Submission
No 103

INQUIRY INTO PROVISIONS OF THE VOLUNTARY ASSISTED DYING BILL 2021

Name: Miss Anna Walsh

Date Received: 21 November 2021

Submissions to the Legislative Council's Standing Committee on Law and Justice Regarding the Voluntary Assisted Dying Bill 2021 (NSW)

Prepared by Anna Walsh, Lawyer/Academic
PhD (Cand), M Bioethics (Harvard), LLM (Syd), LLB (Hons), BNurs (Hons), Dip Leg Prac
School of Law, University of Notre Dame Australia (Sydney)

Introduction

1. Thank you for the opportunity to make a submission on the Voluntary Assisted Dying Bill 2021 (NSW). I am a resident of New South Wales, a health lawyer, and a legal academic in the School of Law at the University of Notre Dame. I have Masters' degrees in both Law and Bioethics and am actively engaged in qualitative research on the phenomena of conscience in the context of conscientious objection by doctors to abortion in New South Wales and Victoria.

2. I make these submissions as an individual. They focus on three aspects of the bill: the potential for 'scope creep', safeguards for informed consent, and protection of conscience for individuals and institutions. I oppose the bill. I do not believe there is any way to amend the bill to make it 'safer'. Once this door is opened, it cannot be closed. Deeming it lawful for a doctor to both assist a patient to commit suicide and perform the killing themselves will have a profound and negative impact on the philosophy and practice of medicine and the law.

A. Physician Assisted Suicide and Euthanasia: A Principled Exception to the Criminal Law?

3. A basic truth in our rule of law is that the criminal law reflects our community's morality. As a civilised society considers human life valuable, it is a crime to kill another person.[1] When it comes to attempted suicide, increased knowledge about mental illness and its impact upon voluntariness and free will has led to the crime of attempted suicide being abrogated, and the focus placed on mental health treatment.[2] To this end, if someone attempts suicide, it is not a crime to use force or infringe their liberty to prevent them from succeeding.[3] However it remains a crime to aide, abet, incite, or counsel someone to commit suicide.[4]

4. If we want to make a significant change to the criminal law's sanction against the basic human tenant that we must not kill, there must be a clear and rational justification for this. This is because markers of good law include that it is based on reason, that it is coherent, and that it is morally acceptable to the community.

[1] *Crimes Act 1900* (NSW) s 18(1)(a).
[2] Ibid s 31A.
[3] Ibid s 574B.
[4] Ibid s 31(c))1).

5. This bill seeks to permit a certain class of persons to kill or assist in the killing of another class of persons. Clause 16 confines it to competent adults with terminal illness who judge themselves to have intolerable suffering and whose life expectancy has been estimated to be 6 (or 12) months, and who are assisted by members of the medical profession who have undergone additional training approved by the state, the details of which are not available at the time of writing.

6. However, the root premise for the legalisation of physician assisted suicide and euthanasia is apparent from the bill's principles set out in clause 4. According to the rules of statutory interpretation, these principles have an important function as intrinsic aides and are not mere platitudes. One notable example includes clause 4(1)(b) which provides that 'a person's autonomy, including autonomy in relation to end of life choices, should be respected.'

7. The absence of any qualifying language in this sub-paragraph to the 'person', or those paragraphs that follow, is troubling. This is because read as a whole, these principles seem to support equitable access to physician assisted suicide and euthanasia without discrimination. Accordingly, they provide a foundation for future amendments to broaden the class of persons who may be killed.

8. In other countries, adult terminal illness is always the initial focus of laws on physician assisted suicide because it may be more palatable to the community to accept a minor shortening of a person's natural lifespan for the purpose of avoiding suffering. However terminal illness is a trojan horse; at the heart of physician assisted suicide and euthanasia is the empowering of a person to eliminate their experience of suffering by choosing the time of their death, and by obliging the medical profession to facilitate it. There are numerous examples of 'scope creep' in European and Canadian laws including where physician assisted suicide has progressed to euthanasia of the non-terminally ill and even to children. The bill's principles seem to anticipate and accommodate this.

9. Making consent to being killed a principled exception to our criminal law based on a worldview in which killing a patient to relieve their suffering is a rational and good choice by the patient, and a morally acceptable application of medicine by the doctor, changes the medical profession. One practical way it does this is by imposing a base premise which affects a doctor's assessment of a patient's capacity to make this request – this is discussed in the next section, overleaf.

10. As only doctors who subscribe to this worldview agree to become co-ordinating or consulting doctors, it raises questions about the training they undergo to prepare themselves to investigate informed consent and exclude coercion and duress, and how such training assists them, if at all, to identify the impact their own bias may have upon how they approach this process. Transparency regarding this training is a vital aspect to considering the efficacy of this bill's safeguards.

