LEGISLATIVE ASSEMBLY
FOR THE AUSTRALIAN CAPITAL TERRITORY

SELECT COMMITTEE ON END OF LIFE CHOICES IN THE ACT
Ms Bec Cody MLA (Chair), Mrs Vicki Dunne MLA (Deputy Chair), Ms Tara Cheyne MLA, Mrs Elizabeth Kikkert MLA, Ms Caroline Le Couteur MLA.

Submission Cover Sheet

End of Life Choices in the ACT

Submission Number: 337

Date Authorised for Publication: 29/3/18

elringtons
LAWYERS

20 March 2018 Our Reference: MGB:173320:TWM

Select Committee on End of Life Choices in the ACT
Legislative Assembly for the ACT
GPO Box 1020
CANBERRA ACT 2601

Via Email: **LACommitteeEOLC@parliament.act.gov.au**

Dear Secretary,

SELECT COMMITTEE ON END OF LIFE CHOICES IN THE ACT

We welcome the opportunity to make this submission to the Select Committee on End of Life Choices in the ACT (hereafter referred to as 'the Committee').

ABOUT ELRINGTONS

Elringtons (formerly Elrington Boardman Allport Lawyers) has been providing legal services to the ACT and surrounding district since 1897. We have expertise in business law, family law, wills and estate planning, personal injury, litigation and health law.

We have, for many years, advised and worked with client's in relation to advanced care directives, powers of attorney, enduring powers of attorney, wills and estate planning. Our expertise now covers health law more broadly including consenting to or refusing treatment, nursing home law, children's health law issues, health treatment disputes, mental health law, and publishing on relevant consumer health law topics.

Our health law expertise recognises the significant role that legal services play in advancing the right to health.

OVERVIEW OF OUR SUBMISSION

Our submission to the Committee addresses terms of reference 3, 4 and 6. We address:

1. Fundamental concepts
   - (a) Right to Health
   - (b) Compliance with the *Human Rights Act*

elringtons pty ltd
info@elringtons.com.au
elringtons.com.au
ABN 26 169 311 326
pmgb_173320_009.docx

Canberra
GPO Box 807, Canberra ACT 2601
Level 7, 221 London Circuit, Canberra ACT 2600
DX 5641 Canberra ACT
t 02 6206 1300

Queanbeyan
PO Box 379, Queanbeyan NSW 2620
122 Monaro Street, Queanbeyan NSW 2620
DX 5641 Canberra ACT
t 02 6206 1200

(c) Right to choose what happens to one's body

2. Key definitions

3. Term of Reference 3

4. Term of reference 4

(a) Victorian Act

(b) NSW Bill

5. Term of Reference 6 – perspectives of lawyers working in the area of succession law

6. Submission on legislative framework for voluntary assisted dying

We have made recommendations on what any ACT legislation in this area should incorporate. Our recommendations arise, in part, from a comparison of the Victorian and ACT models. We have also considered other ACT legislation, such as the *Mental Health Act 2015*. We submit that any legislation should include clearly defined eligibility criteria and assessment process to access voluntary assisted dying. This should alleviate any concerns that sectors of the community may have about the scheme and its potential for misuse.

The law plays a significant role in enabling access to health services and ensuring quality services are provided. It does this through creating frameworks for health services to operate, regulating provision of treatments, creating standards of treatment which consumers can expect health practitioners to abide by, enabling consumers to seek redress when sub-standard treatment is provided and regulating educational and professional requirements for the health provisions. A fundamental aspect of ensuring the proper administration of a legislative scheme is a person's access to legal advice on their rights and obligations, as well as the ability to seek justice in a Court or Tribunal when they consider an injustice has occurred. We adopt the World Health Organisation's articulation on role of the law in regard to health:[1]

> *Collectively, through the legislature, courts and executive and statutory agencies, the State has the capacity to pass public health laws, to implement them and enforce them and to balance health with other policy and social goals.*

The legal profession's role in ensuring the community can access services and ensure that they are of a high quality is paramount.

1. FUNDAMENTAL CONCEPTS

Right to Health

There is a universal right to health.[2] It is understood as the right to obtain the highest standard of health.[3] Principles of availability, accessibility, acceptability and quality are

[1] *Advancing the right to health: the vital role of law.* Geneva: World Health Organization; 2017, p 2.
[2] Ibid p 6.
[3] Ibib.

essential elements of the right.[4] These principles are used to examine health care services and laws and whether they promote the right to health, or whether their administration in a certain matter promoted the right to health.

The right to health is recognised in the Universal Declaration of Human Rights at article 25 and in the International Covenant on Economic, Social and Cultural Rights (ICESCR) at article 12.[5] The *Human Rights Act 2004* ('the Act') does not establish a specific human right titled 'right to health'. But, section 7 of the Act indicates that the rights under the Act are not exhaustive of all the rights a person may have under domestic and international agreements, one example being the ICESCR. Therefore, the mere fact that a right to health is not listed in the Act does not mean that the right does not apply to ACT residents.

