Submission No 24

INQUIRY INTO PROVISIONS OF THE VOLUNTARY ASSISTED DYING BILL 2021

Name: The Hon Greg Smith SC

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Submission on legal aspects of Voluntary Assisted Dying Bill 2021

Author: Hon Greg Smith SC, former NSW Attorney General and Minister for Justice 2011-2014

1. As far as I am aware, this is the third attempt in the New South Wales Parliament by private member's bill to legalise euthanasia. The previous two attempts were made in the Legislative Council and failed.

NSW Law

2. Under the current law, euthanasia and assisted suicide are crimes, under the Crimes Act 1900 and the common law. If the lethal dose is administered by a doctor, other health professional or other person, that person may be liable for murder or manslaughter. The primary provision is Section 18 of the Crimes Act which states:

3. 18 MURDER AND MANSLAUGHTER DEFINED

(1)

(a) Murder shall be taken to have been committed where the act of the accused, or thing by him or her omitted to be done, causing the death charged, was done or omitted with reckless indifference to human life, or with intent to kill or inflict grievous bodily harm upon some person, or done in an attempt to commit, or during or immediately after the commission, by the accused, or some accomplice with him or her, of a crime punishable by imprisonment for life or for 25 years.

(b) Every other punishable homicide shall be taken to be manslaughter.

(2)

(a) No act or omission which was not malicious, or for which the accused had lawful cause or excuse, shall be within this section.

(b) No punishment or forfeiture shall be incurred by any person who kills another by misfortune only.

4. If the doctor's, other health practitioner's or other person's involvement assists the patient to commit suicide they may be liable for aiding and abetting suicide. Don't be fooled by Clause 12 of the Bill which seeks to change the reality of the acts[1]. Aiding or abetting suicide is also an offence against Section 31C of the Crimes Act:

5. 31C AIDING ETC SUICIDE

(1) A person who aids or abets the suicide or attempted suicide of another person shall be liable to imprisonment for 10 years.

(2) Where--

(a) a person incites or counsels another person to commit suicide, and

[1] 12 Voluntary assisted dying not suicide
For the purposes of the law of the State, a person who dies as the result of the administration of a prescribed substance in accordance with this Act does not die by suicide.

(b) that other person commits, or attempts to commit, suicide as a consequence of that incitement or counsel, the first-mentioned person shall be liable to imprisonment for 5 years.

6. An explanation as to why our Courts have been protective of the right to life of our citizens against causing harm to oneself or another is discussed in an important 1992 High Court of Australia decision, ***Department of Health & Community Services v JWB & SMB [1992] HCA 15; (1992) 175 CLR 218 (6 May 1992) known as Marion's Case,*** concerning Court permission to sterilise a 14 year-old disabled girl, Brennan J stated at [5] and [6]:

   "As Blackstone wrote in his Commentaries (127) 17th ed. (1830), vol 3, p 120:

   'the law cannot draw the line between different degrees of violence, and therefore totally prohibits the first and lowest stage of it; every man's person being sacred, and no other having a right to meddle with it, in any the slightest manner.' The effect is that everybody is protected not only against physical injury but against any form of physical molestation."

   "6. Blackstone declared the right to personal security to be an absolute, or individual, right vested in each person by "the immutable laws of nature"(128) Blackstone, ibid., vol 1, pp 124, 129; vol 3, p 119. Blackstone's reason for the rule which forbids any form of molestation, namely, that "every man's person (is) sacred", points to the value which underlies and informs the law: each person has a unique dignity which the law respects and which it will protect.

   Brennan J then stated in Marion's Case a most important principle:

   6…. "The law will protect equally the dignity of the hale and hearty and the dignity of the weak and lame; of the frail baby and of the frail aged; of the intellectually able and of the intellectually disabled." (emphasis added)

   And later continued:

   8 "The law accepts that a person who is sui juris can consent to what would otherwise amount to an assault or trespass without impairment of dignity, although the interest of society in the physical integrity of its members precludes the law from giving effect to a consent to the doing of grievous harm"

7. In New South Wales we have seen criminal prosecutions for murder and aiding and abetting suicide in recent years. These may reflect confusion in the community about the legality and morality of "mercy Killing". The irony is that none of these cases involve homicide by doctors, rather they demonstrate loss of respect for the victim's inalienable right to life.

Trial of Shirley Justins for killing a male friend

8. A prosecution for murder and alternatively, assisting suicide took place in Sydney in 2009, in a case called ***The Queen v Shirley Justins***. In late September 2005, Mr Wylie raised the idea of legal euthanasia with the offender and Ms Jenning. In October 2005, the offender, with the assistance of Ms Jenning, applied for legal euthanasia to the organisation Dignitas in Switzerland.

   Dignitas contacted Dr Phillip Nitschke of EXIT International. Dignitas stated that they required their patients to have full command of their faculties and that they were concerned

about Mr Wylie's Alzheimer's disease. Dignitas asked Dr Nitschke to assess Mr Wylie's cognitive function.

On 16 November 2005, Dr Nitschke visited Mr Wylie at his home. According to Dr Nitschke's evidence, Mr Wylie was unable to recall his date of birth or the number, age or sex of his children Notwithstanding this, on 24 November 2005 Dr Nitschke informed Dignitas that although Mr Wylie suffered cognitive impairment, he retained "significant insight" and wanted to travel to Switzerland to die.

In December 2005 Dignitas informed the offender that Mr Wylie's application had been rejected, due to concern about his mental capacity. In March 2006 the appellant provided her de facto partner, Mr Graeme Wylie, with a quantity of the drug pentobarbitone, commonly known as Nembutal. She placed an open bottle of the drug and a glass within his reach. Mr Wylie then poured the Nembutal into the glass and drank it, knowing that by doing so he would die.

