New South Wale's Voluntary Assisted Dying Act (2022) No. 17

Impact on freedom of conscience for health care practitioners and institutions

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Revision Date: 2022 Sep 27

EXECUTIVE SUMMARY

New South Wale's *Voluntary Assisted Dying Act (2022) 2017*, drafted and introduced by Independent MLA Alex Greenwich, closely resembles Queensland's *Voluntary Assisted Dying Act 2021*. It will legalize euthanasia and assisted suicide (termed "voluntary assisted dying") in the Australian state when it comes into force in January, 2023. This review considers the *Act* may have on health care workers and institutions opposed to euthanasia or assisted suicide (EAS) for reasons of conscience. Part I outlines the main features of the law, providing a context for discussion of provisions relevant to freedom of conscience in Part II (Individual Freedom of Conscience) and Part III (Institutional & Collective Freedom of Conscience).

Overview

Eligibility

People seeking euthanasia/assisted suicide (EAS) must be adults with an advanced, progressive disease or medical condition that is causing suffering (of any degree or kind) and that is expected to cause death within 12 months (in the case of neurodegenerative conditions) or within 6 months in all other cases. They must be acting voluntarily, without pressure or duress, and be capable of making and communicating medical decisions. They can be mentally impaired or have dementia or a disability, but EAS cannot be provided for mental impairment, dementia or disability alone. Decision-making capacity is presumed in the absence of evidence to the contrary if a patient appears to understand the consequences of a decision. The *Act* acknowledges that capacity can be temporarily or permanently lost. It imposes residency requirements that can be waived for compassionate reasons.

Practitioners

Only EAS-trained medical practitioners with least ten years general practice experience or specialist credentials can act as EAS coordinators and consultants. Other EAS trained medical practitioners and nurse practitioners may administer euthanasia.

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Discussion with patients

It appears that NSW legislators muddled the wording of the provision about discussions with patients while attempting to modify the comparable provision in Queensland's *Voluntary Assisted Dying Act 2021*. All health care workers, contracted care service workers and medical practitioners can initiate discussion about or suggest euthanasia/assisted suicide to patients, even if patients have not expressed an interest, as long as they provide other information required by the Act. If a patient asks about EAS, contracted care service workers and health care workers other than medical practitioners can provide EAS information, but need not provide information about available options or suggest that the patient talk to a medical practitioner. However, none are required to suggest or initiate discussion about EAS.

The EAS process

The EAS process begins with a "clear and unambiguous" first request to a medical practitioner made personally by a patient (not a third party). After discussing alternative options, the medical practitioner must accept or reject the request and promptly notify the patient. A practitioner who rejects a request must advise the patient that others may be able to assist, and must provide information about them or the Voluntary Assisted Dying Care Navigator Service. An EAS-qualified medical practitioner who accepts a request becomes the coordinating practitioner, responsible for supervising the EAS request, assessment and administration process.

A medical practitioner who accepts a request must assess the patient's eligiblity. Patients deemed eligible must be referred to a consulting practitioner to confirm the assessment, and can be referred repeatedly to consulting practitioners until eligibility is confirmed. Referrals to specialists are optional, and their opinions are not binding.

A patient deemed eligible by two medical practitioners and who wishes to proceed must make a second EAS request, then a written declaration witnessed by two people, and a final request. Finally, with the coordinating practitioner's assistance, me must make an administration decision: to opt for assisted suicide or euthanasia. Assisted suicide is less reliable than euthanasia, and experience elsewhere demonstrates that very few choose assisted suicide when both euthanasia and assisted suicide are available.

The second request, final request, and administration decision could all occur during the same consultation, although a final request cannot be made until the day after the completion of the second (consulting) assessment, and cannot normally be made within five days of a first request; the latter requirement can be waived if the patient may lose capacity or die before EAS can be provided.

Subject to Australian national laws, the *Act* explicitly allows the use of audiovisual communication for first and final requests and administration decisions. The *Act* does not explicity prohibit audiovisual communication for EAS assessments. Australia's *Criminal Code* currently prevents this. Should the *Code* be amended to allow it, videoconferencing for first and final requests and administration decisions would immediately be allowed, and it appears that professional regulators in New South Wales would be able to permit videoconferencing for EAS assessements.

Providing EAS

Coordinating practitioners must be authorised by the Voluntary Assisted Dying Board (the Board) to prescribe a lethal substance for each patient, whether it is to be practioner-administered or self-administered. A practitioner providing euthanasia must have an adult witness present and ensure that the patient has decision-making capacity and is acting voluntarily. A patient can self-administer lethal medication at any time and place, without notifying anyone. Neither a witness or confirmation of decision-making capacity or voluntariness is required. It is thus possible for death by self-administration to occur in public or inconvenient places or remain undiscovered for some time. If the patient is incapacitated but does not die after being administered or ingesting the lethal substance, it does not appear that an additional lethal dose can be given to kill the patient unless the patient regains capacity and consents.

The wording of the *Act* seems to leave open the possibility that a friend, family member, agent or contact person could put the substance to or into the mouth of a patient who needs help to self-administer it, which, in some circumstances, would be indistinguishable from administering it. A required statutory instruction to patients that they are not obliged to self-administer the lethal substance could contribute to this outcome.

Death certificates

The *Act* requires the cause of death be falsified by reporting it as the disease or medical condition for with EAS was approved. Falsification of the cause of death on death certificates is contrary to international standards for identifying causes of death that are acknowledged by the Australian government. Falsification of death certificates contributed to the murder of over 200 patients by a British medical practitioner and led to unfavourable comments by the chairman of the subsequent inquiry into the murders.

Voluntary Assisted Dying Care Navigator Service

The New South Wales government will establish the Voluntary Assisted Dying Care Navigator service to assist those seeking "support, assistance and information" about EAS services. VADCNS will be a service dedicated to enabling euthanasia/assisted suicide, so it will not be equivalent to a service providing information and assistance related to a variety of government and health services.

