Submission
No 86

# INQUIRY INTO PROVISIONS OF THE VOLUNTARY ASSISTED DYING BILL 2021

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## The Parliament of New South Wales

## Inquiry by the Legislative Council's Standing Committee on Law and Justice

**-into-**

## The Voluntary Assisted Dying Bill 2021 (NSW)

### Introduction

1. Shortly before it was introduced into the parliament, the proponents of the VAD Bill ("the Bill") circulated amongst members of parliament a commentary on the Bill by senior Crown Prosecutor, Mr Nicholas Cowdery QC. Mr. Cowdery's reputation as a distinguished Australian criminal lawyer extends beyond the borders of New South Wales. As such, his commentary on the Bill may be expected to be influential when consideration is given to the Bill by members of parliament. For convenience, I have attached Mr Cowdrey's commentary to this paper.

2. In making my own submission to the Inquiry, I propose to do so by reference to Mr Cowdery's analysis and to challenge his conclusion that the Bill is an otherwise benign and welcome shift in the law of NSW. I fundamentally disagree with important parts of Cowdery's analysis and assessment. With due respect to his experience as a prosecutor, I believe his analysis is superficial, in part based on incorrect assumptions and revealing an apparent blind spot to this Bill's inherent flaws.

3. It has always fascinated me how two lawyers can evaluate the strengths and weaknesses of the same Bill or Act – and arrive at two fundamentally different conclusions about its purpose and effect. The nub of Cowdery's assessment is that there is "nothing to see here" – that the Bill does not do much more than to formalise a process that goes on every day "as we all know" behind the curtains. Furthermore, that there is nothing in the Bill itself which could reasonably be a source of concern for vulnerable members of the community.

4. New South Wales is now the only Australian state where VAD legislation is not in force. People who are philosophically opposed to "assisted dying" would be excused for accepting that this controversy is done and dusted. Despite the apparent inevitability of NSW Bill passing into law, it is nevertheless worth taking a look at whether this Bill delivers what its altruistic objects proclaim.

5. It doesn't. Not even close. The NSW Bill rests upon a series of fictions and manifestly fails to deliver on what is promises; it presents a litany of "protections" for the vulnerable which are illusory and cosmetic; its sanctions are unenforceable because breaches will be undetectable; and the paper trail which Cowdrey empahasises records nothing of substance and is no more than a "tick the box" exercise.

6. But firstly, and to anticipate the familiar refrain "*Of course you don't like euthanasia-why would you - you're a conservative Catholic*", I should explain that my interest in this topic arose not from religious scruples, but from observing the intense resistance to VAD by experienced physicians in my own State of Victoria when its VAD Bill was being debated in 2018. This group of doctors sought assistance from a team of lawyers, of which I was one, in understanding how the VAD Bill would regulate assisted dying in practice, and the efficacy of the Bill's conscientious objection protections for those whose medical ethics and personal beliefs would not allow them to participate in VAD.

7. The opposition of that cohort of doctors (and thereafter those also in Tasmania and Queensland) had little to do with religion and everything to do with medical ethics and medical care. The most outspoken of the doctors was an atheist, others were agnostic, several were Jewish and a good number of them identified as Christians, but were by no means all Catholics.

8. Parliamentarians who are tossing up whether to support this Bill, no doubt motivated by the best of intentions and wanting to alleviate suffering, might nevertheless ponder why it is that so many experienced medical practitioners in every Australian State regardless of whether they are religious or agnostic, are hostile to the introduction of VAD legislation. What is it in *their* experience of treating patients in significant pain and discomfort which persuades them that 'assisted dying' is not in the interest of their patients or in the interests of the community at large?

9. Back to Nicholas Cowdery's opinion.

10. Cowdery introduces his reflections on the Bill by a note on terminology. There he sets up his first straw man – that those who are opposed to VAD characterise are wont to describe the VAD regime as "state-sanctioned murder". True enough that some impassioned opponents of VAD might resort to colourful descriptions of that sort to make their point. Setting up that straw man is a clever device: it portrays opponents of VAD as believing that proponents of VAD are not all that different from stormtroopers in the night. But, given

Cowdery tells us that he has seen the process being described by opponents in those terms (as if all opponents do so) and that people would be "put to death against their will because they are inconvenient" (shades of ethnic cleansing), let's unpack the terminology in which VAD is usually marketed.