Rather than being considered a specific enforceable right, the 'right to health' is, perhaps more accurately, a framework by which laws may be appraised. An example of this approach is the decision of the New South Wales Civil and Administrative Appeals Tribunal in *Health Care Complaints Commission v Istephan* (No 2) [2017] NSWCATOD 116. The decision concerned treatment provided by a dentist to residents in six nursing homes. Sixty-nine residents in the six homes were administered treatment, while only 17 had the capacity to consent to the treatment. The Tribunal stated:

> *Those persons lacking in cognitive capacity are deserving of special care from professionals involved in their treatment. So much is clear from Australia's ratification of the United Nations Convention of the Rights of Persons with Disabilities, particularly Article 25 of that Convention which deals with the provision of health services. That respect of human rights and special care was completely absent in the practitioner's treatment of the 69 patients.*[6]

The Convention referred to above is not a source of an enforceable right that the nursing home residents had. Instead, the Convention served to evaluate the services which had been provided against an internationally recognised standard. This raises two key issues:

1. The role of principles or rights in establishing standards.

2. The role of a State or Territory to implement laws to ensure that a principle or right is protected or fulfilled.

Given that the ACT has enacted the *Human Rights Act*, it is appropriate to contemplate any legislation on end of life choices with regard to the 'right to health' principles of availability, accessibility, acceptability and quality. While a 'right to health' is not explicitly embodied in the Act, as we stated previously, the Act is not exhaustive of all the rights ACT residents have. It would be consistent with the Act to adopt a 'right to health' approach. The utility of the approach is that it serves as a diagnostic function on health laws and health care services.[7]

---

[4] Ibid.

[5] Ratified by Australia 10 December 1975 (http://www.info.dfat.gov.au/Info/Treaties/Treaties.nsf/AllDocIDs/CFB1E23A1297FFE8CA256B4C000C26B4).

[6] *Health Care Complaints Commission v Istephan* (No 2) [2017] NSWCATOD 116 [138].

[7] *Advancing the right to health: the vital role of law.* Geneva: World Health Organization; 2017, p6.

Compliance with *Human Rights Act 2004*

We refer the Committee to the Australian Human Rights Commission issues paper titled '*Euthanasia, human rights and the law*'.[8] We note the Human Rights Commission concluded:

1. There is no right to die;[9]

2. The right to life does not mean that a Government cannot legislate to permit voluntary assisted dying;[10] and

3. "*It would seem from a human rights perspective, the option exists to support legalisation of voluntary euthanasia practices provided that sufficient safeguards are put in place to prevent 'arbitrary' (including discriminatory) deprivations of life.*"[11]

We consider therefore that an appropriately drafted legislative act permitting voluntary assisted dying in the ACT would be compatible with the *Human Rights Act 2004*. We commend the Human Rights Commissions report to the Committee.

Right to choose what happens to one's body and decision making capacity

The common law recognises an adult's right to determine what happens to their own body.[12] We submit that this right is the fundamental starting point for any discussion on health laws. At common law, this right has been linked to an individual's decision making capacity.

In 2015, in the case of *In the matter of E.R* (Mental Health and Guardianship and Management of Property) [2015] ACAT 73, a three member panel of the Australian Capital Territory Civil and Administrative Tribunal (ACAT) reviewed the common law and relevant legislative enactments at the time. After reviewing relevant case law and legislation, the Tribunal stated:

> ***Conclusion on the Legal Framework***
>
> *44. The Tribunal concludes that the authorities discussed above, and other sources referred to in the submissions, may be summarised as follows:*
>
> - *The common law presumes that a person has capacity to make a decision and this presumption is reinforced by the obligation under section 30 of the Human Rights Act to interpret law in a way that is compatible with relevant human rights and the operation of those rights, including the rights to protection from torture and cruel, inhuman or degrading treatment, the right to privacy and reputation and the right to liberty and security of person as well as the UNCRPD.*
> - *Capacity may fluctuate.*

[8] Australalian Human Rights Commission, *Euthanasia, human rights and the law*, May 2016, accessed at https://www.humanrights.gov.au/our-work/age-discrimination/publications/euthanasia-human-rights-and-law.
[9] Ibid p 34.
[10] Ibid p 34.
[11] Australian Human Rights Commission, *Euthanasia, human rights and the law*, May 2016, p 34.
[12] First stated *Schloendorff v Society of New York Hospital* (1914) 211 NY 125 at 129, and cited with approval in *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218 234 and 310.

- *Capacity must be assessed in relation to the decision to be made.*
- *The assessment of capacity is specific to the relevant decision, which in this case is a decision about ER's* [the patient] *psychiatric treatment.*
- *The test is not applied to psychiatric treatment generally, or to different treatment that may or may not be needed in future.*
- *The person making the decision should be given the necessary support to make the decision.*
- *The onus is on the applicant* [chief psychiatrist] *to rebut the presumption of capacity.* [13]

While in the context of mental health treatment, this paragraph summarises relevant principles on the concept of capacity. We submit these principles should guide any legislation on voluntary assisted dying. As we will discuss later in our submission, we submit that a legislated definition on decision making capacity and mandatory principles on decision making capacity, would be the best model adopted for any voluntary assisted dying legislation. This is the approach in the *Mental Health Act 2015* (ACT).

2. KEY DEFINITIONS

There are several important concepts which need to be precisely defined when contemplating regulation of voluntary assisted dying. We adopt the definitions articulated by Wilmont et al. in '*(Failed) Voluntary Euthanasia Law Reform in Australia: Two Decades of Trends, Models and Politics*':

- "*Euthanasia: For the purpose of relieving suffering, a person performs a lethal action with the intention of ending the life of another person.*
- *Voluntary euthanasia: Euthanasia is performed at the request of the person whose life is ended, and that person is competent.*
- *Non-voluntary euthanasia: Euthanasia is performed and the person is not competent.*
- *Involuntary euthanasia: Euthanasia is performed and the person is competent but has not expressed the wish to die or has expressed a wish that he or she does not die.*
- *Assisted suicide: A competent person dies after being provided by another with the means or knowledge to kill him- or herself.*
- *Physician-assisted suicide: Assisted suicide where a doctor acts as the assistant.*" [14]

We consider the terms 'euthanasia' and 'voluntary-assisted dying' to be equivalent.