Institutions ("entities")

Institutions are categorized as "residential facilities" like nursing homes, hostels, group homes, etc. operated by "relevant entities" (excluding individuals) and "health care establishments" like hospitals or hospices operated by "health care entities" (including individuals). They may decide not to provide EAS related services and information.

The *Act* imposes obligations on residential facilities and health care establishments if a person in their care requests EAS information or services that they do not provide. They must allow a VADCNS employee or someone else “reasonable access” to anyone in their to provide EAS information.

Generally speaking, governing entities are expected to facilitate the transfer of patients in health care establishments to and from a location where EAS services can be provided.

On the other hand, they are expected to allow all EAS services in residential facilities for all permanent residents, and for all occupants who are not permanent residents if an EAS practitioner decides that transferring them "would not be reasonable in the circumstances."

Oversight

The operation of the *Act* is to be overseen by an appointed Voluntary Assisted Dying Review Board. It must approve each EAS application and residency exemption, maintain a list of registered health practitioners willing to be involved in EAS services and monitor and report annually upon the operation of the Act. The Supreme Court of New South Wales is empowered to review and overturn decisions about residency, capacity, and voluntariness (not diagnosis or prognosis). Coordinating practitioners may refuse to continue if the Court overturns a decision about capacity or voluntariness, but must then transfer the patient to the consulting practitioner or someone eligible to act as coordinating practitioner.

Illusion of neutrality

The *Act* identifies eleven principles underpinning the statute and seems to give equal weight to all of them. Six are irrelevant to conflicts of conscience in relation to supporting or participating in euthanasia/assisted suicide and five are subject to morally partisan interpretations. This enables an adjudicator to impose subjective and contested views about the meaning and importance of each principle during an ostensibly neutral “rights balancing” analysis. No one should be under the illusion that the principles identified in the Act can be fairly and objectively applied in a “rights balancing” exercise when there is fundamental disagreement about what they mean.

The provision of euthanasia or assisted suicide under the *Act* is not considered palliative care, which is clearly distinguished as an alternative option. People hold different views about the moral acceptability of euthanasia and assisted suicide and whether or not the procedures are forms of health care or medical practice. However, the Act assumes that euthanasia and assisted suicide are morally acceptable forms of healthcare and must be characterized as death by natural causes rather than homicide or suicide. This does not demonstrate respect for different views. On the contrary: it effectively imposes a chokehold on public discourse, suppressing the words needed those opposed to the *Act* to express their reasoning.

Individual Freedom of Conscience

Conflicts of conscience

The health care professions are not divided into sharply defined groups of objecting and non-objecting practitioners. The position of many practitioners depends upon the nature of the illness or condition, opinions about decision-making capacity, voluntariness, or other issues they consider relevant.

The broader the grounds for euthanasia and assisted suicide, the more likely it is that conflicts of conscience will arise. By restricting eligibility to competent adults with terminal illnesses or conditions, and by explicitly ruling out EAS for disability, dementia or "mental health impairment" alone, the *Act* reduces the number of practitioners likely to experience conflicts of conscience when it comes into force.

Capacity assessments

The ability of practitioners to perform capacity assessments for euthanasia and assisted suicide is disputed, and assessment of limited, fluctuating and episodic capacity can be particularly troublesome. Patients could be deemed capable of choosing euthanasia/assisted suicide even if they are considered incapable of challenging medical decisions about alternative treatments and palliative care. The burden of illness may make it easier to understand the EAS process than alternative treatment options, and to choose what is more easily understood rather than what might offer significant symptom relief. Even practitioners willing to facilitate euthanasia for clear-headed patients may not be confident that they can safely act upon a request made when the clouds of major depressive disorder part for a time, or if the patient recovers what another colleague considers "enough" capacity to make a valid request.

Risk assessments by EAS supporters, uncommitted practitioners and EAS opponents may reflect significantly different views about life-or-death decisions based on different underlying philosophical or ethical views. *A priori* biases in favour of an outcome cannot be avoided in EAS assessments.

Overturning practitioner decisions

The New South Wales Supreme Court can overturn a coordinating practitioner's conclusion that a patient is ineligible for EAS because of involuntariness or lack capacity. This can cause a problem for practitioners who are certain of their conclusion because, though they can withdraw, the *Act* requires them to transfer the patient to a colleague willing to continue the EAS process. They may well consider this unacceptable, and it is completely unnecessary. The *Act* should be amended to require the Voluntary Assisted Dying Board to find a new coordinating practitioner should the coordinating practitioner withdraw in these circumstances.

Protection for objecting practitioners

All health care workers, contracted care service workers and medical practitioners can initiate discussion about or suggest euthanasia/assisted suicide to patients, even if patients have not expressed an interest, but they are not required to do so. By explicitly making discussion optional, the *Act* supports both practitioners who want to initiate discussion about EAS and those who think it best to let patients take the lead, responding to their enquiries or apparent interests.

All registered health practitioners who conscientiously object to EAS may refuse to participate in any part of the EAS process and refuse to be present when EAS is provided. The wording of the relevant provision is ambivalent, but the *Act* does not require objecting practitioners to do anything other than record the refusal and the reason for it in the patient's medical record and report the refusal and reason for it to the Voluntary Assisted Dying Board. Further, objecting practitioners who refuse to do something (such as referral) are protected from disciplinary action by regulators if they act in good faith and reasonably believe that the refusal is in accordance with the *Act*. Hence, the starting point for objecting practitioners pressured by regulators or others to do more should be that the *Act* not only does not require it, but (interpreting the ambivalent provision in a fully protective sense) affirms that they need not do so.