Mr Wylie had been diagnosed with Alzheimer's disease in 2003. Psychometric testing performed between 2003 and 2005 had indicated a progressive decline in his cognitive function as a consequence of his illness. The extent of his illness and its impact on his mental capacity was a central issue at trial.

Following his diagnosis, Mr Wylie had attempted suicide on two occasions and had often expressed a desire to die. In 2005, he had applied to an organisation called Dignitas, which, in accordance with the law of Switzerland, provides assistance to people wishing to end their own lives. His application was rejected after Dignitas expressed concerns about his mental capacity.

At the trial, Count 1 was a charge of murder. Count 2, which was in the alternative to murder, was a charge of aiding and abetting suicide. The appellant pleaded not guilty to both counts. During the course of the trial, the appellant offered to plead guilty to aiding and abetting suicide in full discharge of the indictment. The Crown did not accept that plea.

The jury acquitted the appellant of murder but found her guilty of manslaughter by gross criminal negligence. The trial judge had directed the jury that it could convict for manslaughter if it was satisfied that “the deceased lacked capacity to commit suicide” and the appellant was “criminally negligent about the deceased’s capacity”. His Honour gave detailed directions about what, in law, was meant by the term “capacity”. His Honour provided the jury with a list of five cumulative matters that a person “must be able to do” in order to “make an informed and independent decision.” She was sentenced on 12 November 2008 to periodic detention, with a non-parole period of 22 months to date from 21 November 2008, expiring 20 September 2010, and a parole period of eight months to expire on 20 May 2011. The Court of Criminal Appeal allowed the appeal and ordered a new trial: ***Justins v Regina [2010] NSWCCA 242*** (28 October 2010).

9. The Catchwords of the CCA judgment give an outline of the issues in the case:

CRIMINAL LAW

- offences against the person
- homicide
- where the deceased had an illness causing cognitive degeneration

- where the deceased consumed a drug given to him by the appellant knowing that by doing so he would die
- whether the act causing death was that of the deceased or the appellant
- whether the trial judge's directions on the mental capacity of the deceased were erroneous
- whether possessing the capacity to commit suicide requires a person to make an "informed decision to take one's own life"

CRIMINAL LAW

- offences against the person
- manslaughter
- whether manslaughter by criminal negligence available where a person makes a drug available for another's consumption intending that death will result
- whether failure to make enquiries of a person's mental capacity capable of constituting a breach of duty causing death.

10. Ms Justins subsequently pleaded guilty to a charge of aid and abet suicide and as she had already served the sentence imposed for the more serious offence of manslaughter, she was sentenced to "the rising of the Court", effectively a slap on the wrist. The Crown had argued that because she influenced the victim to change his will in her favour, her behaviour was not entirely altruistic, but was motivated in part by self-interest.

Barbara Eckersley convicted for manslaughter after poisoning her mother

11. A more recent case in NSW was ***R v Barbara Eckersley [2021] NSWSC 562 (20 May 2021),*** the facts of which were described by the Trial Judge Justice Beech-Jones as follows:

    "On 7 April 2021, the offender, Barbara Eckersley, was arraigned before a jury panel on an indictment charging her with the murder of her mother, Mary White, on 5 August 2018 at Bundanoon. Mrs Eckersley pleaded not guilty. The trial ensued. After a number of days of deliberation, on 29 April 2021, the jury returned a verdict of not guilty to murder but guilty to manslaughter. The Court heard submissions on sentence on 30 April 2021 and written submissions were filed thereafter.

12. The trial Judge, Beech-Jones in his remarks on Sentence stated:

    "The maximum penalty for the offence of manslaughter is imprisonment for 25 years (Crimes Act 1900 (NSW) s 24). There is no standard non-parole period prescribed under s 54A(1) of the Crimes (Sentencing Procedure) Act 1999 (NSW) (the "Sentencing Procedure Act") for manslaughter.

    Mrs Eckersley killed her mother at her nursing home by mixing the barbiturate, pentobarbitone, into her soup and spoon feeding it to her. The killing of a vulnerable person in those circumstances is necessarily a serious crime. It was common ground that Mrs Eckersley is of otherwise impeccable character and that she loved and cared for her mother.

As I will explain, she administered the drug while suffering from a severe depressive disorder and when her capacity to understand events and know right from wrong was substantially impaired. The Crown Prosecutor described Mrs Eckersley's conduct as an act of love and she described it as an act of despair. All accepted that her distress arose from witnessing her mother's suffering over many years. Despite a factual context that cries out for flexibility in terms of sentencing options, in this case, the legislative regime only provides for a choice between a Community Correction Order and full-time imprisonment. The focus of this judgment is directed to which of those sentencing outcomes should be imposed."

During his summary of the evidence in the trial, his Honour under the heading "August 2018" stated:

"[7] Sometime during the period 1988 to 1998, Mrs Eckersley undertook volunteer work with the ACT Wildlife foundation. She helped with the rescue and rehabilitation of orphaned and injured animals. In her evidence, she said that during the course of that work **a veterinarian provided her with a "little bottle of emergency stuff", which she also referred to as "green dream". This was later identified as pentobarbitone. Mrs Eckersley said it was used as a sedative on badly injured animals and, "not very often", to euthanise them." (emphasis added)**

Later, His Honour discussed conversations between Mr Eckersley and the doctors on the topic of euthanasia:

"16. Third, there was evidence that, at various times during 2016 to 2018, Mr Eckersley raised the topic of euthanasia in some of his discussions with Warrigal staff as well as with Dr Lane and Dr Rajendra in the presence of Mrs Eckersley . The most significant evidence was given by Dr Lane who said that, prior to the first case conference with Warrigal staff on 21 March 2016, his "impression" was that Mr Eckersley asked him in his wife's presence "whether or not [he] was able to perform euthanasia". Dr Lane said that, as a consequence, he called the case conference. Mr Eckersley denied that. I am not satisfied that any conversation in substantially those terms occurred. There is no reference to it in the notes of the case conference that followed.

