PARLIAMENT OF TASMANIA

LEGISLATIVE COUNCIL

REPORT OF DEBATES

Friday 30 October 2020

REVISED EDITION

Friday 30 October 2020

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

TEACHERS REGISTRATION AMENDMENT BILL 2019 (No. 50)

VEHICLE AND TRAFFIC AMENDMENT (ROAD VEHICLE STANDARDS) BILL 2020 (No. 8)

STATE SERVICE AMENDMENT (VALIDATION) BILL 2019 (No. 52)

ANZAC DAY TRUST WINDING-UP BILL 2020 (No. 33)

RAIL SAFETY NATIONAL LAW (TASMANIA) AMENDMENT BILL 2020 (No. 7)

Third Reading

Bills read the third time.

RECOGNITION OF VISITOR

Ivy - Daughter of Member for Pembroke

Mr PRESIDENT - Honourable members, I welcome Ivy to the Chamber, who is joining us for the first time. I am sure all members will welcome her here. It is lovely to see - I was going to say 'some youth in the Chamber', but we do have that.

Members - Hear, hear.

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

In Committee

Resumed from 29 October 2020 (page 56).

New Clause E -
To follow 135

Dr SEIDEL - Madam Chair, I move -

That new clause E be read the second time.

Honourable members, the new clause and proposed amendment specifies the obligation of entities with an objection to VAD. Entities include health service establishments,

establishments specified under the Health Service Establishments Act 2006 as well as residential aged care facilities. It proposes that entities with an objection to VAD must transfer a patient to a health care facility that does not.

This amendment is modelled and based on a similar clause in the draft VAD bill for Queensland. It is modelled and based on the work of Professor Lindy Willmott and Professor Ben White from the Queensland University of Technology. Members will recall professors Willmot and White from the briefing we kindly received in preparation for this debate.

I have also consulted with the Tasmanian Anti-Discrimination Commissioner with regard to this amendment. I also acknowledge Tasmania's leading legal scholar, Professor Margaret Otlowski, from the University of Tasmania and her seminal work on voluntary assisted dying and the common law.

The principle of conscientious objection is integral to this bill. However, it has exclusively been dealt with by provisions for individuals not entities. In this bill, if an individual health practitioner has a conscientious objection, the practitioner must transfer the care to a practitioner who does not. The value and recognition of conscience is different for individuals and institutions. Some argue that only people possess consciousness and so conscientious objection should not be permitted for institutions at all. However, a more inclusive approach suggests some protection of conscience for an institution.

A balance between conscience and access is generally resolved to respect conscience but it must also facilitate access. Not including this amendment would effectively defeat any chance of access for terminally ill patients because of an institutional objection. In other words, an institution objection could have the effect of denying people access to VAD in a way that an individual's objection would not. Institutions such as residential care facilities may object to providing any help or support to residents who may seek even just information about the VAD process or eligibility.

My main concern is that terminally ill patients may feel abandoned. My concern is that terminally ill patients may be coerced into accepting care that is not in their own best interests.

This amendment specifies that entities are required to offer a transfer of care to a health service at which a medical practitioner is able to accept a request with regard to VAD. The amendment further specifies that reasonable steps must be taken to facilitate that transfer. I do not want to hear from an entity that 'there is nothing we can do', just because VAD is contrary to their internal policies. Some entities and care providers have made it clear that is exactly what they are considering.

I would like to refer to the inquiry into end-of-life choices in Queensland and statements from expert witnesses. The committee heard from a number of health and aged care services that oppose VAD. These were mostly run by religious organisations and the opposition to VAD was based on the belief that VAD does not value or respect human life, that no-one should purposely end another person's life, and that it erodes trust in the medical profession who must care for individuals at all points in their journey.

Similarly, Southern Cross Care submitted that it is not in favour of allowing a VAD scheme in Queensland because -

> …assisting someone suicide, or ending their life directly and intentionally, can never be an expression of care for someone who has an intrinsic value and worth. Assisted suicide and euthanasia undermine centuries of clinical practice where the focus is on healing, not intentionally causing harm to patients, nor aiding them to harm themselves.

Catholic Health Australia - CHA - raised concerns that legislation would not be able to implement VAD in any way that guarantees public safety, submitting -

> The risks of VAD are wide-ranging and uncontrollable, threatening the health and safety of vulnerable groups, individuals, and communities, as well as fundamentally undermining the values and ethics that form the fabric of Australian society. It is CHA's belief that there is no way to adequately manage the risks of VAD.

The important opinion comes now. The CEO of Catholic Health Australia told the committee -

> … we will not be allowing third parties to come into our facilities to undertake assessments of the individuals and we will not be referring them to a specific service in that we feel that we will not be in a position to know really where the appropriate place is for people to access these services or who the practitioners might be who have undertaken the training and that sort of thing, but we will certainly not resist any person who wants to access those services.

I am concerned about this. The amendment is necessary as the position of an institution to not permit access to VAD within its premises can also have a major impact on access to VAD. The proposed amendment establishes a process that reflects the usual balance struck on those issues. The amendment aims to ensure that a person eligible for VAD is able to access it, recognising they may need the cooperation of the current institution to achieve this whilst also respecting the position of an institution which does not want to be involved.

Victoria has dealt with this using a policy approach as such a provision was not included in its own legislation. That policy has set out pathways for institutions depending on their position on VAD. However, in practice, there are reports of confusion. A paper published in the *Medical Journal of Australia* in August described the unnecessary barriers a patient faced when the care facility, based on its own internal policies, objected to VAD. In that instance, the person eventually was able to access VAD; however, the article describes the author's view that there is no duty for a health service to refer a patient in the first place.

I consider this unacceptable given the significant potential implications for access to VAD. I believe it should be appropriate to be explicit in the legislation about the process to permit access while it is respecting institutional positions. The proposed amendment adds clarity by legislative recognition. This would help avoid instances where access to VAD is denied or delayed because a transfer is not provided or supported. It addresses issues of confusion and uncertainty about the process that is to be followed when entities object to VAD. The proposed amendment offers legislative clarity and certainty.

We cannot leave terminally ill patients who choose to access VAD unsupported in certain aged care facilities and care facilities. As legislators we cannot abandon them by leaving them to a legal challenge in case their aged care provider has a policy in place that does not support VAD and that does object to VAD out of principle. As legislators we can avoid ambiguity by amending this bill appropriately and accordingly.

I recommend the amendment to the Council.

Mr GAFFNEY - I thank the member for Huon for the proposed new clause. While I understand the member's rationale behind this amendment - his desire to codify responsibility for an entity to facilitate a transfer or should some say an eviction - I find even the idea that this supposedly caring entity might wish to impose greater suffering on a person to be totally repugnant.

I will not be supporting the clause as it stands. As members would be aware, I have drafted an amendment to the new clause that I hope will see some of our most vulnerable people's rights and dignity protected from the significant impact of this clause should it be accepted.

I do not believe this new clause is necessary, but I will listen with interest to other members' contributions.

Mr VALENTINE - When I think about this, I think, 'Why should an entity insert itself in the personal life of an individual?' - that is, the decisions the individual may make, the information they get from their doctor, or the relationship they have with their doctor, and how an entity should be involved in not allowing in some way the person's wishes to be fulfilled, or actions taken that that individual feels are necessary to alleviate pain and suffering.

We have to remember that this is their home. They are paying for services. To my mind, why should a person who is providing the service someone is paying for have any say in other aspects of that person's personal life? That is what goes through my mind on this. I believe it would cause the patient to transfer to a different location if they were determined to carry out their wishes of voluntary assisted dying, and that transfer would be at a time of the greatest pain and suffering that person is going through. That would be difficult.

It is not unlike the issue with telehealth being used. We were talking about the fact that it is difficult for people to access certain services and they could do it via telehealth, especially if they are in a remote location. It would save them quite a deal of pain if they were to have to fly out to get certain services. It is not unlike that in some ways.

I will listen to the debate but I find it difficult to understand how an entity can insert itself into decision-making in that sense between an individual and their doctor. It is their home to all intents and purposes. It is a service they are paying for. They are paying quite significant money to be in these care services. I can understand some entities not wanting to be involved, but they are not involved in the sense that it is a decision between the patient and the doctor, or the patient's personal decision. They do not have to be involved. The fact that this might take place on their premises is probably the matter that concerns them but really it is the individual's choice. That is what this bill is all about - individual choice.

I find it difficult - if we allowed something like this, what else should we be allowing? The anti-discrimination clauses we dealt with in clause 17, I think it is - and it is going back over a number of years now that we have been dealing with anti-discrimination - clearly set out different things that are discriminatory. I think this tends to turn back some of that and I am not sure I am in favour of that. I will listen to debate but at this point in time I do not know that I can support this.

Ms FORREST - Madam Deputy Chair, I am not inclined to support this amendment for a number of reasons. I have given some thoughts to this. This is a person's home and we are talking about someone living in a residential aged care facility. If my husband wanted to have access to voluntary assisted dying and I was conscientiously opposed to that option and I said, 'You better go and find somewhere else to live', that is an extreme example, I know. This is the person's home. As the member for Hobart said, they pay a not insignificant amount of money to live there and to be provided with care. That care should provide for all their needs.

I have a couple of questions about this to the member for Huon. I am interested to know exactly what the advice from the Anti-Discrimination Commissioner was on this. How could a residential aged care facility deny access to one of their residents by a medical professional who was coming in to provide advice, to take an assessment, provide information and carry out a medical procedure that could be carried out onsite? Some things you cannot do onsite. Some residents need to be transferred to hospital to receive treatment. We know, for a fact, that the worst place a person from an aged care residence can go to is hospital. It is best to keep them out of there for all the reasons most of us understand.

I am interested to know how they could actually prevent a health professional visiting that resident and not complying with their wishes, to go through the process we have agreed to leading up to this.

I get frustrated when people put religion in the way of good care. It does not matter whether it is access to termination of pregnancy or any other more controversial, shall I say, health procedures. Some of them would not even do sterilisation procedures, I mean seriously - anyway, I will not be diverted. The question I really need answered is: how can they prevent someone accessing the care they are legally entitled to access? I use the example of a woman who has had a medical termination of pregnancy; she has taken RU486 but has had a complication as a result. She has private cover; she fronts up at Calvary Hospital's Emergency Department and they say, 'What is happening?', she says, 'I have taken RU486 and it has not worked. I have terrible bleeding', and they say, 'Sorry, we are not going to look after you.'. They cannot do that because they object to the fact she has had a termination.

I am really struggling with why we would require someone to be moved from their home because an organisation's policy was that they did not want to be involved in the matter. I cannot understand how they can prevent - and it is fundamentally wrong if they can - another healthcare professional coming into that facility to provide whatever care that person needs in their place.

The director of CatholicCare said they will not allow people to come into their facility. I do not know how they can stop them. I would be interested to know how they can stop them and what the Anti-Discrimination Commissioner says about that.

I was mortified in the briefing we had with the archbishop when I asked him directly that if one of his parishioners who he had supported all through their lives, in their faith and in the exercise of their faith, made a conscious decision they wanted to access VAD, whether he would support them and he said no. The Anglican Reverend Humphrey said of course they would support them - so a completely different attitude.

Where is the moral obligation? I cannot see why or how they could prevent it, even if it is not a policy they want to participate in. We are not asking the staff of the facility to actively provide the substance and administer it; we are asking them to allow the person who is going to provide that service to come into that facility, the same as they can come into a person's home. If a person is doing a self-administration, or even an AHP-assisted administration in their own home, that person comes into that person's home. It is not as if this is going to happen in a hospital all the time. It might, and it will probably. I cannot get my head around why we would even allow this to happen.

That is my question to the member. I am not inclined to support the proposed amendment. It would set a really inappropriate standard if we were to say to somebody, 'We can deny a person who lives in your facility access to a certain aspect of care.'.

Ms PALMER - I, too, have real concerns about this amendment, but probably on a slightly different level. Throughout this whole debate my focus has very much been on trying to allay the fears of members in our community who believe vulnerable people in our society are going to be put at risk by this legislation.

My concern here is that quite adequate things are in place with this legislation with individuals being able to have a conscious objection. If we have an entity - and I think the member for Hobart touched on this - this is someone's home. This is where they live. They know the staff, they know the procedures. My father lived the last nine years of his life in residential full-time care. All these places have different procedures and different staff. At a time when someone has been given a prognosis of only six months to live, and we put that in the legislation, they are at their most vulnerable. We are going to rip them out of the place they know, the people they know, the actual physical environment they know. Where do they go? I do not know where they go. What if they live in a part of Tasmania where it is 100 kilometres until there is the next residential care place that has no problem with this? Then we are taking them out of their community. How does their family get to them? They have obviously chosen that residential care facility for a reason.

