THE LAW SOCIETY OF NEW SOUTH WALES
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# Submission on the Voluntary Assisted Dying Bill 2017 (NSW)

## 24 July 2017

NSW Parliamentary Working Group on Assisted Dying

The Hon. Trevor Khan MLC

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# The NSW Young Lawyers Criminal Law Committee makes the following submission in response to the Voluntary Assisted Dying Bill 2017 (NSW).

## NSW Young Lawyers

NSW Young Lawyers is a division of the Law Society of New South Wales. NSW Young Lawyers supports practitioners in their professional and career development in numerous ways, including by encouraging active participation in its 16 separate committees, each dedicated to particular areas of practice. Membership is automatic for all NSW lawyers (solicitors and barristers) under 36 years and/or in their first five years of practice, as well as law students. NSW Young Lawyers currently has over 15,000 members.

The Criminal Law Committee (**Committee**) is responsible for the development and support of members of NSW Young Lawyers who practice in, or are interested in, criminal law. The Committee takes a keen interest in providing comment and feedback on criminal law and the structures that support it, and consider the provision of submissions to be an important contribution to the community. The Committee is drawn from prosecution, defence (both private and public), police, the courts and other areas of practice that intersect with criminal law.

## Introduction

The Committee welcomes the opportunity to make a submission in response to the public consultation draft of the Voluntary Assisted Dying Bill 2017 (NSW) (**Bill**). In principle, the Committee supports legislation that allows voluntary assisted dying in appropriate circumstances. The Committee submits that with suitable safeguards, such legislation supports dignity and choice, thereby enhancing individual autonomy. This Bill provides terminally ill people with a means to end their life on their terms. It also removes concerns that such patients may hold that their loved ones will be prosecuted for fulfilling their wishes and helping them to end their lives.

This Bill clarifies the circumstances in which family members, loved ones and medical practitioners will not be criminally liable when assisting the death of a terminally ill person. Leaving such an important issue to prosecutorial discretion, even if there are guidelines for the exercise of discretion and/or where the Courts may be lenient, is undesirable. The Committee is of the view that having legislation that provides for controlled circumstances in which voluntary assisted dying may legally take place will ensure that patients

make an informed decision, after being assessed as mentally capable of doing so, and after having been provided with the necessary information. By allowing these patients to choose to end their lives we are also giving residents the comfort of dying in their home surrounded by their loved ones, instead of having to travel to jurisdictions where voluntary assisted dying is legal (such as Switzerland).

## Should the criminal law allow for voluntary assisted dying?

The criminal law reflects the moral values of society by seeking to deter and punish certain types of behaviour, including conduct that interferes with the sanctity of human life and the welfare of others. The issue of voluntary assisted dying squarely raises the question of whether the criminal law should seek to promote individual autonomy, or whether the criminal law should protect human life at all costs. These are issues that, in the Committee's view, the Bill resolves by balancing autonomy with the sanctity of life.

## Cooling off period

Considering the irreversible consequences of the decision to end one's own life, it is imperative that a cooling off period exists. The mandatory seven-day period between the initial request for assistance and signing of the request certificate (clause 18), as well as the 48-hour cooling off period means that there must be at least nine days between the initial request and the assisted death. This gives patients time to consider their decision. It is also important that patients are not forced to wait too long to obtain assistance.

If the cooling off period is extended, consideration could be given to adopting the Canadian approach. The Canadian provision sets out that 'if [the relevant medical practitioners] are both of the opinion that the person's death, or the loss of their capacity to provide informed consent, is imminent — any shorter period that the first medical practitioner or nurse practitioner considers appropriate in the circumstances'[1] may be the wait period for that patient (normally it is 10 days). This provides flexibility to adapt to the circumstances of the specific patient and would be a prudent insertion particularly if the waiting period in the current Bill was extended. As it currently stands, on balance there is probably no need to insert such a provision as the timeframe is sufficient to ensure that the person is likely to still be able to give consent, but that they are also given the opportunity to withdraw their request.

[1] *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)* Bill C-14, assented to 2016-06-15.

