment

After the definition of ***decision-making capacity*** -

Insert the following definition:

'**Deputy Executive Commissioner**' means the Deputy Executive Commissioner appointed under section B(2)(b).

Fifth amendment

After the definition of ***eligible to access voluntary assisted dying*** -

Insert the following definition:

'**Executive Commissioner**' means the person appointed to be the Executive Commissioner under section B(2)(a) and includes the Deputy Executive Commissioner, when acting as the Executive Commissioner.

Members, these amendments are to insert the definitions of deputy executive commissioner and executive commissioner as agreed to in the new clauses we debated earlier.

Amendments agreed to.

Mr VALENTINE - Madam Chair, I do not like my strike rate so I am not sure this one will get up, but I move that clause 4 be amended as follows -

Sixth amendment

Definition of ***driver licence*** -

Leave out 'another person'.

Insert instead 'a person'.

When I read this clause, I was confused about what 'another person' would mean. I was then I was pointed to clause 10, where it says -

(5) For the purposes of this Act, evidence of a person being, or not being, at a particular time, ordinarily resident in Tasmania includes, but is not limited to including, evidence of any of the following:

(a) the day on which the person was issued a driver licence ...

It is an indefinite article and so therefore I really do not think it should have 'another person'. Hence my amendment to a 'person to drive'. It is confusing as to who is this 'another person'.

Mr GAFFNEY - I do not think it is necessary, but I am not going to argue. I am more than happy to take this amendment on board.

Mrs HISCUTT - Is the member for Mersey saying that what is in the bill as it is printed on page 12 is a drafting style and nothing more?

Mr GAFFNEY - That is correct. The Office of Parliamentary Counsel assured me what is written here is fine, but it is also comfortable with the suggested amendment. I want the member to go home happy and improve his strike rate. I am more than comfortable for this amendment to be accepted.

Mr DEAN - I just do not see the reason for the amendment. My interpretation of it is that it is perfectly right. I see absolutely nothing wrong with it - another state or territory authorising another person to drive. With the greatest respect to the member for Hobart, I cannot see the reason for the amendment. It is clear, it is lucid and, in my view, it is the way it should be written. It is absolutely no different - 'another person' to 'a person'. I cannot see we should accept amendments for the sake of accepting an amendment or to keep somebody happy. We should not support the amendment in my view, and I cannot support it.
'

Mr VALENTINE - Throughout this bill, it talks about the 'other person' and 'another person' and it is all in relation to the person who might be 'the person' who is the voluntary assisted dying person. Why is that 'another person', not 'a person', to drive? It is simply a person to drive. If you read it, are they giving it to someone else as opposed to 'the person' who has got the driver licence? It does not read correctly to me, but that is for everybody to decide.

Amendment agreed to.

Ms LOVELL - Madam Chair, I move clause 4 be amended by -

Seventh amendment

After the definition of ***first request*** **-**

Insert the following definition:

'**health service**' has the same meaning as in the *Tasmanian Health Services Act 2018*;

This is in relation to the amendment we moved much earlier in the debate to clause 14, which was to do with the communication and translators. Members will recall that the amendment to clause 14 in my name, inserted the provision that 'the other person … is not directly involved' in providing health services or professional care services to the VAD person.

This amendment is to insert a definition of what is captured by the term 'health services' and keeping that consistent with the Tasmanian Health Services Act 2018.

Mr GAFFNEY - This is an appropriate amendment and I will be supporting it.

Amendment agreed to.

Ms FORREST - Madam Deputy Chair, I move that clause 4 be amended by -

Definition of ***medical practitioner***.

Leave out the definition.

Insert instead the following definition:

'**medical practitioner**' means a person -

(a) who is registered under the Health Practitioner Regulation National Law (Tasmania) in the medical profession (other than a student); and

(b) who is registered under that Law for clinical practice in that profession -

(i) without conditions; or

(ii) on conditions that the Commission has determined under subsection (2) to not be material conditions.

I know the member for Huon proposed amendments to change the definition regarding medical practitioners. I am pretty certain this will not be supported and that is okay, except that in the second part of it, 'without conditions' is the matter that was of significance.

This was raised by some medical professionals who identified the reality that sometimes medical practitioners and nurses or any practitioner registered under AHPRA, the health regulator, can have conditions imposed on their practice, conditions such as requiring supervision or requiring them not to work with a certain sector of the community. It may be that someone has been accused of elder abuse or something like that, and they are not required to work with older people, for example.

This was a concern and I wanted to put this out there. I supported the amendment to the definition relating to medical practitioners which has now been inserted in the bill. It was a more appropriate amendment to clarify whom we are talking about in terms of who could be a PMP in terms of a GP, a specialist in their own right with appropriate skills and qualifications and longevity of experience. I wanted to raise this as a concern. I know that the commission has to approve someone through the training and add them to the list. One hopes that if the concerns regarding a condition that may have been imposed on a health practitioner with regard to their practice, particularly if it related to people who are more likely to die - for example,

elderly people - they would not be issued with a certificate under the training, but it would be one of the assessments made.

I had some discussions with the member for Huon at an earlier time. I wanted to put that out there. If anyone else wants to make a comment on this, I would be really happy to hear it. It concerned me. We get to the next one about nurses. The same thing applies. Nurses can have conditions imposed on their registration that may restrict areas in which they may work.

The amendment we previously dealt with in relation to medical practitioners really makes this superfluous. It is important we acknowledge that some medical practitioners have conditions placed on their registration to practice.

Mr GAFFNEY - I commend the member for Murchison's approach, which is that she has put it on the record. I have been informed it is not common for definitions to be amended or have conditions put on them so in light of that, I do not think it is necessary and I will not support the amendment.

Mrs HISCUTT - I thought it would have been more appropriate for the commission to decide who is an appropriate person. It would make the list of who it thought were the appropriate health professionals to do that. I should imagine they would look very carefully at anybody who put their name forward with a condition attached to them. I would think it would be ticked off when they had it sorted at the commission stage. Is that your understanding of it, member for Mersey?

Mr GAFFNEY - Yes, that is why we had some concerns about putting conditions into a definition, as the definition.

Dr SEIDEL - I am inclined not to support the amendment. Looking at other jurisdictions - for example, Victoria - this is all part of regulation. The conditions are being checked pretty much in real time at any stage of the process. There really is no benefit in legislating for it; it is really part of regulation.

Ms FORREST - I seek leave to withdraw the amendment.

Leave granted; amendment withdrawn.

Ms LOVELL - Madam Deputy Chair, I move that clause 4 be further amended by -

Eighth amendment

After the definition of ***medical practitioner*** -

Insert the following definition -

'**member of the Commission**' means a person appointed to the Commission under section B, including the Executive Commissioner and the Deputy Executive Commissioner;

So, members, just inserting a definition for 'member of the Commission'.

Amendment agreed to.

Ms FORREST - Madam Deputy Chair, I move that clause 4 be further amended by -

Ninth amendment

After definition of ***member of the family*** -

Insert the following definition

'**nurse practitioner**' means a person who is registered under the Health Practitioner Regulation National Law (Tasmania) in the nursing profession and who is endorsed by the Nursing and Midwifery Board of Australia to practise as a nurse practitioner;

We refer to nurse practitioners in this bill but they are not defined. They are nurses, but they have additional qualifications and they should be recognised as nurse practitioners.

Mr GAFFNEY - I am more than comfortable with the amendment and thank the member for Murchison.

Amendment agreed to.