I attended a meeting where a nurse who was present spoke about the conversations families have when they think the staff are not listening. She was very much against this legislation. One of her reasons was that they hear conversations when people are out having a cigarette, saying, 'I just wish this would be over', and 'I wish, whoever it might be, would just go, so we could stop doing this.' Her concern was that families or friends can put forward a certain persona of love and what-have-you, but behind other doors or out in the car park, it is a different matter. She felt that by having this legislation, people were going to be really vulnerable to families who may want to inherit money or whatever it might be.

To people in residential care facilities, where the staff know this - they know the families, they know how often people are visited, they know the care that is given - we are going to say you have a conscientious objection to this as an entity, so we are going to put you somewhere

else where they do not know the patient, they do not know the family, they do not know if they are vulnerable or not.

My whole intention through this process - and I made it very clear that as a Christian, I have struggled with this - has been to put in place things to protect vulnerable people, and I am not sure this carries through with that. When they need familiar surroundings the most, there is now an opportunity for an entity to move them on because they do not want to deal with it, and that really concerns me.

My questions for the member for Huon are: Where are they going to be transferred to? Who makes that decision? Does the patient or the resident make that decision? Do they get to choose who organises it? Does the family facilitate that? Does the entity facilitate that? Who is in control of the decision-making here? I would really like the member for Huon to answer those questions for me, please.

Ms LOVELL - I say from the outset that I will be supporting this amendment or this new clause, but I have thought long and hard on this. It did not sit comfortably with me because without considering not only the new clause but what actually happens in practice, it feels like this is designed to make it easier for entities to put barriers in place in terms of access. I agree with the comments from the members for Rosevears, Hobart and Murchison about the fact that in a lot of cases - and it is not just residential aged care we are talking about here, it is 'entities' so it would be other institutions as well, but I know the primary concern is around residential aged care because it is the person's home - the perception is that this is about making it easier for those entities to put barriers in place is not what this is about.

After a great deal of further research and consideration, the conclusion I have reached is that there is nothing to compel entities to enable access to particular procedures or treatment options, and they do it now. They do it all the time. They do it on a range of issues that they may have an objection to for whatever reason. Let us not fool ourselves that this does not happen now. There are a number of circumstances where that happens. That raises some critical questions more broadly about access to health care particularly in residential aged care where people are living and they have made a home for themselves. That is a conversation we need to have as a society, but we cannot address here and now in this bill.

This new clause is about putting the responsibility for that back on these entities. It is telling them that if you are going to make a decision not to allow access to a legal treatment option in your facility, you cannot make that decision and then wipe your hands of it. Perhaps by sending them that message and making that very clear, it might make them reconsider. If they know the expectation is they will support their client or their resident or their patient, maybe they will be inclined to show greater compassion.

In many instances we are talking about a person's home - and, yes, ideally people should be able to access any legal treatment option in their home - but without this, what is the alternative? Without at least having some level of protection that will mean these entities are legally obliged to support their resident, client or consumer to access this service somewhere, what is the alternative? That they cannot access it anywhere?

That is what I keep coming back to. I do not really like this new clause, but I think it is necessary because without it, the patient could be left with no support and no ability to access this. That is why I am supporting the amendment. I do not like it, but I believe it is necessary.

Mr DEAN - This is an extremely emotional issue. Just thinking about it concerns me greatly. I must say right from the beginning, I cannot support this amendment at all.

These people at this time of their life have a few days to live, a few weeks to live, and it is an extremely difficult time for them. To have lived in a home, as the member for Hobart and others have said, for probably 20 years and longer in some instances, and to suddenly be told that 'If you are going to go down this path, you must move, you cannot remain here any longer', to me is horrendous and abhorrent. I cannot accept and understand that.

I ask the member for Huon: what is the position when these people live in a villa in that complex? Their own little villa, which is the situation of many of these homes. They have lived there probably with their partner for 20 years. Does that mean they too have to move out of their own home - and that is what it is for many of these people - to go down this path of accepting voluntary assisted dying support?

Does it apply to them? I suspect it would do, When does the process start? If you look at proposed new clause A(2), it says -

> … health service establishment owned or occupied by the relevant service provider, of any part of the voluntary assisted dying process in relation to a person who resides in, or receives services at, the establishment …

When does that process start? Does it start when the patient - I use the word patient - first determines they want to go down this path, before they are properly assessed by doctors and all of the other processes that need to take place? When does it start?

Would they then need to identify to the residential care establishment they are in that they are considering this process and they want to talk about it? Is that the time they would then be asked to move? If you look at the clause, the way it is written, I would say it would. Why would we want that to happen at that stage? The more I think about this, the more upset I get. Are these homes able to dictate other conditions on these people? Are they able to say what religious pursuits they might go down while they are in these homes?

Dr Seidel - The answer is yes.

Mr DEAN - Yes. What other conditions can they impose?

Dr Seidel - Many.

Mr DEAN - Well, I suppose conditions are imposed on all of us wherever we live and so on, but this is their home - this is their home. I am trying to get my head around this. As the member for Rosevears - or it might have been the member for Rumney - said, some of these processes would already be occurring in some of these homes. We have heard throughout the debate on this bill of medication being given to people who are in the latter stages of their life who are suffering - and I gave evidence of my brother as a good example of this - who are already being given medication that quickens the process of death.

I suspect that is already happening in some of these homes, so we also have that position. If the home were to know that was happening, could they ask that person to leave or move into another place where that would be acceptable? I am not too sure. To me, the more I think

about it - a horrendous situation, picking up a fragile person and the process doing that would not be an easy one, taking that person out of a bed, moving them by ambulance or by whatever means to another place.

As members have said, it would accept them and receive them at that stage and time. It would be interesting to know just who would receive them in that situation. I would not have thought that any home, any persons operating a home, could see and manage a position in this way, to be quite frank. To me, it is almost inhumane. I certainly cannot and will not support the amendment, Madam Chair.

Ms ARMITAGE - I have to admit I am having difficulty which way to go with this one. I hear the member for Windermere and the other members who have spoken about not supporting it, but my concern, as mentioned by the members for Rumney and for Huon, is if we do not support it and if vulnerable people are not given access in the homes to VAD, that also is a difficult situation.

It has been said it is their home, that these people are at their most vulnerable and what a traumatic thing to have to leave your home to go somewhere else to access something when you are in insufferable pain. That is the thing that comes across. These people have - as we have said, they have six months, 12 months at most to live, depending on their condition, are in insufferable pain and they have made that really hard decision to have assisted dying and they may have to move out. Part of me does not want to support it because I believe they should have access in their home.

They cannot, obviously, go to our general hospital if we do not have any beds - there is bed block anyway - they cannot go in Launceston to either of our private hospitals because they are Catholic. Melwood Wing is our only palliative care. We do not have any palliative care centres in Launceston because no-one has built one yet, no-one has provided the funding. Unfortunately, we do not have anything there and the only ward is in Calvary at St Luke's. Family members may not take them.

They might be able to go home to a family member and that is where I am really struggling with it. I hear from the other members it is an emotional issue. If we do not support the amendment, can the homes not allow someone access to something they desperately want? And, if we do support it, it then gives the homes the option to say, 'Okay, we can do it and move them out'. It is almost as if we are damned if we do and damned if we do not. Whichever way we go with this, it is going to be an awful situation for those people who, as it has been said, pay their money, go in and obviously there are conditions. Some homes may - as the member for Murchison said, when listening to the archbishop or the Reverend -

Mr DEAN - Will these people be asked to sign the conditions of going into one of these homes that if you ever want to access VAD, you should not come into this home?

Ms Lovell - They do already, essentially, when they sign up to the conditions of the home.

Mr Dean - The condition of it that you were going to go down the path of VAD?

Ms ARMITAGE - It is a possibility. They have not at this stage because this has not become law in the state, and I am assuming this bill will pass at least our Chamber. I am

assuming if it passes both Chambers, obviously, that would be something many institutions would have as part of their entry conditions. I am struggling; I do not know which way I am going to go with it because I can see both sides. I am concerned this bill actually gives entities the authority to move them out. It would be hoped if the bill did not go through, that they would allow people very quietly in their room - as we know in discussions with the member for Nelson, sometimes in Catholic hospitals things happen they are against. It is generally more that the doctor lists it under a different name. Whether they would allow a patient who is suffering intolerably not to have the trauma of moving and let them have their VAD quietly in their room, or if the amendment goes through whether they say, 'Okay legally we can move them out, we do not care where you are going, but it could be somewhere a long distance away.'. I am struggling, I really do not know which way to go. I agree with both sides that have spoken to date; it is a difficult one.

Ms WEBB - From my point of view this is a very clear matter. It is absolutely unacceptable to contemplate this new clause. What this new clause does - and it is quite neat that the member for Huon has presented it skipping straight to the second part, which is about the ability to transfer. What we have not focused on, and the member has not focused on, is the assumption built into this new clause, which is these entities have the legal right to prevent people accessing their services or living in their homes to access a legal health service. That is assumed in this clause. If this were to pass, it would become a legal precedent that the assumption is there - it is okay and legally correct for these entities to prevent access to what would then be a legal health service.

I do not accept we should make that assumption. I do not accept the legal case has been made that assumption is valid. I do not accept we have fully understood what the implications of this might be in setting this precedent. What we have is a clause that says, we will accept it is okay for an entity - and it is likely to be a religious faith-based entity - to prevent access to a health service for people who are accessing their services or living in their residence. I do not believe we as a community, broadly, would regard that to be okay. We would understand that a faith-based entity may wish to do this because what will be a legal health service if it passes, is one they do not agree with. They would like to be able to prevent people from accessing it, but to actually do that, my understanding is they would have to seek an exemption from our anti-discrimination legislation.

When faith-based organisations want to in some sense discriminate, for example, in hiring staff or other sorts of activities that they may want to put conditions on that relate to their faith, they have to seek exemptions to do that, and in many cases are granted exemptions to do that.

These entities, for example, which may be providing residential services to people, do have conditions involved in that. I am interested to know: to what extent is it required that they seek exemptions for those conditions? This is an entirely new matter to be contemplated in this space. VAD is not something that has been addressed or prosecuted through, for example, our anti-discrimination legislation, or matters to do with what conditions can and cannot be put on people accessing services, by entities.

It is entirely new. It is yet to be tested. I do not believe that inserting this new clause allows us to come at that, fresh and unadulterated, once this law passes - if it is to pass. If we insert this clause it will set up an assumption that it is already sanctioned for an entity to make

this decision on behalf of its residents and put in this restriction, preventing them from accessing what would then be a legal health service.

We know that a conscientious objection is already available to individuals in all sorts of circumstances around this matter and within this bill. There would not be a situation in which staff members of these entities would have to be involved in this process. They would be able to exercise their personal conscientious objection.

There is nothing to say that the entity itself needs to be an active participant. We have a resident, for example - if we are talking about a residential aged care facility - who is already accessing health services in a range of ways. The entity itself does not have to be involved in that. It does not have to organise it for them necessarily. It does not have to facilitate that. In this circumstance, the entity itself does not have to facilitate that access. The resident personally can be responsible for that, and under this circumstance I believe they could still be responsible for that.

Mr Valentine - Or the resident's family, if they existed, too.

Ms WEBB - Or the resident's family indeed.

It is very problematic for us to set up an assumption that an entity can exercise a conscientious objection in some sense and be allowed to legally prevent certain things to individual citizens - to prevent access to certain things like legal health services.

I am not sure that it is even possible for an entity to have a conscientious objection. I think it is entirely agreed that individuals can exercise that conscientious objection, but I am quite concerned that we are not necessarily legally settled on whether an entity can exercise a conscientious objection.

I am also interested more specifically in proposed new clause A(4)(b), which relates to the transfer matters, where it says -

> an offer is made to the person to arrange a transfer of the care or residence of the person to a health service establishment at which, in the opinion of the relevant service provider, a medical practitioner who does not have a conscientious objection ...

Now, 'in the opinion of the relevant service provider' is the other interesting thing. Can an entity have an opinion? I am not sure if an entity can have an opinion, but we seem to be giving it the opportunity to have an opinion about where the person might likely be able to access VAD elsewhere in order to transfer them. That is an interesting side matter in terms of a specific element of this new clause.