11. Cowdery would have us believe that the concept of "voluntary assisted dying" is something novel. But, it is the *very* thing which has taken place in the care of the dying for all time. It has always been the case that the dying person is free to decide whether or not to accept any further treatment: treatment has *always* been voluntary. And, one of the noblest activities of hospitals and the medical profession has been to assist such patients as they are dying. The proposed legislation is more honestly discussed under the rubric "justified homicide by physicians".

12. Proponents of VAD embrace the expression " a death with dignity". The phrase has been co-opted by the advocates of change. It implies that the only way in which a dying person can die with dignity is by suicide or being killed. It also implies that persons who die under the present laws, without a VAD choice, do so lacking dignity. The phrase corrupts thought and language and with them public policy.

13. When Cowdery says that he has seen the process described by opponents as *"state-sanctioned murder"* and that *"nothing"* he says *"could be further from the truth – factually or legally*", one does not know what Cowdery has in mind. Under the present law, (as Cowdery concedes) it is murder (or manslaughter) for a medical practitioner to administer a lethal dose to a dying person with the intention that the person dies. If the proposed legislation is enacted, when a medical practitioner complies with its terms and administers a legal dose, that will not technically be "murder"; it will still be homicide: but in the eyes of the law permissory or justified. But, the distance between what is at present "murder" and what will become "justified homicide" is technical and nowhere near as remote as Cowdery seems to suggest.

14. Cowdery distinguishes assisting in the suicide of a person not suffering from a terminal condition (lawful, he tells us, in Switzerland) from (assisting in the) killing of a *"deeply suffering person with a limited lifespan".* But he does not explain what the difference is that might justify the killing of the one but not the other. What separates the two deaths in terms of legal principle: why is one homicide justified but the other is not? He has insight that I do not possess: I cannot think of a reason to refuse VAD to a young woman who has become quadriplegic after falling off a horse and who perceives her life as worthless. If the wishes and consent of the person suffering a terminal illness mean that personal autonomy is to

trump public policy, on what rational basis can I refuse to give my young adult showjumper the poisons she seeks even though her "illness" is not terminal and she is not in any physical pain? And what of the patient who is unable to give informed consent because of mental incapacity, but who is, in the eyes of their family, suffering "intolerable pain" and has diminished life expectancy? On what basis should VAD be denied to that patient? Or will it, in practice,actually be denied to them where they have no capacity to decide anything?

15. Medical practitioners who are prepared to end the life of an elderly patient or to assist that patient take his or her own life say they will not collaborate with the killing of a healthy person. Necessarily the distinction they draw involves an evaluation of the *worth* of the lives of respective patients: one is assessed as better off dead, the other not so. Any decision based on an evaluation of the *worth* of the life of another person is something that no civilized society should contemplate. In fact, the refusal ever to countenance the making of such decision has been the principal basis of our society being considered civilized.

16. Cowdrey says that we "*all know that it goes on*". But, what is it that we all know goes on? Cowdery provides no explanation. And if it is "going on" in New South Wales, then it would be fascinating to learn from the prosecutor on how many occasions charges have sought to be laid against persons who have taken life unlawfully.Moreover, if it is in fact "going on as we all know", then what confidence should we have that doctors who are prepared to break the existing law will be prepared to observe the new law if compliance with safeguards is inconvenient to the outcome for which their assistance is sought?

17. The different ways in which a medical practitioner deals with a dying patient can be radically different, and must be kept distinct. It is perfectly lawful for a medical practitioner, in appropriate cases, to administer drugs to a dying patient with the intention of relieving that patient's pain and suffering, even though the practitioner knows, or even expects, <u>but does not intend</u>, that the patient's life may be shortened. These are distinctions with very important differences.

18. Moreover, there is no duty upon medical practitioners to prolong the life of a dying patient. It is bad medical practice to provide treatments that offer no realistic possibility of helping a dying person or which are burdensome for such a patient.Bad as well as unethical. But, the fact that a practitioner cannot cure a patient provides no justification for killing him or her.