Ms LOVELL - Madam Deputy Chair, I move that clause 4 be further amended -

Tenth amendment

After the definition of ***private self-administration request*** -

Insert the following definition:

'**professional care service**' means any of the following services provided to another person under a contract of employment or contract for services -

(a) assistance or support including the following -

(i) assistance with bathing, showering, personal hygiene, toileting, dressing, undressing or preparing or eating meals;

(ii) assistance for persons with mobility problems;

(iii) assistance for persons who are mobile but required some form of assistance or supervision;

(iv) assistance or supervision in administering medicine;

(v) the provision of substantial emotional support;

(b) a specialist disability service within the meaning of the *Disability Services Act 2011*.

Members, this is again in relation to the amendment earlier agreed to regarding interpretation and communication to insert a definition for 'professional care service' which was a term used in that previous amendment.

Mr GAFFNEY - Again I concur and agree with this amendment, and I thank the member for Rumney.

Amendment agreed to.

Ms FORREST - Madam Deputy Chair, I will not be moving the further amendment, acknowledging the comments made in relation to the previous one.

Ms LOVELL - Madam Deputy Chair, I move the following amendment -

Eleventh amendment

Definition of ***VAD substance*** -

Leave out 'Commissioner'.

Insert instead 'Commission'.

I might continue with my other amendments because they are similar.

Twelfth amendment

Definition of ***voluntary assisted dying process***, paragraph (m) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Thirteenth amendment

Definition of ***voluntary assisted dying process***, paragraph (n) -

Leave out 'Commissioner'.

Insert instead 'Commission'.

Amendments agreed to.

Clause 4, as amended, agreed to.

Postponed clause 5 -

Ms FORREST - Madam Deputy Chair, we postponed this, at my recollection, at the point of the second amendment in my name. I seek some clarity from the Clerk. We have already put in the prognostic time frame. So we are good to go.

After subclause (2) -

Insert the following subclauses:

(3) The Commission, on the application of a person, may determine that the person is exempted from the requirement of paragraph (c) of the definition of ***relevant medical condition***.

(4) The Commission may only determine that a person is exempted from the requirement of paragraph (c) of the definition of ***relevant medical condition*** if the Commission is satisfied that the prognosis of the person's relevant medical condition is such that the paragraph should not apply in relation to the person.

(5) The Commission may, so as to assist the Commission to decide whether or not to make a determination under subsection (2) in relation to the person -

(a) request a medical practitioner, who has specialist knowledge as to a relevant medical condition that it is a relevant medical condition in relation to a person, to advise the Commissioner in relation to the relevant medical condition; and

(b) request a medical practitioner to provide to the Commission medical records, in the possession of the medical practitioner, in relation to the person.

I spoke briefly to this when we dealt with the prognostic time frame that we put in at our last sitting. This gives a person who may not fit that prognostic time frame - they still have a terminal illness as per the rest of the requirements to access VAD, but may not have a prognostic time frame of six months or 12 months for neurodegenerative conditions; things that are rarer conditions or where the prognostic capacity is more difficult. The person can make an application to the commission to have that requirement of a six-month or 12-month prognostic time frame for neurodegenerative conditions waived and can actually start the process. It does not remove any other steps in the process. It enables them to make a first request and continue on that pathway if they desire to do that.

In making that determination, I am not suggesting in any way that a commissioner should be making medical determinations. They may have medical practitioners on the commission. We do not know who is going to be on that, but they would be required to consult with a relevant medical practitioner to determine whether that is a reasonable request, why that should be waived and, if they agree, they can notify the person of that, and they can then make that first request and start the process.

As the member for Mersey said, it is a reasonable compromise. I believe it is because there are some conditions where it is more difficult to determine the actual life expectancy of a person. This gives that little bit of flexibility where it enables people who fall outside that quite strict framework we are putting in place for all the right reasons, to potentially access it.

Mr GAFFNEY - Whilst I will put on record it is not perhaps the preferred option I had at the origin of the bill, I do appreciate this opportunity that goes into the bill in this guise. I congratulate the member for Murchison for putting it there to allow no circumstances where there is a possibility for somebody to be brought towards the commission for extra involvement. Thank you, and I am supportive of this amendment.

Amendments agreed to.

Clause 5, as amended, agreed to.

New Clause A to follow clause 2 -
Objectives and principles

Mr GAFFNEY - Madam Chair, I move -

That new clause A be read the second time.

Madam Chair, the Government recommended this through the feedback we received because, due to the length and complexity of this bill, they felt the inclusion of the objects or purposes clauses would be helpful to the interpretation of the bill.

I had been advised before that ordinarily they are not included in legislation because it is no more than a restatement of what the act already does. However, I examined both the Victorian and the Western Australian legislation in this respect and drafted a suitable objectives and principles clause for a Tasmanian context, and introduced both into this bill in this form. That is why we have both the objectives and principles. I encourage members to support new clause A.

Ms RATTRAY - I rise to put my support for this amendment. It is really useful to have the objectives and principles in the bill as was suggested by the Government. It certainly assists anyone who will be looking at this into the future. It was certainly well explained. I certainly support the new clause.

Mr VALENTINE - I really believe this adds a significant amount to the bill. It stops, or at least reduces, the opportunity for people to say what the bill is when it isn't. I think it clarifies it. I am certainly supportive of it.

New clause A read the second time.

New clause A agreed to.

New clause B to follow clause 14 in Part 4
Certain persons not to initiate discussions about voluntary assisted dying

Ms LOVELL - Madam Chair, I move -

That new clause B be read a second time.

This is the clause that has sparked some discussion and has been commonly referred to as a 'gag clause'. I believe that is an inaccurate way of describing this clause because this clause does not gag anyone. What this clause does do is require a healthcare worker or medical practitioner, anyone who is working with a patient or a person in that capacity, to only initiate a discussion about voluntary assisted dying if at the same time they present all treatment options available to that person.

It is not saying that they cannot raise voluntary assisted dying as a treatment option available to the patient or the person but that if and when they do they must also put on the table all of the treatment options available to that person.

Arguments that I have heard against this clause - and perhaps without reading the clause in full and I would not expect everyone who has a view on this to have read the clause in full, that is why we are here - have been that patients, and this is probably the strongest argument, should be, and have the right to be, informed and educated about all the options that are available to them including voluntary assisted dying. That is exactly what this clause would do. It would require the health practitioner to inform the patient of all those options including voluntary assisted dying at the same time.

I urge members to support the amendment. I believe it provides a level of comfort and protection to healthcare workers that is desired by those medical professionals. At the same time, it offers a level of protection to patients without imposing any unnecessary obstacle or barrier in terms of access.

Mr GAFFNEY - While I understand the intent of this amendment I consider it to be unnecessary. There are sufficient safeguards for individuals in this bill. This bill is about the individual, the individual doctors, the nurses, the VAD persons, and all have the right to object to participation on a conscientious ground.

It is not appropriate to create barriers for, potentially, years. For example, a resident in an aged care facility, based on the objections of the provider. This is discriminatory and concerning. In the remote chance that the healthcare practitioner had a holistic care conversation with the person where the VAD might be discussed and inadvertently missed particular elements, there are already robust provisions in the bill to cater for this.

Clause 22 ensures that a person making the first request is provided with all the relevant information about eligibility by their PMP, a fully qualified medical practitioner who meets the experience and VAD training requirements of the act. I ask members to take a little time to reacquaint themselves with clause 22 before voting on this amendment. Members will note that clause 22 extends through an expansive list of requirements drafted over nearly three pages. This ensures a holistic care discussion that includes the person's medical conditions, the interaction thereof, their prognosis, complications, reasonably available treatments that may relieve suffering, together with palliative care options.