We are mostly thinking of this in terms of faith-based organisations, but also other sorts of entities could object to this for other sorts of reasons. It might not be faith-based. What do we then set up as a precedent? If I ran a boarding house and I had a personal objection to VAD, can I then, as the person who runs that facility, prevent in a similar way all the residents in my boarding house, for example?

Mr Valentine - It could be a funeral service.

Ms WEBB - Could a funeral service do that? Could a body corporate come to the decision that they are not going to let their residents access VAD? It is not clear to me what this sets up in terms of potential further ramifications and further iterations beyond the ones that we are assuming here, for the purposes of the conversation today, which is largely centering around things like a faith-based organisation that runs a residential aged care facility.

Other members have made this point well. I am absolutely in agreement that this is a matter that affects people at a highly vulnerable time in their life. They are terminally ill. Imminently terminally ill. They are very sick. They are very vulnerable. They may have been living in their home within a particular facility for a long time. There might be a longstanding care arrangement there, longstanding relationships with staff and others who are involved in their care, and what this provides is an assumption that they can be evicted, effectively, at that most vulnerable and most critical time in their health. Evicted to where?

This is the question that has been raised and I raise it too. Where will they go if there is not a similar facility that does not have an issue with VAD available to them? Where will they go if there is not something available in a hospital? Where will they go if there are no family members who will take them? Where will they go if they live in a part of our state where the only option is a faith-based option for this sort of residential arrangement?

From my reading of this new clause, people are left entirely in limbo if there is no option. I think there is an absolute 'get out of jail free card' here for the entity to only have to have a bit of a look and see if, in its opinion, there is an appropriate alternative facility that is likely to have a medical practitioner who would assist the person access this process. There are so many gaps and questions there that this highly vulnerable person can, and I would expect would, fall through in many instances if this was allowed to occur.

I have thought a lot about this proposed clause. It disturbs me highly and I contacted to a few particular people who I wanted to seek thoughts from, partly because I was contemplating what further implications it might have. One of the people I contacted is Rodney Croome - a previous Tasmanian of the Year and a well-known advocate for LGBTIQ rights. Rodney was happy to share some of his thoughts with me, including that this provision is cruel for people seeking VAD, especially if they are in aged care because it would force them out of their familiar environments and away from friends and staff they know at precisely the time they need those people around them. He feels it would set a terrible precedent by giving organisations the right to conscientious objection, something the LGBTIQ community opposed strongly during debate on the final marriage equality legislation. He feels that faith-based organisations that receive public funding should provide the same services as publicly owned services, and that faith-based organisations would subsequently seek conscientious objection exemptions for other things if this were to pass, especially in relation to LGBTIQ people. He thinks this is putting bishops' sensibilities ahead of patients' needs, and the powerful ahead of the vulnerable and that we should be ashamed of ourselves if this were to pass.

That was Rodney's suggestion to me. I agree with that. I agree this is putting particular rights for one group of people ahead of the rights and the compassionate needs of people who are the most highly vulnerable.

I absolutely cannot support this new clause. We should think long and hard about the precedent it sets, about the implications it could have beyond this issue. There will be an issue where particular organisations will feel uncomfortable about VAD happening in any extent in

their facility. That is going to be there. We know that. It is new to us to contemplate this. The right way for us to step through is, first, to have this legislation passed - let us assume it will be - and become then legal in this state to access VAD as per the legislation ultimately passed.

Then we will have a conversation about how this will be dealt with in relation to these entities who may not wish it to occur. They may wish to put conditions and then we can have a conversation about what requirement there will be on those entities in putting those conditions. Is there an anti-discrimination matter to be addressed? It is a new thing. We have not talked it through yet in terms of anti-discrimination. It has not been tested here under our state anti-discrimination laws. We will have a conversation about what conditions can be put. Whether those entities, for example, can grandfather those conditions on their existing residents or only apply them to new residents. That would be an interesting one for us to have to think through and contemplate.

If necessary, there could be a legal test that occurs in relation to this and perhaps it is important that does occur. Yes, it might be difficult and awkward for that to have to play out but what we are talking about here is new ground we have not yet tested. Often, when that happens we do have to go through a process to test the legal parameters of it. It is appropriate we do that.

This clause short-circuits what should be a well-thought out, careful move forward. I cannot support the clause and encourage others also to think about what we need to do to ensure we have not assumed a legal right that is not necessarily there.

Ms RATTRAY - I was in the member for Launceston's camp trying to work out what is the best way forward for residents particularly of aged care facilities, or nursing homes, or whatever that might be into the future. I was working through whether they would have to tick they support voluntary assisted dying when they were accepted into a facility, and whether that would be a barrier in the future. How would this work? I absolutely agree with the member for Nelson - this is going to take something that will need to be really well thought out and take some time to work out how facilities might work with this. I do not believe now is the time to do that.

I absolutely understand why the member for Huon has brought this forward because we were clearly told through the briefing process that there would be facilities that will not accept the fact somebody might want to end their life and use VAD to do that. I understand, but do not feel we have enough information or we know what the consequences are and the unintended consequences if we were to support this now.

Again, I have thought about it, listened and have been to-ing and fro-ing about where my support lies and what is the best thing for those people because so many of our communities do not have another option. There is not another option at Swansea. There is not another option at St Helens, there is not another option at Deloraine or Scottsdale or Flinders Island or any of those places. Where do they go?

Madam Chair, I will not be supporting the amendment, not because I do not care about what is going to happen. I am not entirely convinced we understand all the consequences of this at this point in time.

Dr SEIDEL - Madam Chair, I thank members for their contributions. I will take a bit of time on this because, yes, you are right - there should not be a need for any new clause on this. There should not be a need at all. As the member for Windermere said, when it comes to aged care, it is their home. It should be protected, it should be theirs. Things should work well because people are in an aged care institution because they do not do well in the community. They might not have family, they might not have friends. They are dependent on care workers and they are dependent on support to allow them to live in a different environment compared to the community.

I am heartened to hear that people are concerned. We know there are restrictions out there. The member for Murchison mentioned it. Yes, there are religious care providers who just refuse to offer clinically-indicated procedures; they just do it. Here in Tasmania it is not that uncommon and, as the member for Murchison said, yes, somehow it works and somehow a doctor seems to make it work. So it is the grey area where things sort of happen somehow and it is better that no-one talks about it anymore. Is this what we want to do with VAD as well? It sort of happens and nobody wants to talk about it? The whole point for legislating VAD is to get certainty of what people actually need and what people with terminal medical conditions who do not find answers in contemporary care should be offered. It should be a no-brainer but, no, let us not talk about it, it is too emotional, it is too hard.

We all hold that people are doing the right things and institutions are doing the right things. Yet, we have a royal commission into aged care and it is confronting to read those reports. It turns out, yes, although everything should be fine - it is regulated and it should all work - it turns out it is not. We had to have a royal commission into aged care and the findings are not pretty. How come? People should have done the right thing there, shouldn't they?

So, we assume the same thing is going to happen here. I sense that the majority of members here are supportive of VAD so, of course, it should be accessible in any area in Tasmania, whether it is an aged care facility or a hospital in the community. Of course, it should be, but I also live in the real world.

In the real world we know that care institutions are restricting access to essential medical conditions and treatments. The member for Murchison mentioned it - it is actually happening; it is not a myth. Multiple examples over and over again - twenty-first century. The way it happens is because you can just put up a policy. You do not have to be a religious organisation. It could be a public hospital. It turns out there is a policy and certain procedures just are not available. It should not happen in a public hospital system. The member for Murchison knows what we are talking about.

Madam CHAIR - It is disgraceful.

Dr SEIDEL - It is disgraceful, yet it happens. I could argue if you are otherwise well, it is just about a procedure; it probably does not matter; make up your own mind; there are other options.

We are dealing with terminally ill patients who are about to die, who need support. They are not going to, potentially, have a family who can make phone calls for them. They might not have friends who are going to be supporting them. That is why they are in an aged care facility in the first place - because they need professional help. There is nothing in the law and nothing in any other legislation that entitles residents and patients to have access to particular

medical health care procedures, there is not anything. We do not have a charter of rights in this country and this state. We do not have that. We have a health care charter. It is a toothless tiger that talks about options and quality care. We have had this charter forever and ever. It has not made a dent of difference, otherwise we would not need a royal commission into aged care. The charter looks very good, everybody has signed up for that, it is lovely. It has made no difference whatsoever to people on the ground in real life. So let us do the same thing: it is too hard to discuss. You are all very uncomfortable. I am hearing words, 'I believe it should not be necessary' and 'why are we dealing with all this?'. Well, because real life tells us it is necessary.

That is not my word, we see evidence. We have had the briefing with religious care organisations. I specifically asked a question, 'How are they going to deal with assisted dying in their facility?' The answer I got, and I was the only member who asked, was, 'Oh, we are not going to be involved.'. The CEO of Catholic Health Australia said -

> We will not be allowing third parties to come into our facilities …

That is where it starts, member of Windermere, because it was your question -

> … to undertake assessments of the individuals and we will not be referring them to a specific service in that we fear that we will not be in a position to know really where the appropriate places for people to access these services …

'We will not be allowing third parties to come into our facilities'. The reason why the CEO of CatholicCare said that is because she knows she is right, because they can do this under law. They can prevent access to their services, they can prevent access to their facilities - they can, they are doing it now. They can restrict the health services that are being offered in those establishments. They can do this now and it can happen in very subtle ways. You do not have to oppose VAD to be carried out in your facilities, but you can have a policy that administration of certain medications is not allowed in those facilities.

If you work in aged care, and I have, this policy is already in place. You cannot just take your own medications; you would have a particular assessment if you want to take your own medication and it depends on the aged care facilities. It is all nice and well for a VAD substance to be delivered, you might still not be allowed under any given policy to take it yourself because you cannot self-administer. For the residents who are requiring infusion or injection or a canula to be inserted, there are already aged care facilities in Tasmania that do not allow that. There is no infusion therapy, there are no injections. If you need an infusion, you go to hospital. You do not have to oppose VAD necessarily; there are subtler ways to do this. This is the real world we are living in.

They could also say, 'We would love to allow VAD here but unfortunately because of our no injection policy or no infusion policy, or because of our certain administration policy unfortunately we will not offer that service'. Imagine, terminally ill patients with the poor prognosis who want to die. As I have said, it can be left to their own devices. We can all hope that aged care facilities and hospital institutions are doing the right thing.

I have not heard the providers come out strongly saying, 'We are going to make it work'. I have read the evidence clearly stating they have no intention at all to make it work. I do not

believe anything. I do not know what I do not know, and if I do not know I find out. It does not matter what I believe, what my feelings are or what I would like to see. It should be fact-based.

When I again read through draft legislation of other jurisdictions, I was puzzled why, in Queensland, we had that clause in there because I had not seen it anywhere else. That is why I asked, 'Why did you feel, based on the inquiry and the committee work you did in Queensland, it was necessary?'. It is clear why it was necessary because the leading academic legal scholars on assisted dying in Australia - and you have all met them - clearly said, 'We are concerned if we do not put the clause in because access to VAD can be restricted in those institutions. There is no entitlement whether we like it or not.'.

I did not ask people for their opinion. I have approached the leading academic legal scholars. I agree that it should not be like this. It should be a given. Of course there should be an entitlement but there is not. We can try to avoid it. We can say it is all too hard, let's see how it goes. We already know how it goes. I have given the example from Victoria. It was published in the *Medical Journal of Australia* in August. We already know it is an issue in other states that do not have a particular clause in there. The Victorian Government felt at the time that it did not need a particular clause - 'We do it on a policy level. We put out some guidelines and see how we work with those guidelines and engage with VAD navigators and so forth'. It turns out it does not work. Less than a year and we have cases published.

Ms Webb - Just to clarify, in that case was the person able to access VAD?

Dr SEIDEL - Eventually, yes.

Ms Webb - Eventually, yes. So, eventually, legally, they were supported to access that option?

Dr SEIDEL - No, I am sorry, it was not supported legally -

Ms Webb - But, they were -

Dr SEIDEL - It was eventually by the institution.

Madam CHAIR - Order, the member has the call.

Ms Webb - I was just clarifying the outcome of the case that was being talked about.

Dr SEIDEL - I really hope patients do not need to be transferred. I really hope all care providers are doing the right thing allowing VAD on their premises.

A member - I certainly do as well.

Dr SEIDEL - That is right but I am not here to hope; I am here to legislate. I want certainty. I do not want ambiguity and I certainly do not want ambiguity if there are precedents of concern. Why would I? We need to learn from other jurisdictions and we also need to learn from the experts.