17.Otherwise, the balance of the evidence concerning the topic of euthanasia was to the effect that it was only raised by Mr Eckersley and he did so at various case conferences. There was a debate about whether he raised the topic of euthanasia as a matter of public interest generally or raised it in the context of something that, if euthanasia was legalised, might be warranted in the case of Mrs White. In her evidence, Mrs Eckersley denied that her husband ever mentioned the issue of euthanasia in relation to her mother. I am not satisfied that any discussion on the topic of euthanasia with Warrigal staff in the presence of Mrs Eckersley ever went beyond the matter as a topic of general public interest.

(Shortly before she was to be transferred from her Nursing home)

"19. Mrs White was due to be transferred out of Warrigal on Tuesday 7 August 2018. On Friday 3 August 2018 Mrs Eckersley attended a case conference which discussed the move.

20. At around 5.00pm on 4 August 2018, Mrs Eckersley arrived at Warrigal and fed her mother. Mr Eckersley did not accompany her. As I will explain, there is an issue as to whether, at that time, she added a large (and unauthorised) dosage of the benzodiazepine, temazepam, to her mother's food.

21. On Sunday 5 August 2018, Mr and Mrs Eckersley signed in at Warrigal at 5.05pm. They went to Mrs White's room. Mrs Eckersley spoon-fed her mother her soup. As I will explain, Mrs Eckersley admitted that she poured a quantity of the "green dream" into the soup. Mr Eckersley was not aware that his wife had administered the green dream. He said that "quite quickly, Mary started coughing a little bit ...her breath became sort of gurgling and she became very unresponsive, sort of floppy and Barb rushed off to get a nurse."[37] One of the nurses recalled Mrs Eckersley coming to the nurse's station asking for help at "5.30ish". [38] Mrs Eckersley did not tell that nurse, or anyone else that evening, that she had put anything in her mother's soup."

She was convicted and sentenced to a Community Corrections Order for a period of 2 years.

Western Australian case in 2018

13. Perth wife's 'mercy' killing was murder: Judge

Retired Perth tradesman and mining worker Kevin John Keath was told by a Supreme Court judge that his duty towards his wife "was to look after her not to kill her".

In sentencing 71-year-old Keath today, Justice Bruno Fiannaca told him that his act of killing his drugged wife Kerrie Anne with a forceful machete blow to her throat was not an act of mercy but murder.

Justice Fiannaca ruled that the only appropriate sentence was life imprisonment, but he said he would allow Keath to become eligible for parole after 10 years in jail.

At his trial, Keath pleaded guilty to murder and said his act was part of a suicide pact with his depressed but not terminally ill wife of 34 years.

On March 8, by mutual agreement, his wife took sleeping pills and went to bed at their property at York, about an hour east of Perth, before her husband entered the room and slashed her carotid artery and jugular vein with a single blow.

Mrs Keath struggled off the bed onto the floor before dying ten minutes later. Justice Fiannaca said the fact that Keath went into the kitchen for a drink as she bled to death "suggests a level of detachment" that did not allow him to impose any sentence other than life imprisonment.

During the trial, Keath's lawyer Karen Farley QC had told the Supreme Court it was her client's "only and deepest" regret that he had not fulfilled the agreement with his wife to kill himself.

Instead, Mr Keath drove to a nearby town and confessed to police on the night of the killing, saying he was "guilty as sin." Keath told police he had not killed himself because he wanted to ensure his wife's body was treated with dignity.

Mrs Keath had left a suicide note saying the couple had a suicide pact and after "dispatching" her, her husband was going to kill himself "as a loving act" to her. The couple had made a suicide pact after they lost a large sum of money from a bad investment.

Justice Fiannaca said that the question of euthanasia "is a vexed question in society." He noted that Keath had repeatedly stated that he had not wanted to become bankrupt and live on in a flat on a pension, or rely on his son for help.

The judge noted that his wife had “wished to die and she wished for you to take her life…Notwithstanding that, you have no right to take her life.”

“It would be very sad indictment on our society if one sought to justify a killing …to avoid a lifestyle that is seen to be intolerable,” he said.

VICTORIA LAURIE SENIOR REPORTER

Tasmanian Case leads to heavy penalty

14. Natalie Maher, daughter of Veronica Corstorphine, sentenced to 23 years for mother's suffocation murder

By Manika Champ ABC News 8-11-21

Veronica Corstorphine's body was found several weeks after her death.

Natalie Maher has been sentenced to 23 years jail for suffocating her mother Veronica Corstorphine in Tasmania two years ago.

Key points:

Veronica Corstorphine's body was found in her bed with a pillow over her face

Ms Corstorphine's bank account was drained and all money was sent to her daughter, Natalie Maher

Maher will not be able to apply for parole until serving at least 13 years

Prosecutors in the trial in the Launceston Supreme Court had alleged 48-year-old Maher smothered her 71-year-old mother with a pillow when they were living together in Keane Street West in South Launceston in October 3, 2019.

The court heard Maher left the state two days later and flew back to Western Australia, where she had lived most of her life.