Additionally, there are extensive provisions within Part 18 - Offences, in particular clause 122, where it was originally suggested this amendment should be placed. I draw members' attention to clause 122, Inducements and dishonest or undue influence -

A person must not -

(a) offer to another person an inducement for the other person to make a request under this Act, to give a final permission or to inform a PMP or AHP under section 15; or

(b) exercise dishonest or undue influence on a person in order to induce the person to make a request under this Act, to give a final permission or to inform a PMP or AHP under section 15.

The penalty is imprisonment for a term of five years, or a fine not exceeding 200 penalty units, or both.

I believe this clause offers the safeguards that the member may be seeking, together with a wider scope and far stronger penalty. Within this bill, I have been mindful to ensure that medical practitioners who may wish to discuss legal medical options with a person are not found automatically guilty, simply through an inadvertent omission in the flow of conversation when responding to a patient's needs.

The bill, as drafted, ensures that every person must receive an all-encompassing exploration of all their care options at the time of determining their eligibility in a truly holistic way, together with strong safeguards against collusion by any person.

Members are reminded to agree to this amendment. I will move an amendment to this before it is put to the Chamber -

After 'health practitioner is'.

Insert 'capable of constituting the proposed new subclause (5)'.

This is to mitigate the automatic assumption of guilt without due process and align the clause with the wording and the scope of clause 134. After all, which members in this place will want to see nurses and care assistants be automatically be found guilty?

It is still my preference that the final version of this amendment should fail. However, if it is to be accepted, I believe it needs to be tempered with a commonsense approach, and to be fit for Tasmania.

The only person who may raise the topic of VAD with a person unconditionally is a medical practitioner or a doctor. Anyone else may inadvertently find themselves being found instantly guilty of a professional offence through a simple misunderstanding. Definitions used in the amendment - the definition of a healthcare worker as a registered health practitioner and any other person who provides a health service or professional care service is further defined in an additional definition, at page 14, meaning anyone employed to help a person in virtually any capacity.

Does this mean that the district nurses, the care assistants and NDIS staff need a whole suite of training so as not to inadvertently fall foul of this clause? Is this expected to be an additional role of the VAD commission, or will THS, NDIS service providers and individual staff members be responsible for devising this?

Then we have a medical practitioner. A medical practitioner 'means a person who is registered under the Health Practitioner Regulation National Law (Tasmania) in the medical profession (other than a student) and who is not a psychiatrist'.

We have a registered health practitioner. It means 'a person registered under the Health Practitioner Regulation National Law (Tasmania) to practise a health profession (other than as a student)'.

I would like to provide a few quotes here. As Dr McLaren says -

> [The bill removes] what we refer to as the 'gag order'; the clause of our legislation that states that we cannot raise the option of VAD with our patients. This disadvantages patients who are not as well educated or aware of legislative change, or who are non-English speaking background. Tasmanian doctors will be able to offer their patients the full range of end-of-life care options, that are not exclusive to each other - in the course of my assessments, I often advocate for and refer to community palliative care services if symptom control is the patient's main issue for applying. Victorian VAD doctors don't see VAD in opposition to palliative care, rather complementing it to provide end-of-life care for patients that is in keeping with what they want.

New clause A is the reinstitution of the gag clause. Please note, just legislate that it is illegal for any individual to coerce a patient with regards to their choice to pursue VAD. That will provide the same level of protection without us having to resort to playing an elaborate game of charades with patients, and to automatically qualify it as unprofessional conduct is very judgmental.

Already there is enough evidence in clause 122. According to Ben White and Lindy Willmott -

> Clause A is really not initiating discussions. This is modelled on the Western Australian approach, which is certainly better than the blanket prohibition of Victoria. That said, it adds unnecessary complexity to the bill, and addresses the mythical situation that a doctor would suggest VAD but not have a wider discussion about the person's illness, options, et cetera.

Further, they say -

> Clause 22 of your bill requires the provision of this information during the process, so this would have had to have occurred then as well.

Here is an excerpt from the second reading speech of the Honourable Pierre Shuai Yang MLC, the Government Whip in the Legislative Council, and devout Catholic -

> I wish to move on to the last concern that caught my eye, which is doctors raising the subject of voluntary assisted dying. The Victorian model prohibits a doctor from discussing and bringing up the subject of voluntary assisted dying with their patient. Initially I was inclined to support or at least look at that as an option. If Victoria chose a certain path, we should probably look at

it and seriously consider whether we should adopt it. Again, with further research, I found that Victoria is the only jurisdiction in the world that prohibits the doctor from raising the subject of voluntary assisted dying.

New clause B, which follows clause 122 - and which is also known as a gag clause - seems to have infiltrated Victorian legislation, is not included in the Western Australian legislation, and serves no purpose other than to be an obstacle making life miserable for vulnerable people.

In concluding, it is important to remember that this legislation is intended to help vulnerable people who are having a thoroughly miserable time to be offered and allowed a wide range of options that they can accept or reject as they please. It is not intended to be, and should not be allowed to become, yet another bureaucratic nightmare adding bureaucratic misery to their medical misery. I will not be supporting the amendment.

Dr SEIDEL - I know it is late, but I am mindful that it is important to discuss the detail of the amendment, and not just driving to conclusions looking at the heading or title of the amendment, and then labelling it a gag clause, and then saying the gag clause in Victoria is the same as the gag clause in Western Australia, and the same as something that has been proposed here - because it is just not the case.

I appreciate the comments from the member for Mersey about the issues with the Victorian gag clause, and the response of the Victorian doctor who rightly identifies that health practitioners in Victoria are not allowed to initiate a discussion about VAD.

Extensive comments have been made, but that is not what this amendment proposes at all. This amendment certainly proposes that a health practitioner - which is a medical doctor, a registered nurse, and it can actually also be a medical student, if they are registered under the AHPRA, and most of them are these days - who is directly involved in this patient's care, cannot raise VAD in isolation. They can initiate a discussion about VAD, but they also have to say there are other options.

It is specifically designed to reassure the public that you are not going to see Dr Death, who is only going to talk about VAD and nothing else. That is all it does. It has nothing to do with the gag clause in the Victorian legislation at all.

We heard earlier from the member for Rosevears about emails and social media traffic that we are exposed to. I appreciate the public often does not read through the amendments. They might read a title or an interpretation of an amendment. Interpretations often come through particular lenses, and that is unfortunate.

It is late, but we should not be falling into the trap of just looking at titles or the perceived intentions of amendments. We should actually look at the amendments as they are written and printed and provided in writing.

The member for Mersey's amendment is very much modelled on Western Australia. Certainly, it allows health practitioners who are directly involved in the respective patient's care to initiative VAD, period. Yes, they are also obliged to explain and explore other options with the patient, which I believe is entirely appropriate.

It is not a gag clause. It prevents coercion. It prevents that the health practitioner will raise VAD as the only option. If they do, then this will be a contravention of subsection (2). That would be considered unprofessional conduct for the purposes of the health practitioner and national law. It is a reportable offence which again is entirely appropriate. I support the amendment from the member for Rumney.

Ms WEBB - I agree that this new clause is not a gag clause on medical practitioners, the way I read it, because it does what we would assume would happen anyway. When the medical practitioner brings up this option, initiates conversation, they do it in the context of presenting the full range of options that are available. I do not see it as a gag clause on medical practitioners. However, I do see it as a gag clause on other healthcare workers and professional care service workers.

If we look at (2) where it says 'a health care worker who provides health services or professional care services to a person must not, in the course of providing services to that person, initiate discussion', et cetera. In (3), we exempt medical practitioners, under certain circumstances, from the requirement to present the other options. We say people can provide information if it is asked for. In (5), we talk about contravention in relation to the registered health practitioners.