I am not reassured we can afford to leave that particular clause out. It is not about transfer. It is not about the academic argument about whether entities can have a conscience or not. Certainly, boards consisting of board members and board directors better have a conscience but they certainly have power and they have power to put up policies and those policies can be enforced.

In southern Tasmania we just had a situation where an aged care provider changed ownership. Overnight they are bought up by a religious aged care organisation. Imagine you are a resident in a non-religious institution and they supported VAD potentially and they enabled this. Then they go bankrupt and somebody else comes in and they might have policy that VAD is not possible, injections are not possible, certain administrations are not possible. What is going to happen with those people?

I am hoping if you legislate accordingly that those aged care organisations or health care organisations are really trying to get their act together to ensure they are allowing access. They should not be forcing patients to transfer.

Right now, they can do nothing. They can just raise their hands and say, 'We are not interested, it is nothing we want to be involved with'.

I am warning that then a doctor might come in, in some other way. This is not going to work. Are we telling the commissioner, 'We apply for this patient who does not really quite live in this aged care facility, he lives somewhere else'? It is ridiculous. Legislate for certainty, avoid ambiguity. That is why we have laws in the first place, to add clarity to the debate.

I want to make reference again to what Professor Ben White said earlier. He just sent me an email because people are watching. It is very clear people have an interest in this. He has allowed me to read it out -

> I agree with all the points being made about this being a person's home. In an ideal world, my view would be that VAD as a lawful option would be available universally in all facilities, that means no objection permitted by institutions. However, if the legislation is silent about this, institutions will in practice prevent access to VAD. That is the experience in Victoria and has been foreshadowed in the Queensland parliamentary committee inquiry.

Members who are committed to universal access to VAD would need to commit either to a clause in the legislation that makes it clear that institutions cannot impede access within their facilities, or this clause. A copy of the email was sent to the member for Mersey as well because he has been in contact with Professor White.

We know we do not live in an ideal world. There is evidence for it. I urge members not to ignore it because it is too hard. Yes, it is hard, but here in parliament we have been elected to make the hard decisions. We cannot avoid them. Let us inform legislation based on evidence whether it is an emotional topic or not. Let us be mindful of how the legislation affects the real world we live in.

Mr GAFFNEY - I appreciate the depth that the member for Huon has gone into. I believe members in this place really understand the real world and how it is working. I appreciate we were reminded of that. I also think evidence is really important and we have

explained that. That is why I had Ben and Lindy speak to us as a group. That was really good. I also have to say the Queensland inquiry report is just draft legislation. It has not been through the parliamentary process. It is not evidence of legislation that has included - it is a recommendation. That has been delayed now for 18 months. I wanted to make it clear that whilst it is possible that Queensland legislation may include it, it is not a given because it has to go through the parliament process.

I am not going to speak for too long on this but I would like to make a few points. If we reflect on three ethical implications of pledges that our doctors choose to sign that are part of the World Medical Association Declaration of Geneva 2017, they say, the health and wellbeing of my patient will be my first consideration. The second one, I will respect the autonomy and dignity of my patient. Another one is -

> I WILL NOT PERMIT considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient

The argument that VAD is unethical and deserving of an entity's objection completely fails on these points. For an entity to suggest otherwise is unconscionable and a disservice to the health practitioners. We are expecting our doctors to do this and we are allowing on the other hand, our entities to say, 'Sorry, we do not agree with that. You have been here for a few years now, but you have to find somewhere else or we might find you somewhere else if there is a place to go.'.

If we consider the intergenerational transmission of the ongoing impact of a loved one's traumatic death to the surviving family members and friends, is this what entities are hoping to accomplish? Should we allow it? Should we open the door through legislation, not policy, to allow discrimination? As soon as we open that door, the foot is going to go through it and it is going to be wider, because they will have a legal framework and base so their policy reflects VAD law. They can actually use that against this. I am really concerned.

Maybe we look at the British Medical Association's view of a limited right to conscientious objection, one that does not subvert a patient's right of barrier-free access to legal and appropriate medical services and a patient's right to choose. One where a patient's needs take priority and the doctor or entity's needs are secondary to those of appropriate patient care. It is the patient that has the priority.

There is, and I thank the member for Rosevears for raising it, the other issue, a practical issue, of availability and cost. As of two weeks ago, according to the aged care guide website in Tasmania, only 12 nursing beds were available and some of these were in shared rooms. The stinger in this requirement for what is known as a refundable accommodation deposit is a room price set by the aged care facility that based on the current vacancies can be up to $650 000. There is also the equivalent option of a daily accommodation payment paid periodically.

Not only are we asking a person to leave their place 'There is a bed three hours away or an hour-and-a-half away, you have been in this residence for a long time but you are not actually a resident anymore, you are a client.'. Most people in our aged care facilities see themselves as part of the community. Through this bill, why would we allow any opportunity

for any entity or institution to grab hold of a legal framework and use that as a policy, reinforcing our policy, because we are allowed to do it?

If we accept this amendment, are we looking at, as Rodney Croome said, the start of the slippery slope of allowing religious discrimination into Tasmania as a barrier to what we now will have as a legal medical procedure? This is a legal medical procedure people who are dying need to be able to have in their home, in the place where they call their home. We should not attempt or allow any organisation - and we should definitely not back it up - any legal framework for that to happen.

It is time for religious entities to adjust their approach to the expectation of the community. Why do we not ask the religious to look at their policies, look at their work? Not allow them the foot in the door. Only last week we saw the Pope endorse the right of same-sex couples to have civil unions and be seen as a family. They can change and we should not allow them not to change. We should be accepting. Most of us would have received a short email from Annie Fagan -

> How could anyone in their religious mind turf a dying person out of their own home (yes their own home, despite that it is managed by a religious denomination) to die with assistance, when that person is suffering intolerably and unrelievably. As a retired nurse, I know what this suffering might entail, haemorrhaging, vomiting, incontinent of urine and faeces, bedsores to the bone, gasping for breath, choking on their own saliva, screaming in pain, unable to move, to talk, they may have a drip, oxygen, catheter, need frequent nappy changes, all this besides the mental and emotional unrelievable anxiety of it all. Where would they go?

What are we going to do? At that times needs saying - 'Well, sorry, our policy says that you cannot access those professionals here.'

This amendment does not help. It opens the door for that to happen and we should not - we should not. It was interesting, I also have some friends who are very interested in this with the legal background and asked Greg Barns, whom many of you would know and have heard of, and Greg calls it how it is, he says -

> But the bottom line is that (The Hon. Member for Huon's) amendment would allow discrimination against vulnerable people with no responsibility for that discrimination.

This amendment, as the member for Nelson said, sets a precedent which will allow an entity to transfer one of its clients somewhere else. Another person, Keith, answered -

> This amendment has not been well considered. … It is greedy, selfish and deceitful to welcome customers with promises of care and respect but then to announce when the residents become unwell and frail and vulnerable, that they have become unwelcome, can't receive the respect promised, and must seek other accommodation.

Helen Brookfield said -

> I am horrified and disappointed by the proposed cruel and inhumane amendment to the End of Life Choices (Voluntary Assisted Dying) 2020 Bill, that Entities be exempt from this proposed law.
>
> Entities are just Legal Constructs and not people. Within Entities, as staff or patients, there can be people who do support VAD along with those who don't.

Professor Ellen Weibe was one of the people I met in Vancouver on my world tour and, interestingly, in recent times she has been involved in a situation where the faith-based organisation would not allow her access and wanted the person to be moved out. They went in, the procedure was done. It went to the High Court and they chose in favour of the client, of the person, because the person's rights overrode the policy position of the organisation. So, it is really, really important we understand at the highest level with the Canadian Charter of Rights and Freedoms, they agreed with the doctor's work.

Dr Seidel - We do not have a charter of human rights in this country.

Mr GAFFNEY - That is right. I did not say we did.

Dr Seidel - So what is -

Mr GAFFNEY - All right. Also, Dr Cam McLaren, a person who does work in this area and has worked there a long time and is involved and has done lots of work in Victoria, says -

> Proposed New Clause A. No. This validates Conscientious objection from entities without consciousness! Not only that, but it prioritises it above the patient's right to access legal health care options. Absolutely not. I appreciate the proposal in (4)(b), but don't let them make it so a Nursing Home resident who's lived there for years, who wants to die there, be transferred out – that is just cruel.

Dr Seidel - It happens in Victoria.

Mr GAFFNEY - 'That is just cruel.' We should not accept this amendment. It sets a precedent. I am not comfortable with it. I agree with the member for McIntyre. Sitting and listening to the debate, now is not the time. We have a review process in three years. We have perhaps 10 or 11 people on statistics - I know they can change - but not a lot of people will access this over a 12-month period. Woe betide any institution in this state that says to a person living there, 'By the way, you have to find elsewhere now because we do not agree with VAD'. Woe betide that institution, because in any community I know in Tasmania, it will not survive very long because the talk around the town and the talk around this place would not allow that.

I do not think we should give any ground on this, and I have also presented evidence in other sections - you do not win all the time. I do not think we should accept this amendment and I encourage members in this place not to. I thank members for their consideration.

Ms LOVELL - I was not going to make a second contribution on this, but I am because I feel quite strongly about this. Despite what has been said, I want to be clear about what we are doing here. For me, this is not about 'the entity'. This is not about trying to make it any easier for them, or to send a message that it is okay to object to VAD or any other medical procedure or treatment option, or any other issue that may be covered by a policy.

The member for Mersey talked about the Geneva declaration, but let us be clear: doctors sign the Geneva declaration. We do not ask entities to sign anything like that. We do not ask their board members to sign anything like that. There is no similar obligation by these entities. They make no similar promise. There is nothing.

Nobody is arguing that voluntary assisted dying is unethical, and I am certainly not suggesting that by supporting this new clause this would be grounds for an entity to argue that it is unethical. But let us again be very clear, we are allowing people to have a conscientious objection. We are allowing those doctors who sign the Geneva declaration to have a conscientious objection. So, despite making all those promises, we are even allowing those doctors to have a conscientious objection.

For me, this is not about allowing entities to have a conscientious objection because as we have seen, we know this happens already and it will continue to happen. We can have an expectation and the community can have an expectation that religious entities will adjust their model of care, adjust their policies, to move along with the community expectation. But let us be pragmatic about this.

Yes, we have had a statement from the Pope recently about same-sex partnerships. How long has that taken? Do we really think that in reality by passing this into legislation - and I am very hopeful that is what is going to happen - that all of a sudden all these religious entities are going to say, 'Okay we get it, we got the message.'. It is not going to happen. They have said as much. They are doing it already in other states.

We could say, if they do not do that, that an aged care facility in St Helens will not survive. The community will be outraged. Yes, the community will be outraged, but, of course they will survive. Who is going to come in and shut down an aged care facility? It is not going to happen.

Mr Gaffney - You have missed my point. That is fine.

Ms LOVELL - I am happy for you to make your point because we need to be really clear. We can all stand here today and say 'we believe this' and 'we think this' and 'they should do this' and 'this is an outrage if they do not'. Yes, it is an outrage but let us not pretend that it is not going to happen, because it is. It happens all the time. It happens now and it absolutely will continue to happen.

The other point I wanted to address is the point about discrimination. I am very mindful of this and I have looked into this in depth. I have sought advice on this because the very last thing I want to do is enshrine in the legislation anything that goes anywhere near allowing any kind of discrimination to happen. We have some of the best anti-discrimination legislation in the country and I am a strong supporter of that.

A policy that applies to all residents of a facility is not discrimination. For it to be discrimination, and let us be clear, and for there to be a case under the Anti-Discrimination Act,

the discrimination has to be action taken against a person due to an attribute of that person. A blanket policy of a facility, whether that is on religious grounds or not, applies to all residents, it applies to all consumers, it applies to all clients, is not discrimination. I wish it was that easy, because if it were that easy, perhaps there would be grounds to enforce this to be offered in all facilities. There just is not a way, legally, that entities or facilities or hospitals can be compelled to offer VAD. There just is not.

We can make an argument that needs to be tested but who really wants to be the person to test that? Who do we want to set up to be that person? Somebody who is at the end of their life suffering from a terminal illness, trying to access voluntary assisted dying and that person has to then be the person to test that?

The member for Mersey has argued, and others have argued, that now is not the time and that we have a review process in three years and we can look at it then. Yes, we do. But what happens to people in the meantime? What happens to those people who are living in these facilities in the three years from when this becomes legal and enacted, who might want to access voluntary assisted dying, who are living in a facility that has one of these policies? What happens to those people?

