THE LAW SOCIETY
OF NEW SOUTH WALES

Our ref: MLC/ELC/HRC/JJC/CLC:GUml1189604

5 August 2016

The Hon. Trevor Khan MLC
Deputy President and Chair of Committees
6 Macquarie Street
Parliament of NSW
Sydney NSW 2000

By email: trevor.khan@parliament.nsw.gov.au

Dear Mr Khan,

Voluntary Assisted Dying Bill 2016

Thank you for the opportunity to provide a submission to the NSW Parliamentary Working Group on Assisted Dying on the Voluntary Assisted Dying Bill 2016 (NSW) ("Bill").

The Law Society of NSW notes that the objective of the Bill is to provide a legislative framework for the rights of terminally ill persons to request and receive assistance to end their lives voluntarily. This submission outlines a number of concerns that we have with the Bill, and makes a number of suggestions to address them.

The Law Society's submission is confined to technical elements and unintended consequences arising from the operation of the Bill. The Law Society provides no comment on the merits or otherwise of the objectives of this Bill.

1. Definitions

1.1 "Decision-making capacity"

The Law Society considers that the definition of "decision-making capacity" needs to be carefully drafted. A definition of "decision-making capacity" may have broader application in other areas of law.

Clause 3(1) provides that:

> ***decision-making capacity***, in relation to a patient requesting assistance under this Act, means the capacity of the patient to:
> (a) understand the facts relevant to the patient's illness and condition, and
> (b) understand the medical treatment and other options available to the patient, and
> (c) assess the consequences of the patient's decisions and understand the impact of those consequences on the patient, and
> (d) communicate the patient's decisions (whether by speaking, sign language or any other means).

We have concerns about the very broad meaning that may be given to clause 3(1)(c) and the term "consequences".

Clauses 14 and 15 of the Bill provide that medical practitioners and psychiatrists will be the arbiters of a person's "decision-making capacity". We consider that this places a very onerous specific obligation on members of the medical profession.

We have observed that the Bill only operates where a person is assessed as having decision-making capacity. We note that it is unclear how the Bill would affect the operation of existing advance care directives that provide for the termination of life if and when certain medical circumstances arise.

1.2 Other defined terms

The Law Society has concerns about the definitions of "illness" and "terminal illness", as currently defined.

Clause 3(1) provides that "illness includes injury or degeneration of mental or physical faculties". We consider that the meaning of this definition is unclear. By way of example, it is unclear whether an "illness" would include a disease. We query whether "degeneration of mental or physical faculties" would include the general effects of ageing.

Clause 3(1) provides that:

> "***terminal illness***, in relation to a patient, means an illness which in reasonable medical judgment will, in the normal course, result in the death of the patient.

We consider that the words "reasonable medical judgment" and "in the normal course" are ambiguous and are open to broad interpretation. We note that the explanatory note accompanying the Bill does not assist with interpreting the meaning of these words.

1.3 Undefined terms

The Law Society notes the use of the terms "close relative", "associates" and "relative" in clauses 12(4) and 18(e). We consider that, for certainty and clarity, these terms should be defined.

2. Age restriction

2.1 Adults

Clause 4(a) provides that the patient must be at least 25 years of age to be eligible to request a medical practitioner for assistance to end their life.

By contrast, the Law Society notes that this particular age limitation was not included in any of the most recent bills across Australia seeking to legalise euthanasia, such as the Rights of the Terminally Ill Bill 2013 (NSW) ("2013 NSW Bill"), the Voluntary Assisted Dying Bill 2013 (Tas) ("2013 Tasmanian Bill"), or the Medical Services (Dying with Dignity) Exposure Draft Bill 2014 (Cth) ("2014 Commonwealth Exposure Draft Bill"), nor was it included in the successfully enacted *Rights of the Terminally Ill Act 1995* (NT) ("1995 NT Act") (which was subsequently overridden by the

Commonwealth). Rather, the above bills and the 1995 NT Act provided that the patient must be at least 18 years of age.

It is arguable that a minimum age of 18 years would be a more appropriate eligibility criterion in this Bill. This is consistent with the above bills. It is also consistent with the legal age at which persons can consent to or refuse medical treatment, as well as the age at which persons have full legal capacity.