19. On this account, it can readily be anticipated that the legislation will radically affect the care of the dying. As just stated, it is lawful to administer drugs in order to control the pain of a

dying person, even though it is known that they may work to shorten life. If this Bill is enacted, the prospect of a patient's death will surely cause doctors to resort to VAD before prescribing pain relieving drugs, interfering, thereby, in the traditional care given by members of the medical profession who are overwhelmingly trustworthy. It is apt to distort thinking as to the proper care of dying patients.

20. As Cowdery says, the proposed legislation will be available to "a deeply suffering person with a limited lifespan, with mental capacity who freely and voluntarily chooses to end it in a dignified fashion, which requires professional assistance".

21. There will be people who can be assessed as having freely given informed consent to a medical practitioner to inject them with a lethal dose. For people in this category, the Bill offers sufficient protections. But they are not the ones who really need protection. Legislation of this type is to be considered by reference to the public good and the public good should not be prejudiced to the advantage of such a limited group of people.

22. Many people approaching death lose the capacity to make any such informed choice. Both depression and the onset of dementia cause confusion and a willingness to go along with the suggestions that those closest to the dying person may wish to make. (This is recognised by Cowdery in his discussion of those suffering from dementia).

23. Evidence of the presence of this frailty abounds. Lawyers know of the problems that can arise in the case of testamentary dispositions made by people close to death.As every legal practitioner who works in the area of probate, administration and guardianship knows, the involvement of the relatives of the dying person in testamentary matters can be malign. The law reports contain innumerable cases where courts have found that the dispositions of a dying person were not free and informed but resulted from pressure being placed on the dying person by those who stand to profit from his or her death. There will be more cases, not less, as life expectancy increases as it has profoundly over a generation. The temptations placed before potential beneficiaries who observe their expected patrimony being eaten up by long term care will be considerable. The pressure can be very subtle and, as the testator who is subject to this legislation approaches death, the ability to give free and informed consent diminishes rapidly.

24. For these reasons, my analysis focuses upon those very many members of the community who are vulnerable, usually but not always because they are elderly. I am less concerned here with the Rational and the Willing, so called.

25. Before moving to evaluating the much-vaunted "safeguards" in this Bill, I want to draw attention to one other mistaken assumption in Cowdrey's article.

## VAD in other countries

26. Cowdery says that other "*countries and jurisdictions have legislated to enable a person in the position I have described to end his or her life and the sky has not fallen in".* But, this is another straw man. Where has anyone argued that this legislation should not be enacted "because the sky will fall in"?

27. Cowdery encourages his readers to consider the examples of the various American jurisdictions that have made assisted suicide lawful. The first of these was Oregon; other states have largely followed the example of Oregon. See *Oregon's Death with Dignity Act, Oregon Revised Statutes*, 127.800-127.995.

28. But, there is a radical difference between the American examples and the proposed legislation. The Oregon law contains the following provision (1 27.880 S3.14. Construction of Act):

> "Nothing in ORS 127.800 to 127.897 shall be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia."

29. The Californian *End of Life Option Act* 2015 contains an identical provisions: 443.18.

**30.** Section 60 of the NSW Bill is radically different. It authorises a medical practitioner to administer the lethal dose to a patient.

## The Bill is replete with "safeguards"

31. One of the main objects of the Bill is to establish safeguards to ensure that VAD is accessed only by persons who meet the eligibility criteria prescribed in the Bill.[1] One of the principles informing the exercise of powers conferred by the Bill is that persons who are vulnerable should be protected from pressure or duress.[2] Ultimately, the decision which has to be made is whether VAD statutes can be drafted in such a way that genuine autonomy of vulnerable patients in matters of health care and ageing are effectively protected and that these members of the community are not at risk of an involuntary and deliberately hastened death.

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[1] Clause 15 (b).

[2] Clause 4 (j).