What about other healthcare workers who are not registered practitioners and who are not medical practitioners and may be providing, for example, professional care services to the person? We have included a definition for them in clause 4. They could be people providing assistance with anything such as bathing, showering, personal hygiene, toileting, et cetera.

This appears to be gagging the support services or healthcare workers who come into that category who are not medical practitioners according to the definition in the bill and are not registered medical practitioners. I am also concerned because not only are we gagging them in part (2), but we are not defining what the consequence is if they were to initiate a conversation. The consequence presented in part (5), contravention of subsection (2) by a registered health practitioner is unprofessional conduct, which I presume has consequences in the professional realm for that person, but what is the consequence for a healthcare worker who is providing professional care services who initiates conversation?

Initiating a conversation does not necessarily go to clause 122, which is about the penalties that apply for inducing or encouraging VAD. Raising it, making somebody aware of it, is not necessarily the same as inducing or encouraging, which is what you can imagine the healthcare worker or a professional care service person providing assistance might do.

That person cannot be captured by (3). I am someone who began my career providing community aged care services and I was showering, toileting, shopping and doing all those sorts of things we have defined in professional care services. If I am there doing that and I have mentioned VAD as an option or as a concept to that person in the context of what their circumstances are, I cannot then, in that circumstance, because I am certainly not qualified to, talk about the treatment options available to the person, the likely outcomes of the treatment or the palliative care treatment options. That is all something that a medical practitioner can do and we are requiring them to do here. We cannot necessarily require professional care service workers to do that.

I am concerned about the gag here. Not on medical practitioners but on others. I am not sure how that can be rectified. It is quite distracting to talk about how wonderful it is and it is not a gag on medical practitioners. However, you are gagging someone. Unfortunately it is going to be a lot of the people who are spending a great deal of intimate time with people in these particular circumstances. If we are saying that those support services and assistance services who are spending a lot of intimate time with and caring for these people cannot mention VAD in the context in which they are operating, not to encourage, not to induce but to make the person aware that it is there as a legal option should this pass, that is problematic.

It is one step from saying family members cannot mention it to other family members, or friends cannot mention it to friends, or work colleagues cannot mention it to work colleagues.

It becomes problematic when we are gagging that group of people. I am interested to hear what other people think about that, or if I have read this incorrectly and we are not gagging workers in those categories.

Mr GAFFNEY - I thank both members for that. I mentioned two things right at the beginning of the bill: the VAD process has to be truly patient-centric with the needs of the person who may be seeking a VAD process; and is this a necessary safeguard or is it an unreasonable bureaucratic hurdle to fair and equal access?

I know it is not meant to be a hurdle. If there was any part in that clause that I thought was not already covered in the bill then I would be introducing it. All that is initiated in here is actually in the bill without some of the issues that the member for Nelson has just raised. In our wider community at the moment everybody seems to be talking about this issue. I would hate to get to the stage where somebody in conversation close to somebody could then be held responsible for having an indirect conversation. I do not think it is necessary. That is why this is not necessary. That is why people have commented to me, people who have worked in this space, that this is an unnecessary bureaucratic hurdle for people and it should not be accepted. I hope members will not accept this new clause.

Ms LOVELL - I want to address some of the comments that have been made. Others have addressed them already, but I remind people how important it is that we stick to the facts and we are very clear about what we are intending to do. We have given members the respect of that. We have spoken about why that is so important when this is a bill that people are watching closely, that people feel strongly about and that people are voicing their views about, which is entirely appropriate. It is incumbent on all of us to stick to the facts and not to be making implications about intent that is nowhere near the intent of this clause. The member for Mersey would know that.

I am surprised by the contribution from the member for Mersey. The member for Mersey mentioned he has an amendment to this clause. I would support that amendment. I would be very happy with that amendment, as the member for Mersey knows, as we have discussed that and discussed who would move that amendment and how it would be best dealt with. I am happy to support the member for Mersey if he chooses to move that amendment.

I want to go back to the comments that the member for Mersey made in his contribution, particularly the quotes that he included. Primarily they were from people who have experience in Victoria. He quoted Dr McLaren, who spoke about a gag order and how difficult that made things for them in Victoria, how that was an issue and created an obstruction. We can put those

comments aside because that is not what we are dealing with here. Dr McLaren and I think it was Dr Carr have raised arguments in the Victorian context that vulnerable people, people from non-English speaking backgrounds and people with low health literacy may not otherwise be aware of all their options and how important it is that those patients have all their options on the table. This clause would require that all their options were on the table.

Mr Gaffney - It is already in the bill.

Ms LOVELL - It is not in the bill. That is why we are inserting this new clause. The bill as it stands does not require them to put all those options on the table in this way.

This is about helping vulnerable people, as the member for Mersey raised. That is exactly what this new clause is intended to do. The member for Mersey argues that this adds a level of unnecessary complexity. I disagree with that statement. I believe this adds a level of protection for vulnerable people, for people who might not know all their options and who may not be aware of voluntary assisted dying as an option, who may not be aware of many of their options. Most people when faced with a terminal diagnosis are probably not aware of all of their options because they have not probably come across that before.

The member for Nelson raises questions about the inclusion of healthcare workers and professional care workers in this clause. I confirm that is what is in the new clause. That is the intention of it. When we are thinking about the circumstances in which people should be presented with their treatment options, including voluntary assisted dying, it is their medical professional that should be presenting those options. It is their treating doctor who understands their condition and understands the options that are available to them. That is appropriate.

This goes nowhere near saying that a family member or a friend or a neighbour or anyone else, even one of these healthcare workers, if they are not in the course of providing services to the person, if that is somebody that knows that person outside of that role, they can still talk to them about it outside of that role. This is just about initiating that conversation in the course of providing those services because they have not been engaged by that person to raise those options. That is not what their role is.

Members, I urge you consider this carefully. I do not believe this adds any unnecessary complexity. I do not believe it adds any unnecessary barrier. What it does is add a level of protection and a level of increased information and education that will be given to those people who this bill is designed to assist. Particularly those people for whom it is a real issue, those people who do not understand, who do not know that this is an option because of their networks outside of home or because they have not been following the news or they do not know what is available or they might not speak English. We have heard that the clause in Victoria prevents doctors from raising voluntary assisted dying for those people. Whatever the reason, those people, under this new clause, would be made aware of all their treatment options, including voluntary assisted dying. This is entirely appropriate and I urge members to support the new clause.

Mrs Hiscutt - Professional care services, which the member for Nelson was probably referring to, (5) where it says a 'contravention of subsection (2) by a registered health practitioner', there is no sanction on the professional care service. Do I read that correctly?

Ms LOVELL - Thank you for raising that. Yes. The consequence of contravening this is applied to registered health practitioners because that is the appropriate sanction. The member for Mersey has an amendment, which I have already said I would support. This new clause is being inserted into this part of the bill and not into the offences part of the bill. When this was drafted it was drafted to be inserted in the offences part of the bill. The member for Mersey brought that to my attention and I thank him for that because it was not intended that this would become an offence. Yes, that is the appropriate sanction for registered health practitioners. There is no equivalent appropriate sanction for those people in a personal care support role. We did not want to make it an offence, which would be the other way of dealing with that.

Mr GAFFNEY - I appreciate the member for Rumney's passion in this. I have to take members back to clause 22. I cannot see what the provision of clause 22 misses that this clause corrects. This bill has additional safeguards in clause 22 that negate the need for this.