2.2 Children

If consideration were given to removing any age restriction from the Bill, the Law Society submits that the following matters with respect to children should be considered.

From a children's rights perspective, several articles of the United Nations ("UN") Convention on the Rights of the Child ("CRC")[1] are relevant, including:

- Article 6(1), which provides that "every child has the inherent right to life";
- Article 3(1), which provides that "[i]n all actions concerning children... the best interests of the child shall be a primary consideration"; and
- Article 12, which provides that a child "who is capable of forming his or her own views" has "the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child". It also requires that the child "be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body".

The common law position relating to a minor's competence to consent to medical treatment was established by the English decision in *Gillick*,[2] and was adopted by the High Court of Australia in *Marion's case*.[3] The court in *Gillick* held that a child with the maturity to understand the nature and consequences of the treatment has the legal capacity to consent on their own behalf, without the need for parental consent or knowledge. For a child to be "Gillick competent", he or she must have "sufficient understanding and intelligence to enable him or her to understand fully what is proposed", which must be assessed on a case-by-case basis. However, while these principles may be relevant in determining a child's capacity to consent to assisted dying procedures, we are not convinced that Gillick competence is adequate.

Maturity and capacity rather than age have been stressed in several other jurisdictions that have legalised euthanasia. In Belgium, which in 2014 amended its 2002 euthanasia law to remove any reference to the age of the patient, maturity rather than age is given consideration in evaluating if a patient has the capacity to make the decision to die.[4] Belgium's Constitutional Court has rejected appeals against the lifting of age restrictions, recognising that this was based on "the right of everyone to choose to end their life to avoid... [an] undignified and distressing life, which derives from the right to respect for private life".[5] In the Netherlands, where

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[1] Opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990).
[2] *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112.
[3] *Secretary, Department of Health and Community Services v JWB and SMB* ("Marion's case") (1992) 175 CLR 218.
[4] Child Rights International Network, 'Belgium: age restrictions lifted on euthanasia', 13 February 2014, accessed at https://www.crin.org/en/library/publications/belgium-age-restrictions-lifted-euthanasia.
[5] *ASBL "Jurivie", ASBL "Pro Vita" and ASBL "Jeunes pour la Vie" v Belgium*, Arrêt n°153/2015.

terminally ill children aged 12 years or over can request euthanasia, the Dutch Paediatric Association has called for the age limit to be removed, stating that "each child's ability to ask to die should be evaluated on a case-by-case basis".[6] In Canada, where proposed legislation on medical assistance in dying received royal assent in June this year,[7] an expert panel advising the provinces had stated that access to euthanasia for terminally ill patients suffering extreme pain should not be restricted by "arbitrary age limits", and recommended that eligibility "be based on competence rather than age".[8] We note, however, that euthanasia under the Canadian law is available only to those aged 18 years or over.

UN treaty bodies have, however, expressed concern with the application of the Netherlands' euthanasia law to children aged 12 years or over. The UN Committee on the Rights of the Child and the UN Human Rights Committee ("UNHRC") in their reviews of the Netherlands have emphasised the need for better safeguards and controls, and monitoring and reporting of requests under the country's euthanasia law.[9]

The UNHRC in its 2001 concluding observations on the Netherlands stated the following:

> The Committee considers it difficult to reconcile a reasoned decision to terminate life with the evolving and maturing capacity of minors. In view of the irreversibility of euthanasia and assisted suicide, the Committee wishes to underline its conviction that minors are in particular need of protection... [The State party] must ensure that the procedures employed offer adequate safeguards against abuse or misuse, including undue influence by third parties.[10]

The UN Committee on the Rights of the Child in its 2015 concluding observations on the Netherlands recommended that the State party:

> (a) Ensure strong control of the practice of euthanasia towards underage patients;

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[6] Agence France-Presse, 'Dutch paediatricians give terminally ill children under 12 the right to die', *The Guardian*, 19 June 2015, accessed at: https://www.theguardian.com/society/2015/jun/19/terminally-ill-children-right-to-die-euthanasia-netherlands.