It was not until late October — several weeks after the murder — that police found Ms Corstorphine's heavily decomposed body in her bed in the South Launceston home.

Police body camera vision, which was shown to the jury, showed the moment the body was found. A pillow was covering Ms Corstorphine's face and her hands were up beside her head.

The court also heard Ms Corstorphine's phone was found with Maher in Western Australia when she was arrested and that she could not explain why the phone was in her possession.

Today, after a total of six and a half hours deliberation, the jury returned a unanimous verdict of guilty.

Maher's sentence has been backdated to November 7, 2019 when she was taken into custody.

Pauline Robinson says the death of her sister Veronica Corstorphine has "left a big hole in a lot of our lives".

Outcome 'helped us get closure'

Ms Corstorphine's sister and Maher's aunt Pauline Robinson sat in the Supreme Court in Launceston throughout the four-week trial.

She said it had been a long few weeks.

"The fact that we lost our sister and I've also lost my niece is a double whammy and that's hard, that's really hard," Ms Robinson said.

"I knew it was going to come to this, but the minute you hear the result, it's a punch in the face.

"Thank you very much for the people who have helped us get some closure from this."

Ms Robinson described her sister as "beautiful".

"She left a big hole in a lot of our lives," she said.

"She was so kind and loved Tasmania. [She was] vivacious and very intelligent."

Throughout the trial, jurors heard Ms Corstorphine had only lived in Tasmania for about three years, was an avid studier and reader and was part of the Tasmanian Labor party.

In sentencing, Justice Robert Pearce said long-term relationship tensions between Maher and her mother had re-emerged, which led to the murder.

"I am satisfied that an escalation in your long held personal antagonism towards your mother was the primary motivation for the murder," Justice Pearce said when sentencing Maher.

"You were angered by her persistent complaints about how much she thought you were drinking and how you should change your life.

"The deceased was a small and very slightly built person. You were younger and stronger.

"I think it likely that some further conflict occurred during the evening of October 3 which caused you to commit the crime through loss of self-control or passion, perhaps inflamed by consumption of alcohol," he said.

Maher won't be eligible for parole until serving at least 13 years.

15. **In my view, legalisation of assisted suicide and euthanasia involving doctors will lead to reduction of sentences for non-medico criminals. (emphasis added)**

Court decisions upholding the illegality of Assisted Suicide

16. The criminal laws especially of homicide of various nations have developed from the Common Law of the United Kingdom. In order to highlight the enormity of the proposed changes which the enactment of this Bill would entail, I propose to review some important decisions concerning euthanasia and assisted suicide, as well as some concerning the cessation of medical treatment, so as to provide a background to attempts to legalise conduct which has been for centuries and remains currently illegal and unethical.

United Kingdom

17. Pretty v UK (2002) 35 EHRR; R. (Pretty) v DPP [2001] UKHL 61, [2002] 1 AC 800.

Diane Pretty died of natural causes on 11 May 2002 from motor neurone disease, a paralysing, degenerative and incurable illness. Her fight to choose the time and manner of her death assisted by her husband was a resounding legal failure. A unanimous body of judicial opinion in both the English Divisional Court and the House of Lords, followed by the European Court of Human Rights, denied that her rights under the European Convention on Human Rights had been infringed. Thus, the refusal of the Director of Public Prosecutions (DPP) to exempt Mrs. Pretty's husband from prosecution were he to undertake efforts to assist Mrs. Pretty in taking her own life was ultimately held to be lawful. At the same time, the domestic legal prohibition on assisting suicide, found in Section 2.1 of the Suicide Act of 1961 was found to be in conformity with the Convention.

In the course of his leading judgment in the House of Lords, Lord Bingham said at [9]:

“In the convention field the authority of domestic decisions is necessarily limited and, as already noted, Mrs Pretty bases her case on the convention. **But it is worthy of note that her argument is inconsistent with two principles deeply embedded in English law. The first is a distinction between the taking of one's own life by one's own act and the taking of life through the intervention or with the help of a third party. The former has been permissible since suicide ceased to be a crime in 1961. The latter has continued to be proscribed. The distinction was very clearly expressed by Hoffmann LJ in Airedale NHS Trust v Bland [1993] AC 789 at 831. Bland was suffering from a persistent vegetative state and hospital authorities wished to terminate his hydration and tube -feeding: (emphasis added)**

"No one in this case is suggesting that Anthony Bland should be given a lethal injection. But there is concern about ceasing to supply food as against, for example, ceasing to treat an infection with antibiotics. Is there any real distinction? **In order to come to terms with our intuitive feelings about whether there is a distinction, I must start by considering why most of us would be appalled if he was given a lethal injection. It is, I think, connected with our view that the sanctity of life entails its inviolability by an outsider. Subject to exceptions like self-defence, human life is inviolate even if the person in question has consented to its violation.** (emphasis added) That is why although suicide is not a crime, assisting someone to commit suicide is. It follows that, even if we think Anthony Bland would have consented, we would not be entitled to end his life by a lethal injection."

The second distinction is between the cessation of life-saving or life-prolonging treatment on the one hand and the taking of action lacking medical, therapeutic or palliative justification but intended solely to terminate life on the other. This distinction provided the rationale of the decisions in ***Bland***. It was very succinctly expressed in the Court of Appeal in In ***re J (A Minor) (Wardship: Medical Treatment) [1991] Fam 33***, in which Lord Donaldson of Lymington MR said, at p 46:

"What doctors and the court have to decide is whether, in the best interests of the child patient, a particular decision as to medical treatment should be taken which as a side effect will render death more or less likely. This is not a matter of semantics. It is fundamental. At the other end of the age spectrum, the use of drugs to reduce pain will often be fully justified, notwithstanding that this will hasten the moment of death. What can never be justified is the use of drugs or surgical procedures with the primary purpose of doing so."