My concern is we are adding something that is not necessary. It is fully catered for. When making the facts request, the person has a full and expansive conversation. The only person that can raise the VAD is a doctor. I am concerned that we should not be potentially spreading anxiety through other service providers because of this. I know that is not the intention, but I cannot see any advantages that are not covered in clause 22. It is an expansive range which covers everything in this new clause A. It is just not necessary.

I said if this did get passed there was a clause that I would be adding. I am pleased the member for Rumney has said, yes that would be, but it is not my preference. I was concerned here the other day when people said, 'We did not know about that and you are playing politics'. I did not want to do that. I do not think it is necessary. When we spent time with this it was very important that the bill was person-centric, working with OPC about what is best, how can we do this with all the safeguards and checks. That is what we came up with.

I do not believe that we need to have this new clause A from the member for Rumney. I encourage members to vote against the new clause.

Mr VALENTINE - If I was to go to my doctor and I thought my doctor was holding something back from me because of an act of parliament I would be shocked. I cannot understand why we would try to insert ourselves in private conversations between healthcare workers and their patients. We are talking about somebody who might, if they knew about it, access voluntary assisted dying. They have to prove competence to make the decision. You might say they are vulnerable, but they are individuals. This bill is all about having a choice.

I hear what the member for Huon is saying, that the person gets the fullest information. Maybe it is expressed in the wrong way -

> a health care worker who provides health services or professional care services to a person must not, in the course of providing the services to the person, initiate discussion.

It might have been better stated something like:

> a healthare worker, if talking to the person about voluntary assisted dying, ensured *x*, *y*, *z* was provided.

That is why people are saying it is a gag clause. It has this 'must not' feel about it. It is worded incorrectly. I repeat the point that healthcare workers and patients have conversations all the time.

It is like teaching someone to drive and you teach them about the accelerator but you do not teach about the hand brake, or the other way around, and they mistakenly drive themselves over a cliff because they did not know that this other thing existed. That is a ridiculous example but you get what I am saying. Why are we inserting ourselves in a conversation between the doctor or healthcare worker and a person? Some would say they are vulnerable. They are vulnerable, but they are also in a situation where they need to know what the options are that they have before them. What are we protecting them from in that regard? It is a personal choice.

While I might not choose it, this whole bill is about providing choice. This has been mentioned a few times, and I have mentioned it myself in the second reading contribution about it being a choice between death and death, not life and death. It is actually providing the choice that is important. Somebody wrote and told me that it is offensive to suicide, people who take their life. This is not about choosing between life and death, and death and death. It is about providing an option, and that is an interesting one.

When I pull all that together, I do not think an act of parliament should get between the doctor or healthcare worker and a patient who is suffering. They may not choose to go down this line, but to say that you cannot talk about it - you can if you are a medical practitioner, but not if you are some other level of healthcare worker - that does not seem right to me, and I will be voting against this on those grounds.

If you were thinking of putting it forward again, maybe downstairs, I would be looking at rewording it. I am sure of that.

Mr DEAN - You were saying that clause 22 covers all the areas that are referred to in this amendment. To include this amendment in this bill is simply a repetitive clause. I have often said in this place that when we are putting bills together, we should be careful not to have repetitive clauses with repetitive sections, because it simply confuses people. It is not the best way to put legislation together.

I support to some degree what the member for Hobart is saying in relation to healthcare workers. The way I read this is that they are not to initiate a discussion - but if the patient was to raise it, then it would be open slather for the healthcare worker to go into some detail about it and how they could access it and so on in that circumstance. They are protected once the other person raises it in some form or another.

Mr Valentine - How would you ever police it?

Mr DEAN - You are right. That is a matter the Honourable William Cox referred to in the report he provided to us, that it would be almost impossible to police. It would be very difficult indeed.

The decision I have to make is, if it is already covered in this bill, all these areas, whether I should support repetition within the bill. That is something I have said before I would not do.

Proposed section (5) has been raised, and the member for Huon referred to this. This is where a contravention of proposed subsection (2) by a registered health practitioner is unprofessional conduct for the purposes of the Health Practitioner Regulation National Law (Tasmania). That would mean they are open to some sanction in that area. I am not sure what it is. I suppose sanctions are removal of their right to practise perhaps, or whatever happens in there.

I am wondering why we would move that sanction outside of this bill, because everywhere else you look through this bill, where there are offences that are being identified as being committed under this bill, they are provided for under this bill. It does not go outside of this bill. I am not sure why, all of a sudden, we would have the one area here, and one area only, where any sanction that can be applied fits within another area, that is the Health Practitioner Regulation National Law (Tasmania). I am not quite sure why that is the most suitable option in the circumstances. I find that fairly difficult.

I am hoping there will be some further debate on this, but I am not quite sure where I will get it.

Ms FORREST - I was going to avoid getting out of the Chair, but I felt it was important to make a few points on this clause, and to reassure the member for Windermere. This is not actually a duplication. It is setting up a framework that a health professional can have a conversation with a person at any stage.

The requirements of section 22 relate to the first request. We have narrowed that down to that prognostic time frame. We have done that for all the right reasons. This a situation where someone comes in and gets a diagnosis of a terminal illness. They are not facing death for some time. In fact, they may recover. It could be a form of cancer that a new treatment has been developed for, and it may be experimental and they actually survive. So they discussed with their doctor their treatment options.

As I said in a previous comment, you always give a patient bad news in person. When you have given them bad news - this is bad news we are talking about - you do not then go in at that point to all the options, because they cannot take it in. So, you make an appointment for them to come back. At that point, they still could be a long way off from having to make a first request, if they want to consider that.

This provides an opportunity and a requirement that if you are going to talk about VAD as one option that may be available, you must also talk about all the palliative care options, the treatment options, if there is experimental treatment being offered. All those things, so the person can make a well-informed decision, and then consider perhaps at a later time going down the VAD pathway if that is what they choose.

This provides not a duplication, but an enhancement to the processes by enabling these discussions to happen in an appropriate framework where all the information is put on the table, not just one - as the member for Huon says, turn up to see Dr Death, because we are only talking about VAD; there are not many doctors who would operate in that way. But there is a requirement if you are going to discuss VAD, or initiate discussion around it. It is about the initiation of discussion. It is not about subsequent discussions. It is about the first time it is raised.

This supports the member for Mersey's desire to have a more open process, where it can be discussed earlier than when the person is actually facing death, in what you would term a more imminent time frame, which we are putting into the bill.

We need to be honest about this. This is not a duplication. It is a similar process that is required when the first request is made, but it is a process that can happen much earlier. It is an appropriate process to encourage that. The member for Rumney has already addressed a couple of those other matters.

In terms of the sanctions and appropriateness of having a registered health practitioner dealt with under AHPRA, that is what happens with all aspects of the health practitioner's conduct. There are two offences, unprofessional conduct and professional misconduct, and there is a range of sanctions that might be imposed. One might be that the person is required to undergo additional training. One might be that they do not work in a certain field anymore. The big heavy stick that hangs over people is the removal of your right to practise. That is not the thing that you are hit over the head with first. Usually it is training or supervision, or whatever. AHPRA does that sort of thing based on the advice of the medical councils and nursing council that regulates that.

It is the only appropriate process, in my view, to sanction a health practitioner who does not abide by the law. If they are guilty of some of the more serious offences in clause 122, that is much more serious and requires a harsher approach. But matters where there is an error of judgment, or something has happened within the health practitioner's normal role of work, that is appropriately dealt with under AHPRA. That is why it has been drafted that way, I assume. I did not have any role in the drafting, but I would assume that to be the case.