Yes, let us review it in three years and hopefully let us review it and wind it back. We need something in there to protect people now. I am not disagreeing with almost anything that has been said by every member who has made a contribution. I am not disagreeing with any of it. People should be able to access this in their own home. People should not have to transfer when they are suffering from a terminal illness. Religious entities should shift their expectation and their policy to match community expectation. I agree with all that, but the one thing I do not share is this seeming faith that people have that, without this new clause, those entities will not leave their residents with no option and with no support.

We can say they should access it, they should be able to access it in their home. I wholeheartedly agree with that - I could not agree more strongly with that - but without a legal requirement or a legal compulsion to either offer it or facilitate that person being able to access it elsewhere, they will not be able to access it all.

We have had a very distressing picture painted by the member for Mersey of a person who will be at their end-of-life who may need to transfer to access this. My question is, without this clause, without a requirement on that facility to facilitate that transfer, what happens to that person? The alternative is not that that entity will say, 'Okay you can do it here'. They will be left with nothing; they have said as much, they have said it. We know their intention, we know what they are going to do. So, for the person in that very traumatic situation the member for Mersey described, the alternative is not that they will be able to access it peacefully in their home - they will not access it all, or they will be left to find their own way or their family members will be left to navigate that system, to try to help that person access the treatment option they have chosen.

I want to clear about this. This is not about entities, this is not about making it easier for them, this is not about trying to make it an option for them to discriminate. For me, this is about the person who is trying to access a legal treatment option, who, without this clause, in reality, let us be pragmatic, will not have that option.

That is why I support the new clause. I ask members to think carefully about how you vote and why you may vote that way. It is all well and good to say 'We do not want to support this clause because we do not agree with the principle of it and we do not agree with the expectation that it sets up or the precedent that it might set'. I do not believe it sets a precedent, but that is an argument that has been put. It is all well and good to say that, but think very carefully through the consequences of not supporting it, for those people we are trying to assist with this legislation.

Mr VALENTINE - It has been very interesting listening to all of the different opinions flying across the Chamber in relation to this. I hear the member for Huon saying we need certainty, but if we pass this, there will be great uncertainty as to how it offends or otherwise clause 17 of the Anti-Discrimination Act. We have been told by the member for Rumney, it will not. That is legal opinion, and we all know 50 per cent of lawyers are wrong at any one time. There are transgressions of human rights that come to mind - the principles of human rights. It is a whole other issue. As the member for Huon says, there is no legislation in that regard and he is right. That really needs addressing- charter of human rights - it does. I do not think there is too much disagreement across the Chamber as I hear the hear, hears.

We also have to remember that in quite a significant amount of the time, these are federally funded aged care services, or a certain portion of their operational funding comes through federal funding. The chief executive officer of CatholicCare was quoted regarding not allowing entry to those who may wish to have this service made available to them and this amendment is not about voluntary assisted dying, it is about individual rights. That is where this amendment is at the moment. It is about individual rights, not about whether someone is choosing voluntary assisted dying. It could be any aspect a service provider disagrees with. If this gets through, that is what we are dealing with.

Are we going to let service providers of any persuasion - and I am not just saying it is Catholics, Anglicans, Muslims, or whoever it is that provides those services - in any way dictate the person's right to services under the law?

Ms Lovell - They do that now. They can and they do.

Mr VALENTINE - Well, maybe they should not be. That is all I would be saying.

Ms Lovell - I agree.

Mr VALENTINE - It gets down to the fundamental principle: Are we going to let them dictate? As we have already heard from the member for Rosevears, where do they go? We all know there are waiting lists in the aged care services. It is going to get worse because baby boomers are gradually getting to that and there is a lot of baby boomers and the services are going to be in short supply.

Ms Rattray - It takes quite some time to get an entry into a residential care facility. I worked with somebody for a year to get in.

Mr VALENTINE - We have heard that. So, there is that aspect to it. The member for Mersey has certainly described the person's condition at the time when they are expected to move on.

We are really talking about a person's individual right. Open this door, and we need to start talking about where does it go from there. We have had this sort of debate before. We had it during the same-sex marriage debate, whether a cake shop owner had the right to refuse to provide cakes to people who were homosexual. Do we really want to let that start to come into this?

This is about individual rights. I have listened to the arguments going across the Chamber and we have heard from the word go this is about individual decision-making. If we open it up for entity decision-making, it is a whole other world and set of circumstance. It is something that may wish to be addressed in the future, but for Pete's sake, do not try to change the absolute principle and nature of the bill before us about individual choice.

About facilities referring their residents to other places, I remember during the debate on terminations there were those saying that doctors did not even want to have to refer to another doctor for a service they knew was going to be against their particular ethics. It might even get to that with some of these facilities. We do not know. We are opening a whole new horizon of debate in regard to what this bill is trying to achieve.

It draws into question too, the whole issue of how public funding of aged care services should be considered when it comes down to human rights, individual rights, anti-discrimination and all of those sorts of things from a federal and state level. Of course, it is funded federally for the most part.

I have heard the arguments, the passion, the member for Huon's passion in particular because it is his amendment. But I cannot see - and it has been a very difficult bill for me to deal with. My whole approach to this bill is that it is not my right as an individual to dictate how someone else may wish to choose certain services for their life. I am really, really firm on that. It is not my right as an individual and therefore I do not think it is the right of parliament to be making or putting things in the way of an individual being able to have that right to choose services that really is none of their business. It is the business of the individual, between the individual and their doctors or those providing services to them with regard to their own health and welfare.

Why would we be wanting to insert something like this into that debate? I do not think we should and we must stick with the well thought-out objectives the member for Mersey put forward through amendment of what this bill was all about.

I cannot support your amendment, member for Huon.

Mr DEAN - I will be a little more controlled this time.

I hear what the member for Rumney said about discrimination, but wished I was so sure on that point. Tasmania has the lowest bar of any state in this country and territory when it comes to discrimination. A very, very low bar. In actual fact, I was only reading an article this morning, if you look at Canada, New Zealand and a number of other countries in the world, Tasmania's bar is so much lower than anywhere else and that is often commented on.

I would not be in a position to say it would not meet the discrimination laws if a person was moved out and an action was taken and so. I would like to be sure, but I cannot be that certain.

I will attempt not to be repetitive about what has already been discussed today, but the Catholic Church has changed tremendously over the past years. We saw their position originally on abortion. We saw it on homosexuality, same-sex relationships and all those issues where they have relented and have changed significantly their position in relation to all of those matters. I feel that in this case, if this legislation becomes law, we would see a change there also over a period of time. It would probably take a time but there would be a change.

The member for Huon puts forward a very strong case, there is no doubt about that, and he is very knowledgeable in this area and understands it well. As is the member for Mersey, who, with the work he has done, has put forward a very strong argument as to why it should not be supported; he has raised many very significant and important points as well. The member for Launceston made the comment, and I must say that I am on the side of the patient and not that of the aged care facility in this instance.

Homes want their business in the first place. Homes are out there wanting to get people in and there are not that many vacancies in these homes. They are accepting of the person at that time, accepting of their money, accepting of their business, accepting of everything that goes with that but, at a time of real need, at a time when they do need absolute care, support, and humanity to be a part of this, the home will not want to know them. They do not want them to be there. They want them to be somewhere else at that final stage and time in their lives. That is something I cannot accept.

If the surveys we hear are right, and I have no reason to suspect they are not, I think there was about 87 per cent support in a major survey done in support of voluntary assisted dying legislation. If that is right and if there are aged care facilities, and we know there are, requiring a client to sign a condition of entry that should they wish at a time in the future to access an end of life process, at the very beginning of the process of that, irrespective of their medical condition - bedridden or not - they will need to leave the home, I suspect that home will probably have vacancies.

The problem with people getting into an aged home, as the member for McIntyre and others have mentioned, is that those places are not that plentiful. There would be, in the case of some of these people, the position of probably not reading the fine print, of not understanding all the conditions of entry, and so on. I certainly would not be entering a home with those conditions. I would be surprised if some others did not see it that way as well.

Members have mentioned that if there is no home available, where do these people go to at that time? Will these homes have an agreement somewhere else to send these people to, to push these people into? And the money has been referred to - I am not going down that track because it has all been referred to.

If all the criteria are met for a patient in one of these homes where the conditions are that they must leave if they are considering VAD and starting that process, we could see some secret activities occurring within those homes. In other words, they take an action with the medical support that they need and with the family and so on to access and go down this process in a very secretive and underhanded way. It could cause that to happen. Should we have legislation in place that might cause that to happen? No, we should not, in my view. That would not be the way to go.

The other point I wanted to make was that in a villa, and I mentioned this before to the member for Huon, where people go into a separate home in these facilities, where they buy the villa under certain conditions, it becomes their home. We all know that your home is your castle. In your castle you can do whatever you want, provided it is lawful. You can live in the conditions that you want provided it is lawful and acceptable in all the circumstances. If this legislation gets up, VAD will be lawful. So what right would any facility have to kick you out of your home, a home that you own, a part of that facility that you own, that is yours? I believe it would bring a number of legal issues to the front. I can see legal action perhaps being taken in all the circumstances.

Should we be moving in a direction that causes people to want to do that? No, we should not, in my view.

Having said that, I have not changed my position at all. My position is that I cannot support the amendment. I considered that we needed a further briefing in this area. There has been a lot of evidence given and a lot of information given as to whether we should have been seeking a face-to-face connection with a home - CatholicCare, for instance, where they may have conditions in relation to this legislation if it gets through included in their documentation. I am not sure if that would really help at this stage. Other members are not going down that path so -

Mr Gaffney - I have the three values for the Christian faith - I think this comes from Southern Cross Care - they have three short ones. It says, under the heading ' Compassion' -

- We respond willingly and positively to help meet the needs of those around us.

- We promote a sense of belonging and community.

- We demonstrate and foster empathy and sensitivity towards residents, clients, their families, our colleagues and the whole community.

So, if those are their values, I think they can change the way they operate.

Mr DEAN - No doubt they will listen closely to what is happening here today. I would be very surprised if there is not a lot of discussion within that facility, within that organisation, on what might happen in the future. This is not about being strong in regards to religion and the Catholic faith and so on; this is about providing support to a very vulnerable person - a person in the final stage of their life. That is what this is about. I cannot support the amendment we have before us.

Ms WEBB - I will respond to a couple of issues raised that I believe are really interesting for us to contemplate. I note that the member for Huon implores us to live in the real world and to make hard decisions in the real world. I think in objecting to this clause and refusing to support it, that is precisely what we are doing. We typically, on most issues, look at the world around us; we look at the real world. When we observe something that is not right, or should be reviewed or improved, or that is outright wrong because it is harming vulnerable people, when we observe that in the real world, what is the step most of us here in our public service roles - and perhaps in other parts of our lives - take? We look to address it; we look to improve it; we look to fix it. We look to making the real world better. That is what we do in the real

world when we have people of conviction and people who care about making our communities better.

What this clause does is look at the real world. It says, 'There is this thing which is less than ideal', and members who have supported the clause have acknowledged that there is a less than ideal circumstance occurring where people's access to legal health services is being blocked by faith-based organisations. They have admitted that that is a less than ideal circumstance. But, instead of saying, 'What can we do to help progress that towards a better outcome and fixing it?', they have said, 'Let's enshrine in legislation an acceptance of that and an acknowledgement that that is okay, and try to find a workaround that helps people a bit'.

To me, that is not an acceptable way forward. To me, that is exactly the opposite direction that we should be travelling in. If we have some generalised agreement - and I think in the community there would be this generalised agreement - on the situation in which a faith-based organisation can restrict the individual choices and the individual rights of somebody to access a legal health service, we would accept that that is not right and not ideal and something to be fixed.

The way to do that is to let this play out. I believe VAD and the situation around the passage of this legislation presents us with a unique, new opportunity to look at this less-than-ideal situation that exists in our community and progress it. It presents an opportunity that we have probably never had before. That is because often when this less-than-ideal situation has reared its head in times past, it has been on issues that can be trickier to deal with, perhaps have less broad general support in the community, or do not affect the community as broadly as this issue of VAD does.

While we may not have had a chance to materially and substantially progress as a community in how we respond to and deal with the restrictions put on individuals by faith-based organisations in this way, on other matters such as, in times past, terminations or other sorts of access to health services that do not fit into that faith's value base - those matters might have been harder for us to stand up to and make a point and progress how we address as a community what is occurring within our community from those faith-based organisations.