32. My analysis is written on the premise that the VAD Bill will be debated in the milieu of a concerted and well-financed campaign by groups such as Go Gentle and Dying with Dignity which frame the debate in terms of a contest between self-autonomy and a terminal illness causing undignified,and intolerable pain and suffering. Framed in that way, opposition to medically assisted suicide is a no brainer. As stated, I have no difficulty with VAD legislated democratically by the peoples' representatives in parliament to create a statutory right for members of the community who truly satisfy the stated eligibility requirements to choose that form of assisted suicide. Render into Caesar what belongs to Caesar. But as a lawyer I am strongly opposed to a Bill which affects to safeguard the vulnerable when those safeguards are hollow and cosmetic.The vulnerable are **not** adequately_protected by this Bill.

*33.* Cowdery's opinion lists features of the Bill which he says provide checks and balances. But he offers no analysis of the measures included in the Bill which are offered up as protections for the vulnerable. That is particularly disappointing for the reader given his considerable experience as a Crown Prosecutor. I will attempt to do so because I believe that rigorous analysis of "the checks and balances" does not warrant Cowdrey's conclusion that they *"ensure that the scheme is not abused for improper motives"*. Ensure, in this context, is a big statement.

34. Whether or not it may be theoretically possible to draft legislation which achieves these outcomes, in my view, the NSW Bill manifestly fails to do so. While Bill includes an array of protections for those who do not need protection, for those who truly need protection, the Bill comes up short. The protections much vaunted by the proponents of the Bill are only paper thin, wallpaper as it were, to assuage concerns of the parliamentary middle ground and to garner their support which is necessary to secure its passage into law. To the extent that the Bill confers protection on anyone, ironically, the Bill protects those who may honour the law in its breach and not its observance, such is the lack of any effective sanctions for breach.

35. In this short piece, I will explain why the so-called checks and balances do not survive critical scrutiny and do not fulfill one of the Bill's core principles: the need to protect persons who may be subject to pressure or duress.[3] I focus here upon what the Bill has to say in Parts 3 and 4 about assessment of decision-making capacity and the absence of coercion. I then propose, in subsequent shorter specific issues papers, to develop this high-level summary into more detailed analysis of subsequent Parts of the Bill. I will demonstrate how easy it will be for those whom Cowdery warns "*might abuse the scheme for improper motives*" to get around the safeguards without reasonable likelihood of detection. If abuse of the scheme is a

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[3] Clause 4(1)(j).

realistic, and not a fanciful possibility, that means that unlawful homicide (what used to be called, dare I mention the word, "murder") can occur.

## The design of the Bill

36. The process designed by the Bill is a notable for the number of discrete steps, permissions, certifications, determinations, etc. The sheer number of these successive steps might suggest that the drafters have gone to extraordinary lengths to ensure that VAD may be accessed only by those patients who have requisite decision-making capacity (that is, they are aware of the nature of the act and its finality), that two doctors must be satisfied that the patient has that capacity and that the person is voluntarily undertaking VAD without pressure or coercion from others, who are likely but not necessarily, to be family members. Cowdery notes this as a feature of the Bill.[4] And that only those persons who are experiencing disease, illness, injury or a medical condition that is advanced, incurable and irreversible, which is expected to cause the person's death and which is causing intolerable and enduring suffering, are permitted to access VAD.[5] With all these safeguards, one asks: how could this Bill possibly pose a threat to the life, liberty and free choice of vulnerable members of the community?

37. The critical decisions to be made under the Bill – for example, as to whether the patient has a terminal illness, is suffering intolerably on account of that illness, has requisite decision-making capacity, whether their decision is voluntary, and their consent is informed as to the nature and finality of the consequences of their action – **all of these matters are evaluated by medical practitioners**. However several of these matters, particularly whether the decision has been made free from pressure or duress, are not medical judgments at all. They are more usually regarded as forensic decisions to be made on the basis of evidence and inquiry, not impression or assumption.

38. An extraordinary feature of this Bill is that the two medical practitioners making these critical judgments may never have set eyes on the patient before. They enjoy none of the benefits which result from an established doctor-patient relationship. They need have no direct *personal* knowledge of the patient's medical history, let alone any knowledge of the patient's personality, moods, belief systems, or previously discussed wishes. They are permitted, but

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[4] On p. 4.