Protection for other care workers

The protection for individual freedom of conscience offered by the *Act* is limited to registered health care practitioners. No protection is provided for the many people involved in the provision of health care, personal care and aged care who are not registered health practitioners, even though the *Act* explicitly recognizes their work. For example, nothing in the *Act* prevents employers from requiring a personal care worker or social worker to actively support the provision of EAS or to be present when lethal medication is administered.

Falsification of death certificates

Regardless of their views about euthanasia and assisted suicide, some medical practitioners are likely to object to falsifying the cause of death in death certificates. They may be uncomfortable about lying or dissembling to families about how their loved ones died or concerned that falsifying records and lying is likely to undermine the trust essential to the practice of medicine. Others may have principled objections to falsifying documents, lying, dissembling and other forms of deception under any circumstances. Finally, some may consider falsification ill-advised because it is likely to compromise important epidemiological data. If the state insists that death certificates must be falsified, the *Act* should be amended to make a medical member of the Voluntary Assisted Dying Review Board responsible for completing EAS death certificates (assuming that a Board member’s objection to doing so would also be accommodated).

Institutional & Collective Freedom of Conscience

Factors relevant to moral decision-making by entities/collectives are not necessarily identical to those concerning individuals, and the concept of individual freedom of conscience is applied analogically to collectives, so some differences are to be expected. This paper presumes that entities/collectives are entitled to rely upon constitutional guarantees of freedom of conscience, notwithstanding differences between individuals and collectives in the exercise of that freedom. Individuals and entities/collectives are equally concerned to avoid complicity in perceived wrongdoing. This obviously includes taking part directly in what they deem to be a wrongful act, but also causally contributing to by collaboration or contingent cooperation.

The *Act* does not admit the possibility of conscientious objection by entities/collectives. Consistent with this, the *Act* acknowledges the need to respect individuals' culture, religion, beliefs, values and personal characteristics, but not those of entities/collectives. It imposes a number of constraints and requirements on objecting entities/collectives specifically to compel their cooperation and even collaboration, some of which go beyond legal constraints arising from legal occupancy status. Refusal to participate in or facilitate killing people for moral reasons is placed on the same level as refusals based on pragmatic considerations like lack of trained personnel or management of institutional branding. The *Act* thus implies that guarantees of freedom of conscience or religion are irrelevant to decision-making by entities/collectives about involvement in killing people, and, if they defend refusals on that basis, the *Act* puts them at a disadvantage.

The *Act* is is concerned with two kinds of institutions: "residential facilities" like nursing homes, hostels, group homes, etc. operated by "relevant entities" (excluding individuals), and "health care establishments" like hospitals or hospices operated by "health care entities" (including individuals).

Regardless of structure, an "institution" in the sense relevant here always manifests a collective enterprise by individuals, so the term "entity/collective" is used here to keep this in mind.

Participation, cooperation, collaboration

The *Act* does not require entities/collectives to provide euthanasia or assisted suicide or even to provide information about the procedures, so it does not threaten institutional freedom of conscience in relation to direct participation in EAS services. Instead, the *Act* is designed to enable the state to compel unwilling entities/collectives to cooperate and perhaps collaborate in killing people in their care or helping them kill themselves, and to disadvantage any that resist by appeals to freedom of conscience.

However, patients and practitioners cannot proceed with EAS in an objecting institution unless they notify institutional authorities at each stage in the EAS process. This is fortunate, because providing EAS services in a private apartment in a residential facility would be radically different from providing them behind a curtain in a room shared with others, and the Act does not distinguish between the two situations. Nothing in the *Act* prevents objecting entities/collectives from imposing conditions on EAS-related activities that they are required to permit in their facilities once they have been notified.

EAS information

With respect to providing EAS information, objecting entities/collectives could direct all patient enquiries about EAS to staff members trained to provide patients with information necessary to enable informed decision-making without compromising institutional moral integrity. Hence, the cooperation required in providing information about EAS does not appear to undermine institutional freedom of conscience.

First and final EAS requests

The *Act* leaves room for objecting entities/collectives to direct staff to fully and compassionately explore and document first requests, refuse those found to be clear and unambiguous, and provide information enabling patients to seek EAS elsewhere. They can thus comply with a number of the *Act's* provisions without compromising institutional moral integrity. However, the *Act* also requires objecting entities/collectives to allow EAS practitioners to accept first and final requests from anyone in their health care establishments and residential facilities. Accepting requests (i.e., agreeing to act upon them), especially final requests, is more directly supportive of and causally related to euthanasia and assisted suicide than merely receiving and responding to requests, and thus more likely to be problematic for objecting entities/collectives.

Declarations, EAS assessments, administration decisions, and administration of lethal substance

Moreover, the *Act* demands that objecting entities/collectives allow EAS practitioners to provide all EAS assessments, consultations and euthanasia/assisted suicide for permanent residents in residential facilities. Contingent cooperation of this kind is likely to be problematic, especially in relation to patients who share rooms with others. If EAS practitioners cannot attend, objecting entities/collectives must "take reasonable steps to facilitate the transfer" EAS candidates to a location where they can receive EAS services, including lethal injection. This suggests that active collaboration might be expected, and it goes well beyond merely granting the equivalent of a residential tenancy right to service delivery at home. Landlords are not forced to help tenants travel to see EAS practitioners who can't make home visits.

Objecting entities/collectives may refuse to allow the EAS process for institutional occupants in health care establishments and residential facilities only if, once more, they "take reasonable steps to facilitate" transfers to enable the procedures elsewhere. If that means initiating rather than simply cooperating in a transfer requested by others, the purported compromise may amount to a choice between two objectionable alternatives. In addition, the *Act* allows legal action against objecting entities/collectives that require transfers from their health care establishments for EAS procedures (including euthanasia and assisted suicide) if transfer "would not be reasonable in the circumstances." It also enables patients and EAS practitioners to veto transfers of institutional occupants from residential facilities, thus forcing objecting entities/collectives to cooperate.