B. The practical value of safeguards

11. The bill has very detailed processes but at the end of the day, safeguards must eliminate the risk of death occurring otherwise than by the criteria set out in the law. Commentary is limited to three key areas of concern relating to assessing a terminally ill person's capacity to provide consent to the irrevocable decision to end their life, the ability of professionals to exclude coercion and duress from the decision-making process, and the value of witnesses. These safeguards are highly unlikely to prevent abuse of process. In truth, there are no safeguards that can achieve this end.

12. In our law, there is a rebuttable presumption that an adult person has capacity to make decisions which is displaced by evidence to the contrary.[5] Capacity is decision specific, hence a person may have capacity to make one decision but not another. To avoid unjust discrimination, the presumption applies to people suffering from mental illness however where their consent or non-consent produces a result which is judged to be objectively harmful to them, a greater degree of scrutiny is applied by those tasked with assessing their capacity, to consider the impact which their mental illness may have had upon their decision to consent or refuse treatment.[6]

13. There is no one test in the law as to how to assess a person's capacity for a specific decision. As an acknowledged complex process, assistance is provided to doctors and other professionals through the Capacity Toolkit published by the Attorney General's Department, and recourse can be had to the Supreme Court or specialist tribunals such as the Guardianship Tribunal. Courts and Tribunals consider different types of evidence to determine a person's capacity including the opinion of various medical experts, the results of neuro-cognitive test results, and evidence from the patient about their worldview and preferences, and those closest to them.

14. This bill anticipates problems with a terminally ill patient's capacity to request physician assisted suicide. As a decision beyond all other decisions a person can make, one might think that to provide a safeguard, the bill would specifically withdraw the presumption of capacity to allow the doctor to conduct a fulsome inquiry into the patient's capacity from scratch. But as the purpose of the law is to normalise the decision to end one's life prematurely, the bill confirms the general presumption about capacity, and specifically provides that a person who meets the criteria for physician assisted suicide is presumed to have capacity to make this specific decision (see clause 6(2)).

---

[5] See, *Re B (Adult: refusal of medical treatment)* [2002] 2 All ER 449.
[6] See, *Re C (Adult: refusal of medical treatment* [1994] 1 All ER 819.

15. This should be no great surprise. This is because by legalising physician assisted suicide and euthanasia, the law supports the conclusion that these decisions are good decisions. However, the consequences of this provision are that the doctor need not actively make enquiries into determining capacity. Instead, they have a reactive duty to investigate when concerns are presented to them. Accordingly, even though the outcome is the patient's death, the scrutiny that might usually be applied by them to this request is necessarily restrained.

16. This might have significant implications for those suffering a mental illness such as mood disorders. If they meet the other criteria in the bill, it is not an irrational decision to seek to be killed or to seek assistance to be killed. Strictly speaking, the fact that the patient's desire for early death might be averted by intense psychiatric treatment is not something which the co-ordinating or consulting must consider. Instead, against the backdrop of the decision being objectively rational and, in the circumstances, not a form of harm, referral for further psychiatric evaluation and perhaps treatment of the mood disorder, may be seen as harmful to the patient's autonomy and human dignity and an obstruction to the patient's timely access to standard healthcare.

17. It should be remembered that the role of co-ordinating and consulting doctor need not fall to the patient's treating doctors who have knowledge of the patient's condition and expertise to treat it. It could be filled by new doctors who have only ever met the patient for the purpose of physician assisted suicide. Whilst the bill anticipates the doctor might not be able to determine capacity, the involvement of a psychiatrist is not compulsory for the co-ordinating or consulting doctor. Rather, it is an option where the doctor is unable to determine capacity for themselves. In this instance, the doctor ***may*** refer the patient to a psychiatrist or other registered health professional with appropriate skills and training (see clause 27(2)(a)) and adopt that professional's views as their own.

18. As there is no detail as to what qualifies this person as having appropriate skills and training, what information they can access, how often they must assess the patient, and their ability to make adequate enquiries given the privacy element surrounding this process, this is a poor safeguard.

19. The bill also anticipates problems with coercion and duress. We have all heard about how 'elder abuse', inadequate family support, mental illness, and the fear of not wanting to be a burden on others can fuel a request for physician assisted suicide, and we rightly determine these reasons to be of great concern. Coercion and duress cannot always be detected, especially if you do not know the patient. A doctor has no specific training in how to know whether a person's will has been overborne. Rather, this requires a proper forensic analysis from persons who have the time, skills, and access to information to satisfy themselves of this vital component of informed consent.[7]

[7] It must be acknowledged that the bill in clause 108 (and following) provides for review of decisions on capacity and voluntariness by the NSW Supreme Court. However, such applications are made by patients who want to access

20. Whilst pursuant to clause 16(1)(f), the doctor must determine that the person is acting voluntarily, there is no recognised form of training or investigation pathway that has been held up to public scrutiny to ensure doctors or other people can determine this in the given context of a person requesting assistance to kill themselves or to be killed by another.[8] This must be particularly challenging where the doctor has no prior relationship with the patent prior to the request for assistance to die. This is an avenue of inquiry that the Committee should consider in detail.