---

[13] *In the matter of E.R* (Mental Health and Guardianship and Management of Property) [2015] ACAT 73 [44].
[14] Wilmont L, White B, Stackpoole C, Purser K, and McGee A, '*(Failed) Voluntary Euthanasia Law Reform in Australia: Two Decades of Trends, Models and Politics*, UNSW Law Journal (2016, 39(1), 6. Accessed at https://eprints.qut.edu.au/95429/.

The definition of euthanasia above demonstrates the importance of the concept of 'suffering'. There are two important considerations of 'suffering' in this context:

1. Alleviation of suffering is the purpose of euthanasia.

2. The degree of suffering is considered from the viewpoint of the person experiencing it.

For the purpose of regulation of voluntary assisted dying, suffering has been associated with physical ailments. This is the framework adopted by the Victorian *Voluntary Assisted Dying Act 2017*. Section 9 of that Act, which deals with criteria to access voluntary assisted dying, establishes this requirement. That section expressly states that mental illness does not entitle someone to accessing voluntary assisted dying, unless they establish the disease, illness or medical condition criteria. The same applies to a person with a disability, as defined under the Victorian *Disability Act* 2006. The effect is that access to voluntary assisted dying under the Victorian Act is restricted to those with an illness, disease or medical condition, not being a mental illness or disability, and who are suffering as a result of the illness, disease or medical condition. The Victorian provision is well drafted. We submit it would not discriminate against those with a mental illness or a disability from accessing voluntary assisted dying, if the person satisfied other eligibly criteria.

3. TERM OF REFERENCE 3 - RISKS TO INDIVIDUALS AND THE COMMUNITY ASSOCIATED WITH VOLUNTARY ASSISTED DYING AND WHETHER AND HOW THESE CAN BE MANAGED

The law has long recognised that there may be members of the community who may be vulnerable to coercion when exercising decisions in relation to their health and property. Put simply, persons may be at risk of not being able to exercise their choice freely. At Elringtons, we routinely assist people to safeguard their decision making autonomy by drafting advanced health directives, drafting wills and drafting powers of attorney which reflect a person's preferences. It is foreseeable that a scheme providing for and regulating voluntary assisted dying, may expose people to those same risks.

We submit that the Victorian Act provides safeguards to prevent this risk, as follows:

1. Defining what constitutes decision-making capacity,[15] and creating a rebuttable presumption that a person has it.[16]

2. Establishing principles which must be taken into account when applying the Act, including:

   (a) Valuing all human life equally,[17]

   (b) Stating a person's autonomy "*should*" be respected,[18]

   (c) Establishing a person's right to be supported in making their decision,[19]

[15] *Voluntary Assisted Dying Act 2017* s 4(1).
[16] Ibid s 4(2).
[17] Ibid s 5(1)(a).
[18] Ibid s 5(1)(b).
[19] Ibid s 5(1)(c).

(d) Requiring information about different treatment options to be provided in a way that each person, uniquely to them, understands,[20]

(e) Creating an entitlement to genuine choices available to a person; [21] and

(f) Identifying a need to protect those who may be subject to abuse.[22]

3. Prohibiting access to only those with decision-making capacity, as defined under the Act.[23]

4. Requiring that a first request (the initial step under the Act to access the scheme) be made personally by the person requesting the intervention to end their life.[24]

5. Requiring the medical practitioner who assesses eligibility to be satisfied the person making the request has done so voluntarily and without coercion.[25]

6. Requiring that a person, after undergoing two assessments by medical practitioners to satisfy eligibility, complete a written declaration indicating the request is made without coercion and with understanding of their decision and then requiring this to be witnessed by two people who cannot be beneficiaries under a will, as well as other classes of excluded people.[26]

7. Permitting review at the Victorian Civil and Administrative Tribunal (VCAT) about a decision of medical practitioners that a person has or does not have decision-making capacity.[27]

We submit to the Committee that those measures set-out in the Victorian Act demonstrate the ways in which safeguards can be drafted and that subject to our submissions on the role of lawyers in the scheme, these should be adopted in any ACT legislation.

With regard to community risks, we consider that a decision whether to access voluntary assisted dying is a personal decision. We acknowledge the very important role that representative government has in providing for conditions which promote health and well-being. We adopt the following passage from *Advancing the right to health: the vital role of law*:

> *Law has a flexible and enabling role in helping to realise the right to health. For example, the law has a role in: eliminating discriminatory barriers to the accessibility of health services, ensuring the accountability of health service providers, strengthening the components of an effective health system, creating a framework for the discharge of core public health functions, and reducing health inequalities.* [28]

We consider that risk to the community should be considered in terms of individual risks to its members. For example, the risk of coercion to an individual is a risk to the community.

---

[20] *Voluntary Assisted Dying Act 2017* s 5(1)(c).
[21] Ibid s 5(1)(h).
[22] Ibid s 5(1)(i).
[23] Ibid s 9(1)(c).
[24] Ibid s 11(2)(b).
[25] Ibid s 20(1)(c).
[26] Ibid s 35.
[27] Ibid s 68(1)(iii).
[28] *Advancing the right to health: the vital role of law.* Geneva: World Health Organization; 2017, p6

We submit that this approach is consistent with how elder abuse is considered, in terms of risks to individuals being a community concern.

We reiterate the individual nature of health decisions and our understanding of access to voluntary assisted dying as an individual health decision. Community considerations should not outweigh an individual's right to determine what happens to their body. Rather, as the above passage demonstrates, community interests should be focussed towards helping a person to access any rights under ACT law.