This issue is an interesting and new one. We know that the support is very high in the community to allow people access to VAD. That it is really cherished. We have all heard, overwhelmingly, from so many members of our community, that they want this option to be there. They see it as a right and compassionate and proper way for our community to offer end-of-life care amongst a range of other options.

This topic presents an absolutely golden opportunity, if the legislation passes without this clause, to face as a community, to contemplate and discuss and legally explore as a community, the reality we know is there with restraints put on people because of faith-based organisations and what they allow or do not allow within the facilities.

The fact is, they are publicly funded to deliver and provide services, but still put on those sorts of conditions. I believe the appropriate thing to do is to allow this unique and valuable opportunity presented by VAD to have us, as a community, substantially progress the broader conversation around individual rights and a charter of human rights. The broader conversation around whether our current anti-discrimination laws, which may, we are given to understand,

allow this, can be improved. Do we need to expand it to be able to contemplate matters such as this, that we have never encountered before?

Instead of, as the member for Huon invited us to do, learning and copying from other jurisdictions, I believe Tasmania should step up, as we have done before in delivering the best anti-discrimination clause in the country that we have now, and lead and teach others about how to progress a community conversation about better protections for individuals, better access to legal health options, and a better way to respond when faith-based organisations attempt to put restrictions on access to legal health services. That is our opportunity in rejecting this clause to live in the real world with the intent to make it better. Not the intent to acknowledge and excuse the things that are not right and make a workaround somehow to try to alleviate the impact that has on vulnerable people.

I do not accept that is a way for us as legislators to behave, to lead and to drive community conversation. Absolutely not. This clause is unacceptable. It looks at the real world and it says, 'Let us accept that it is not right and just try to find a way to feel okay about it'. We should step up and say, 'We live in the real world. This issue has highlighted something that is wrong and deficient in our community'. We have an opportunity to make sure we do not condone it and that we provide an opportunity on this issue to progress as a community and deliver better outcomes, not just on this, but quite possibly on other matters too.

Ms FORREST - I have been listening intently because you cannot afford to switch off in the Chair, as you know.

I want to respond to some of what has been said. Much has been said but I do think it is important to respond to some of this. We need to understand that some of the things put forward are not accurate when you read what this clause suggests. I have been very challenged by this. I said I was not inclined to support it. I am still not sure it is the right framework. I will come to the member for Mersey's subsequent amendment to this, should this be successful as well.

The member for Nelson asked if this could apply to a boarding house or some other facility. Well, no, it cannot. It is limited to health service establishment as defined in the amendment at the outset.

Ms Webb - I meant as a subsequent, down the track. Not this clause.

Ms FORREST - No, we are looking at the legislation that is here before us today. So we are not jumping at shadows. We are talking about what is in front of us. What is in front of us is a reference to the Health Service Establishments Act, which are facilities registered under that process. It is not about boarding houses, it is not about a body corporate in a residential tower, or something like that. We need to focus our attention on that.

I do not like the fact at all that we even need to have this conversation. Whether it is supported or not, it is a disgrace. It is a disgrace, just to digress very slightly for a moment, that we cannot access a termination in a public hospital here because of a government policy for a health service that is legal and part of a normal health service. It should be. It makes me really frustrated that we have to have these discussions.

I can argue both sides of this debate and I will, because it is important to try to get to the end here somehow. It says -

> A relevant service provider may refuse to authorise or permit the carrying out, at a health service establishment … any part of the voluntary assisted dying process in relation to a person who resides in or receives services at … including any assessments as to whether a person is eligible to access voluntary assisted dying.

You can argue thank goodness we have a time frame in the bill now because without that I can move into an aged care facility in 10 years time and think, if I get certain conditions, I want access to it. But I cannot start the process. I could then if I was diagnosed well out from the point of actually dying. The member for Windermere talked about people at the point of death. We are not talking about the point of death - we are talking about at the beginning of the process.

Mr Dean - I did say at the beginning of the process several times.

Ms FORREST - The member is talking about the person with all the unfortunate things that can happen at the end of life which is not always pretty, neither is birth. We need to remember this is about saying you cannot live here if you are going to undertake any of these services, including the assessments. Obviously, it does not stop a resident going out and seeing their GP who can do the processes outside that facility. People who are diagnosed with a terminal illness and have six months to live or 12 months with a neurodegenerative condition under the general arrangements can still leave a facility to go to see their GP; they do it all the time. GPs also do home visits there.

What we hear from the Victorian experience from the member for Huon is these facilities are saying, 'No, the GP cannot come in and do that.'. I still want you to address to me how they actually physically stop them? How do they know they are doing it? It is a privacy breach if I understand it properly. Both sides of this are really quite vexed. As far as moving out of the facility, I accept there are limited options where else you could go. A lot of the aged care facilities in small regional communities are single and you cannot go and live in hospital for six months or 12 months and cannot always go to a family member.

I look around my electorate and most of the aged care facilities that are single are not the only ones nearby that are religiously run. I do not know about the rest of the state, I do not know what else is around, this is a really difficult one. It should not be a torturous approach with someone having to test this to find they are being denied access to a legally available medical treatment, and then find they have to go to the court to try to get access.

The member for Mersey's subsequent amendment was - I do not seem to have that one in front of me. I am looking at a requirement if this be successful that the health service establishment and the relevant service provider must permit the person's PMP, CMP, AHP and a contact person to actually come to that person. I wonder why we did not go down that path anyway. Why did we not say 'if a person is in a residential aged care facility'? You could argue there is not an institutional conscience, but the individuals within the institution have a conscience and they can conscientiously object, and whether you agree with that or not we allow it.

Even in a non-religious aged care facility, there would be people there who do not want to participate and assist that person, same as the medical professionals - some who do, some who do not. Why would we not say that they have allowed access for their health practitioners

to visit them and provide that care rather than this more torturous process of requiring a person to be transferred? Is there a better way to do this? There probably is; I have read through all of these and I was not clear on that until listening to the debate to really understand these complexities.

On the issue with the anti-discrimination, I tend to agree with the member for Rumney when you look at the Anti-Discrimination Act at discrimination in relation to attributes, we look at clause 16, Discrimination on ground of attribute -

> A person must not discriminate against another person on the ground of any of the following attributes:

I will read them because it is relevant -

> Race; age; sexual orientation; lawful sexual activity; gender; gender identity; intersex variations or sex characteristics; marital status; relationship status; pregnancy; breastfeeding; parental status; family responsibilities; disability; industrial activity; political belief or affiliation; political activity; religious belief or affiliation; religious activity; irrelevant criminal record; irrelevant medical record; associated with a person who has or is believed to have any of these attributes.

I know VAD is not legal yet, but the fact that you might want to access a health service that is legal is not an attribute, so I do not think we are risking opening the door to discrimination based on that. But I do believe we should be enabling people to access care in their own home - which is where they are in a residential care facility - if they choose that, and it should be able to be provided.

I am not suggesting we in any way force or require a member of the staff or a member of the management team or anyone who works at or is involved with that facility to have to participate in that. All I am suggesting is they need to enable access to the primary health practitioner, the consulting health practitioner, the administering health practitioner, and the contact person and the relevant family members, if they want to choose that.

That is a different question I know. It is a different question to what we are debating but to me that seems like a much more sensible, tidy approach. I am sure the organisations would not be happy with it. I know they would not.

Ms Webb - They already say they are not. The organisations will object to that. That is exactly what they do not want to do. Allow access.

Ms FORREST - I know. Yes. If this person is living in this facility having paid a not insignificant sum of their own money, and they all have and they are getting public money through the government funding -

Ms Webb - We are all agreeing.

Ms FORREST - Yes, I know. I am just saying, is there a better way or a more direct and fairer way? We are not asking them to participate, we are asking them to allow access.

Allow carers, medical staff, to come in if there are not people on the site that are willing to do it. They do not have to be anywhere near it.

I used to refuse to hold babies down for circumcisions when I was a midwife because I had a conscientious objection to circumcising a newborn baby boy. As a student I did not feel I had any choice. I was young, not very confident. It is the most horrendous thing to do, so I would then refuse. The obstetrician would come looking for me and I would say 'No, you will have to go and find somebody else, or you cannot do it.'. I was happy for the baby to have circumcision a bit later on when they had some anaesthetic and there was less risk of bleeding and infection, if that was the choice of the parents, but not the way we used to do it. They have stopped doing that quite frankly, too.

I accept that we need to provide a conscientious objection framework within this, and we do. I accept the points made by the member for Rosevears about not having to move from that facility because they are known by the staff and they have a family who interact with that resident. They know the people who come and go in that space. They do not have to be involved in that particular aspect of care because they will have their own GP or their own PMP who can facilitate it. If we are going to support this legislation overall but you are not going to support it to make it accessible to anyone who wants it, are you not failing?

I think the patients or residents need to take priority in this decision, not the doctor or the facility. They should take second priority. The person has a right to have a conscientious objection but the patient's wishes should be respected even if I do not personally agree with them. I do not have to actually involve myself in the process, but I need to respect their choice.

The member for Nelson mentioned we have a chance to be leaders here in Tasmania and not follow other jurisdictions. I do not believe we are following other jurisdictions. What the member for Huon is trying to do is to react to the cold harsh reality of what we actually see happening - denial of access to legally available and legitimate services. We know it happens, we have seen it happen. Even with the Victorian situation where that person did eventually get access, they should not have had to go through the whole process, at a difficult time in their lives, to access it. It needs to be much simpler than that.

I am sure the members may have a view on this. Either we support both of these or neither of them. If we do not have either of them, we need to have some other framework, as I have just proposed, to address this to make it clear that people can have people come to their home, where they live, to provide this legal care if they want it. They should not be barred by policies. It does not have to be a policy that we do not support VAD. It could be a policy that we do not allow intravenous injections onsite. We do not allow self-administration, whatever it might be. Either you support the principle of this legislation, and if you do, you make it accessible, otherwise what are you doing? If you do not support the principle, that is fine, vote against it.

I would like another member or two to reflect on what I have said because I do not know quite where to go.

Ms WEBB - It is my final call. I would not necessarily have had a third call but the member for Murchison just invited other members to reflect on what she had said, so I thought I would do that before the member for Huon finishes up with his final call.

I think you are absolutely right, member for Murchison, in identifying that a better option would be something potentially explicit that could be in the legislation that required access to be granted to people. Not that the facility has to be involved, but at the very minimum grant access to that. That has not been proposed at this stage to be included in the legislation, so we do not have that on the Table to look at and contemplate.

What is a pathway where we still have the opportunity for that to come about? In my view, if we were to support this clause, we would close the door on that opportunity because this clause basically acknowledges entities can say 'no' and prevent that, and gives this other less preferable option of transfer which we have identified has a whole range of problematic parts to it.

How might we progress to exactly what, as the member for Murchison has said, would be the best outcome? That is having an explicit requirement that access is granted. My view is the pathway to that is to absolutely not put this clause in. That will act as a barrier to that down the track. Something could be brought here in this place to insert that. If the bill were to pass this place, something could be brought in the other place to insert that explicit opportunity. We could leave the door open for that.

Ultimately if it did not occur as it went through both Chambers this time around, at the time of the three-year review such a thing could be contemplated and inserted at that review stage. So, leaving the door open there is a range of opportunities in this place, in the other place, at the three-year review opportunity for something explicit to be put in there.

If this clause is supported and the bill goes through with this clause in it, we have tacitly endorsed the idea that these agencies are allowed to prevent, and we have created a less preferable option of transferring of people, so we have put the onus on the patient - the person at the centre of this - to change their arrangements, rather than the entity - ultimately - to change its arrangements. To me, the passing and the support of this clause by any member in this place would be the exact opposite of the outcome you, as the member for Murchison, were suggesting we might best want on this part of the issue.

In an effort to achieve what you, as the member for Murchison, have said is the best outcome here, what I am imagining is this means you would not support this clause, because this clause presents the only possible barrier we might put in place towards that outcome. That is my reflection - that the barrier this presents is the most explicit barrier we could put there to get the outcome you have proposed and we close the door on those further opportunities.

Dr SEIDEL - It is a useful discussion to have and to also put on the record. I am not necessarily influenced by opinions, but I am influenced by expert advice. I mentioned before - so I will read it out just for the record because that is the explicit advice by the nation's leading legal scholars and academic experts on end-of-life legislation. It says -

> If the legislation is silent about this, institutions will in practice prevent access to VAD. That is the experience in Victoria and has been foreshadowed in the Queensland Parliamentary Committee Inquiry.