21. Despite this, the bill's solution is to have the doctor who cannot determine the absence of coercion or duress refer the patient to a psychiatrist, other health professional, or another person who 'has appropriate skills and training to make a decision about this matter' (see clause 27(2)(b)).

22. A plain reading of the clause is that it is the first doctor, who cannot determine the question, who has the responsibility of deciding whether the second person has the appropriate skills and training to discharge this function. As with determining capacity, this second person may never have met the patient, may be reliant on information the patient gives them, and may lack the time and skills to properly investigate this concern.[9]

23. The requirement for witnesses is seen as another safeguard in the bill however all they must do is attest that the patient ***appeared*** to have capacity and was not coerced (see clauses 44, 45). This is a very low threshold but is appropriate given witnesses may not be family members, beneficiaries under the will or someone who derives a benefit from the death. It is very possible that a witness does not really know the patient very well and hence their attestation may be of little value. Whilst a penalty applies if it is later shown they were an ineligible witness, the patient is already dead and there is no requirement for the doctor to make enquires about the witness' eligibility beforehand.

24. The three areas mentioned above are not safeguards to prevent abuse. They are merely detailed processes that depend very heavily on the integrity of a class of doctors willing to commit physician assisted suicide, but which the bill anticipates may not be able to determine whether the patient is exercising their free will to seek an early death.

VAD and have been deemed not to meet the criteria or another person with genuine interest in the rights and interests of the patient. The intensely private nature of this decision cannot guarantee that a patient's family or friends will even know that a VAD request has been made in order to challenge the decision in Court.

[8] A parallel can be seen in the *Abortion Law Reform Act 2019* (NSW) whereby after many years of abortion being available from private clinics upon a doctor being satisfied that continuing pregnancy poses a risk to the woman's health, abortion coercion is now recognised as a crime. However, there are no guidelines to assist doctors to exclude coercion in the consent process especially when the patient is usually unknown to the doctor and has no prior relationship with them. This is an area which requires more reflection and research.

[9] See clause 27(4). They also must not be a family member of the patient, or know or believe they are a beneficiary under the patient's will, or someone who will derive benefit from the patient's death other than by reasonable fees for their services

C. Embedding Untruth in the Law and Making Doctors Accomplices to it

25. The bill embeds untruths into the law. This must be resisted because it is simply wrong. The bill provides that assisted suicide is not suicide (clause 12). This is not true. It also requires doctors to record the cause of death as the underlying illness. According to the bill, if a death certificate is issued, it will not record that the person was subject to VAD (see Schedule 1A).[10] This is also not true. These requirements abuse the doctor's reputation for integrity and truthfulness to make the patient's death request seem more palatable and socially acceptable. It also has epidemiological consequences for statistics and data, for prognosis of disease processes, and the planning and provision of health services.

26. If physician assisted suicide is healthcare, then the substance used to achieve its end should be a medication. However, the substance used to cause death is poison. This is because as commonly understood, medication is not meant to kill someone. Medication that causes death would never be the subject of clinical trials for safety and efficacy[11] or meet the TGA requirements that it is intended for diagnosis, cure, mitigation, treatment, or prevention of disease, ailment, defect, or injury.[12] If it the substance used to cause death is considered a medication, it would require changes to commonly held definitions in other legislation about drugs and medications.

27. These three examples highlight how physician assisted suicide is not a neatly contained principled exception to the criminal law for those who choose it and those who are willing to facilitate it – in order to be coherent, other important foundational concepts need to change to accommodate it. This is a sign that physician assisted suicide is not a logical development of current laws.

D. Conscience Protection

28. Whilst freedom of conscience is considered an inviolable fundamental freedom, conscience is a complex, often misunderstood concept that has no juridical definition. As we do not have human rights legislation in NSW, and conscience is not a protected attribute under our *Anti-Discrimination Act 1977*, the conscience protections in this bill are stand-alone provisions that must be scrutinised for their impact on those most affected (which includes the doctor or institution with a conscientious objection as well as the community) and the precedent effect that such clauses will have on how we understand the operation of conscience and conscience protection in our laws.