Similar observations were made by Balcombe LJ at p 51 and Taylor LJ at p 53. While these distinctions are in no way binding on the European Court of Human Rights there is nothing to suggest that they are inconsistent with the jurisprudence which has grown up around the convention. It is not enough for Mrs Pretty to show that the United Kingdom would not be acting inconsistently with the convention if it were to permit assisted suicide; she must go further and establish that the United Kingdom is in breach of the convention by failing to permit it or would be in breach of the convention if it did not permit it. Such a contention is in my opinion untenable, as the Divisional Court rightly held."

The words of Lord Hoffmann in Bland should be carefully considered by Members of Parliament considering this current Bill: " In order to come to terms with our intuitive feelings about whether there is a distinction, I must start by considering why most of us would be appalled if he was given a lethal injection. It is, I think, connected with our view that the sanctity of life entails its inviolability by an outsider. Subject to exceptions like self-defence, human life is inviolate even if the person in question has consented to its violation." (emphasis added)

This Bill if enacted would fly in the face of these long-established principles of law.(emphasis added)

The United States of America

18. Two decisions of the US Supreme Court ruled that State prohibitions against assisting suicide were valid under the US Constitution. Glucksberg and Quill.

19. In ***WASHINGTON, et al., Petitioners, v. Harold GLUCKSBERG et al. (1997) 521 US 702.***

Delivering the majority judgment, Chief Justice Rehnquist commenced by stating:

Held: Washington's prohibition against "caus[ing]'' or "aid[ing]'' a suicide does not violate the Due Process Clause.

(a) An examination of our Nation's history, legal traditions, and practices demonstrates that Anglo-American common law has punished or otherwise disapproved of assisting suicide for over 700 years; that rendering such assistance is still a crime in almost every State; that such prohibitions have never contained exceptions for those who were near death; that the prohibitions have in recent years been re-examined and, for the most part, reaffirmed in a number of States; and that the President recently signed the Federal Assisted Suicide Funding Restriction Act of 1997, which prohibits the use of federal funds in support of physician-assisted suicide.

(b) In light of that history, this Court's decisions lead to the conclusion that respondents' asserted "right'' to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause. The Court's established method of substantive-due-process analysis has two primary features: First, the Court has regularly observed that the Clause specially protects those fundamental rights and liberties which are, objectively, deeply rooted in this Nation's history and tradition.

Second, the Court has required a "careful description'' of the asserted fundamental liberty interest…..(citations removed) The Ninth Circuit's and respondents' various descriptions of the

interest here at stake-e.g., a right to "determin[e] the time and manner of one's death,'' the "right to die,'' a "liberty to choose how to die,'' a right to "control of one's final days,'' "the right to choose a humane, dignified death,'' and "the liberty to shape death''-run counter to that second requirement. Since the Washington statute prohibits "aid[ing] another person to attempt suicide,'' the question before the Court is more properly characterized as whether the "liberty'' specially protected by the Clause includes a right to commit suicide which itself includes a right to assistance in doing so. This asserted right has no place in our Nation's traditions, given the country's consistent, almost universal, and continuing rejection of the right, even for terminally ill, mentally competent adults. To hold for respondents, the Court would have to reverse centuries of legal doctrine and practice and strike down the considered policy choice of almost every State. Respondents' contention that the asserted interest is consistent with this Court's substantive-due-process cases, if not with this Nation's history and practice, is unpersuasive. The constitutionally protected right to refuse lifesaving hydration and nutrition that was discussed in Cruzan, supra, at 279, 110 S.Ct., at 2851-2852, was not simply deduced from abstract concepts of personal autonomy, but was instead grounded in the Nation's history and traditions, given the common-law rule that forced medication was a battery, and the long legal tradition protecting the decision to refuse unwanted medical treatment. And although Casey recognized that many of the rights and liberties protected by the Due Process Clause sound in personal autonomy, (citations removed)….it does not follow that any and all important, intimate, and personal decisions are so protected, …(citations removed).

(c) The constitutional requirement that Washington's assisted-suicide ban be rationally related to legitimate government interests, see …(citations removed) is unquestionably met here. These interests include prohibiting intentional killing and preserving human life; preventing the serious public-health problem of suicide, especially among the young, the elderly, and those suffering from untreated pain or from depression or other mental disorders; protecting the medical profession's integrity and ethics and maintaining physicians' role as their patients' healers; protecting the poor, the elderly, disabled persons, the terminally ill, and persons in other vulnerable groups from indifference, prejudice, and psychological and financial pressure to end their lives; and avoiding a possible slide towards voluntary and perhaps even involuntary euthanasia. The relative strengths of these various interests need not be weighed exactingly, since they are unquestionably important and legitimate, and the law at issue is at least reasonably related to their promotion and protection.

20. Dennis C. VACCO, Attorney General of New York, et al., Petitioners,

v.

Timothy E. QUILL et al

In New York, as in most States, it is a crime to aid another to commit or attempt suicide, but patients may refuse even lifesaving medical treatment. Respondent New York physicians assert that, although it would be consistent with the standards of their medical practices to prescribe lethal medication for mentally competent, terminally ill patients who are suffering great pain and desire a doctor's help in taking their own lives, they are deterred from doing so by New York's assisted-suicide ban. They, and three gravely ill patients who have since died, sued the State's Attorney General, claiming that the ban violates the Fourteenth Amendment's Equal Protection Clause. The Federal District Court disagreed, but the Second Circuit reversed, holding

(1) that New York accords different treatment to those competent, terminally ill persons who wish to hasten their deaths by self-administering prescribed drugs than it does to those who wish to do so by directing the removal of life-support systems, and (2) that this supposed unequal treatment is not rationally related to any legitimate state interests.