I support it. I believe it provides an additional process that can actually help the person. It can build the patient and health professional relationship. It enhances the availability of information, so people are making a decision over time, and not having to try to digest all the information at once at a highly stressful time.

Ms WEBB - It is important to be clear and honest about our conversations here. The issue arises because there are two things being done in this proposed new clause.

One of them is what the member for Murchison has just discussed. That adds something new to the bill. It is not covered by clause 22, because clause 22 is when the person has made the first request and the information is then provided to them. This captures on the one hand where a medical practitioner can initiate the conversation about VAD at an earlier stage than that as long as they, according to this, put all options on the table. We could all agree that there is nothing particularly wrong with that. It makes explicit something that we assume would happen anyway. I do not know how many Dr Deaths you have met in your life; I have not met any. We would assume that were someone to sit down with their doctor and the doctor was to bring up the options it would be highly unlikely that the doctor would only present VAD and not present the other things.

This is a bit belt and braces. We are making something explicit that is incredibly hard to imagine would ever happen otherwise. There is an appropriate penalty, sanction, involved if it did. That is fine. If it was just that I would think it was unnecessary but not harmful to add as a new clause. That is only one thing that this new clause is doing.

The second thing, which the member for Murchison did not address in her remarks and no-one has addressed thus far to my satisfaction other than the member for Rumney admitting that this is what it does, is that this gags other health professionals and care professionals who are involved with a person who are not medical practitioners, who are not captured by (3) and (5) with the sanctions. It is problematic that it captures those care professionals. It is now also highly ambiguous and somewhat meaningless because there is no sanction, there is no penalty, there is no way we can respond if somebody did do this.

If I was providing professional care services to somebody in a terminal condition and I am interacting with them because I am in there showering them and cooking their dinner, this says I cannot initiate a discussion about VAD while I am undertaking that role. It does not say anything about how we identify whether I did or not and what happens if I did. That is not here, so it leaves us hanging. If I am in that role I cannot do that, but how will we know? If we did know, what would we do? We do not know.

As someone who has worked in that capacity, the concept of initiating a discussion in those circumstances is really murky. It is different from going to my doctor and we discuss what my condition is. The doctor lays out options. That is a straightforward interaction.

If I am going in two or three times a week to shower someone, help with the cleaning and make the dinner, we are going to be conversing and interacting in all kinds of daily ways. We are going to be talking about all sorts of things relating to our lives, what is going on, what is happening for that person. What does it look like in that circumstance for me to initiate a discussion about this? Does it mean that out of the blue I say, 'Gosh, so you have a terminal condition, have you thought about VAD?' That could be an overt way I have initiated it, but that is unlikely.

What I imagine is the person is talking about the health condition they are in, talking about what life is like for them on a daily basis and they say, 'I really do not know what to do, I am not sure where I am going to go from here'. If I say, 'Have you talked to your doctor about a range of options? We do have VAD as an option in this state now', is that initiating the conversation? In some sense they initiated the conversation and I have engaged in the conversation. I find this problematic because of this murkiness.

If I am that professional, what am I not allowed to do? Where is the line we draw? How does that look in the nature of the interaction which is different from the nature of the interactions between a medical professional? What would we do in response if I had, in some way we could identify, initiated that conversation?

It is problematic because we put two groups of healthcare professionals and care professionals together in here. One of them, to do with the medical practitioners, was a clear thing, which although maybe unnecessary was not particularly problematic. The other thing is problematic. It puts people in a situation of jeopardy. There are thousands of Tasmanians currently working in these sorts of roles in the community and within facilities, caring for people, providing things that we have defined as professional care services. This is very problematic in relation to an understanding that we can give them, give their employers, their clients and that we can give the general community about what they can or cannot say and under what circumstances they can or cannot say it.

The member for Rumney said they could bring it up if they are not actually there doing their job. If I am not there showering them, but ran into them in the street and we had a casual conversation and we chatted about their health then, according to the member for Rumney, I could mention VAD. If I am in their home and doing the showering, I cannot mention it. This is murky and problematic.

If we are to have the bit that covers the medical practitioners in this, which I would not object to, I would like that separate. I do not know why it was not made separate. The matters relating to the other categories of workers in there either need to be removed entirely or reconceptualised in a much clearer way that does not leave thousands of Tasmanians who work in this space in such jeopardy and with such lack of clarity around what they can and cannot do under these circumstances.

Dr SEIDEL - I will make a few comments on concerns raised by the member for Hobart, about why we are potentially interfering with the doctor/patient consultation - and we should not. To a certain extent we do not. Certainly, medical practitioners and health practitioners are obliged to explore all options with patients. However, the main complaint is that patients often feel they have not been given all the options, whether it is surgical, medical or treatment options. The intention of the amendment is to say that is right, if the doctor initiates it they have to provide an overview of other treatment options as well, just to make sure those options are clear and very specific.

There is a distinction between health practitioners and medical practitioners in particular, because medical practitioners are the ones who would initiate the process. There is an argument to say, well, if the doctor tells me I should consider VAD, it must be quite bad and maybe I should consider it. It could be considered as coercion. If that is the only option on the table it can be really challenging. That is why we believe that should considered to be professional misconduct, if that is the case.

If it is healthcare worker who raises it, a social worker or psychologist, there is no entity because they are not upper registered, but they are still subject to the Health Complaints Commissioner. So, if you are a healthcare worker and a patient or a client felt there was inappropriate conduct and concerns raised, it is referred to the Health Complaints Commissioner.

Ms Webb - I do not believe that is true for a community aged care worker, for instance.

Dr SEIDEL - Who provides care services?

Ms Webb - Who provides professional care services as we have defined them, showering, shopping and cleaning. I do not believe that can be taken to the Health Complaints Commissioner.

Madam CHAIR - We passed legislation here to do that.

Ms Webb - I do not believe in that circumstance it relates to the Health Complaints Commissioner but I would be very interested to know. This why I think it is murky because we do not know and you have not put something in here that relates to it.

Dr SEIDEL - If it is a care service as provided through a care provider, I am quite certain the Health Complaints Commissioner would be the entity who would deal with the complaints.

There is an argument - and it was specifically raised in the lead-up to the Victorian bill - that in order to control for coercion and to ensure that the patient has capacity, it should be the patient who initiates the discussion as well. Again, I reject that argument. That is why we did not propose it for the Tasmanian context. There is an argument to say if it is voluntary it should be patient-initiated in the first place. I do not think that is reasonable. That is why we are proposing it can be initiated by a medical practitioner but only when other options are being put on the table as well.

Mr DEAN - Hopefully I have this right, but I see this amendment as a less formal process than that included in clause 22. That clause requires the PMP at the end of that process to report those circumstances to the commission, under clause 22(3) -

> As soon as reasonably practicable, but in any case within 7 days, after giving to a person the relevant information …

and is to report that to the commission. Under this amendment, hopefully I am right, it seems to me to be a process that will take place before that and in a less formal way. As I interpret this, there is no requirement here for the medical practitioner to report those circumstances to the commission. Am I right?

Ms Lovell - Clause 22 is a process for when the first request has been made to the primary medical practitioner. This new clause is referring to the initial conversation which could be many months before and it is less formal because it is a less formal conversation.

Mr DEAN - A less formal process.

Ms Lovell - Clause 22 is the formal request process.

Mr DEAN - That is exactly what I am trying to get to. It is a far less formal process. If you look at clause 22 it is interesting because it starts with -

> A person's PMP must, before determining under section 24 a first request …

Ms Lovell - That is making the determination, but that is the primary medical practitioner. Remembering this is the stage when they have made the request, the primary medical practitioner has accepted that role. That could happen many months down the track from them having this first conversation with any medical practitioner that may or may not end up being their PMP.