I believe it has been foreshadowed in our briefings also with Southern Cross Care, for example. Professor White states -

So, I think members who are committed to universal access to VAD -

I am hearing we are all committed to universal access to VAD now. It is very clear there is broad consensus in this Chamber that we are committed to universal access to VAD. If members are committed to universal access to VAD, they need to commit either to a clause in the legislation that makes clear that institutions cannot impede access within their facilities or to my proposed clause.

The interesting part is the member for Mersey has already drafted an amendment to this clause. If we pass the clause I present, it is clear that members of this Chamber would have no hesitation passing the amendment from the member for Mersey.

Ms Webb - We do not know that yet.

Dr SEIDEL - But it is pretty clear in the amendment what the intention of the amendment is and we have all in principle agreed to it, so we can do this. We can do this today. We can protect the most vulnerable residents in health and aged care facilities. We can do this now, not in three years or five years time; we can do it now.

My recommendation to the Chamber is that we vote and pass my amendment - my clause - so, we can then pass the amendment from the member for Mersey, because my feeling is, based on what I have heard, this is what members of this Chamber actually want.

New clause E negatived.

Ms WEBB - Madam Chair, I move -

> That you do report progress and seek leave to sit again for the purpose of reconsidering new clause B as amended.

Leave granted.

Progress reported; Committee to sit again.

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

In Committee

Resumed from above.

New clause B, as amended, reconsidered -

Ms WEBB - Madam Chair, I move -

> That new clause B be read the second time.

I put these amendments to the clause we passed the other evening in relation to what we could colloquially call the gag clause introduced into the bill. The amendments pick up on - I will read it. I am going to deal with them separately, so I will do the first amendment then.

Madam CHAIR - It is better to do them all together because they do refer each to the other in many respects.

Ms WEBB - There are two separate parts.

Ms Lovell - Do one and two together and the third one separately.

Ms WEBB - The second and third ones become relevant if the first one is supported.

Madam CHAIR - We will do the first one.

Ms WEBB - I move the member for Rumney's first amendment -

First amendment

New clause A(1) -

Leave out the subclause.

I will talk that through so people can understand the intent. If you will look at the new clause A we inserted the other evening, you will recall that.

Madam CHAIR - It is new clause B.

Ms WEBB - Sorry, on my piece of paper it says new clause A. Members will recall this clause and the constraint it applies on initiating discussion around VAD as it stands has been put on a broad category called healthcare workers. The broad category includes a number of different categories of worker, that includes registered health practitioners, (1)(a) and (1)(b) says -

> … any other person who provides a health service or a professional care service.

We defined professional care service in the definition part of the bill and included the care services such as community aged care, disability support, and those sorts of personal and other support services.

This gag clause, this constraint, is put on that category of workers as well as registered health practitioners. At the time we passed this, I said it concerned me the constraint would be put on that broader category of professional care service workers, and that it captured a very broad array of people providing services in the community in Tasmania. The nature of that relationship between those workers, the services they provide and their clients is very different to a medical relationship where someone goes to see their doctor or another registered health practitioner and has an explicitly medical interaction with them, typically about seeking medical advice, diagnosis or treatment in that interaction.

In the case of professional care service workers or that broader category that captures community aged care and disability support, that is a really different relationship to a health treatment relationship. It is a support service; it involves regular, often intimate, provision of services and support to somebody. The sorts of conversations and interactions occurring in that context are really different to the sorts of conversations and interactions when people talk

with their doctors or other registered health practitioners of some sort where it is a very purposeful interaction regarding a health matter.

Madam CHAIR - I remind the member she covered a lot of this on Tuesday, so she needs to focus on the need for this amendment.

Ms WEBB - My first proposed amendment, on the basis of the concern I had about the inclusion of those groups, seeks to remove those groups from this clause and leave the clause applying only to registered health practitioners. That is why deleting subclause (1) is proposed in this first amendment. It takes out the mention of those other professional care services groups and leaves the rest of the clause applying only to registered health practitioners.

I remind people, again, during our previous debate, it was identified there had been no consultation on the inclusion of those professional care service workers and the broader category of non-registered people. No consultation with groups who are impacted, no consultation with workers and unions or employers of those categories of workers and no consideration in that sense of what the broader impact might be. Subsequently, I have spoken briefly and specifically about this with some of those stakeholder groups involved, such as unions, and they have distinct concerns about the inclusion of these workers, and confirmed they were not consulted when this clause was put together, brought to us and passed the other evening.

The indication I have from them is there is a concern, and they do not agree with the inclusion here, not having gone through an appropriate consultation process to fully explore and understand the impacts of including those workers and that kind of work in the gag clause. I will leave my first contribution at that and see if there are a few things that come up to answer.

Madam CHAIR - Are you going to cover all three amendments?

Ms LOVELL - Yes, across the three amendments but I will be brief.

I wanted to be really clear the new clause - as drafted and moved by me in the debate in the debate on Tuesday - was really about providing guidance to healthcare workers and their clients about what is and is not appropriate. That was where the intent behind it came from.

It does raise some questions and this debate now may raise some questions around the level of training that is provided to people in these roles on a whole range of matters. It is not just the voluntary assisted dying that could become an issue in this regard, it is a whole range of matters. As in the previous amendment and the previous debate, that is not a matter that we are going to be able to resolve here today.

It is really important to remember in this debate that any dispute under the new clause would be complaints-driven. It would be sparked by a complaint being made by the client, or potentially their family or someone connected with that client, about the fact that client was uncomfortable with comments that were made or a conversation that was had. That is as it should be, because it should be about the level of comfort of the client or the patient. That is how these matters should be dealt with.

That applies across the board. It applies not just to conversations about voluntary assisted dying. It would apply to any conversation about health treatment options. It could be a

questionable joke that someone tells. It could be a whole range of matters. That level of judgment comes into every interaction these workers have with their clients, or consumers, or patients and it is determined by a range of things including how long they have been working together, their relationship and the level of trust they have.

That will apply regardless of whether that is in the bill or not. It applies on every interaction on every topic, so that process will still be there. People will still have that avenue to pursue if they felt uncomfortable with a conversation or a topic that was raised.

The other point I want to make is that we are only talking about initiating the conversation here. It was initiating the conversation in relation to that person. Examples were given the other day such as talking about how you have had a tough day because you have been with your dad at the doctor who is looking at VAD. That was never the intent of this clause to cover. It was intended to cover the initiation of that conversation, so them bringing it up out of the blue in relation to that person. I wanted to be really clear about what the intent was.

I am not convinced that this is the clearest way to resolve this and the concerns that have been raised. I accept that the concerns are there. However, I am mindful of where we are at in this process, and we are very close. While it may not be the clearest or the neatest way to resolve the concerns, it will go some way to resolving those concerns.

On that basis, I will not be opposing this amendment. I will not oppose the other amendment, because I am very keen to see us work a way to forward from this and have always had that approach through this process. I just wanted to speak to assure members and assure the member for Nelson that I will not be opposing these amendments.

Mr GAFFNEY - I thank the member for Rumney. I think this will demonstrate to people how this place works. I congratulate the member for Nelson for following through with this because it will strengthen the bill. I also understand how it might need further work, but that is why we have the review. I think at this stage it is a really good compromise and I will be supporting the amendments. I thank the member for Rumney for taking this path and for what you have said is part of the whole proceedings, the intent of your initiative.

So, congratulations and well done to the member for Nelson for following through with this to make this bill stronger. I support all three clauses.

Ms WEBB - I was just rising briefly to say thank you for the contribution from the member from Rumney. I appreciate the support for not blocking the amendments. Perhaps if there are improvements that can be made in a timely way, we can go about doing that down the path.

Amendment agreed to.

Ms WEBB - I move the member for Rumney's amendments -

Second amendment

New clause B(2) -

Leave out 'health care worker',

Insert instead 'registered health practitioner'.

Third amendment

After subclause (3)

Insert the following subclause:

(3A) Nothing in subsection (2) prevents a registered health practitioner who is not a medical practitioner from taking an action referred to in subsection (2) in relation to a person if the registered health practitioner, before the conclusion of the discussion, with the person, in which the action is taken informs that person that a medical practitioner would be the most appropriate person with whom to discuss the voluntary assisted dying process and care and treatment options for the patient.

Amendments agreed to.

New clause B, as further amended, agreed to.

Long title -

Ms LOVELL - Madam Chair, I move -

Long title -

Leave out 'Commissioner of Voluntary Assisted Dying', *insert instead* 'Voluntary Assisted Dying Commission'.

Members this is just the final amendment required as a consequence of the adoption of a voluntary assisted dying 'commission' as opposed to 'commissioner'

Title, as amended, agreed to and bill taken through the remainder of the Committee stages.

Bill reported with amendments, and amendment to long title; report adopted.

Motion - Leave Sought

[12.01 p.m.]

Mr GAFFNEY (Mersey) - Mr President, I seek leave to move a motion without notice.

Ms FORREST (Murchison) - Mr President, I would like to check the intent of this granting leave. If this motion is to suspend Standing Orders, I wish to speak against that - is the member going to move that Standing Orders be suspended?

Mr PRESIDENT - It is a question of leave. There is no debate around the question of leave.

Ms FORREST - Sorry, there is not.

Leave granted.

Suspension of Standing Orders

[12.02 p.m.]

Mr GAFFNEY (Mersey) - Mr President, I move

> That Standing Order No. 280 be suspended to allow the bill, as amended in Committee, to be now taken into consideration.

Ms FORREST (Murchison) - Mr President, I rise to speak against that motion. This House has bent over backwards to facilitate proper and full debate on this bill. It is completely inappropriate now to ignore a proper process in which an important matter with such a complex and heavily amended bill would see us progress right through to the end of it now. It is not urgent it is done today. Both Houses sit again in two weeks time - less than two weeks now - one-and-a-half weeks time.

The third reading can be done and the consideration of the amendments can be done at that time. I need time to think about particularly the last debate we had around the new clause proposed by the member for Huon, whether there does need to be something added and the only time we can do is before we progress to this next stage. There is a proper process in this place, which I only ever support, as many members will know here, when it is an urgent matter and it is urgent the bill proceed right away. That is not the case here.

Our role here must not be undermined by undue haste. We have a very important role and very clear procedural processes in place to prevent errors and to ensure proper consideration of these matters are made. This is not about who might be watching here or in other places; our job is to get it right and ensure proper process and consideration have been given to this heavily-amended bill.

The member for Mersey, himself, said yesterday there would hopefully be a vote, so he knew there was a chance it would not get to a vote today. Because there has been such robust debate earlier this morning, only a matter of a very short time ago - which we potentially could have proceeded with yesterday, but we did not - now that this has happened today, we need time to consider if we have the best outcome we can.

This House has bent over backwards to facilitate the process of the passage of this bill. We have cancelled committee hearings; we have cancelled other things to be here.

Yesterday, the member for Mersey informed us he was not ready to proceed with the amendment from the member for Huon because he was still receiving advice on it. I now need time to consider advice on whether there is a better way forward on that particular matter or any other that may come forward related to the most recent debate from the member for Nelson.

We agreed yesterday to allow time for members to consider fully the new clause from the member for Nelson, and we did. There may be other areas that become apparent to

members as they take time to really consider this bill as a whole in its entirety with all the amendments agreed, not agreed, whatever.

Before we take the final vote, we need time. It is a complex bill. There have been many clauses amended. Even to go through those clauses now, the Clerks need time to get everything in order and we do not want errors made.

It will take quite a bit of time to read through all the amendments in itself. That will take another half hour or so. It is an important matter and members may need time to consider speaking on the third reading. All members may wish to speak on the third reading. I do not know. I know I want to and I am not ready to.

Normal process would suggest we have that period between the completion of the Committee stage and the progressing through to the third reading. I need time. I expect others may do too. It has been a really challenging and taxing time for all of us. I think I can say that for everyone in this Chamber. I do not think we should rush at the final hurdle just for some media or other opportunity, if that is what is going on.

[12.07 p.m.]

Ms LOVELL (Rumney) - Mr President, this is a really tricky one. Personally, I would like the bill to progress because - and this is me speaking personally - I have scrutinised the amendments, I have been following the process, I feel ready. I feel as if I know what the bill is looking like with the amendments, because I have been monitoring that, so I feel comfortable to progress it. I hear what the member for Murchison is saying and I would like to hear if other members have a view.

If other members feel the same and they would like more time to consider the bill as a whole -

Ms Forrest - Normally, you are allowed time for members who need more time.