[7] Government of Canada, Department of Justice, 'About the proposed legislation', 28 July 2016, accessed at http://www.justice.gc.ca/eng/cj-jp/ad-am/legis.html.

[8] Provincial-Territorial Expert Advisory Group on Physician-Assisted Dying, Final Report, 30 November 2015, 34.

[9] UN Committee on the Rights of the Child, *Concluding Observations on the Fourth Periodic Report of the Netherlands*, 69th sess, UN Doc CRC/C/NDL/CO/4 (8 June 2015); UN Committee on the Rights of the Child, Consideration of Reports Submitted by States Parties under Article 44 of the Convention: *Concluding Observations: Netherlands*, 50th sess, UN Doc CRC/C/NLD/CO/3 (27 March 2009); UN Committee on the Rights of the Child, Consideration of Reports Submitted by States Parties under Article 44 of the Convention: *Concluding Observations: The Kingdom of the Netherlands (Netherlands and Aruba)*, 35th sess, UN Doc CRC/C/15/Add.227 (26 February 2004); UN Human Rights Committee, Consideration of Reports Submitted by States Parties under Article 40 of the Covenant: *Concluding Observations of the Human Rights Committee – Netherlands*, 96th sess, UN Doc CCPR/C/NLD/CO/4 (25 August 2009); UN Human Rights Committee, Consideration of Reports Submitted by States Parties under Article 40 of the Covenant: *Concluding Observations of the Human Rights Committee – Netherlands*, 72nd sess, UN Doc CCPR/CO/72/NET (27 August 2001).

[10] UN Human Rights Committee, Consideration of Reports Submitted by States Parties under Article 40 of the Covenant: *Concluding Observations of the Human Rights Committee – Netherlands*, 72nd sess, UN Doc CCPR/CO/72/NET (27 August 2001), para. 5(c).

> (b) Ensure that the psychological status of the child and parents or guardians requesting termination of life are seriously taken into consideration when determining whether to grant the request;
> (c) Ensure that all cases of euthanasia towards underage patients are reported, and particularly included into annual reports of the regional assessment committees, and given the fullest possible overview; and
> (d) Consider the possibility of abolishing the use of euthanasia towards patients under 18 years of age.[11]

However, neither Committee has explicitly stated that euthanasia for children is incompatible with the CRC or the International Covenant on Civil and Political Rights ("ICCPR").[12]

It appears that neither the UN Committee on the Rights of the Child nor the UNHRC have addressed the topic of children and euthanasia in Belgium in their reviews of the State Party since the 2002 law was enacted. The UN Committee on the Rights of the Child reviewed Belgium's compliance with the CRC in 2010 and 2002, and the UNHRC reviewed Belgium's compliance with the ICCPR in 2010 and 2004. These reviews took place after the commencement of the 2002 law under which emancipated children could request euthanasia, though prior to the 2014 amendment that extended euthanasia to all children.

In light of the above, if consideration were given to extending voluntary euthanasia to children, the Law Society submits that:

a) A two-stage process should be adopted addressing adults first, then children. This phased-in approach would provide the opportunity for broader consultation to take place with children and other affected groups within society. This approach was proposed by UNICEF Canada when examining Canada's recently approved euthanasia legislation, and was adopted in Belgium;[13] and

b) Stringent safeguards should be established to prevent abuse of children and ensure consistency with the CRC. Consideration should be given to the following matters:

    - The need to consider and comply with Australia's obligations under international human rights law, including under the CRC, ICCPR, and UN Convention on the Rights of Persons with Disabilities;[14]
    - The need to consider the views of the child, and to give such views due weight in accordance with the child's age and maturity;
    - The need for an individual assessment of the child by more than one independent qualified psychiatrist to determine whether the child has decision-making capacity and whether the child's decision has been made freely, voluntarily and after due consideration;
    - The need for an individual assessment of the child by a children's specialist;
    - The role of parents, guardians or other carers, including the need for consultations with parents, guardians or other carers and whether their consent would be required; and

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[11] UN Committee on the Rights of the Child, *Concluding Observations on the Fourth Periodic Report of the Netherlands*, 69th sess, UN Doc CRC/C/NDL/CO/4 (8 June 2015), para. 29.
[12] Opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976).
[13] UNICEF Canada, Brief submitted by UNICEF Canada to the Special Joint Committee on Physician-Assisted Dying, 12 February 2016.
[14] Opened for signature 30 March 2007, 999 UNTS 3 (entered into force 3 May 2008).