4. TERMS OF REFERENCE 4: THE APPLICABILITY OF VOLUNTARY ASSISTED DYING SCHEMES OPERATING IN OTHER JURISDICTIONS TO THE ACT, PARTICULARLY THE VICTORIAN SCHEME

The only Australian jurisdiction to legislate on this issue has been Victoria. In 2017 Victoria enacted the *Voluntary Assisted Dying Act 2017* ('the Victorian Act'). The other most recent attempt to legislate on this issue was in NSW with the *Voluntary Assisted Dying Bill 2017* ('the NSW Bill'), which was introduced in 2017, but not yet legislated.

Victorian Act

The Victorian Act establishes four criteria which must be met in order for an individual to access voluntary assisted dying. The four key criteria that an individual must satisfy are:[29]

1. Be 18 or over;

2. Satisfy residency requirements, including being an ordinary resident in Victoria for at least 12 months;

3. Have decision-making capacity (as defined under the Act); and

4. Be diagnosed with a disease, illness or medical condition which is incurable, will cause death in an expected period of no more than six months and which causes the person suffering which cannot be relieved in a satisfactory matter for that person. If the person has a neurodegenerative disease, the expected period of death is 12 months.

The Victorian Act creates a formal process which must be undertaken in order for a person to access voluntary assisted dying. The process can be summarised as follows:

1. A person ('the requesting person') makes a first request to access voluntary assisted dying to a medical practitioner (a specialist or GP with at least five years experience and with relevant experience in relation to the specific terminal illness) in writing or by another form appropriate to the person.[30]

2. Within seven days of receiving the request, the medical practitioner must accept the request, or refuse it on grounds permitted under the Victorian Act (such as conscientious objection).[31]

[29] *Voluntary Assisted Dying Act 2017* s 9.
[30] Ibid s 11.
[31] Ibid s 13.

3. If the request is accepted, the medical practitioner becomes the 'co-ordinating medical practitioner'.[32]

4. In an unspecified timeframe, the co-ordinating medical practitioner must assess the requesting person's eligibility. The practitioner may only do this if they have completed approved assessment training for the purposes of the Victorian Act.[33] Part of this assessment requires satisfaction that the requesting person is acting voluntarily and without coercion.[34]

5. If the co-ordinating medical practitioner is unable to assess eligibility in an unspecified timeframe, a referral must be made to an appropriate specialist for assessment.[35]

6. The specialist, in an unspecified timeframe, must conduct an assessment and report to the co-ordinating medical practitioner.[36]

7. The co-ordinating medical practitioner has the discretion whether to accept the specialist's recommendation, unless the specialist's opinion relates to a neurodegenerative disease, as in those circumstances the opinion is binding on the co-ordinating medical practitioner.[37]

8. If the co-ordinating practitioner assesses the requesting person as eligible under the Act, in an unspecified timeframe they must refer the person to a consultant.[38]

9. Within seven days of receiving the referral, the consultant must accept the referral or refuse it under permitted grounds in the Act.[39]

10. If the referral is accepted, within an unspecified timeframe, the consultant must conduct an assessment,[40] providing they have undergone specified training.[41]

11. If the consultant is unable to assess eligibility, they must, within an unspecified timeframe, refer the requesting person to a specialist.[42]

12. The specialist, in an unspecified timeframe, must conduct an assessment and report to the consultant.[43]

13. The consultant has the discretion whether to accept the specialist's recommendation.[44]

14. In an unspecified timeframe, the consultant must conduct an assessment of eligibility

---

[32] *Voluntary Assisted Dying Act 2017* s 15.
[33] Ibid ss 16 and 17.
[34] Ibid s 20(1)(b).
[35] Ibid s 18.
[36] Ibid s 18.
[37] Ibid s 18(3) and (6).
[38] Ibid s 22.
[39] Ibid s 23.
[40] Ibid s 25.
[41] Ibid s 26.
[42] Ibid s 27.
[43] Ibid s 27.
[44] Ibid s 27(3).

and satisfy themselves the requesting person is acting voluntarily and without coercion.[45]

15. If at this stage the requesting person is found ineligible, the co-ordinating medical practitioner may refer the person for another consultant assessment.[46]

16. If the requesting person has satisfied eligibility criteria, they may then make a written declaration requesting access to voluntary assisted dying.[47] There are strict witnessing requirements, including ruling certain classes of persons as ineligible to witness the declaration, such as persons who are named as beneficiaries under a Will of a requesting person.[48]

17. The requesting person may then make a final request to access voluntary assisted dying.[49] This request need not be in writing, but must be made to the co-ordinating medical practitioner.[50] This cannot be made earlier than nine days after the first request.[51]

18. On receipt of a final request, the co-ordinating medical practitioner, within an unspecified timeframe, must conduct a review and confirm the procedural steps have been completed.[52] If satisfied, the co-ordinating medical practitioner may (not must) apply for a voluntary assisted dying permit.[53]

As can be seen, the process outlined above is exhaustive. Throughout, there are safeguards alerting assessing practitioners to the possibility of coercion. Further, a requesting person is not obliged to continue with their request, even if they have completed all of the procedural steps.[54]

There are two types of voluntary assisted dying permits available under the Victorian Act:

1. **Self-administration permit**, which enables a person to self-administer a dose of a substance prescribed by the co-ordinating medical practitioner in order to cause their own death.[55]

2. **Practitioner administration permit**, which permits a co-ordinating medical practitioner to administer a dose of a substance to cause death if a person has made an administration request.[56] The requesting person, when making the administration request, must be physically unable to administer a dose themselves and have decision making capacity.[57]

---

[45] *Voluntary Assisted Dying Act 2017* s 29.
[46] Ibid s 31.
[47] Ibid s 34.
[48] Ibid s 35 and 36.
[49] Ibid s 37.
[50] Ibid s 37(2) and (3).
[51] Ibid s 38.
[52] Ibid s 41.
[53] Ibid s 43.
[54] Ibid s 44.
[55] Ibid s 45.
[56] Ibid s 46.
[57] Ibid s 46(c).