---

[10] This authorises an amendment to the *Births, Deaths and Marriages Registration Act 1995* to insert s 49(A)(3).
[11] See, National Health and Medical Research Council, 'National Statement on Ethical Conduct in Human Research (2007)' General Guidance Section 2, see especially 2.33-2.38, 2.44, 12.
[12] *Therapeutic Goods Act 1989* (Cth) s 4(1).

Anna Walsh, School of Law, University of Notre Dame Australia (Syd). Email: anna.walsh@nd.edu.au

29. Before physician assisted suicide, conscience clause protections for health professionals have largely been restricted to abortion. Australia has no national consensus on the scope and content of conscience clause protection. Australia has three different frameworks for managing conscientious objection to abortion which ranges from a shield to protect anyone from having to participate in an abortion (ACT and WA) to limitations on freedom of conscience which create a statutory duty on objecting doctors to refer patients on to practitioners who they know do not have an objection (VIC, NT, QLD) or which permit the duty to refer to be discharged by the provision of government information about a third party all options service (TAS, NSW, SA).

30. These frameworks are controversial and have not been the subject of judicial review regarding their practical application, however the most recent iterations of conscience clause protections for abortion in New South Wales and South Australia, and for physician assisted suicide in other states, have favoured referral to a third party to break the causal chain of co-operation. However, it should not be assumed that these clauses are acceptable to all doctors with a conscientious objection. Some of the problems involve the level of information which these government or other chosen 'third party organisations' provide to patients and their knowledge about other options.[13]

31. In this bill, clause 9 provides a shield for doctors to refuse involvement with specified processes of physician assisted suicide. However, clauses 21(4) and (5), require them to give the patient information approved by the Health Secretary. There are likely to be concerns by objecting doctors where government information (which we have not seen) is not considered complete regarding palliative care. In addition, clause 23(2)(h) requires them to report the fact they refused a request due to their conscientious objection and explain the reason for it, to the VAD Board. This raises real concerns about privacy and confidentiality that are worthy of further discussion. If a doctor professes his or her opposition to the ideology underpinning physician assisted suicide and euthanasia, will they be considered a threat to the public's health? Will they be seen as 'imposing' their views on others or 'offending' the dignity of those who support it?

32. These third-party referrals seem, on the surface, to be a reasonable solution to managing conscientious objection but they raise issues in relation to complicity, which is a poorly understood moral notion. One possible way of accommodating doctors with a conscientious objection to physician assisted suicide to break the causal chain is to allow them to supplement government information with their own information and referrals for the patient, where appropriate. However, the bill is silent as to whether objecting doctors may do this, and it is unclear whether regulatory authorities will consider this behaviour to be a form of misconduct.

[13] This reflects the findings of my doctoral research which involved empirical research into the attitudes and experiences of doctors with a conscientious objection to abortion who practiced in New South Wales and Victoria.

33. In addition, the bill fails to anticipate scenarios in which health professionals other than doctors, as well as healthcare workers, may be exposed to physician assisted suicide in a way that requires them to participate in or facilitate it in a way which offends their conscience. It is not possible in this brief note to contemplate the range of scenarios where this may arise, but lawmakers who value freedom of conscience and acknowledge that regardless of whether it is lawful, physician assisted suicide remains a moral issue which reasonable people may disagree upon, should ensure they have heard from key stakeholders before being satisfied that the protection is wide enough.

34. Institutional conscientious objection is a new concept for New South Wales (see clauses 88-107).[14] Facilities with ethos objections can advertise that fact, but reasonable access must be given to patients on their premises for consultations and assessments by doctors and even the carrying out of the death if the doctor considers the patient should not be moved. So, preference is given to VAD over the rights of associational organisations to uphold their ethos, and any distress which patients/residents who have chosen to be in that facility because of its ethos might experience due to being in the vicinity of patients undertaking the VAD process. This is a significant and new issue that has not been explored in NSW before and is deserving of further research and reflection.

E. Conclusion

35. Passage of this bill should not be based upon the fact that other states have enacted similar legislation or because one supports freedom of choice. It is a ground-breaking decision that will impact the community in many ways, most especially the practice of medicine, as well as principles of law which must bend to accommodate it. The objects of the bill must be considered carefully. The prospect of scope creep is real, and the question is whether one perceives scope creep as a welcome development or not. The safeguards must be considered carefully. The prospect of abuse is real, and the question is whether one perceives the legal right to be assisted to die at a time of one's choosing to be more important than the justifiable concerns raised by stakeholders. The potential to corrupt the integrity of the medical profession must be considered carefully. The prospect of doctors killing their patients is real, and the question is whether this is something we believe a civilised society can live with.

Anna Walsh
Lawyer/Academic
School of Law, University of Notre Dame Australia (Sydney)
21 November 2021

[14] Similar provisions exist in Queensland's legislation, but it as it has not been activated, it is unknown how it will operate in practice.