- The role of judges, magistrates or other independent bodies if there is a conflict of interest between the child and the parents, guardians or carers, and to guarantee that the child's decision was not the subject of undue influence or misapprehension; and
- The role of judicial oversight in all cases of voluntary euthanasia of children, whether or not there is a conflict of interest between the child and the parents, guardians or carers.

3. Fixed life expectancy

Clause 4(c) of the Bill provides that, in order for a patient to request a medical practitioner for assistance to end their life, the illness must, in the medical practitioner's view, be likely to result in the patient's death within the next 12 months. This appears to be unjustifiably restrictive.

The Law Society notes that the 2013 NSW Bill, the 2013 Tasmanian Bill, the 2014 Commonwealth Exposure Draft Bill, and the 1995 NT Act simply required that the patient be suffering from a terminal illness. While terminal illness was variously defined, there was no restriction regarding the patient's life expectancy as a result of the terminal illness.

It would seem inhumane to deny a request for assistance by a patient suffering from a terminal illness that is causing unacceptably severe pain, suffering or incapacity on the basis that they are expected to live for over 12 months, as this would simply prolong their pain, suffering or incapacity up until the time that they would become eligible to request such assistance under the proposed legislation. Indeed, a 12-month life expectancy limit beyond which individuals are not entitled to end their suffering is arbitrary.

The restriction regarding life expectancy could be removed from the Bill to ensure that provision is made for all persons suffering from a terminal illness that is causing such pain, suffering or incapacity, regardless of their life expectancy.

4. Assessment that patient is experiencing severe pain, suffering or incapacity

Clause 4(d) of the Bill provides that, in order for a patient to request a medical practitioner for assistance to end their life, in the course of the illness, the patient must be experiencing severe pain, suffering or incapacity to an extent unacceptable to the patient. Clauses 15(a)(ii) and (b) of the Bill provide that the primary and secondary medical practitioner must also form an opinion about the severe pain, suffering or incapacity experienced by the patient.

The Law Society notes that this threshold requirement is subjective and would require the patient to confirm that the requirement in clause 4(d) is met in order to fulfil the request. We suggest that this requirement and the "declaration of patient" set out in Form 1 in Schedule 1 be consistent.

We recommend that consideration be given to adding the words "the patient declares that" at the commencement of clause 4(d), and that "*severe* pain" be used in the declaration of patient set out in Form 1 in Schedule 1.

5. Right to rescind request

Clause 5(2)(a) of the Bill provides that the primary medical practitioner must destroy a patient's certificate of request for assistance if it is rescinded by the patient.

The Law Society notes that this is contrary to legislation requiring retention of medical records. If the purpose of this provision is to stop the certificate of request being used, we suggest that marking rather than destroying the certificate of request would achieve this purpose.

6. Nominees

Clause 7 of the Bill provides that a substance may be administered by a "nominee" to end the patient's life so long as the patient has nominated that person and the nominee has agreed to do so. There are no safeguards regarding who can be a nominee, such as a requirement that the nominee be medically qualified or otherwise fit to administer the substance. This creates a risk that the substance may not be administered to the patient properly, which may result in unnecessary suffering for the patient or in the procedure being ineffective. There are also no provisions for returning or destroying the potentially lethal substance.

The Law Society recommends that safeguards be put in place to ensure that any involvement of a nominee to end a patient's life does not place the patient at risk of unnecessary suffering or a failed procedure, and that provision is made for returning or destroying the substance.

7. Substance "reasonably available for use"

Clause 9 of the Bill requires a primary medical practitioner to "be guided by appropriate medical standards and such guidelines, if any, as are prescribed by the regulations" and to "consider the appropriate pharmaceutical information about any substance reasonably available for use in the circumstances" of providing assistance under the Bill.