Credentials (privileges)

The *Act's* demands that qualified practitioners be allowed to provide EAS services to patients in facilities poses a dilemma for objecting entities/collectives in granting credentials. Granting credentials for EAS would explicitly affirm the acceptability of euthanasia/assisted suicide and authorize the procedures, thus contradicting their moral commitments. However, granting credentials may be necessary to avoid legal liability, and it may be the only way for objecting entities/collectives to impose enforceable conditions and restrictions on provision of the service in order to protect other patients, staff and mitigate harm to institutional moral integrity.

Bias

The provisions of the *Act* suggest that NSW legislators not only believe that it is morally acceptable to kill patients or help them kill themselves in accordance with their law, but are unable to imagine or unwilling to concede that others could reasonably and collectively hold and live in accordance with the contrary view, and should be entitled to do so in a democratic state. This demonstrates a lack of moral imagination or unreflective and entrenched authoritarianism inconsistent with the best traditions of liberal democracy.

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PREFACE

New South Wales' *Voluntary Assisted Dying Act 2022 No. 17*,[1] drafted and introduced by Independent MLA Alex Greenwich,[2] closely resembles Queensland's *Voluntary Assisted Dying Act 2021*. Running to 84 pages, it will legalize euthanasia and assisted suicide (termed "voluntary assisted dying") in the Australian state when it comes into force in January, 2023. This review considers the impact the *Act* may have on health care workers and institutions opposed to euthanasia or assisted suicide (EAS) for reasons of conscience. Part I outlines the main features of the law, providing a context for discussion of provisions relevant to freedom of conscience in Part II (Individual Freedom of Conscience) and Part III (Institutional & Collective Freedom of Conscience).

PART I: OVERVIEW

Introduction

I.1 Part I of this paper sets out EAS eligibility criteria, explains how requests for EAS services are to be processed and draws attention to some aspects of the law. The overview assumes the willing participation of the practitioners involved and omits details not essential to a general understanding of how the *Act* is expected to function.

Not palliative care

I.2 The *Act* defines palliative care as “care and treatment” for a progressive, life-limiting "disease, illness or medical condition" intended to prevent, identify, assess, relieve or treat "pain, discomfort or suffering" in order to improve a patient's "comfort and quality of life" [Schedule 1]. It is distinguished from "voluntary assisted dying" at numerous points in the *Act* [§4(1)i, §10(2), §10(3), §28(1)c, §30(4)k, §41(4)l, §180(d), §185, §186(2)b].

Eligibility

Age, residency

I.3 An eligible patient must be an adult [§16(1)a], must have lived in New South Wales for at least one year, and those who are not Australian citizens or permanent residents must have lived in Australia for at least three years [§16(1)b], though citizenship and residency requirements can be waived for compassionate reasons [§17].

Diagnosis

I.4 The patient must have an "advanced, progressive" and terminal “disease, illness or medical

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[1] Voluntary Assisted Dying Act 2022 (NSW), online: https://legislation.nsw.gov.au/view/html/inforce/current/act-2022-017

[2] Alex Greenwich, "Voluntary Assisted Dying" (25 March 2021), Alex Greenwich (blog), online: https://www.alexgreenwich.com/vad_update

condition" that is expected to cause death within 12 months (in the case of neurodegenerative conditions) or within 6 months in all other cases. The disease must cause suffering "that cannot be relieved in a way the person considers tolerable"[§16(1)d]. Note that "suffering" is undefined and unqualified by the *Act*, so any degree of mental or physical suffering would suffice for eligibility, and that patients are entitled to refuse even probably effective palliative measures they are unwilling to tolerate. The *Act* does not preclude EAS for otherwise eligible patients if they are disabled or mentally ill, but EAS cannot be provided for disability, dementia or "mental health impairment" alone [§16(2)].

Capacity

I.5 The patient must be capable of medical decision-making [§16(1)e] and must act voluntarily [§16(1)f] and without "pressure or duress" [§16(1)g], which is defined to include "abuse, coercion, intimidation, threats and undue influence" [Schedule 1]. The *Act* amended the *Crimes Act* to make it an offence to induce someone to *request or access* "voluntary assisted dying" by "dishonesty or pressure or duress" (emphasis added) [Schedule 1A.2]. This is reflected in numerous references to "pressure or duress" in the *Act*, so it is clear that friends or family members hoping to dissuade someone from euthanasia/assisted suicide cannot be accused of violating the *Act* by exerting undue pressure or influence.

I.6 For purposes of EAS, a person must **understand** "information or advice" about decisions required by the Act, **remember** the information or advice for the purpose of making a decision, **understand** "matters involved" in a decision, **understand** the effects of a decision, **weigh up** the information or advice for the purpose of making a decision, and **communicate** the decision "in some way" [§6(1)]. The six elements are presumed to be present if it "reasonably appears" that a patient understands an explanation of the consequences of a decision [§6(2)a], so the six elements seem superfluous. All that the *Act* actually requires is that a patient appears to understand the consequences of a decision. This conclusion is supported by the fact that none of the reports the *Act* requires of EAS practitioners refer to any of the six elements of capacity [§30, §41, §52, §62].

I.7 Decision-making capacity is presumed unless it is shown that the patient does not have it [§6(2)b]. Eligible patients must manifest an "enduring" desire for EAS [§16(1)h]. The *Act* states that a patient who "permanently" loses decision-making capacity becomes ineligible for EAS [§16(3)] and defines "permanently" to mean "forever" [§16(4)]. It is unclear why the definition was required, but the section obviously recognizes that patients may temporarily lose capacity. The *Act* does not require the EAS process to be re-started if a patient temporarily loses capacity, though this might well involve full or partial loss of understanding, memory and evaluation in relation to decisions made prior to the temporary loss.