We consider the oversight mechanisms to be very important. Review at the VCAT is permitted for certain decisions of co-ordinating and consulting medical practitioners. Reviewable decisions include decisions on residence and decision making capacity.[58] The Victorian Act permits application for review by a requesting person, as well as any person with a "*special interest in the medical treatment*".[59] We consider a better model to be one which identifies classes of persons eligible to seek a review and which then permits leave to review in certain circumstances. Such a scheme operates in the ACT under the *Mental Health Act 2015* (ACT) ("the Mental Health Act").[60] The advantage of the approach contained in the *Mental Health Act* is that it is patently clear who has standing to seek review. There is provision for a person to seek leave of the ACAT to appear, meaning any person with a sufficient justification may appear.

The risk with the Victorian Act is that a person with a 'special interest' who may oppose voluntary assisted dying, may be able to seek a review, thus delaying the process for a person seeking to access voluntary assisted dying. So much is seen by section 70 of the Victorian Act, which operates to suspend the process until the review is conducted.

The Victorian Act creates the Voluntary Assisted Dying Review Board. Its functions include:

- Monitoring the Act,
- Reporting to parliament,
- Providing information to health practitioners to promote compliance,
- Consulting with community groups; and
- Referring matters to the Police and other bodies where necessary.[61]

The Board has an important function to monitor the process a person undergoes to access voluntary assisted dying. For example, on conducting a final review, the co-ordinating medical practitioner must provide to the Board a final review form, along with all other required forms.[62]

The Victorian Act establishes protections for health practitioners from criminal and civil penalties. Section 79 protects practitioners from criminal liability for actions done in good faith and in the reasonable belief that a person is accessing voluntary assisted dying in accordance with the Act. Section 80 contains an equivalent provision in relation to civil liability. These are key provisions. The Victorian Act also protects practitioners and paramedics who do not administer lifesaving treatment to a person who has administered or been administered a substance to end their life in accordance with the Act.[63] We submit these provisions are essential and should be adopted in the ACT. Without these provisions, inconsistencies with criminal and civil law (such as duty of care) would arise.

The Victorian Act balances the protections afforded to health practitioners by also creating new offences. For example, a practitioner in Victoria will be charged with a serious offence

[58] *Voluntary Assisted Dying Act 2017* s 68.
[59] Ibid s 68(2).
[60] *Mental Health Act 2015* s 190.
[61] *Voluntary Assisted Dying Act 2017* s 93(1).
[62] Ibid s 41.
[63] Ibid s 81.

where a person has a voluntary assisted dying permit, but the practitioner administers a substance with the intention of causing death and knowingly administers the substance otherwise than in accordance with the permit.[64] This important provision is clearly aimed at preventing situations where the voluntary assisted dying process has been abused by a health practitioner.

NSW Bill

The *Voluntary Assisted Dying Bill 2017* (NSW) ("the Bill") proposes to permit access to voluntary assisted dying to people. A person applying for voluntary assisted dying under the Bill must have satisfied the following eligibility criteria:[65]

1. The person is at least 25 years old.

2. Residency criteria are satisfied, including being an ordinary resident of NSW.

3. The person suffers from a terminal illness, being an illness which will cause their death within 12 months;[66]

4. The medical practitioner who receives the person's first request to access voluntary assisted dying has informed that person that the practitioner believes they are suffering from a terminal illness; and

5. Due to the terminal illness, the person is experiencing pain, suffering or physical incapacity to an extent unacceptable to them.

The Bill permitted a medical practitioner to refuse to provide assistance, for any reason.[67] The Bill also prevented the medical practitioner from providing assistance where they have a reasonable belief that they, or those closely associated to them, will receive a financial benefit from the death of the person accessing the scheme.[68]

If the medical practitioner accepted the request, they would become the 'primary medical practitioner'.[69] After the request is made to a medical practitioner and it was accepted, the following process applied:

1. In an unspecified timeframe, the primary medical practitioner must assess the person ('the requesting person') for eligibility to access the scheme.[70]

2. In an unspecified timeframe, the requesting person must also be assessed by a second medical practitioner, referred to as the 'secondary medical practitioner'.[71] This practitioner must have specialty relevant to diagnosis and treatment of the person's terminal illness.[72]

---

[64] *Voluntary Assisted Dying Act 2017* s 83.
[65] *Voluntary Assisted Dying Bill 2017* (NSW) s 9.
[66] Ibid s 4 definition of "terminal illness".
[67] Ibid s 11(2).
[68] Ibid s 14.
[69] Ibid s 9(2)(d).
[70] Ibid s 17 and 18.
[71] Ibid s 17.
[72] Ibid s 17(3).

3. The primary medical practitioner must be satisfied that there are no other medical measures which are acceptable to the requesting person that can reasonably be undertaken in the hope of providing a cure, otherwise they are unable to provide assistance under the Bill.[73] The Bill is unclear whether the secondary medical practitioner must also satisfy this requirement.