The Law Society is concerned that no information has been provided regarding any such substances "reasonably available for use" to end a patient's life. We are concerned about the lack of clarity around the determination of the substances that would be "reasonably available for use in the circumstances", and the potential lack of regulation of the substances that may be legally prescribed to end a patient's life. We are also concerned that this clause requires the primary medical practitioner to simply "consider the appropriate pharmaceutical information" about a substance, rather than requires them to use certain substances as prescribed by a regulation.

We recommend that clause 9 of the Bill be strengthened to ensure clarity around the determination and type of substances that may be used to provide assistance under the Bill.

8. Independence of professionals

Clause 3(1) of the Bill provides that the independent qualified psychiatrist and independent qualified social worker must not be a relative or employee of the patient's primary or secondary medical practitioners. Additionally, the psychiatrist must not be a member of the same medical practice as the medical practitioners. Clause 12(3)(b) provides that the patient's primary and secondary medical practitioners must not be "closely associated with each other", which is defined as

being "a relative or employee of, or a member of the same medical practice as, the other medical practitioner".[15]

However, there are no specific provisions that require the primary medical practitioner, the secondary medical practitioner, the psychiatrist or the social worker to be independent from the patient.

The Law Society queries whether the Bill should be amended to include provisions that ensure the independence of such professionals from the patient.

9. Financial or "other advantage"

Clause 10(1) of the Bill makes it an offence for a person to give or promise any financial or "other advantage" to a primary medical practitioner or other person for assisting or refusing to assist, or for the purpose of compelling or persuading the primary medical practitioner or other person to assist or refuse to assist, a person to end their life. Clause 10(2) of the Bill also makes it an offence for a person to accept any financial or "other advantage" for assisting or refusing to assist in ending the patient's life. Clause 18 provides that the primary medical practitioner must be satisfied that, as a result of the death of the patient, no financial or "other advantage" will be gained by specified persons in that clause.

The Law Society notes that there is no definition in the Bill of "other advantage", which is vague and open to interpretation. We consider that, for certainty and clarity, this term should be defined.

10. Primary medical practitioner

Divisions 2 and 3 of the Bill set out the requirements relating to requests for assistance. In particular, clause 13 requires a primary medical practitioner to provide the patient with certain information relating to the patient's illness and medical treatment.

The Bill does not provide a definition or guidance as to who the primary medical practitioner would be. Members of the Law Society have advised that there may be confusion amongst the medical profession as to whether the primary medical practitioner would be a GP or a specialist. Our members have advised that often a GP would not have the appropriate qualifications or skills to provide some or all of the prescribed information to the patient.

To avoid restricting the definition, we recommend that some guidance be provided in the explanatory notes regarding the primary medical practitioner.

11. Opinion of medical practitioner and independent psychiatrist

Clause 14(2) of the Bill requires an independent qualified psychiatrist to provide a written report that indicates whether, in the opinion of the psychiatrist, the patient has decision-making capacity and the decision has been made freely, voluntarily and after due consideration. Clause 15(a) provides that a primary medical practitioner must not provide assistance to a patient under the Act unless the primary medical practitioner has, after "considering" the report by the independent qualified

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[15] Clause 12(4), Bill.

psychiatrist, formed the opinion that the patient has decision-making capacity and the decision has been made freely, voluntarily and after due consideration.

The Law Society is concerned that, even if an independent psychiatrist is of the opinion that the patient does not have decision-making capacity, the psychiatrist's assessment can be overruled by the opinion of the primary medical practitioner.

We submit that clause 15(a) should be strengthened to provide that the opinion of the primary medical practitioner as to the patient's decision-making capacity must be based on the written report by the independent qualified psychiatrist, or that the primary medical practitioner cannot proceed unless the psychiatrist confirms that the patient has decision-making capacity.

Additionally, we recommend that consideration be given to amending clause 15 to add that a primary medical practitioner "must not sign the declaration of primary medical practitioner", or provide assistance to a patient under this Act, unless the requirements in clause 15(a) and (b) are met.

12. Certificate of request

Clause 16 requires a formal certificate of request to be completed confirming the patient's request for assistance. Clause 16(4) requires the primary medical practitioner's declaration to be signed in the presence of the patient and the secondary medical practitioner.