Practitioner participants

I.7 The *Act* authorizes direct participation in EAS by medical practitioners, nurse practitioners and nurses. Participants are functionally differentiated as coordinating practitioners, consulting practitioners and administering practitioners. A fourth group — identified here (but not in the *Act*) as "determiners" — includes registered health practitioners and other individuals who can be asked to provide expert opinions about diagnosis, prognosis, capacity and voluntariness.

I.8 The *Act* authorizes direct participation in EAS by medical practitioners and nurse practitioners. Participants are functionally differentiated as coordinating practitioners, consulting practitioners and administering practitioners. A fourth group — identified here (but not in the *Act*) as "determiners" — includes registered health practitioners and other individuals who can be asked to provide expert opinions about diagnosis, prognosis, capacity and voluntariness.

I.9 Medical practitioners are the principal EAS agents; only they can act as coordinators and consultants [§18]. They must be registered specialists or have at least ten years general practice experience, fulfil EAS training requirements [§18(a),(b)], and not be a family member of the patient nor in a position to benefit from the patient's death [§18(d),(e)].

I.10 While only EAS-trained medical practitioners may act as coordinating and consulting practitioners, euthanasia can be provided by EAS-trained nurse practitioners and by EAS-trained medical practitioners who are registered specialists (including overseas-trained specialists with provisional registration), or who have at least five years' general practice experience [§55]. Once the *Act* is in force it will be interesting to see how much this statutory division of responsibilities affects practice. It is possible that nurse practitioners will become the principal euthanasia providers, while most physicians might prefer to act as process decision-makers, supervisors and facilitators rather than personally providing euthanasia.

Discussion with patients

I.11 The *Act* addresses conversation with patients about EAS by "health care workers," which, in this provision [§10], includes anyone providing a health service or "professional care services" (anyone contracted to provide assistance, support or supervision in personal hygiene, dressing, meals, mobility, taking medicine, "substantial emotional support" or services or support to persons with disabilities) [§10(5), Schedule 1].

I.12 The heading of the section is "Health care worker not to initiate discussion about voluntary assisted dying," but this is incorrect. If NSW legislators intended to prevent anyone other than medical practitioners from intiating discussion about euthanasia/assisted suicide, that is not the effect of the Act. It appears that NSW legislators muddled the wording of §10 while attempting to modify the comparable provision in Queensland's *Voluntary Assisted Dying Act 2021*.[3] Part of the problem is that the definition of "health care worker" is broad enough to encompass medical practitioners, so any intended distinctions between medical practitioners and health care workers are blurred.

I.13 The *Act* first states that health care workers (which includes contracted care service workers) must *not* initiate a conversation about or suggest euthanasia/assisted suicide to a person [§10(1)]. It later states that they *may* initiate a conversation about or suggest EAS if they also advise the person that palliative care and treatments options are available, and should be discussed with the responsible medical practitioner [§10(3)]. Finally, "to avoid doubt," the Act states that health care workers/contracted care service workers may provide EAS information to someone who asks for it [§10(4)], but, in responding, they are not required to provide any additional information or suggest

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[3] *Voluntary Assisted Dying Act 2021* (Qsld) s 7, online: <https://www.legislation.qld.gov.au/view/html/asmade/act-2021-017#sec.7>.

discussion with a medical practitioner. Medical practitioners *may* also suggest or *initiate* discussion about euthanasia or assisted suicide — but only if they also advise the patient about available palliative care and standard treatment options and the likely outcomes of such alternatives[§10(2)].

I.14 In sum, all health care workers, contracted care service workers and medical practitioners can *initiate* discussion about or suggest euthanasia/assisted suicide to patients, even if patients have not expressed an interest, as long as they provide other information required by the *Act*. If a patient asks about EAS, contracted care service workers and health care workers other than medical practitioners can provide EAS information, but need *not* provide information about available options or suggest that the patient talk to a medical practitioner.

I.15 Note, however, that, while medical practitioners and health care workers/contracted care service workers *may suggest* euthanasia and assisted suicide or *initiate* discussion about EAS - even if a patient has not expressed an interest - they are *not required* to do so.

Request and assessment process

I.16 The EAS process involves three requests by a patient: the first by any means available to the patient [§19], the second in writing and witnessed (a "declaration")[§43], and a final request by any means available to the patient [§48]. A second request/declaration cannot be made unless the patient is first found to be eligible [§43(1)] The final request cannot be made until the day after completion of the consulting assessment [§49(1)b], but can be made five days after the first request [§49(1)a], or earlier if the coordinating and consulting practitioners agree that the patient is likely to lose decision-making capacity or die before EAS is provided [§49(2)].

I.17 The *Act* explicitly allows the use of audiovisual communication for first and final requests and administration decisions if person-to-person contact is not practicable, but only to the extent that such communication is not contrary to or inconsistent with Australia's national laws [§176]. Australia's *Criminal Code* prohibits the use of telecommunications and similar technology to counsel or recommend suicide. The government of Queensland and others want the *Criminal Code* amended to allow videoconferencing for EAS services. The national government was resistant to the change,.[4,5] but was recently defeated in a national election.

I.18 Note that the *Act* does not explicity prohibit audiovisual communication for EAS assessments. Thus, if Australia's *Criminal Code* is amended to allow EAS videoconferencing, it appears that professional regulators in New South Wales would be able to permit EAS assessments.

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[4] Queensland Health, "Voluntary Assisted Dying in Queensland: Access for regional and remote Queenslanders" (17 September, 2021) Queensland Health (website), online:<https://www.health.qld.gov.au/system-governance/legislation/voluntary-assisted-dying-act/access-for-regional-and-remote-queenslanders>.

[5] Eliana Close et al, "Voluntary assisted dying and telehealth: Commonwealth carriage service laws are putting clinicians at risk" (Nov 2021) Medical J Australia 215:9 406, online: <https://www.mja.com.au/system/files/issues/215_09/mja251287.pdf>.