Held: New York's prohibition on assisting suicide does not violate the Equal Protection Clause. Pp. ____-____.

(a) The Equal Protection Clause embodies a general rule that States must treat like cases alike but may treat unlike cases accordingly. E.g., Plyler v. Doe, [1982] USSC 182; 457 U.S. 202, 216[1982] USSC 182; , 102 S.Ct. 2382, 2394-2395[1982] USSC 182; , 72 L.Ed.2d 786. The New York statutes outlawing assisted suicide neither infringe fundamental rights nor involve suspect classifications, e.g., Washington v. Glucksberg, --- U.S. ----, ---------[1997] USSC 75 ; , 117 S.Ct. 2258, 2267-2271, --- L.Ed.2d ----, and are therefore entitled to a strong presumption of validity, Heller v. Doe, [1993] USSC 92; 509 U.S. 312, 319[1993] USSC 92; , 113 S.Ct. 2637, 2642[1993] USSC 92; , 125 L.Ed.2d 257. On their faces, neither the assisted-suicide ban nor the law permitting patients to refuse medical treatment treats anyone differently from anyone else or draws any distinctions between persons. Everyone, regardless of physical condition, is entitled, if competent, to refuse unwanted lifesaving medical treatment; no one is permitted to assist a suicide. Generally, laws that apply evenhandedly to all unquestionably comply with equal protection. E.g., New York City Transit Authority v. Beazer, [1979] USSC 45; 440 U.S. 568, 587[1979] USSC 45; , 99 S.Ct. 1355, 1366-1367, 59 L.Ed.2d 587. This Court disagrees with the Second Circuit's submission that ending or refusing lifesaving medical treatment "is nothing more nor less than assisted suicide.'' The distinction between letting a patient die and making that patient die is important, logical, rational, and well established: It comports with fundamental legal principles of causation, see, e.g., People v. Kevorkian, 447 Mich. 436, 470-472, 527 N.W.2d 714, 728, cert. denied, 514 U.S. 1083, 115 S.Ct. 1795, 131 L.Ed.2d 723, and intent, see, e.g., United States v. Bailey, [1980] USSC 11; 444 U.S. 394, 403-406[1980] USSC 11; , 100 S.Ct. 624, 631-633[1980] USSC 11; , 62 L.Ed.2d 575; has been recognized, at least implicitly, by this Court in Cruzan v. Director, Mo. Dept. of Health, [1990] USSC 122; 497 U.S. 261, 278-280[1990] USSC 122; , 110 S.Ct. 2841, 2851-2852[1990] USSC 122; , 111 L.Ed.2d 224; id., at 287-288, 110 S.Ct., at 2856-2857 (O' CONNOR, J., concurring); and has been widely recognized and endorsed in the medical profession, the state courts, and the overwhelming majority of state legislatures, which, like New York's, have permitted the former while prohibiting the latter. The Court therefore disagrees with respondents' claim that the distinction is "arbitrary'' and "irrational.'' The line between the two acts may not always be clear, but certainty is not required, even were it possible. Logic and contemporary practice support New York's judgment that the two acts are different, and New York may therefore, consistent with the Constitution, treat them differently. Pp. ____-____.

(b) New York's reasons for recognizing and acting on the distinction between refusing treatment and assisting a suicide-including prohibiting intentional killing and preserving life; preventing suicide; maintaining physicians' role as their patients' healers; protecting vulnerable people from indifference, prejudice, and psychological and financial pressure to end their lives; and avoiding a possible slide towards euthanasia-are valid and important public interests that easily satisfy

the constitutional requirement that a legislative classification bear a rational relation to some legitimate end. See Glucksberg, ante. P. __.

[1996] USCA2 257; 80 F.3d 716 (C.A.2 1996), reversed.

Lack of Safeguards in VAD Bill

21. **Conscientious objection** must be immediately announced to the patient [s.21(5)(a)]-this means that health practitioner who might want to conscientiously object has no opportunity to consider it; it assumes that conscientious objection is always an instant decision. It might be for some, but there are others who might only come to the decision after a period of reflection, particularly if it is the first request made to them.

22. **Conscientious objectors still must provide" the information approved by the Health Secretary, by Gazette notice."** [s.21(5)(b)]- this is similar to the wording in the abortion legislation, which requires a doctor with a conscientious objection to nonetheless provide information to the patient, likely a Government-run number and website that will connect them to a "VAD coordinator". This can be seen as akin to an obligation to refer."

    Similar provisions exist for medical practitioners who refuse to accept a referral from a PMP for a second opinion.

23. **Conscientious objectors need to advise the Board of their conscientious objection** (s.23(2)(h), s.34(2)--requiring a medical practitioner to "out' themselves to the VAD Board could be career-limiting, particularly for those who want to specialise in oncology/palliative care etc., just like it is for obstetricians who object to abortion.

24. **The promised protections for faith-based hospitals and aged care facilities were false.** In announcing his Bill, Alex Greenwich disingenuously said that there would be protections for faith-based hospitals and aged care providers. Not so. Faith-based aged-care facilities that object to euthanasia still need to allow doctors and nurses onto the premises for every stage of the euthanasia process, including allowing them to enter and kill a patient on site.

25. **Faith-based residential aged care facilities must allow all stages of euthanasia and assisted suicide process on the premises for permanent residents.** [s91-97]. This includes allowing a doctor on the premises to administer lethal injections.