[5] Clause 16(1)(d)(i) to (iii).

not required, by the Bill to consult with the patient's own GP and to access the patient's medical history collated by that GP.

39. The Bill requires doctors to have acquired a certain level of professional qualification, but it does not require them to *know* the patient or to have had any prior consultative *relationship* with the patient. The Bill does not require the doctors to be specialist or experienced in the illness or disease from which the person is suffering.[6] Certifying a patient's access to an assisted and hastened death involves far more profound considerations than diagnosing whether a patient has a cold, or the flu, or even cancer.

### Decision-making capacity: first base is loaded

40. The scheme of the Bill is to require two medical practitioners to carry out an assessment of eligibility criteria in respect of the patient.[7] Each separately assessed and the decision of each must be recorded: clause 24(3)(a). The bill stops short of requiring the two medical practitioners to be professionally independent of one another. That means the two doctors can work together in the same medical practice partnership, one might be the employer or supervisor of the other, and they may associate together socially. What the Bill does, instead, is to require the second doctor to "act independently" of the first doctor and to form his or her own opinions on matters to be decided. But unless the two doctors are truly independent of one another, in a professional practice sense, there is a Buckley's chance that they will come to differing conclusions in reality. Moreover, that their failure to act truly independently would ever be capable of detection.

41. What is meant by requisite "decision-making capacity" is set out in clause 6(1). So that <u>when</u> the patient makes the VAD decision, the person must have the cognitive ability to process five discrete matters, which can be summarised as:

(a) understanding the nature and effect of decisions about access to VAD;
(b) freely and voluntarily making decisions about access to VAD; and
(c) communicating decisions about access to VAD in some way.

42. As stated, the assessment of those features (and all <u>must</u> be demonstrable) is left to the medical practitioners involved. One might have thought that a practitioner would need to undertake at least some form of cognitive evaluation before an assessment of requisite decision-making capacity could be made. Or even that the medical practitioners have some

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[6] Clause 18(a)..
[7] Clauses 14, 16, 18 and 25.

specialist training in the particular terminal illness being suffered by the patient. Not so under this Bill.

**Statutory presumption: second base is also loaded**

43. The Bill does not require a medical practitioner to carry out any such cognitive testing by the operation of a statutory presumption: Clause 6(2)(b).

44. The statutory presumption exists because of the use of the words "*is presumed to have*" in the Bill. Because of the statutory presumption, the doctor is under no duty to undertake any cognitive testing; in fact, the practitioner could walk into the patient's room, see the patient asleep or staring into the abyss and tick the box affirming requisite capacity - because there was "*no evidence to the contrary*". As to the practitioner being satisfied that the consent of the patient is an informed consent (understanding, etc.), the statutory presumption operates so that the medical practitioner may conclude that it *reasonably appeared* to him or to her that the patient understood the consequence of a decision to proceed with VAD.

45. The Bill might have applied a contrary presumption – or said nothing at all. If it had said that a person is presumed <u>not</u> to have decision-making capacity unless there is evidence to the contrary, then the responsibilities upon the medical practitioner would be significantly heightened. In that scenario, the practitioner would need to undertake specific examination of the patient to be satisfied that he or she has requisite decision-making capacity. The evidence to be relied upon would, primarily, be the conduct of that examination by the doctor. Whereas under clause 11(2) as currently drafted, the less inquiry the better, because inquiry might dilute the force of the presumption. Second base is also loaded with a pro-VAD bias.

46. In theory, at least, VAD would not be accessible by a patient who suffers from dementia or some other mental illness which impairs the patient's ability to understand, remember or evaluate. But there is no positive duty in the Bill requiring a PMP or CMP to interrogate the clinical history of the patient. The patient's own GP would, by contrast, be across that medical history as well as any existing prescribed drugs for the patient which might reveal the presence of a mental illness.

47. It may be seen, therefore, that the requirement that a patient has demonstrable decision-making capacity is paper-thin, and is entirely dependent upon the opinion of two medical practitioners neither of whom may have set eyes on the patient before. The drafters'

calculated decision to exclude any compulsory role for the patient's own GP in this process is significant: it means that the opportunity for exploitation of the vulnerability of aged and infirm patients is unnecessarily increased.

