28 January 2022

Hon. Wes Fang, MLC
Committee Chair, Legislative Council
Standing Committee on Law and Justice

Response to Supplementary Question Two to Dr Rachel Hughes from Legislative Council Law & Justice Committee *Voluntary Assisted Dying Bill 2021* (NSW) per Mark Green

We refer to the above subject. Calvary submits the following response to the question from the Committee.

Supplementary Question

2. Clause 6 of the Voluntary Assisted Dying Bill 2021 deals with the matter of decision-making capacity. Sub-clause 6(2) deals with the specific matter of patients, for particular purposes of the legislation, having "presumed capacity". Can you please comment on the presumed capacity provisions (sub-clause 6(2)) of the Bill and in doing so, express your view about the appropriateness, or otherwise, of such provisions in a bill that provides for the establishment and operation of a Voluntary Assisted Dying procedure? Do the provisions pose any particular and specific threats and dangers to certain patient cohorts?

Response

Clause 6

6 Decision-making capacity

(1) For the purposes of this Act, a patient has ***decision-making capacity*** in relation to voluntary assisted dying if the patient has the capacity to—

(a) understand information or advice about a voluntary assisted dying decision required under this Act to be provided to the patient, and

(b) remember the information or advice referred to in paragraph (a) to the extent necessary to make a voluntary assisted dying decision, and

(c) understand the matters involved in a voluntary assisted dying decision, and

(d) understand the effect of a voluntary assisted dying decision, and

(e) weigh up the factors referred to in paragraphs (a), (c) and (d) for the purposes of making a voluntary assisted dying decision, and

(f) communicate a voluntary assisted dying decision in some way.

(2) For the purposes of this Act, a patient is—

(a) presumed to have the capacity to understand information or advice about voluntary assisted dying if it reasonably appears the patient is able to understand an explanation of the consequences of making the decision, and

(b) presumed to have decision-making capacity in relation to voluntary assisted dying unless the patient is shown not to have the capacity.

(3) In this section—

voluntary assisted dying decision means—

(a) a request for access to voluntary assisted dying, or

(b) a decision to access voluntary assisted dying.

Presumption

The statutory presumption exists because of the use of the words *"is presumed to have"* in the Bill. Because of the statutory presumption, the doctor is under no duty to undertake any cognitive testing; in fact, the practitioner could assess the person as having decision making capacity under sub-clause (1) because there is *"no evidence to the contrary".*

As to the practitioner being satisfied that the consent of the patient is an informed consent (understanding, etc.), the statutory presumption operates so that the medical practitioner may conclude that it *reasonably appeared* to him or to her that the patient understood the consequence of a decision to proceed with VAD.

The Bill might have applied a contrary presumption - or said nothing at all. If it had said that a person is presumed not to have decision-making capacity unless there is evidence to the contrary, then the responsibilities upon the medical practitioner would be significantly heightened. In that scenario, the practitioner would need to undertake specific examination of the patient to be satisfied that he or she has requisite decision-making capacity. The evidence to be relied upon would, primarily, be the conduct of that examination by the doctor.

Specific threats and dangers

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

It is possible to conclude on this basis, therefore, that the requirement that a patient has demonstrable decision-making capacity is not sufficiently robust, and is entirely dependent upon the opinion of two medical practitioners neither of whom may have set eyes on the patient before. The drafters' calculated decision to exclude any compulsory role for the patient's own GP in this process is significant: it means that the opportunity for exploitation of the vulnerability of aged and infirm patients may be unnecessarily increased.

The Bill *enables* the CMP, **in** conducting the first assessment, to have regard to any relevant information about the person that has been prepared by, or at the instigation of, another registered health practitioner (i.e. the person's own GP). However, this clause is permissory, not mandatory. The **Bill** would be more protective of vulnerable persons if each of the coordinating and consulting medical practitioners were required to consult with the person's usual GP or, at the very least, to obtain the person's medical history from the general practice usually attended by the person. Without such a requirement, how can it be said per Clause 4, that that "[the] therapeutic relationship between a person and the person's health practitioner should, wherever possible, be supported and **maintained.**

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

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For more information

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