First request

I.19 A patient must personally make a "clear and unambiguous" first request for EAS to a medical practitioner by any means; a request cannot be made by a third party on behalf of a patient [§19], though an accredited interpreter may be used [§19(4), §23(2)f]. A practitioner may spend some time exploring a patient's request before concluding that it is "clear and unambiguous," since that must surely imply include an understanding of alternatives. Only if a practitioner reaches that conclusion do the other provisions concerning a first request become operative.

I.20 Upon concluding that a first request is clear and unambiguous, medical practitioners must accept or reject it and notify the patient accordingly [§21]. They must refuse the request if they are not qualified EAS practitioners or otherwise disqualified [see I.9]. If the practitioner refuses the request for reasons of conscience, the patient must be notified immediately [§21(5)]: otherwise, within two business days [§21(4)]. An EAS qualified medical practitioner who accepts the request becomes the coordinating practitioner, responsible for supervising the EAS request, assessment and administration process [§24].

I.21 Whether or not medical practitioners accept a first request, they must provide the patient with "information approved by the Health Secretary, by Gazette notice," unless they have refused the request for reasons of conscience [§21(4)b]. All medical practitioners must record the first request and decision in the patient's medical record [§22] and report the request and decision to the Voluntary Assisted Dying Board (the Board) [§23].

Coordinator assessment (First assessment)

I.22 A patient's eligibility must be confirmed by two medical practitioners (coordinating and consulting practitioners), with the assistance of specialists if need be.

I.23 The coordinating practitioner must assess the patient's eligibility for EAS [§25, §29]. If the patient is found to be eligible, the coordinating practitioner must provide the patient with specific information relevant to informed medical decision making [§28(1)a to f], the remaining steps in the EAS process [§28(1)g to i] and patient rights [§28(1)j, k]. A coordinating practitioner who remains unsatsified as to any of the eligibility requirements must find the patient ineligible [§29(2)]. The patient must be informed of the outcome, a written report of the assessment must be submitted to the Board within five business days, and the patient must be given a copy of the report [§30]. Patients deemed eligible must be referred to another medical practitioner for a consulting assessment to confirm eligibility [§31].

Consultant assessment (Second assessment)

I.24 The procedure for consulting assessments is virtually identical to the procedure for first assessments. Medical practitioners must accept or reject a referral for a consulting assessment and notify the patient and coordinating practitioners accordingly [§32]. They must refuse the request if they are not qualified EAS practitioners or otherwise disqualified [see I.9]. If the practitioner refuses the request for reasons of conscience, the patient and coordinating practitioner must be notified immediately [§32(5)]: otherwise, within two business days [§32(4)]. They must record the referral, decision and reason for refusal in the patient's medical record [§33] and report the request and decision to the Board [§34].

I.25 A medical practitioner who accepts the referral becomes the consulting practitioner [§35] and must assess the patient's eligibility [§36], replicating all of the steps taken by the coordinating practitioner [§39-41]. A consulting practitioner who remains unsatisfied as to any of the eligibility requirements must find the patient ineligible [§40(2)].

I.26 If a consulting practitioner finds a patient ineligible, the coordinating practitioner may continue to refer the patient for consulting assessments until a consultant practitioner finds the patient eligible, or the patient dies [§42]. The request and assessment process ends if the coordinating practitioner concludes that the patient is not eligible [§29(2)b], unless the decision is overturned by the Supreme Court of New South Wales (see Judicial Review).

Specialist assessments (optional)

I.27 Coordinating and consultant practitioners may refer patients to specialists to help them reach conclusions about diagnosis, capacity or voluntariness. Coordinating and consultant practitioners may (but need not) adopt specialists' opinions [§26-27, §37-38].

Declaration (Second request)

I.28 Once eligibility is confirmed by coordinating and consulting practitioners, a patient must make a "declaration" - a second request for EAS, in writing - though an adult who is not a witness to the signature and not the coordinating or consulting practitioner may sign on the patient's behalf [§43(4)]. The second request must be witnessed and certified by two adults who are not in a position to benefit from the patient's death, not a family member of the patient or coordinating or consultant practitioners, nor the coordinating or consulting practitioner [§44-45]. The coordinating practitioner must record the declaration in the patient's medical record [§46] and, within five business days, give notice of the request to the Board [§47]. A patient could make a declaration/second request immediately after being notified of eligibility.

Final request

I.29 After having made a declaration/second request, a patient must personally make a "clear and unambiguous" final request for EAS to the coordinating practitioner by any means; a request cannot be made by a third party on behalf of a patient [§48]. If the patient makes a final request, the coordinating practitioner must record it in the patient's medical record [§50] and forward a final request form to the Board within five business days[§51]. A final review of forms and reports must be conducted and a final review form submitted to the Board within five business days [§52].

I.30 A final request cannot be made until the day after completion of the consulting/second assessment, and cannot normally be made within five days of a first request [§49(1)]; the latter requirement can be waived if the coordinating and consulting practitioners agree that the patient may lose decision-making capacity or die before EAS can be provided [§49(2)]. Subject to these considerations, a final request can be made immediately after a declaration/second request, during the same consultation.

Administration decision

I.24 I.31 In consultation with a coordinating practitioner, eligible patients can choose euthanasia (practitioner administration of a lethal substance) or assisted suicide (self-administration of a prescribed lethal substance [§57(1)]. An administration decision could be made immediately after making a final request, and during the same consultation. All but a small fraction of patients choose euthanasia in jurisdictions that authorize both euthanasia and assisted suicide,[6] and assisted suicide is less reliable than euthanasia,[7,8,9,10] so it seems likely that euthanasia will be the norm in New South Wales.

I.32 The patient's choice for either practitioner-administration or self-administration must be“clear and unambiguous,” though expressed in any way available to the patient and with through an interpreter if necessary [§57(2)-(4)]. The decision must be recorded by the coordinating practitioner in the patient’s medical record [§57(5)] and reported to the Board within five business days [§57(6)].