48. True it is is that the Bill *enables* the CMP, in conducting the first assessment, to have regard to any relevant information about the person that has been prepared by, or at the instigation of, another registered health practitioner (i.e. the person's own GP). However, this clause is permissory, not mandatory. The Bill would be more protective of vulnerable persons if each of the coordinating and consulting medical practitioners were required to consult with the person's usual GP or, at the very least, to obtain the person's medical history from the general practice usually attended by the person.Without such a requirement, how can it be said that that "[the] therapeutic relationship between a person and the person's health practitioner should, wherever possible, be supported and maintained"?[8]

49. The Bill recognises situations where the decision could not be said to be voluntary (duress, coercion etc brought to bear upon a person). The Bill therefore recognises, and identifies, in both express and implicit terms, the very situations where abuse of vulnerable elderly patients is most likely to occur the person's own family and aged-care providers. I describe these situations as identified 'risk scenarios'.

### Whether a request to access VAD is made voluntarily

50. In numerous parts of the Bill, emphasis is placed on the requirement that a patient's access to VAD must be voluntary.[9]

51. So how is it to be determined that a particular person's decision is truly voluntary and not caused, or contributed to, by pressure, duress or manipulation? In truth, the Bill requires no active inquiry into the existence of these matters. Provided that no evidence or circumstances of pressure or duress is otherwise apparent to the doctors, that is all that is required for the doctors to conclude that the person is acting without pressure or duress. In other words, the inquiry is not proactive, but reactive. The vice of this drafting only worsens when it is realised that the Bill imposes no duty on the doctor(s) to prepare notes of what he or she observed at the time the decision of eligibility is made, in terms of the absence of pressure or duress. Just a box or two for the doctor to tick on a form to be provided to the Board.

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[8] cf Clause 4 (1)(j).

[9] Four example,the preamble refers to 'voluntary' assisted dying;The principles emphasise the need for pressure or duress to be absent; the patient must be able to communicate a voluntary assisted dying decision in some way.

52. The determination of eligibility under the Bill is made by the two doctors who will examine the person in sequence. The first doctor must decide whether the person has decision-making capacity in relation to VAD.[10] The Bill recognises that there may be circumstances in which the first doctor is unable to determine whether or not the person is acting voluntarily and without coercion. Being unable to make a positive determination does not necessarily constitute a red flag. But the mere fact that the first doctor is unsure, or harbours doubts, ought be a red flag.

53. A theme of the bill is that a consent given by a patient in the presence of someone who has a financial or other material benefit in the death of the patient is not a valid consent. Accordingly, members of the patient's own family cannot lawfully witness the patient's signature or other assent to VAD. Nor can a doctor who has an equivalent interest exercise a function in that patients decision to access VAD. This is held up as emblematic of the safeguards in this Bill. Just how easy it is to get round these "prohibitions" will be illustrated in a separate paper. For the present, it is enough to see that a family member motivated by what Cowdery describes as improper motives can simply have a friend or associate step in and do the witnessing in place of the family member. How would the Board ever know that this had occurred? Even though there may be a sanction applied to those who breach the Act, by the time any breach surfaces, the patient will be dead.

54. The issue remains: having identified these risk scenarios, how effective are the protections within the Bill to prevent that abuse from occurring? The premise of any statute containing protections is that unless effective protections are included, the patient will be unprotected; moreover, that parliament has a role in enforcing the protections. Ineffective protections in the present context are likely to result in the death of patients who lack genuine decision-making capacity, or who feel pressured to go along a path chosen not by them, but for them, by others. The Bill also implicitly states who those others are: they are the person's own family (including the VAD doctors) who will often have self-interested motives in getting their hands on the patient's assets via a grant of probate[11] or the owner or manager of an aged-care facility who has a financial interest in having someone new occupy the bed of the patient subject to VAD.[12]

55. There is no positive duty of inquiry on the part of the doctor. Nor is the doctor required to consult with the patient's own GP who might be expected to know the personality of the

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[10] Clause 19(1).

[11] Cf Clause 38(2)(a).