4. The requesting person must be examined by a psychiatrist or psychologist, who must provide a written report addressing whether the person has decision making capacity and their decision has been made freely, voluntarily and with due consideration.[74] Unless those criteria are satisfied, the primary medical practitioner must not provide assistance under the scheme.[75]

5. A request certificate, in a specified form contained in the Bill, may then be completed.[76] This may not be completed within seven days after the first request was made.[77] The certificate includes a declaration by the requesting person and declarations by the primary and secondary medical practitioners.[78] The primary medical practitioner must be present when the requesting person makes the declaration. An audio-visual declaration is permitted.

6. There is a cooling-off period for 48 hours after completion of a request certificate, in which no assistance under the Bill may be provided to the requesting person.[79]

The Bill permits review of request certificates by "*close relatives*" at the NSW Supreme Court.[80] In conducting a review, the Court must satisfy itself of the eligibility criteria, excluding the primary medical practitioner's requirement in relation to cure options.[81]

The Bill goes on to create civil and criminal protections for health practitioners who, in good faith, perform functions under the Bill or refuse to perform them.[82] The relevant section goes on to address specific circumstances where liability is exempted, such as administering substances and failing to provide lifesaving treatment.[83]

The NSW Bill also includes special provisions on the construction of Wills and contracts.[84] The Bill renders void in full any Will, contract or agreement purporting to restrict a person from accessing voluntary assisted dying, or requiring a person to access it.[85] A clause of a contract or agreement will be void where it attempts to limit or exclude liability arising under this Act.[86]

---

[73] *Voluntary Assisted Dying Bill 2017*(NSW) s 18(1)(c).
[74] Ibid s 20.
[75] Ibid s 20(4).
[76] Ibid s 22.
[77] Ibid s 22(4).
[78] Ibid s 22.
[79] Ibid s 12.
[80] Ibid s 24.
[81] Ibid s 24(2).
[82] Ibid s 29.
[83] Ibid s 29(3).
[84] Ibid s 30.
[85] Ibid s 30(1).
[86] Ibid s 30(2).

Finally, the NSW Bill sought to establish the Voluntary Assisted Death Review Board.[87] The Board's operations are equivalent to the Victorian Board, which include monitoring and reviewing the scheme and reporting to Parliament.

5. TERM OF REFERENCE 6 'ANY RELEVANT MATTER': PERSPECTIVES OF LAWYERS WORKING IN THE AREA OF SUCCESSION LAW

Lawyers are often called upon to provide certification that advice has been given in relation to a particular matter. Some examples include:

- In family law, a certificate of legal advice is required prior to entering into a Binding Financial Agreement.
- In property law, a certificate of legal advice is required before taking out a mortgage or providing a guarantee.
- In litigation matters, a lawyer is required to provide certification of reasonable prospects of success before embarking on a court case.
- In succession law, for an Enduring Power of Attorney in NSW, it is necessary for a lawyer to provide a certificate under the Powers of Attorney Act. In the ACT, the requirement is for an "authorised witness to a statutory declaration" to certify voluntariness in execution and understanding of the nature and effect of the Enduring Power of Attorney by the principal.

These examples reflect the essential role the legal profession has in ensuring a person is appraised of their legal rights. They also demonstrate the legal profession's role in facilitating the operation of laws. Take the litigation example. The requirement for certification of reasonable prospects of success means that only those claims with reasonable prospects (with merit) are progressed to Court. Legal practitioners therefore investigate and assess prospects with regard to the facts of a matter and the relevant law. This promotes the effective administration of justice.

We submit that an appropriately drafted voluntary assisted dying law will, like the Victorian Act, require stringent examination of a person's decision-making capacity. As accessing voluntary assisted dying under legislation will involve accessing a person's legal right or rights, the distinction between legal and health decision-making capacity must be drawn. This distinction was identified by the ACT Law Reform Council Guardianship Report, who acknowledged the distinction made by the United Nations:

> "*Legal capacity is the ability to hold rights and duties (legal standing) and to exercise these rights and duties (legal agency). It is the key to accessing meaningful participation in society. Mental capacity refers to the decision making skills of a person, which naturally vary from one person to another and may be different for a given person depending on many factors, including environmental and social factors.*"[88]

[87] *Voluntary Assisted Dying Bill 2017* (NSW) s 35.
[88] ACT Law Reform Council Guardianship Report, 26 July 2016, p 52.

Any ACT voluntary assisted dying law will, if drafted in terms similar to the Victorian Act, raise issues of legal decision making capacity and mental decision making capacity. One's capacity to exercise their legal decision making capacity, is influenced by their mental decision making capacity. We submit the legal profession should have a central role in ensuring a legal test for decision making capacity is followed and satisfied on evidence available, which will include medical evidence.

Legal practitioners in our Wills and Estates Planning Division provide a unique and relevant perspective into the issue of voluntary assisted dying. This is because on a daily basis they consider legal and mental capacity in the context of determining testamentary capacity. Elringtons regularly receives calls from clients, their relatives, friends, or social and hospital staff, to attend on patients for the purposes of providing end-of-life advice on a range of issues such as entering into nursing home contracts or preparing estate planning documents such as wills, Powers of Attorney and Guardianship, Health Care Directives and the like. It is crucial for the lawyer involved to have a comprehensive understanding of the issues affecting these people and a capability in applying the legal tests for determining testamentary capacity. In fulfilling this role, the lawyer must attend on patients, sometimes previously unknown to them and determine if they are mentally fit to record their wishes legally. We submit that the concept of determining decision making capacity as per section 4 of the Victorian Act crosses over the legal test for assessment of testamentary capacity.