Mr DEAN - I am being converted to support your amendment. I am looking at it more closely, and looking at the fact that this could happen. The discussion under this amendment could occur, as you have said, six months prior to the situation arising for the first request and so on. A long time before it - and as I said, without any requirement here to report to the commission that this information is being passed on and there is this discussion that is occurring between the medical practitioner and the patient, and also a healthcare worker in some

circumstances where it has been raised with the healthcare worker in the first place and they have then been able to talk about.

I see that as a far less formal process. At this stage I am becoming more supportive of the amendment.

Dr SEIDEL - A point of clarification, it is the Health Complaints Commissioner and the act was passed in 2018.

Ms Webb - For community aged care workers?

Dr SEIDEL -Yes.

Ms LOVELL - I will address a couple of the comments that have been made. I am mindful of the lateness of the evening and the complexity of the matters that we are dealing with. This is an important matter and I want everyone to be very clear before we make our decision.

I believe we have addressed the issue around clause 22 and that this is not duplication because clause 22 is the process that happens at the first request, which as we have established could be some months down the track. It could be years down the track from when this first conversation happens. This is in relation to initial conversations between the medical practitioner and the patient.

The member for Hobart asked the question why we would be inserting ourselves in conversations between medical practitioners, between doctors and patients. There is an argument that we are not because we are only requiring them to put all options on the table.

We have inserted ourselves into the entire process really by legislating the process, the requirements, all the way through. Those decisions are being made. In fact, an amendment was passed earlier this evening by this Chamber requiring doctors to give information about the VAD process to the patient's family - with the consent of the patient. Once again, that is an insertion of the parliament into the conversation between a medical practitioner and their patient and their family. I understand your concern but I think we do that -

Mr Valentine - It is not preventing a conversation though, is it?

Ms LOVELL - But we do that a lot. We do that fairly consistently through this bill. We have inserted ourselves into the process and into the requirements that we are placing on medical practitioners.

The question was raised by, I believe, the member for Hobart and the member for Windermere around how this would be policed. The response is , we do not want to be policing it in the sense of monitoring every conversation between every doctor and patient, but it would be policed, it would be monitored in the same way as any concern or complaint about a person's interaction with their medical practitioner. We have established that is through the appropriate regulatory body and that is what is stipulated in this new clause as well. It would be policed in the same way that all health matters are policed - for want of a better term.

Member for Windermere, your question about why the sanctions in proposed subsection (5) goes to a process that is outside this bill. That has been addressed. That is consistent with health complaints and concerns and other instances of unprofessional conduct or professional misconduct. Anything that constitutes unprofessional conduct, as this would if this clause was supported, is dealt with in that way.

There has been conversation and answers to questions that the member for Nelson had on how sanctions or possible sanctions are regulated and governed for those other professional care service workers or healthcare workers.

Ms Webb - The questions I asked have not been answered in terms of where is the line and the murkiness? Those were my concerns.

Ms LOVELL - No, that is not what I am talking about. I am talking about the question you raised in relation to who governs and where the sanctions would come from for people in that role. We have established that would be the Health Complaints Commissioner.

Ms Webb - We have not put it in here. That is not in here.

Ms LOVELL - No, but I would suggest that is unnecessary because that is consistent with any concerns or complaints around their conduct in the execution of their role.

Ms Webb - We put the medical contravention in there; we did not put the other contravention in.

Ms LOVELL - That is how I have decided to move the amendment. You are welcome to move an amendment to the amendment, if you feel that it is appropriate.

In relation to questions of murkiness, I do not think it is murky. I accept that the member for Nelson does. She is within her rights to have her opinion but I disagree. We would be stipulating if this was supported by the Chamber that it would be in the course of providing services to the person. The member for Nelson argues that makes it murky because if the person runs into someone in the street they could then raise it. That is the kind of conversation we do not want to be trying to insert ourselves into.

We do not want to start talking about who can and cannot, in the course of going about their private business and their private conversations, talk about anything. That would be ludicrous. That is not a line I want to go anywhere near. That is very different from conversations that would happen during the course of the person providing that service that they have been engaged to provide.

I accept the member for Nelson's view that there is murkiness around what would constitute initiating a discussion and how that is policed and monitored. It comes back to the way the conduct of these workers in their duties is monitored and governed. That comes down to the patient, or the person they are caring for. If the person feels that it was inappropriate, the person involved would then have the appropriate avenue to follow through with the Health Complaints Commissioner. That is how it would be monitored.

Ms Webb - The monitoring was the second question. The initial question was, where is the line drawn? Where is the definition around what is initiating? I gave some examples about

where there is already a conversation and bringing it up. The way I read that, perhaps you can clarify this, it does not even need to be mentioning VAD in relation to the person that is receiving the service and the care. If I was a worker I would not be able to mention, for example, a member of my family was undertaking VAD.

Madam CHAIR - Order, if you want to take another call - the member for Rumney is using her third call. We need to try to make a point and avoid repetition.

Ms Webb - It goes to that question I was raising that is yet to be answered on the definition. I could not mention a member of my family accessing VAD according to 2(a).

Ms LOVELL - My intention behind the way this was worded, how I read this and how I would intend that it is read is that it is about initiating discussion with the person that is in substance about the voluntary assisted dying process. It will come down to the level of comfort of the person in that conversation. If the person is comfortable with this and the way it is raised, they will not go to the Health Complaints Commissioner and it will not be raised.

I am reluctant to get into definitions because there is a broad spectrum. This says it is not appropriate for people in that role to be initiating a conversation - not participating in but initiating a conversation - with the person they are providing care for about the voluntary assisted dying process, or about whether or not they person might wish to participate in that process.

It is not about if the patient brings it up or asks their opinion or asks if they know of anyone who has gone through it or asks if they know anything about it. That is appropriate. These are the conversations that should be initiated by medical professionals in the context of providing medical advice around that person's condition. I accept that you may disagree with that, member for Nelson, and that is fine.

Ms Webb - Madam Chair, can I have a clarifying question while the member is on her feet?

Madam CHAIR - A very succinct question.

Ms Webb - Yes, it is. The way I read this, the person who is receiving the care does not have to be imminently or not imminently wishing to access VAD or it to be relevant to them to access VAD. It could be anyone who is receiving professional care services, who -

Madam CHAIR - I am going to pull this up. We cannot keep having this to and fro.

Ms LOVELL - I am not comfortable with the level of detail we are getting into in relation to what people can and cannot say.

Madam CHAIR - The member with the call can explain her understanding of how she issued the drafting instructions to give effect, which she has done. We do not need to repeat all that. I will pull you up if you start repeating it again. It is all on the record and the intention is clear. If you want to add anything in addition to what you have already said, feel free but we are not going back down the path of you having to say that all over again.

Ms LOVELL - Thank you, Madam Chair. I do not intend to repeat myself. We have exhausted this as much as appropriate in this forum. I would like this amendment to be put to the Floor because I can tell there are conflicting views on it, so the Chamber can make a determination. We have got to the point in the debate where we are not going to reach agreement that has not been reached. I am comfortable to leave my contribution there. I have put my case and members can make their decision. I ask members to consider supporting the amendment.

Mr GAFFNEY - I am concerned about this after listening to the debate. I am concerned that in the first section, the member for Nelson said that there were some parts of this new clause that could be agreed to.