[12] Clause 38(2)(b); clause 82(1)(c) and (d).

patient, past expressions of wishes when diagnosed with a terminal illness, or the dynamic within the patient's own family. The complexity of inquiries needed to be undertaken to decide whether a person is subject of undue influence, pressure or duress is the subject of academic comment.[13] Nothing in this Bill recognises the complexity of the task in detemining where illicit pressure is, or is not, evident when the CMP meets the patient.

56. The Bill itself recognises the risk scenario of reliance upon a member of the patient's own family when determining whether a patient's decision is truly voluntary and without duress: Clauses 27 and 38. These clauses provide that where the first doctor "*is unable to determine whether or not the person is, in fact, acting voluntarily and without pressure*", the first doctor "*must refer the person to another doctor (a referee) who has appropriate skills and training*" to determine the question. Immediately, it can be seen that the Bill says nothing about the first doctor possessing those "appropriate skills and training"? The Bill says nothing about what those "appropriate skills and training" may consist of. The referee cannot be a member of the person's own family, or a potential beneficiary under the person's will, or someone who stands to benefit financially or materially, from the person's death[14]. The reasons are self-evident.

57. These provisions describe the very situations where motive and opportunity have an insidious role to play in the death of a vulnerable person. What does the Bill say about what steps the referee must take before the referee is competent to express an opinion? It says nothing. And how does the first doctor come to decide who will be that patient's referee? We don't know. Could the referee be nominated by a member of the patient's own family? Yes. At the least, there is nothing in the Bill which prevents that from happening. Why would the Bill not require the consultant doctor to approach the patient's own GP as <u>the</u> referee? It doesn't and, as set above, the patient's own GP appears to have been purposefully excluded from having <u>any</u> role to play under the VAD process. Surely, the proponents of the Bill must explain and justify why the patient's own GP is not mandated to be consulted as part of the process?

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[13] See, for example, NM Ries and E Mansfield *"Action on Elder Abuse: A New South Wales Pilot Project on the Role of Legal and Health Practitioners in Elder Abuse Screening, Response and Prevention*". Volume 30 UNSW Law Journal (2020) at p. 738.

[14] Clause 27(b)

58. The Bill enables, but stops short of, requiring the coordinating practitioner and the consulting practitioner to have regard to the person's existing medical history. This means an assessment of eligibility can be made without any attempt at obtaining that history.[15]

59. By now, one might reasonably conclude that these much-vaunted safeguards are not much chop. Let us return to the concept of "*appropriate skills and training*" in the context of VAD eligibility. Duress and undue influence are not medical judgements – they are intrinsically factual and are familiar to lawyers practising in family, probate, criminal, industrial or commercial law, whose professional training is very much more forensic in nature than that of medical practitioners.They are not to be equated with a doctor asking a patient to sign a Consent Form before surgery.

60. For centuries, courts of equity have refused to enforce agreements where one party has been subject to undue influence or coercion. The agreement is not recognised as effective in law because mutual consent to the transaction necessary for a binding agreement is lacking. Again, a legacy to a beneficiary under the Will of a person subject to undue influence or coercion will be invalid and unenforceable because the testator was not acting voluntarily.[16] Commercial entities whose employees are subject to coercion by representatives of a trade union will have an actionable claim against the union. Entry into a contract, or performance of a party to the contract, as a result of coercion or undue influence will be remedied by a Court. Because principles of duress and undue influence touch upon lack of true consent and have such wide application, it is unsurprising that they are given a role to play in the Bill.

61. When examples of the above occur, ultimately only a judge will have "the appropriate skills and training" to determine whether conduct was truly voluntary, consensual and without coercion. For a judge to make that determination, he or she will necessarily undertake an inquiry, which can be resolved only by evaluating the evidence put before the Court. The task of collecting, reviewing and assessing evidence is not measured in hours or minutes, but more usually, days. Under the Bill, the task is delegated to medical practitioners and might involve only a matter of minutes; as stated above, it is competent for the doctor to make a determination of the absence of pressure or duress when he or she may never have previously

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[15] Clauses 25(3) and 36(3).