I.33 The patient may revoke an administration decision at any time, verbally, in writing or in some other way. The *Act* requires that revocation be "clear and unambiguous" and directed to either the coordinating or administering practitioners [§58]. This suggests that a "clear and unambiguous" administration decision would stand if followed by an unclear or ambiguous revocation, even though one would expect that the original decision should be nullified by subsequent ambiguity. Granted: coordinating practitioners may ensure that unclear revocations are reforumlated in unambiguous terms, but patient doubts manifested in an ambiguous (and legally null) revocation could also be

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[6] Australia, Queensland Law Reform Commission, A legal framework for voluntary assisted dying (Brisbane: QLRC, May 2021) (Peter Applegarth) [*QLRC 2021*] at Table 10.1, online: <https://www.qlrc.qld.gov.au/__data/assets/pdf_file/0020/681131/qlrc-report-79-a-legal-framework-for-voluntary-assisted-dying.pdf>.

[7] C Harty et al, “The Oral MAiD Option in Canada, Part 2: Processes for Providing — Review and Recommendations.” (18 Apr 2018) *Canadian Association of MAiD Assessors and Providers* (website) at 7, online: <https://camapcanada.ca/wp-content/uploads/2022/02/OralMAiD-Process.pdf>.

[8] C Harty et al, “The Oral MAiD Option in Canada, Part 1: Medication Protocols” (18 Apr 2018) *Canadian Association of MAiD Assessors and Providers* (website) at 6, online: <https://camapcanada.ca/wp-content/uploads/2022/02/OralMAiD-Med.pdf>.

[9] F Bakewell and VN Naik, “Complications with Medical Assistance in Dying (MAID) in the Community in Canada: Review and Recommendations” (28 Mar 2019) *Canadian Association of MAiD Assessors and Providers* (website) at 7, online: <https://camapcanada.ca/wp-content/uploads/2022/02/Failed-MAID-in-Community-FINAL-CAMAP-Revised.pdf>.

[10] Royal Dutch Medical Association (KNMG/RDMA), “Guidelines for the Practice of Euthanasia for the Practice of Euthanasia and Physician-Assisted Suicide 13 (Aug 2012) *KNMG/RDMA* (website), at 17 online: <https://www.knmg.nl/web/file?uuid=bc11990b-d37a-4fa9-9e36-69d34bd229db&owner=5c945405-d6ca-4deb-aa16-7af2088aa173&contentid=223>.

overlooked. In any case, patients who revoke administration decisions can make another administration decision at any time [§58(7)].

I.34 Revocations of administration decisions must be recorded in the patient medical record by the coordinating practitioner and a revocation form submitted to the Board within five business days [§58(7)].

I.35 Upon choosing to self-administer a lethal substance, the patient must, in an approved form, appoint an adult contact person [§66] willing to assist with obtaining a prescribed lethal substance, prepare and supply it and return unused parts of it to an authorized disposer [§68]. The contact person must notify the coordinating practitioner if the patient dies [§68(2)]. A coordinating practitioner must have received the required contact person appointment form before prescribing a lethal substance for the patient [§67(5)].

I.36 A patient can revoke a contact person appointment by informing the person [§66(5)] and must then appoint a new contact person [§66(6)]. A contact person may withdraw by notifying the patient, who must then make a new appointment [§69].

Authorisation of lethal prescription

I.37 Once a patient has made an administration decision, the coordinating practitioner must apply to the Voluntary Assisted Dying Board (the Board) for authorisation to prescribe a lethal substance for the patient, whether it is to be practitioner-administered or self-administered [§70]. The Board will have been apprised of the progress of an application at each stage in the process. When it receives the application for authorisation the Board must approve the application and grant authority to prescribe a lethal substance [§71]. Alternatively, if all required documents have not been received, or if the Board "suspects" that the *Act's* requirements have not been met, it must refuse the authority and notify the coordinating practitioner within two business days [§72].

Prescribing and supplying a lethal substance

I.38 Before prescribing a lethal substance for self-administration, the coordinating practitioner must provide the patient with written information about the nature lethal substance and instructions about safekeeping, preparations for use, self-administration and disposal of it, as well as potential risks and the time it will likely take to die [§73(2)]. Similar information and instructions must be provided before prescribing a lethal substance that will be administered by a practitioner [§73(3)].

I.39 The *Act* states that patients who have opted for self-administration must be advised in writing that they are "not under an obligation to self-administer the substance" [§73(2)e]. No doubt the intention is to advise patients that they can change their mind about proceeding with suicide. However, patients who have opted for assisted suicide may take from the wording of the instruction required by the *Act* that they can have someone else - a friend, family member, agent or contact person - administer the lethal substance (see I.43).

I.40 Prescriptions for lethal substances must clearly indicate that they are for "a voluntary assisted dying substance" [§74(2)]. They are to be filled by "authorised suppliers": persons or a class of registered health practitioners authorised by the Health Secretary [§74(5), §84].

Administration of lethal substance

I.41 In the case of euthanasia, the administering practitioner must ensure that the patient has decision-making capacity, is acting voluntarily and without pressure or duress, has an enduring desire for euthanasia and must administer the lethal substance in the presence of a witness [§60(6)]. The witness must be an adult, but not a family member nor employed, engaged or under contract to the administering practitioner. The witness must certify that the patient's request for euthanasia appeared to be "free, voluntary and enduring" and the administering practitioner administered the lethal substance in his presence [§63]. The coordinating practitioner and administering practitioner are forbidden to delegate responsiblity for administering a lethal substance to another health professional [§85(2)].

I.42 No one is required to witness self-administration, nor is anyone who does witness it required to confirm the decision-making capacity of a patient who decides to ingest a lethal prescribed substance. The *Act* does not require self-administration to occur in private or in any particular place. A patient is not required to advise anyone of his plans. Thus, in some cases, death by self-administration may occur in public or inconvenient places or may not be discovered for some time.