Lawyers practising in the area of succession law must rely on a combination of common law, legislative instruments and policy documents in order to guide their judgement and advice in treating elderly or other persons with suspected capacity issues.[89] In *Guthrie v Spence* [2009] NSWSC 369, Campbell JA commented upon the various thresholds for testing capacity in different circumstances, for example in determining whether one can marry, appoint a Power of Attorney, or execute a Will.[90] More recently the NSW Supreme Court has stated that determining capacity comes down to the facts and that "*no rule of procedure will cover every case to avoid the possibility for litigation*".[91]

We submit that the benefit of legislative advancements in the area of voluntary assisted dying will be felt by those lawyers working in day-to-day practice.

We submit a number of those questions posed by Ward J in *King v Hudson* [2009] NSWSC in relation to testing a person's testamentary capacity, could be amended for determining capacity for persons wishing to pursue assisted dying.[92] We submit these questions should not be determinative of a person's ability to access the scheme, but could be applied by practising lawyers in assessing capacity at a time of providing end-of-life advice. For example, the questions could be amended to read as follows:

1. Was the person able to understand the nature of the act of [euthanasia] and the effect of [euthanasia]?

2. Was the deceased able to weigh up the relative [interests and the personal and monetary consequences of their decision]?

3. Was the person's mind possessed of a delusion that influenced the [decision to

[89] For example *Banks v Goodfellow [1870] LR5 QB 549*, *King v Hudson* [2009] NSWSC 1013
[90] *Perpetual Trustee v Fairlie Cunningham* (1992) 32 NSWLR 377
[91] *Ryan v Dalton; Estate of Ryan* [2017] NSWSC 1007 at [106-107]
[92] *Banks v Goodfellow [1870] LR5 QB 549 by Cockburn J, and King v Hudson* [2009] NSWSC 1013 at [58] to [59] by Ward J

> euthanize] which, if their mind had been free of that delusion, would not have been made?

As well those as principles founded in common law, which judges and lawyers practising in succession law regularly turn to for answers, there are various policy documents which lawyers working 'on-the-ground' in this area may utilise to assist them in circumstances where they might be called upon to test a client's mental or testamentary capacity. The NSW Attorney General's "Capacity Toolkit" was published to provide those persons faced with questions of determining mental capacity with a workable policy framework.[93] The NSW Government's policy document also reflects the changeable nature of capacity and divides the assessment of capacity into three areas:

1. Personal life;

2. Health; and

3. Money and property.[94]

Clearly, the decision to end one's life has far-reaching implications for each of those three areas identified above and therefore the test for capacity in a person contemplating euthanasia must be more comprehensive than any current test set-down in common law or government policy. For this reason, we submit that any legislative act on voluntary assisted dying should include a specific definition of decision making capacity, as well as principles on decision making capacity. We submit the model in the *Mental Health Act 2015* (ACT) at sections 7 and 8 be adopted.

One of the most important factors of any test established by law in this area will be determining the patient's ability to weigh up any consequences of their decision. In her paper '*Dealing with clients with (Possible) Impaired Mental Capacity*', Barrister Therese Catanzariti states:

> *"The most relevant issues for testamentary capacity may be frontal lobe functions such as executive function including abstract reasoning, problem solving and insight; and temporal lobe function such as memory including holding multiple relevant information in mind, as these impact whether the testator can comprehend and weigh competing claims, "to remember reflect and reason" and whether there is any delusion."*[95]

Catanzariti and Dr Jane Leonie, in a joint paper on testamentary capacity, speak to the intrinsic relationship between medical and legal professionals in this complex area and the need for both medical and legal professionals to make detailed, extensive professional assessments of their patient's circumstances before decisions are made about their lives, by them or for them by others.[96]

---

[93] NSW Attorney General's Department, "Capacity Toolkit", NSW Government, 2009

[94] Ibid p. 72

[95] Therease Catanzariti, *Dealing with clients with (Possible) Impaired Mental Capacity*, 13 Wentworth Selborne Chambers, http://www.13wentworthselbornechambers.com.au/wp-content/uploads/2017/10/DEALING-WITH-CLIENTS-WITH-POTENTIALLY-IMPAIRED-MENTAL-CAPACITY.pdf.

[96] Dr J Leonie, "*Assessment of Testamentary Capacity form a Medical Perspective", 12 September 2017, Expert Experts, St Leonards NSW, pp. 8-12*

The legal profession currently has an essential role in assessing testamentary capacity. Lawyers have a wealth of experience and skills when it comes to working with clients who are making decisions with significant implications on themselves and others. We submit that experienced lawyers with day-to-day 'coal-face' understanding of determining their client's capacity, should be involved in the process of developing legislation and policy in this area. Lawyers currently play a vital role in testamentary matters, as well as other areas, to ensure the proper administration of laws. We submit that any voluntary assisted dying law should contain a requirement for legal advice to ensure the proper administration of any law. This would add additional safeguard protection against coercion of vulnerable people.

6. SUBMISSIONS ON LEGISLATION

In addition to those points previously made in our submission, we make the following submissions for any legislation on voluntary assisted dying in the ACT:

1. The Victorian model be adopted in terms of:

   (a) Establishing principles which must be applied for the purpose of any voluntary assisted dying legislation.

   (b) Creating eligibility from 18 years of age. This would coincide with the meaning of 'adult' in the *Legislation Act 2001* (ACT) and also section 5 of the *Age of Majority Act 1974* (ACT).

   (c) Establishing a rigorous procedure for accessing voluntary assisted dying. The NSW process under the Bill, by comparison to the Victorian Act, is less stringent and less clearly defined. The Victorian Act creates a process whereby access is vetted by several medical practitioners, along with an oversight board.