26. **Faith-based hospitals are required to allow VAD navigators into the hospital to provide information** [s99(2)]—For all other parts of the process, the hospital is allowed to transfer a patient out, but they are required to let a VAD navigator on site.

27. **Informing the patient's treating doctor is optional. [s.28(1)(j)]—**A patient is encouraged to inform their treating doctor, but the coordinating or consulting doctors are not required to inform the treating physician

28. **Referral to a psychiatrist is only needed to assess capacity, pressure or duress. [s.27]—** psychiatric referral is not required if a person is suffering from a mental illness. Views will differ as to whether such a person is able to give informed consent.

29. The first piece of euthanasia legislation enacted in Australia, the Northern Territory's Rights of the Terminally Ill Act 1995 required examination by a Psychiatrist who "confirmed that the patient is not suffering from treatable clinical depression in respect of the illness." So the patient was ineligible for euthanasia if found to be suffering from a treatable clinical depression. Despite this requirement a study by Dr David Kissane and two others, including Dr Philip Nitschke, into seven cases of euthanasia, found in four cases the deceased had symptoms of depression. This meant they were not eligible for euthanasia. (The Lancet Vol 352, Oct 3, 1998 p.1097 et seq)

30. **The Board is not required to be notified of the presence of a mental health condition [s.30(4)]—**The list of information required to be provided to the Board does not include anything about the patient's mental health status or whether they have been seen by a psychiatrist.

This is a deterioration in safeguards.

31. **Limitation period for prosecutions is inadequate** [s135]-there is a 2-year statute of limitations for prosecutions under the Act. Given that breaches of the Act can result in death (murder and manslaughter have no limitation period), it is unclear why such a short limitation period should apply.

32. The most serious offences under the Act (s123 Unauthorised administration of prescribed substance and s125 Inducing self-administration of prescribed substance) each carry a maximum penalty of life imprisonment and should be prosecuted by the Director of Public Prosecutions on indictment. However the Act is silent on who the prosecutor for the more serious offences should be; in what Court cases should be prosecuted; and the only reference as to who should prosecute is s134 which under the heading **Who may commence proceedings for simple offence states:**

A prosecution for an offence under this Act may only be commenced by— (a) the Health Secretary, or

(b) a person authorised, in writing, by the Health Secretary.

33. **Coercion hard to detect**

Elderly frail and sick people sometimes feel guilty about continuing to live, particularly if they rely on younger family members to look after them. In a New Zealand piece by Jeremy Rees, "Assisted dying's risk of coercion" published on the website, Newsroom, in July 2018, the author reviewed submissions made about David Seymour's End of Life Choice Bill and commented:

"A long-time nurse, Bernadette Brocklebank, worries about the subtle pressure that can be placed on the old and ill. "I have been nursing for 38 years, and believe me people, the elderly in particular are without doubt coerced into making decisions by family and others who think they have nothing to offer society."

"In their submission, the Anglican Bishops of Aotearoa/New Zealand, agree. They point to instances of elder abuse. "It is a well-established reality of our society and increasing year on year. Family members and care providers might bring subtle, or not so subtle, pressure to bear on an ageing family member to 'do the decent thing' and exit this life. We have known situations of such pressure driven by family members alarmed to see their inheritance evaporating with the costs of caring for an ageing parent…."

"The Royal College of Anaesthetists, too, highlights the subtle coercion that may be placed on a patient, in pain, confused and vulnerable. And it worries how a doctor can spot that coercion."

Do doctors who are willing to assist have the ability to detect coercion? There is no requirement under the Bill that they have previously been a treating doctor of the patient and/or his/her family. The primary witness of coercion would be the patient and gathering evidence after that person's death would be most difficult.

34. Decision Making Capacity

The Australian Care Alliance has published details of a Study concerning decision making capacity of terminally ill patients. In a landmark study of decision making capacity of persons with terminal cancer and a prognosis of less than six months to live – that is a cohort that would be eligible for assisted suicide under the schemes in Oregon and other US States as well as in Victoria, Australia – 90% were found to be impaired in regard to at least one of the four elements of decision making – Choice (15% impaired), Understanding (44%), Appreciation (49%) and Reasoning (85%).

Under Victoria's Voluntary Assisted Dying Act 2017, for example, "a person is presumed to have decision-making capacity unless there is evidence to the contrary" (Section 4(2)). The Greenwich Bill contains a similar provision: S.6(2)(b)

This study suggests that, at least in the case of persons with cancer and a prognosis of less than six months to live, it would be more prudent to start from the presumption that they are likely to have impaired decision-making capacity unless it is demonstrated to the contrary.

The study also found a significant discrepancy between physician assessments of decision-making capacity compared to the actual decision making capacity as tested on the MacCAT-T scales.

Physicians assessed as "unimpaired" 64% of those who, according to the MacCAT-T assessment had impaired Reasoning; 70% who had impaired Appreciation; 61% who had impaired Understanding and 100% of those who had impaired Choice.

This lack of ability of physicians who are actually caring for terminally ill cancer patients with a prognosis of less than six months to live to accurately assess their patients' decision-making capacity is likely to be exceeded in flawed assessments of decision-making capacity by other doctors – who do not necessarily have an established relationship with the person – making an assessment of decision making capacity in relation to a request for assisted suicide.