I was concerned, for example, if the VAD person went to their doctor and said they had talked to the lady coming to clean or to bathe them and had a big discussion about VAD, does the doctor have to report that because that would be an issue of concern? It says that a healthcare service or professional care service person must not, in the course of providing services to the person, initiate discussion with the person that is in substance about the voluntary assisted dying process. A care person works for the person, that person goes to a doctor and says 'the person who came in saw me on Thursday spoke to me about this and we had a good discussion about it'. There is some area of concern. There would be a number of professional healthcare service providers a bit anxious about what this could mean.

Ms Lovell - If I could respond to that question. The doctor, without being privy to that conversation and knowing who initiated it would not be in a position to make any kind of report. I am not suggesting they would do this, but elaborating on your hypothetical - if a patient came to a doctor and said 'my care worker brought this up and I am not sure about her, I am uncomfortable with that.' In the same way that if a patient said my healthcare worker brought up some other topic that I was not comfortable with or did something else that I was not comfortable with then yes, of course you would expect a medical practitioner to talk to that person about what their avenues might be to raise a complaint.

We are not talking about mandatory reporting or anything like that, which I feel that that is the line you are heading towards.

Mr GAFFNEY - You said that was not what you intended, but interpretation is done in the case of the law. Legally it might not be what you had intended, but that is the interpretation.

It has been suggested in this place that I have not done enough consultation. Have you consulted with the professional care services and the healthcare services that operate in this space about how they feel about this new clause and what concerns they might have? I have some concerns over what implications this might have. There is a punitive side to this. The proposed subclause (5) states it is unprofessional conduct, so there could be a punitive aspect.

Ms Lovell - Whether there is a sanction stipulated in the new clause that would apply to medical practitioners, so doctors. Yes, we have consulted with the College of GPs and the AMA on this.

Mr GAFFNEY - I am talking about the professional care services to a person - the people who go in to bath, clean and work there. How might this impact on what they are saying? Who is going to do that training for them? Who will be responsible for providing that information?

Ms Lovell - No, but you asked if I had consulted with those bodies in the context of proposed subclause (5), which is to do with sanctions and where a sanction can be applied, and yes, I have consulted with those bodies.

Mr GAFFNEY - My concern is whether it would be appropriate, Madam Chair, to report progress with a view for potentially the member for Rumney looking at some concerns with this one.

Ms Lovell - I have used all of my turns to speak.

Madam CHAIR - We still have to deal with this and there has been broad debate on it. I suggest we put it to the test.

Ms Lovell - If I withdraw my amendment now and had to move it again, I would not be able to speak to it.

Madam CHAIR - My advice is that we proceed with the question that is before the Chair, that the new clause B be read a second time. There are opportunities later on in the process to further consider these amendments, as we do in the next stage if you really felt there was a fundamental flaw with it, as with any of the amendments. If you would like to propose a further amendment at a later time you can do that. We cannot deal with any of that until we have dealt with this question.

Mr GAFFNEY - I encourage members to vote against this. It has been suggested to me that within three years there will be a review of the act and this would fall within the scope of that review. At that time they could look at the circumstances which might require there to be some work in that space. I encourage members to vote against this new clause, because I believe there is some murkiness. I also consider it raises a punitive aspect and it will cause anxiety for those people who work as health service providers or provide professional care services to a person. They obviously have not been consulted in this matter, although some doctors have been consulted through their associations.

I encourage members to vote against this new clause because I consider much of it is replicated in the bill as intended. Additionally, if there is a review of the act in three years time, this is clearly within the scope of such a review. If there has been an issue, it could be reintroduced at the review stage if need be, without some of the areas in it that are unclear.

I encourage members to vote against the new clause.

Mr DEAN - Is your reason for not supporting the amendment because it has repetitive parts? That is the only reason, as I understand it. It is not that it would wreck the bill. It is not that it would create any monstrous issues or problems within the bill other than the fact that it has repetitive parts.

Mr Gaffney - I am also concerned about the issue raised by the member for Nelson with some of the health service providers and the professional care services not being able to have a conversation. I believe that has been highlighted. In light of that I would not be supporting the amendment. I consider most of the rest of it is included in the current bill and so it is not

necessary. If it was to be deemed to be necessary, that could be included when the act is reviewed in three years time.

Mr DEAN - I understand you asked the member moving the amendment whether they had done any work to determine whether it is an acceptable amendment. I understand that the member commented on that.

I have this fairly clear now. Right now when the vote is taken on this matter I am going to sit on the fence there.

Madam CHAIR - The question is that new clause B be read the second time.

The Committee divided -

AYES 10	**NOES 4**
Ms Armitage	Mr Gaffney (Teller)
Mr Dean	Ms Rattray
Ms Forrest	Mr Valentine
Mrs Hiscutt	Ms Webb
Ms Howlett (Teller)	
Ms Lovell	
Ms Palmer	
Dr Seidel	
Ms Siejka	
Mr Willie	

New clause B agreed to.

And the Legislative Council having continued to sit past midnight -

WEDNESDAY 28 OCTOBER 2020

New clause B -
Certain persons not to initiate discussions about voluntary assisted dying

Mr GAFFNEY - Madam Chair, I move that proposed subclause (5) be amended by -

After 'health practitioner is'.

Insert 'capable of constituting' '.

At the moment it says -

> A contravention of subsection (2) by a registered health practitioner is unprofessional conduct for the purposes of the Health Practitioner Regulation National Law (Tasmania).

It might be unprofessional conduct but we would need to be able to add that it is capable of constituting unprofessional conduct, which would make a pre-judgment of that before it has gone through the correct processes. I had discussed this with the member for Rumney beforehand. Hopefully members will support this amendment.

Ms LOVELL - Yes, I am very happy to support this amendment.

Ms RATTRAY - I would like to place on the record my support for this. It is some way to protecting those health workers who may get caught up in the amendment that has just been passed. My understanding is if that if a healthcare worker is proven to have, or is put up to the Health Complaints Commissioner, they lose their job. At least there is some protection for those workers with this amendment.

Amendment agreed to.

New clause B, as amended, read the second time.

Mrs HISCUTT - Madam Chair, in light of the hour, I would like to move that we report progress and adjourn.

Madam CHAIR - We have to report progress first; we cannot adjourn.

Mrs HISCUTT - And seek leave to sit another time.

Madam CHAIR - The question is that we report progress and seek leave to sit again.

Ms RATTRAY - One question: do we have just one more amendment left?

Madam CHAIR - Two new clauses.

Ms RATTRAY - Thank you.

Mrs HISCUTT - I have had a look at the new clauses. One is about the entity and the other is about setting up the commission. I can see another three hours debate in it.

Ms Rattray - I am just checking.

Madam CHAIR - Member for Mersey, do you want to speak on whether we report progress?

Mr GAFFNEY - Yes, I do. I am comfortable that we report progress. I put on the record my gratitude to all members for starting early this morning and continuing well into the night to try to get as far along the track as possible. It is a credit to you individually and to us as a group to show the rest of Tasmania we are serious about getting this done. It is wise now that we close and we resume this on Friday. I also thank the staff very much for being here.

Members - Hear, hear.

Mr GAFFNEY - Thank you. I look forward to recommencing the bill at a later date.

Madam Chair, I move -

That we report progress.

Progress reported; Committee to sit again.

ADJOURNMENT

[12.07 a.m]

Mrs HISCUTT (Montgomery - Leader of the Government in the Legislative Council) - Mr President, I move -

That at its rising the Council adjourn until 11 a.m. on Wednesday 28 October 2020.

Mr President, as I have mentioned earlier, I have moved our 9 a.m., briefing to later in the day. We will start our briefings at 9.30 a.m., so have an extra half hour sleep in.

Motion agreed to.

The Council adjourned at 12.08 a.m.