## Age and residency requirements

The Committee submits that the age and residency requirements are appropriate. Although a person is legally an adult at 18 years old, this is not a necessary indicator of the degree of cognitive or emotional maturity needed for a decision of this magnitude. Accordingly, the Committee endorses the age limit because it protects against terminally ill young adults making an irreversible decision where they are not fully equipped to do so. It also removes responsibility from these young persons by taking away any pressure on them to make a decision to end their own lives.

The residency requirement also discourages the 'suicide tourism' seen in jurisdictions such as Switzerland where there are no such residency requirements.

## Psychological or Psychiatric examination

The Committee submits that the requirement that a patient only be examined by one psychologist or psychiatrist may be too limited. This is because the psychologist or psychiatrist is required to consider potentially contentious questions (clause 16). It is the Committee's view that the better approach would be to require two psychiatrists/psychologists to examine the patient, akin to the provisions that currently exist in the Bill for medical practitioners. The psychological/psychiatric assessment addresses issues that are at the heart of this Bill – the patient's capacity to choose to the end of their life. The Committee submits that it is appropriate that a second opinion be obtained as a pre-requisite for issuing a certificate.

Furthermore, the psychiatrists or psychologists should be required to consider the question currently set out in clause 17(a)(v) in relation to medical practitioners: namely, has the patient considered the possible implications of the patient's assisted death for the spouse or de facto partner or family of the patient. This appears to be a question that also would be appropriately considered by a psychologist or psychiatrist, considering the training of these professionals.

In light of the medical and psychological examination requirements, the Committee is of the view that the Bill – or subsequent regulations – will also need to prevent 'doctor shopping'. Specifically, the Committee suggests that there be a clear framework for choosing secondary medical practitioners and psychologists/psychiatrists. The Committee notes that clauses 11-13 provide some deterrence in relation to improper conduct, the gaining of an advantage and the influencing of others, but they do not directly deal with this issue.

A related concern is whether a patient should be allowed to make multiple attempts to obtain the requisite clearance. That is to say, if the medical practitioners do not agree, (i.e. one believes the condition is terminal and the secondary practitioner does not) the Committee submits that the legislation should clearly state whether the patient is allowed to seek the opinion of a third practitioner. Similarly, if the psychologist/psychiatrist does not think the patient has the requisite mental capacity the law should clarify whether another opinion may be sought from another psychologist/psychiatrist.

Finally, the Committee submits that clause 17(a) should expressly require the primary medical practitioner to consider and be satisfied of the matters in the report given pursuant to clause 16.

## Supreme Court Review

The Committee submits that judicial review by the Supreme Court is an appropriate mechanism to allow for relevant parties to challenge the provision of assistance. This approach provides an important safeguard to protect against abuse of the provisions. However, the efficacy of this mechanism depends on the availability of legal advice and representation. Accordingly, the Committee submits that free legal services should be available to the parties in such an application.[2] The Committee also submits that a source of financial assistance should be identified to meet the cost of obtaining medical evidence. This is because the criteria that the Supreme Court needs to consider indicates that the review will in many cases turn on medical opinion as to a patient's capacity to make a request. This is likely to involve expert reports and expert witnesses. Financial assistance should be provided to those concerned relatives who meet a means-test to obtain such reports and have such experts as witnesses. If not, concerned family members may be effectively precluded from challenging the provision of assistance.

Considering the time sensitive nature of this issue, provision should also be made for an expedited hearing of these issues (ensuring that they are still given due consideration). If patients are made to wait too long pending the outcome of the Supreme Court proceedings, they may lose their capacity to make a further request for a certificate, as is their right under the Bill (clause 22(2)).

## Close Relative definition

The Committee is of the view that the definition of "close relative" is unduly narrow. Particularly for older patients without children and whose partners have died, the closest people in their life may not fall within that definition. This definition should be expanded to include next of kin and also potentially nieces and nephews.

[2] For example, through Legal Aid grants, representation by specialist community legal centres, referrals for pro bono assistance through the schemes maintained by the NSW Bar Association.

Moreover, the Committee submits that the Working Group investigate amending the definition to include indigenous kinship ties.

