Standing Committee on Law and Justice
Provisions of the Voluntary Assisted Dying Bill 2021

HOPE: Preventing Euthanasia and Assisted Suicide Ltd

Answers to Questions on Notice
Proceedings conducted on Monday 13 December 2021

1. How does the law, as broadly stated, deal with identifying coercion as a general proposition?

The law in general deals with the issue of coercion by way of factual inquiry, requiring a person with the requisite skills and training to review the circumstances in which parties have entered into particular legal agreements, and seeks to establish, as a matter of fact, whether coercion or undue influence were operative.

Where coercion, or undue influence are found to have been operative, an agreement may be rescinded on the basis that it was not entered into voluntarily. The law will then seek to restore the parties to the position they were in before entering into the respective agreement or legal instrument. As stated in our submission, in the case of euthanasia and assisted suicide, where coercion may have been operative, there is no way to restore parties back to the position they were in before the person's death. Thus, the law concerning this issue must provide the most stringent possible safeguards concerning vulnerable people accessing the regime.

Whilst the Bill asserts that 'there is a need to protect persons who may be subject to pressure or duress' (section 4(1)(j)), it provides no safeguards to ensure this occurs. The physician is not required to provide any information about what factors led them to conclude that the person has capacity and is not acting under undue influence or as a result of coercion.

This bill leaves the determination of whether a patient has decision making capacity in the hands of the two medical practitioners and establishes a presumption in favour of capacity. There is no positive duty imposed on a physician to make inquiries about capacity. The presumption should be reversed; a physician should be required to demonstrate that the person requesting euthanasia and assisted suicide *does* have capacity and is acting free of coercion, and to provide an explanation as to the reasons for forming this assessment.

Related to this issue of undue influence is the matter of coercive control. We note that an inquiry regarding this issue has been undertaken by the NSW Joint Select Committee on Coercive Control. The state government has committed to implementing measures to tackle coercive control. There is a growing recognition in the community about the hidden nature of coercive control, and the importance of legislative measures and education regarding the issue. It is concerning that the *Voluntary Assisted Dying Bill 2021* as currently drafted provides less protection and safeguards for vulnerable people than those being proposed with respect to combating coercive control. Given that many of the people who may be at risk of wrongful death under the Bill are the frail elderly and terminally ill (thus rendering them particularly vulnerable), there is arguably a greater impetus to tighten provisions regarding this issue to ensure the Bill seeks to prevent wrongful deaths as much as possible.

2. I wanted to see whether, from your knowledge, any of the other States have that in place in terms of their voluntary assisted dying regimes, and if not, why you think it is important to have medical professionals on that board.

We note that the amended Bill now includes a requirement that the Board must include 2 members who are medical practitioners (section 143(2)).

However, we would strongly recommend, in the interests of comprehensive oversight of all cases under the Bill, that section 143 be amended further to require that a representative from the NSW Coroner's Court, NSW Palliative Care and a representative from the Director of Public Prosecutions also form part of the membership of the Board.

3. I take it 'prosecution' refers to criminal prosecution. Is that right?

The reference to prosecution in the HOPE submission to the Committee (page 16) is a reference to criminal prosecution. This is to be distinguished from the issue of disciplinary action, which is a civil matter.

The matter of compliance and oversight regarding physicians participating in regimes that permit euthanasia and assisted suicide is not straightforward.

The Committee may wish to note that in the state of Oregon in the USA, which is often cited by proponents of euthanasia and assisted suicide as an example of a regime in which there is no evidence of abuse and reporting and assessment systems work well, there are serious shortcomings regarding compliance and oversight of its assisted suicide regime. Oregon's system of collecting and publishing data about individual cases of assisted suicide may convey a false impression that there is adequate prosecutorial oversight of the regime; however, this does not translate into monitoring or compliance.

Indeed, representatives of Oregon's Public Health Division have given public evidence to this effect:

"The reporting requirement [in Oregon] lacks teeth. On paper, the law requires physicians to report all lethal drug prescriptions, but sets no penalties if physicians fail to report. Thus this requirement is not enforced. Noncompliance is not monitored. The law requires annual statistical reports from the Oregon Public Health Division (OPHD) but OPHD does not monitor underreporting, noncompliance or violations. Many of Oregon's reports acknowledge that the state cannot confirm compliance with the law. For example, OPHD announced in its first year that the state cannot determine if assisted suicide is practiced outside the law's framework, stating "[W]e cannot detect or collect data on issues of noncompliance with any accuracy."[1]

Furthermore, regarding Oregon's regime, it is important to note that:

"There is no investigation of abuse. The state has no resources or even authority to investigate violations, cases of expansion, and complications reported in the media or documented by others. There is no method for the public to report abuse. The Oregon Department of Human Services (DHS,

[1] Oregon Public Health Division (1999) 'Oregon's Death with Dignity Act: the first year's experience,' Portland: Public Health Division, cited in Hon Nick Goiran MLC, *The safe approach to End of Life Choices: Licence to Care not Licence to Kill,* Minority Report submitted under Legislative Assembly Standing Order 274, *My Life, My Choice*, The Report of the Joint Select Committee on End of Life Choices, August 2018, p.210.

of which OPHD is a part) acknowledged in a press release that DHS "has no authority to investigate individual Death with Dignity cases.""[2]

Conclusion

We thank the Standing Committee for the opportunity to appear before the Committee and this opportunity to provide answers to questions on notice. We are happy to provide any further clarification if requested.

Kind regards,

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Director, HOPE
28 January 2022

[2] Hendin and Foley (2008) 'Physician assisted suicide: a medical perspective,' Michigan Law Review 106 at 1613-40, cited in Hon Nick Goiran MLC, *The safe approach to End of Life Choices: Licence to Care not Licence to Kill,* Minority Report submitted under Legislative Assembly Standing Order 274, *My Life, My Choice*, The Report of the Joint Select Committee on End of Life Choices, August 2018, p.210.