[16] For example, the seminal statement of Sir James Hannen in *Wingrove v Wingrove* (1885) 11 Probate Division 81. For a comprehensive review of case law on the topic, see F.R. Burns "*Elders and testamentary undue influence in Australia*": http://www.austlii.edu.au, published in the University of New South Wales Law Journal.

met the patient and know nothing whatsoever of the dynamic within the patient's family. In other words, the doctor may evaluate the person's risk scenario while blindfolded.

62. For these reasons, high-sounding phrases like "voluntary", "no pressure", "no duress" and the like promise much but deliver little. It is not realistic for two doctors, who may know nothing about the patient, the patient's personality, family relationships or the possibility of past and present elder abuse by family members of the patient to arrive at a sufficiently informed decision on a sometimes vexing matter when, before a judge, the inquiry will often take a significant period of time to determine safely.

63. Hence, doctors who may never have met the patient before are ill-equipped to evaluate whether the patient's request is truly voluntary. This Bill is profoundly deficient in this regard. Some event or circumstance would need to occur while the doctor is present that would indicate <u>at that moment</u> the presence of pressure, duress, coercion, etc. This is inherently unlikely to occur where members of the family who may have "encouraged" the patient's request to access VAD are present with the patient when the doctor meets the patient for that eligibility assessment.

64. It requires little imagination to know that there is little prospect that the doctor will become aware of circumstances that indicate a patient's decision is involuntary. The absence of any role for the patient's own GP in the VAD process is, without fear of understatement, extraordinary. This flaw the Bill, on it own, would justify its rejection.

65. The discretions reposed on doctors who may never have met the patient before in terms of both the assessment of decision-making capacity and voluntariness are remarkable given the consequences of a flawed or misguided exercise of those discretions. The vice of the Bill in this regard is that the community, the State and perhaps members of the patient's own family (who may be unaware of VAD activity on foot) is that any breach of statutory obligation is unlikely to be detected. Because death is "privatised" by the Bill, there is no realistic prospect that the death of a patient as a result of unlawful conduct will ever be detected, let alone the subject of punitive sanction. Can a Crown Prosecutor assure parliamentarians that detection of unlawful conduct will occur – and, if so, by what means when those who bring pressure to bear on the unwitting patient share a community of interest in death resulting?

66. At the very least, the Bill must be amended to ensure that a person's own GP is consulted by the two VAD doctors and that the latter must obtain the patient's medical history before any assessment of eligibility is undertaken by them. The Bill should also be amended to

require the VAD doctors to record the reasons relied upon by them in concluding that the person is eligible to access VAD. This would not be an onerous obligation – doctors do very little without recording matters in clinical notes.

**Conclusion**

67. It is one thing to respect personal autonomy; it is quite another to pass legislation where vulnerable members of the community may be led into a VAD death not by a genuine exercise of personal autonomy, but rather because they feel pressured to agree – or, worse, are actually unaware of the nature of the process being undertaken "for" them. The current Greenwich Bill provides inadequate protection for vulnerable members of the community. The "safeguards" have not received the critical scrutiny they warrant. In my respectful view, Nicholas Cowdrey fails to apply that scrutiny in his opinion. In the Bill as designed, the risk scenarios of patients who do not possess sufficient decision-making capacity and/or who are not acting voluntarily – are manifest. In their case, we are talking euthanasia, not voluntary assisted dying. Nicholas Cowdery's contribution to the debate on the topic of *detection* of unlawful conduct will be important as will his experience of prosecutions where the prosection bears the burden of proving that an accused did not have reasonable grounds for conclusions reached.

68. Moreover, all the statutory "protections" that are incorporated into the Bill type are not worth a pinch of salt unless there are realistic opportunities for unlawful conduct of family members, aged-care operators or, heaven forbid, unethical medical practitioners to be detected – and prosecuted. Nothing in this Bill ought encourage diligent parliamentarians to believe that prosecution for unlawful conduct which has caused the death of vulnerable persons is other than the stuff of dreams.

69. Despite acknowledging the argument that community attitudes have changed in a manner more receptive to euthanasia, this Bill is simply not good enough. When this Bill is held up to the light and its flaws become visible, it will be seen that all that glitters is not necessarily gold.

Dated: 22 November 2021

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