## Patients who change their minds more than once

Clause 5 provides an option to rescind a request, and provides for how that is to be recorded. However, the Bill provides no provision to the effect that a patient who changes their mind multiple times (makes a request and then rescinds) is ineligible. This issue is distinct from a patient who makes a second request after review by the Supreme Court (clause 22(2)).

This is certainly not a straightforward issue. On one hand, such a provision would be difficult to introduce – questions would arise as to how many times a patient could make a request for assistance and then rescind that request. At the same time, if a patient makes multiple requests and then rescinds those requests, this might suggest that the patient's decision to end their life is not an enduring one. Such a patient may be found to be ineligible for a request certificate, either by the medical practitioner or the psychologist/psychiatrist so the issue may not arise. However, it may be desirable to consider limiting the number of requests a patient may make, thereby taking a cautious approach and strengthening the safeguards in the Bill.

## Patients who would not be eligible for assistance

The Committee agrees with limiting the Bill to terminally ill patients. This ensures that the provision cannot be widely used (or misused) and that the sanctity of life is upheld and the right to life protected. As the Bill currently stands, patients who are eligible for voluntary assisted dying would have already received a terminal diagnosis. However, there is a very real question whether the Bill should also include patients suffering from a debilitating, incurable and permanent disability. For example, Al-Alosi notes that there have been assisted suicide cases involving people suffering from multiple sclerosis (in Australia and the UK) and other degenerative but not necessarily fatal illnesses.[3] Such people would not be eligible under the draft Bill.

The Committee submits that limiting the Bill in this way is a prudent approach at the moment. If the Bill is passed for this limited class of patients (terminally ill patients), consideration can later be given to how effective the safeguards are, and the question can then be debated as to whether the Bill should be extended to people with permanent disabilities and if so, which ones. That being said, many of the justifications for allowing voluntary assisted dying for terminally ill patients (dignity, quality of life, pain and

[3] Hadeel Al-Alosi "A Time to Fly and a Time to Die: Suicide Tourism and Assisted Dying in Australia Considered" (2016) 17(2) *Marquette Benefits and Social Welfare Law Review* 257, particularly at 270, 276.

suffering) would apply to those who are chronically but not terminally ill, and even to some people with disabilities.

The Committee submits that there needs to be serious and public consideration of these concerns so as to identify a logical and principled basis for any distinctions or exclusions in the law. While ultimately the act of legislating requires a line be drawn somewhere, the Committee submits that this line must be based on sound evidentiary, ethical and practical considerations. Moreover, it should look to the experiences of other comparable jurisdictions.

Accordingly, the Committee submits that the legislative review in clause 33 be expressly broadened so that the Minister's review of the operation of the Act also considers whether it is appropriate for the class of eligible patients to be extended to those with certain types of permanent disabilities. Guidance in this respect may be gained from the experiences of other jurisdictions where the criteria for eligibility includes that the patient has 'a grievous and irremediable medical condition', which includes an 'illness, disease *or disability*.'[4]

## Advanced Care Directives

The Committee submits that the Working Group consider whether a person should, by advance care directive (with or without an expiration date), be able to consent to voluntary assisted death if a condition (e.g. dementia) progresses to a certain stage and the patient loses their capacity to consent. Such directives are allowed in some jurisdictions such as Belgium and the Netherlands. This is a very difficult issue, and raises in particular questions about the possibility of abuse, and of patients who once signed an advance care directive, but then change their mind. It also removes the temporal element of the requirement that the patient be of sound mind to consent. The Committee is of the view that due to the difficult issues these directives raise, it is appropriate that this Bill does not allow for advance care directives, especially when it is not known how the provisions will operate. However, the Committee submits that it is appropriate that the review under clause 33 include a requirement to consider whether advanced care directives should be incorporated into the legislation at a later stage.

## Concluding Comments

NSW Young Lawyers and the Committee thank you for the opportunity to make this submission. If you have any queries or require further submissions please contact the undersigned.

[4] *Crimes Act,* RSC 1985, C-46, s 241.2(2)(a) (Canada).

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