   (d) Defining the only circumstances where a health practitioner may refuse to provide assistance, such as conscientious objection.

   (e) Permitting both self-administered and practitioner-administered assisted methods of voluntary assisted dying and the criteria for each.

   (f) Permitting review at the ACAT at first instance. This will ensure a cheaper and usually more expedient process of review is available than that available through the Supreme Court.

   (g) Containing provision stating that a person with a mental illness or disability, but who does not also have a terminal illness, is not able to access voluntary assisted dying.

   (h) Creating an oversight Board with equivalent functions to the Victorian Board.

   (i) Requiring provision of forms to the oversight Board.

   (j) Civil and criminal protections for health practitioners.

   (k) Establishment of new offences, including the offence to induce a person to

requesting voluntary assisted dying.

2. The definition of 'terminal illness' under the NSW Bill be adopted. This definition incorporated concepts of suffering, pain or physical incapacity. The Victorian Act only refers to suffering. Arguably, there is little difference. However, the NSW Bill avoids any doubt. Both the Victorian Act and NSW Bill have qualified suffering in terms of it being unacceptable to the person. This can be contrasted with an objective appraisal. We submit the subjective appraisal should be adopted.

3. The NSW eligibility criteria of death within twelve months, as opposed to the Victorian six months, be adopted.

4. Time on medical practitioners for completing any assessment or tasks under any Act be imposed. Without imposing strict timeframes, a person accessing the scheme is at risk of experiencing delay in what could, in any event, be a lengthy application process. We submit the summary of the Victorian process on pages eight to ten of our submission clearly show various steps where delay for a requesting person may be experienced. Timeframes could be enforced by identifying breaches that may constitute misconduct under the *Health Practitioner Regulation National Law* (ACT).

5. The requirement in the NSW Bill for decision making capacity to be assessed by a psychiatrist or psychologist not be adopted. People make health decisions routinely. We see no reasonable justification to require either psychiatric or psychological advice, solely for the purpose of determining decision making capacity. With clearly articulated definitions and principles contained in legislation in relation to decision making capacity, medical practitioners and lawyers, we submit, are able to establish decision making capacity. We note that the *Mental Health Act* creates a definition and principles for the purpose of that Act and that decision making capacity in that Act does not require satisfaction by a psychiatrist or psychologist. We consider medical evidence will be extremely important in determining decision making capacity, but that a medicalised model of decision making capacity should be avoided.

6. An equivalent model to the *Mental Health Act 2015* for defining decision making capacity and then creating decision making capacity principles, which must be taken into account, be adopted.

7. After assessment of eligibility has been completed by a medical professional, require certification by a lawyer that all procedural steps have been completed. This would include satisfaction of decision making capacity as defined under the law (being a non-medical question but informed by medical evidence).

8. Require a person to have a Will in order to access voluntary assisted dying. People who die intestate or without updating a Will, create a burden on the Courts and system of estate administration. Contentious probate matters filed in the NSW Supreme Court have almost doubled since 2012. [97] We submit that permitting a person to die intestate, pursuant to a Territory provided program, would create a risk that the administration of justice would be impeded. We submit that a person ought to have arranged their testamentary affairs.

[97] Supreme Court of New South Wales provisional statistics (as at 25 January 2017) http://www.supremecourt.justice.nsw.gov.au/Documents/Publications/Provisional%20statistical%20data%20(as%20at%2025%20Jan%202017).pdf

9. Consideration be given to enabling people who are unable to afford legal services to access legal aid funding for advice on, and assistance with, accessing voluntary assisted dying. In the same way that current legal aid funding to private legal firms operates, private firms can respond to the needs of the community in ways that do encumber statutory bodies such as the Human Rights Commission or Public Advocate. While those statutory bodies play a vitally important role, we consider private legal services are well placed to provide consumer choice, particularly with urgent or expert legal services, which will likely be required under a voluntary assisted dying scheme.

10. Include provisions preventing non-voluntary euthanasia and involuntary euthanasia.

11. Create standardised forms which must be used, ensuring all criteria are addressed and promoting consistency.

12. Enabling review of a health practitioner's final decision at the ACAT. Standing should be given to specified classes of person, with leave to appear permitted. Specific reviewable decisions relating to eligibility should be identified.

13. Adopt the NSW Bill position on construction of Wills, contracts and agreements.

CONCLUDING REMARKS

We have borne in mind the 'right to health' framework approach. We submit that if the above recommendations are adopted, the legislation would:

1. Promote availability of services;

2. Provide accessibility to all members of the ACT community;

3. Provide acceptability of services in terms of accessing voluntary assisted dying in defined circumstances and by mitigating risks to consumers; and

4. Promote quality services delivered by health practitioners with the availability of review to ensure access to justice.

A final observation we make is that the ACT has a distinct geographical profile to Victoria. We have concerns that additional training is required for medical practitioners in Victoria in order to assess eligibility. We consider this requirement to be excessive. An ACT scheme could provide for a centralised assessment process through ACT Health. We consider ACT Health likely has the expertise to administer assessment of eligibility, with the assistance of lawyers.

We thank the Committee for its consideration of our submission. This submission was prepared by lawyers Thomas Maling and Jessica Barker. Should clarification on our submission be required, please do not hesitate to contact our firm. We would welcome further opportunity to be of assistance to the Committee where appropriate.

Yours faithfully

ELRINGTONS LAWYERS

[redacted]

Matthew Bridger
Director
Accredited Specialist Personal Injury
Direct Line: [redacted]
Email: [redacted]