The Law Society queries whether this provision allows for the declaration to be signed via a telehealth consultation for rurally-located patients.

13. Protection from liability

Clause 20 of the Bill protects persons, including medical practitioners, psychiatrists, social workers, health care providers and nominees, from criminal and civil liability for participating in, or refusing to participate in, the provision of assistance under the Bill.

The Law Society submits that these persons should also be protected from professional disciplinary action for participating, or refusing to participate, in the provision of assistance. This was provided for by the 2013 NSW Bill, the 2013 Tasmanian Bill, the 2014 Commonwealth Exposure Draft Bill, and the 1995 NT Act.

We recommend that consideration be given to including a provision to the effect that a professional organisation, association or health care provider must not subject a person to discipline, censure, suspension, loss of fellowship, membership or loss of clinical privileges merely because of their involvement in the process pursuant to the Act. This was provided for in the 1995 NT Act and Oregon's *Death with Dignity Act 1997*.

14. Provisions affecting wills and contracts

Clause 18 of the Bill provides that:

> A primary medical practitioner who provides assistance to a patient under this Act must be satisfied that, as a result of the death of the patient, no financial or other advantage (other than a reasonable payment for medical services) will be gained by:
> (a) the primary medical practitioner, or

> (b) the secondary medical practitioner, or
> (c) the independent qualified psychiatrist or independent qualified social worker who has conducted an examination of, or consultation with, the patient in accordance with section 14, or
> (d) any interpreter required under section 17 to be present at the signing of the certificate of request, or
> (e) a close relative or associate of any of them.

The Law Society considers that the meaning of clause 18(e) is unclear. This sub-clause could be interpreted broadly to mean all beneficiaries under a will or only a close relative or associate of the professionals described in clause 18(a) to (d).

Clause 21 provides that:

> (1) Any will, contract or other agreement, whether or not in writing or executed or made before or after the commencement of this Act, is void to the extent that it affects whether a person may make or rescind a request for assistance, or provide assistance, under this Act.
> (2) Any provision of a contract or other agreement is void to the extent that it purports to exclude or limit the liability of a party to the contract in the event of a person making or rescinding a request for, or receiving or providing, assistance under this Act.

We note the retrospective application of this provision in relation to wills and contracts. We note generally that retrospective laws are commonly considered inconsistent with the rule of law. In general, we do not support amendments to laws that will retrospectively change legal rights and obligations. This is especially the case where those retrospective changes derogate from rights, or as in this case, change legal and contractual entitlements.

15. Insurance policies

The Law Society submits that consideration should be given to including a new provision in Part 3 of the Bill that insurance policies (such as life policies) should not be conditional upon, or affected by, making or rescinding a request under the Act. This was provided for in the 1995 NT Act and Oregon's *Death with Dignity Act 1997*.

16. Medical records to be kept

Clause 22 of the Bill sets out the information that a primary medical practitioner must keep as part of the patient's medical record, and imposes a maximum penalty of $11,000 for failure to comply with this clause.

The Law Society submits that this penalty is too harsh and is likely to be a disincentive for medical practitioners to provide assistance under the Bill.

17. Form 1 – Certificate of request

Schedule 1 of the Bill sets out the form of certificate that must be used in relation to a request for assistance.

The Law Society has concerns about the "declaration of patient" part of the form. It is unclear in paragraph (c) how a patient may be "fully informed" of the information listed in this paragraph. The information provided in this paragraph refers to the "information to be provided by primary medical practitioner" in clause 13 of the Bill.

We suggest including a reference to the requirements of this clause in the form, and also a reference to the requirement to provide the information in writing.

We also note that the patient is not required to declare that they have undertaken a mandatory examination by an independent qualified psychiatrist and social worker.

18. Compatibility of the Bill with Australia's international law obligations

The Law Society also wishes to comment on the Bill's compatibility with Australia's international law obligations. Australia is a party to several key human rights treaties. The most relevant obligations when discussing voluntary euthanasia are contained in the ICCPR. The following rights in the ICCPR may be engaged by the practice of voluntary euthanasia:

- right to life (article 6);
- freedom from cruel, inhuman or degrading treatment (article 7);
- right to respect for private life (article 17); and
- freedom of thought, conscience and religion (article 18).