Ms LOVELL - I do not want to prevent that from happening either. This is such an important issue to so many people in our community. I am not worried about who is watching or media events or what have you; I could not care less. What I am concerned about and focused on is that there are members in our community who want this legislation to progress. The question for me is whether not doing the third reading today would delay the progress of the bill through the lower House.

Ms Forrest - It will not.

Ms LOVELL - I am getting to that. On that basis - that it will not delay the progression of the bill - I am leaning towards not supporting the suspension of Standing Orders for that reason. I would be very keen to hear from other members whether they need more time to consider or are comfortable to progress because I am comfortable to progress. I do not want to take away anyone else's opportunity if they want to further consider the bill and potentially make further contributions. I would be very keen to hear what other members are looking for and what their preference would be.

[12.09 p.m.]

Ms RATTRAY (McIntyre) - Mr President, I have in the past, I would pretty much say 95 per cent of the time, supported the government of the day when they have called for a third reading directly after we have completed the Committee stage. For various reasons it has always been that there is not an issue as such, with what we have just done. But we have always in this place - I would say again 99 per cent of the time - when a member gets up, takes their turn and indicates they are not ready to proceed with something, given them that courtesy and allowed them to have that time. I did it two Thursdays ago where I asked for some time before we considered the bill.

I am going to support the member - unfortunately not support the member for Mersey in this instance and for the reasons that were already shared. There is a process in this place and we normally do the third reading at a later time. I expect that process was put in place a long time ago for very good reasons. I understand there are people waiting but there have been people waiting for a very long time and I know they would expect us to get it right. There is still the support for the bill; it is just the third reading has not occurred.

[12.11 p.m.]

Ms ARMITAGE (Launceston) - Mr President, I certainly understand where the member for Mersey is coming from. It has been a long period and I am sure he is very anxious to have the third reading, but I will be supporting the member for Murchison.

I remember in the contribution on the member for Huon's amendment today the member for Murchison saying there possibly might be another way forward rather than the amendment that was before us. It is obviously a bill with many amendments and I, too, would like to go through and just refresh the amendments in my mind and just reconsider.

I do not believe one week will make any difference to getting this bill to the other place. We will sit again in one week's time. That is the process that we normally follow. As was said by the member for McIntyre, if a member is not prepared or not ready and they have other things they would like to look at, and with all fairness to the member for Murchison, her amendments and certainly her scrutiny of the bill has been extremely thorough and if it is felt there needs to be more time, I will certainly support that.

12.12 p.m.]

Ms HOWLETT (Prosser - Deputy Leader of the Government in the Legislative Council) - Mr President, I will be supporting the member for Murchison. Many amendments have been put forward and I feel I need time to consider them. I do not feel I am ready to do so at this stage.

[12.13 p.m.]

Mr VALENTINE (Hobart) - Mr President, looking at the timetable of sittings, the budget is coming up. How much time the other place may need to consider the bill - I know we have certainly spent a lot of time on the bill before us. With the amendments coming through, we have had a fair old bit of time to consider some of the implications of that in relation to the original bill as we received it.

I hear what the member for Murchison is saying. I believe we need to deliver a bill that is as good as it can be, but I also would not want to see the other place without enough time to

fully consider the total impact of what they are about to receive. That is my conflict. It means that we would not be able to have the third reading until 10 November.

Ms Forrest - They do not sit till then anyway.

Mr VALENTINE - Not until 10 November, yes, but they are not going to have the full bill before them, are they, until that time. That is what I am saying. We have the budget coming up.

I know that we should not necessarily do things in this place just to suit the other place but I am thinking of the full issue of this bill being properly assessed. We are the other way around this time. We are not reviewing it, we are making it and they are reviewing it which is an interesting thing. I just want to make sure that they have really good time to do that. I am a bit conflicted in the sense of it being the budget week they are going to receive it, and it is going to be very difficult. But I will listen to other offerings on this. I suppose it would mean that it would have to be recommitted, would it? If you get this deferral -

Ms Forrest - It is not a deferral, it is using proper process. It is allowing proper process to occur.

Mr VALENTINE - If you get this proper process happening and you decide -

Ms Forrest - Or anyone.

Mr VALENTINE - or anyone, says I think this needs extra treatment, or whatever, does the bill then get recommitted and -

Ms Forrest - It is up to the will of the House, that is.

Mr VALENTINE - Is that what would happen? One would expect that is what would have to happen.

Ms Forrest - It is not just about that. It is time to make a third reading contribution, as I said, to make a third reading contribution that is considered.

Mr VALENTINE - Okay, I will listen to other offerings.

[12.15 p.m.]

Mrs HISCUTT (Montgomery - Leader of the Government in the Legislative Council) - Mr President, as Leader, when I ask for the third reading, I am often very keen to receive it, and every time the member for Murchison stands up with the same procedural problems -

Ms Forrest - Except I did agree during COVID-19; I did not hold things up.

Mrs HISCUTT - Yes, which is the right and proper process. Having said that, just for clarity, this bill when it gets to the other place has to sit there for maturity, so it has to sit there until the end of the week. If it goes down to the other place on the Tuesday morning, if we pass it, they cannot deal with it that week.

Ms Forrest - It cannot go down any earlier anyway; they do not sit. They sit the same week as we do.

Mrs HISCUTT - Which is on 10 November, that is what I am saying. If we do the third reading, it would go to the other place if we pass it. The other place cannot deal with it on 10, 11 or 12 November; it would have to be the following week, which is straight into the budget and Estimates. I just want it to be clear - it has to sit in the other House for three days or a week.

Ms Lovell - If we were to proceed with the third reading today, can it get to the lower House any quicker than if we were to proceed with the third reading on 10 November? I think that is the question that people have.

Mrs HISCUTT - That is clarified. Even though we would send the message today, they will not get it until 10 November. It will not be dealt with immediately, is what I am trying to say. Being the Leader, I am not going to try to sway members one way or the other; I just want you to be clear of what may happen.

[12.18 p.m.]

Ms PALMER (Rosevears) - Mr President, I am completely unclear and a little bit confused. The mitigating circumstances are I only arrived here a few months ago. I am still working through how procedures work and suddenly I am sitting here - I thought this was all about to be over and then a member whom I respect very much with many years of experience put a whole other thing on the Table and I am really not quite sure what to do.

I just want to be really clear. I feel it is even an inappropriate conversation to have in this forum, but I am about to have to vote on this, so I have to ask it in this forum. If we go through to Tuesday, which the member has asked for and is saying is due process, it will not impact the amount of time that the other place has, it will not hold up the process?

Ms Forrest - If we do it on Tuesday, yes.

Ms PALMER - That will not impact the other place. It will not hold up the process. It will give you as the member, and anyone else who feels that way, the opportunity to reflect on what has happened here today and in past weeks. I did not know you could do a third reading speech.

Ms Forrest - There are limitations around the third reading; it is in the Standing Orders.

Ms PALMER - I am learning all the time. I wanted to be really clear because I am floundering over here but that is the case. It will not hold up because we are running out of time; Christmas is coming. I want to be really sure on that before I make a decision which way to go because five minutes ago I thought this was almost done.

Ms Forrest - The normal process is when a bill is dealt with in Committee, it then sits on the Table overnight, which may be the next week or two weeks later. It is read the third time. Any amendments made are considered again at that time because things may have come up and it is an opportunity for members to raise new things or explain why they have changed their vote, and all sorts of things. Particularly on contentious bills, or bills that are heavily

amended, it is really a process to facilitate a look at the whole thing at the end of it. We would not normally rush it through.

Ms PALMER -Thank you very much; I appreciate your indulgence.

Mrs Hiscutt - Point of clarification, the maturation time in the other House is two days.

[12.21 p.m.]

Dr SEIDEL (Huon) - Mr President, I appreciate the comments made by the member for Murchison. However, I believe everything that could have been said on VAD has been said. Realistically, if we think of the contributions today, the new clause or amendments we discussed were straightforward. The new clause I proposed was defeated so it is inconsequential that we are now going to look at -

Ms Forrest - No, it is not - that is the whole point.

Dr SEIDEL - I disagree because we could have thought about this earlier. I am comfortable for that clause to have been defeated and to move on to the third reading.

With regard to the amendment made by the member for Nelson, that was supported by the initial proposer, the member for Rumney.

There comes a time where we have to come to a conclusion. Realistically we have all had ample opportunity to contribute to the debate. I appreciate the concerns about due process but it is still the same due process. We just changed the time lines for it. I am comfortable to support the member for Mersey and on indulgence may I also congratulate our New Zealand colleagues who passed their referendum on VAD with 65 per cent of the total vote.

[12.23 p.m.]

Mr DEAN (Windermere) - Mr President, I have listened to the debate and because it cannot slow the process down at all, why can we not defer it until we come back again? It does not slow it at all, as I understand the process it has to go through. The only interference might be with arrangements the member for Mersey has in relation to where he is going with this. I do not think that should be the determining factor when members want to look more closely at some of the amendments and some of the other issues. They are able to speak on the third reading providing it is new information they did not see at the time. It is not a time for a second reading but they do have that opportunity. I am of the view at this stage, unless the member for Mersey is able to convince me otherwise, of supporting the motion as well.

[12.24 p.m.]

Mr GAFFNEY (Mersey) - Mr President, to clarify a few things, if you were in my position and working on this bill everybody would have tried to move on as quickly as they could. That is what I have done. It is correct parliamentary process; it has happened before in other places where the third reading is done straightaway.

I have to acknowledge, and this is probably not the time that I was going to do it, the work and effort put in by everybody to get the bill to this place. It has nothing to do with trying to limit people from speaking. When people mention lots of amendments, 132 of them were because we changed 'Commissioner' to 'Commission'. I wanted to put on record that all bills get strengthened and all bills get amendments. I am comfortable with that because it is a better

bill. I am always going to try to move this as quickly as possible, and that is what I am going to do, but it comes down to the will of the House.

I am not doing anything that is outside parliamentary process. I have put something forward; members will vote on it, and it will either get passed or it will not. That is what it is. It is nothing more, nothing less. I do not organise my media opportunities; that is not how I work and members know that. It is going to happen anyway.

I thank each and every person for getting through this, I really do, from the bottom of my heart. I have tried to move it on as quickly as I can. It is up to the will of the House.

Suspension of standing orders negatived.

Third reading of the bill, as amended, made an Order of the Day for tomorrow.

SUSPENSION OF SITTING

Member for Windermere

[12.27 p.m.]

Mrs HISCUTT (Montgomery - Leader of the Government in the Legislative Council) - Mr President, I move -

That the sitting be suspended until the ringing of the division bells.

This is to enable the member for Windermere to conduct some business.

Mr VALENTINE (Hobart) - Mr President, I am not quite sure - maybe others are in the same boat - what we are agreeing to here. If it could be explained a bit more, I would appreciate it.

Mr DEAN (Windermere) - Mr President, the reason for the very short suspension is that I raised a matter last night in this Chamber in relation to medicinal cannabis. There has been quite a lot of discussion on that speech. I have been asked to bring the matter forward by way of a motion for further discussion in this place to give everyone in this Chamber the opportunity to talk on that matter.

It is impacting on many people. It is impacting on the person I referred to last evening and the treatment of her son who is in a perilous position. I have put forward some idea as to the way the motion should proceed and passed that to the Clerks for their consideration as to whether it should go the way I have put it, or whether it should be amended. I suspect it may well be slightly amended.

I ask for members' support in this. My intention would be that the matter would be debated when we resume on 10 November.

Mr PRESIDENT - Honourable members, the member for Windermere is seeking leave so he can have questions put on the Notice Paper; this is similar to giving a notice of motion.. That is what it is about. I do not imagine it would be long at all.

[12.28 p.m.]

Ms FORREST (Murchison) - Mr President, I would like an indication of time and if the member only needs a forum for that, maybe some of us could go. What is the time frame?

Mr Dean - Five, 10 minutes.

Ms FORREST - All right.

Motion agreed to.

Sitting suspended from 12.29 p.m. to 12.45 p.m.

TABLED PAPER

Answers to Questions

[12.46 p.m.]

Mrs HISCUTT (Montgomery - Leader of the Government in the Legislative Council) - Mr President, during debate on the State Service Amendment (Validation) Bill 2019 the Deputy Leader undertook to provide answers to questions asked by the member for McIntyre. I seek leave to table that answer.

Leave granted.

ADJOURNMENT

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. 10 November 2020.

Motion agreed to.

The Council adjourned at 12.46 p.m.