Clause 6 provides, inter alia:

6. When person has decision-making capacity

(1) For the purposes of this Act, a patient has decision-making capacity in relation to voluntary assisted dying if the patient has the capacity to—

(a) understand information or advice about a voluntary assisted dying decision required under this Act to be provided to the patient, and

(b) remember the information or advice referred to in paragraph (a) to the extent necessary to make a voluntary assisted dying decision, and

(c) understand the matters involved in a voluntary assisted dying decision, and

(d) understand the effect of a voluntary assisted dying decision, and

(e) weigh up the factors referred to in paragraphs (a), (c) and (d) for the purposes of making a voluntary assisted dying decision, and

(f) communicate a voluntary assisted dying decision in some way.

Discussion

35. The question of capacity is fundamental to a decision by a very ill person considering assistance in dying. Eminent medico-legal expert from Georgetown University, Professor John Keown has raised this issue, saying that "lawmakers and academics have in general failed adequately to point out the practical and ethical challenges embedded in the question when, and under what circumstances, a person has the capacity to choose and consent to VAE and PAS. "

    He refers to a considered analysis on this topic by Canadian Academic Louis C. Charland et al., who argued:

    "There is a single issue that absolutely must be discussed when one considers the role of 'mental capacity' in consent to MAID (medical assistance in dying). The issue in question is present in all cases of consent to MAID. But it is especially acute in cases that involve persons diagnosed with mental disorders. It can be summarized in one question that is rarely explored in sufficient detail but is very practical indeed: When, and under what circumstances, does a person seeking MAID have the mental capacity to decide to choose and consent to such a medical intervention? The question is absolutely fundamental since the decision-making capacity of an individual to consent to or refuse treatment is a pillar of our medical and legal system.

Charland argues that Medical professionals, Politicians, academics and others "have in general failed to adequately point out the practical and ethical challenges embedded in this question. In particular, even the exceptions mentioned above do not discuss the detailed state of science in this area and its remaining limitations – which is the focus of the present discussion – even though they raise concerns about the problems of relying on capacity and informed consent to determine access to MAID. One could argue that the general public and law-makers have thus not been adequately educated and prepared for proper discussions on the challenges we will face, particularly when we rely on the concept of 'mental capacity' for more drastic life-ending interventions. Perhaps this is because the technical literature and current institutional practices that surround the assessment and determination of decision-making capacity, specifically, are so complex and specialized. Whatever the case may be, and while this obviously already raises questions about current end-of-life medical practices, the assessment of capacity as a tool for accessing life-ending interventions raises the stakes for all of us. Discussion is in order."

Conclusion

36. The Greenwich Bill is heavily reliant on the Victorian Voluntary Assisted Dying Act 2017 and suffers from lack of critical analysis of its main provisions. It should be remembered that the original Bill was drafted by the Victorian Law Reform Commission on a reference from the Attorney General to draft a bill which would legalise euthanasia and assisted dying.

    Professor John Keown made a critical examination of the several Committees involved in drafting the Victorian Bill . After considering the deficiencies of the Parliamentary Committee Report, he referred to the Ministerial Advisory Panel on Voluntary Assisted Dying, which was then appointed to explore how best to implement the Parliamentary Committee's recommendation; it reported in July 2017. Though the members of both committees were doubtless well-intentioned, both reports were seriously flawed.

    The Panel's remit was not to consider whether but how the law should be relaxed. It was charged to advise the government **"about how a compassionate and safe legislative framework for voluntary assisted dying could be implemented."** (emphasis added)

    Dr Keown was critical of the fact that the Parliamentary Committee's "Report stated that the summaries of the arguments were informed by four recent "investigations" into "assisted dying." First, why only these four? Why did the committee ignore the reports of the New York State Task Force on Life and the Law (the finest yet published); the House of Lords Select Committee on Medical Ethics, and the Scottish Health Committee. Second, why did the Parliamentary Report not consider whether, and the extent to which, the authors of the four "investigations" were supporters of legalization? One of the four was the UK Commission on Death and Dying, which was cited several times. The Parliamentary Report noted that this committee was chaired by Lord Falconer, funded by Sir Terry Pratchett and included a "broad range of experts." The Report omitted to inform the reader that Lord Falconer is the leading activist in the UK Parliament for PAS; that Sir Terry was a patron of the pressure-group "Dignity in Dying"; that nine of the twelve appointees were known to favor legalization and that many bodies, including the British Medical Association, declined to give evidence to this self-styled "Commission." Again, the Parliamentary Report noted that another of the four "investigations," by the Panel of the Royal Society of Canada, was produced by a group of academics but the Report omitted to mention that four of the six academics were internationally prominent advocates of legalization . If one's understanding

of the ethical arguments is influenced by "investigations" dominated by those who are pro-legalization there is a risk that one will fail to appreciate the nature and force of the arguments against. The Report nowhere evinced an understanding of the key principled argument against legalization (and of the logical, and not only practical, implications of rejecting it), an argument to which we shall turn after we have criticized the Report's failure to articulate a clear and coherent case for legalization.

37. Dr Keown was critical of the Panel Report, which "stated that whereas deaths from suicide were avoidable and every effort should be made to prevent them, the people who were the focus of its report were facing an "inevitable, imminent death" as a result of an incurable illness or condition. (Id. at 8) But why shouldn't every effort be made to prevent their suicide? Was it because they were facing an "inevitable, imminent" death from illness? If so, many people who kill themselves for all sorts of reasons – such as being old, lonely and neglected – have short life expectancies. And the Panel recommended that people with up to 12 months to live should be eligible for VE/PAS (id. at 13), even if they refused a treatment which could maintain their life beyond 12 months. (Id. at 67-68) In what sense is death 12 months or more away "imminent"?"

    It would be an ongoing disservice to the citizens of New South Wales to enact this Bill without considering in detail the reasons for not allowing euthanasia and assisted suicide to become lawful.(emphasis added)