Relevantly, article 6(1) of the ICCPR provides that "[e]very human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life."

The 2016 Australian Human Rights Commission Report *Euthanasia, human rights and the law* references recent commentary that notes that the right to life has been characterised as the "supreme human right", as "without effective guarantee of this right, all other rights of the human being would be devoid of meaning."[16] Furthermore, the report notes that this is the only right in the ICCPR that is expressly described as "inherent".[17]

We understand that recent commentary from the UNHRC, particularly in the context of assessing the compatibility of such laws with human rights principles in the Netherlands, suggests that laws allowing for voluntary euthanasia are not necessarily incompatible with States' obligation to protect the right to life.[18]

We understand that international human rights law has not yet determined whether the right to life also encompasses a correlative right to choose to die.[19] However, the right to life also does not require a State to ensure that a person's life is protected when this is against the express wishes of that person. Therefore, in the case of a request for voluntary euthanasia, the State's obligation to protect life must be balanced against the right to personal autonomy, which is contained within the right to privacy.[20] For example, legislation that prohibits access to voluntary euthanasia may interfere with the right to respect for private life as guaranteed under article 17 of the ICCPR, and, as such, it would need to be justified as a legitimate limitation of that right.[21]

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[16] Australian Human Rights Commission, *Euthanasia, human rights and the law* (2016), 26.
[17] Manfred Nowak, UN Covenant on Civil and Political Rights: CCPR Commentary (NP Engel, 2nd rev. ed, 2005), 122.
[18] UN Human Rights Committee, Consideration of Reports Submitted by States Parties under Article 40 of the Covenant: *Concluding Observations of the Human Rights Committee – Netherlands,* 72nd sess, UN Doc CCPR/CO/72/NET (27 August 2001).
[19] Australian Human Rights Commission, *Euthanasia, human rights and the law* (2016), 34.
[20] Ibid.
[21] Ibid.

The Australian Human Rights Commission therefore notes that, if a State does choose to legalise voluntary euthanasia, article 6 of the ICCPR requires that the legislation include strict and effective safeguards against abuse. In order to be compatible with the right to freedom of thought, conscience and belief, such laws may need to include an appropriately worded 'conscientious objection' provision.[22]

We acknowledge that the Bill provides for the right of a medical practitioner to refuse to provide assistance to a person to end their life.[23] We also note that the Bill requires the examination of a person seeking assistance by an independent qualified psychiatrist and social worker, which provides for additional independent oversight of the decision-making process.[24]

However, we submit that consideration should be given to providing for judicial oversight in the decision-making process outlined in Division 3 of the Bill. For example, the court could hear any challenges to a medical practitioner's decision to provide assistance, if it is considered that the person's decision was influenced in some way or if there was third party interference. This additional independent oversight is consistent with comments made by the UNHRC in assessing the compatibility of Dutch euthanasia legislation with international human rights obligations. Here, the UNHRC noted its concern that a physician can terminate a patient's life without any independent review by a judge or magistrate to guarantee that this decision was not the subject of undue influence or misapprehension (article 6, ICCPR).[25]

19. Other legislation

The Law Society submits that:

- The *Crimes Act 1900* (NSW) should be amended to remove assisted suicide as an offence;
- The *Coroners Act 2009* (NSW) should be amended to include assisted suicide as a reportable death; and
- The Coroner should provide some oversight of the process and outcomes of assisted suicide under the Bill, and publish statistics.

Should you have any questions or require further information, please contact Meagan Lee, Policy Lawyer on (02) 9926 0214 or email Meagan.Lee@lawsociety.com.au.

Yours sincerely,

Gary Ulman
President

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[22] Australian Human Rights Commission, *Euthanasia, human rights and the law* (2016), 35.
[23] Clause 6, Bill.
[24] Clause 14, Bill.
[25] UN Human Rights Committee, Consideration of Reports Submitted by States Parties under Article 40 of the Covenant: *Concluding Observations of the Human Rights Committee – Netherlands*, Human Rights Committee, 96th sess, UN Doc CCPR/C/NLD/CO/4 (25 August 2009), para 7.