I.43 By way of an amendment to the NSW *Criminal Code* the *Act* makes it an offence for anyone other than an administering practitioner to administer a prescribed lethal substance to a patient [Schedule 1A.2]. However, the *Act* does not define administration or self-administration, and the definition of "voluntary assisted dying states that it "includes steps reasonably related to the administration" [Schedule 1]. This seems to leave open the possibility that a friend, family member, agent or contact person could put the substance to or into the mouth of a patient who needs help to self-administer it, which, in some circumstances, would be indistinguishable from administering it. The statutory instruction to patients that they are not obliged to self-administer the lethal substance could contribute to this outcome (see I.39). Should this happen, persons responsible could argue that they were acting "in good faith" to help the patient "access" EAS in accordance with the *Act* or reasonably believed it to be in accordance with the *Act*, thus securing protection from criminal and civil liability [§130-131].

I.44 If a patient is incapacitated but does not die after being administered or ingesting the lethal substance, it does not appear that an additional lethal dose can be given to kill the patient unless the patient regains capacity and consents [§60(6)a]. Presumably, a patient who does not recover capacity will die within 12 months from an underlying terminal neurodegenerative condition or within six months from other causes [§16(1)d].

I.45 Within five business days of becoming aware of the death of a patient approved for EAS, the coordinating or administrating practitioner must notify the Board [§87(1)], unless the administering practitioner has provided the Board with a practitioner administration form [§87(3)]. Other medical practitioners who become aware of a death by EAS are also required to notify the Board within five business days if they must complete a death certificate for the patient [§87(5)].

Classification of death

I.46 Deaths are classified as homicide, suicide, accidental, natural causes or (when it is not certain which of the previous four categories applies) undetermined. Death classification is distinct from the cause of death.

I.47 Homicide means "the killing of one human being by another," which can be justified or excused in some circumstances or punished as murder, manslaughter, etc.[11] Suicide is the "act of intentionally killing oneself."[12] New South Wales is a common law jurisdiction that assumes the meaning of but does not define these terms in statute law, though it identifies some homicides like murder and manslaughter as "punishable"[13] and alludes to taking one's own life in defining "suicide pact."[14]

I.48 The *International Statistical Classification of Diseases and Related Health Problems* (ICD) was originally designed "to classify causes of mortality as recorded at the registration of death." It now serves a broader purpose: "to permit systematic recording, analysis, interpretation and comparison of mortality and morbidity data collected in different countries or areas and at different times."[15] However, it remains the key international standard for identifying causes of death in death certificates,[16] and it is explicity recognized as an authoritative standard for this purpose by the government of Australia.[17]

I.49 For purpose of statistical coding of external causes of injuries and death, the ICD includes homicide in the category of assault: "injuries inflicted by another person with intent to injure or kill,

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[11] The Editors of Encyclopaedia Britannica, "homicide" in Enclyopedia Britannica (26 May 2022), Britannica (website), online: <https://www.britannica.com/topic/homicide>.

[12] *The Shorter Oxford English Dictionary,* 6th ed, *sub verbo* "suicide".

[13] *Crimes Act 1900 No. 40* (NSW) s 18(1)b, online: <https://legislation.nsw.gov.au/view/html/inforce/2022-06-01/act-1900-040#sec.18>.

[14] *Ibid*, s 31B(2).

[15] World Health Organization, International Statistical Classification of Diseases and Related Health Problems: 10th Revision, 5th ed, vol 2 (Geneva, Switzerland: 2016) [ICD 2016], online: <https://icd.who.int/browse10/Content/statichtml/ICD10Volume2_en_2016.pdf > at 2.1.

[16] *Ibid* at 4.1.1

[17] Australian Institute of Health and Welfare, "How are causes of death coded?" (6 June, 2021) Government of Australia (website), online: < https://www.aihw.gov.au/about-our-data/our-data-collections/national-mortality-database/deaths-data/how-are-causes-of-death-coded>.

by any means."[18] The point of this arrangement is to identify and distinguish the sources of lethal acts, not to reflect their legal status. For example, the ICD category "assault" would include injuries inflicted in a mixed martial arts competition (cage-fighting), even though such consenual fights may not be considered assaults in law.

I.50 Practitioner-administered euthanasia under the Act is identifiable as "homicidal poisoning" under the ICD[19] (though a non-punishable form of homicide in New South Wales). While the intervention is legal in NSW if it conforms to the Act, it is not a death caused by a "legal intervention" within the meaning of the ICD, which explicitly limits legal interventions to actions by the police, military "or other law-enforcing agents" during some kind of law enforcement action[20] under some kind of permanent or temporary "ruling authority."[21]

I.51 Self-administration of a lethal substance under the Act is identifiable as "purposeful self-inflicted poisoning" under the ICD.[22] The ICD explicitly states that suicide must not be attributed to any other cause.[23]

Falsification of death certificates

I.52 The Act does not require the medical practitioners responsible for euthanasia or assisted suicide to complete the death certificate for the patient [§87]; nurse practitioners cannot do so even if they act as administering practitioners.[24]

I.53 The Act does not mention homicide. Notwithstanding the ICD, the Act declares that someone who dies from ingesting a lethal substance by self-administration or by practitioner-administration under the specified conditions does not die by “suicide”[§12].

I.54 The Act is silent about reporting EAS deaths to the coroner, and the consequential amendments to other statutes do not include the NSW Coroners Act. It appears that the reason for this is that, under the NSW Coroners Act, a death is not reportable if it is the expected outcome of "a

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[18] World Health Organization, International Statistical Classification of Diseases and Related Health Problems: 10th Revision, 5th ed, vol 1 (Geneva, Switzerland: 2019) [ICD 2019] , online: <https://icd.who.int/browse10/2016/en#/X85-Y09> at X85-Y09.

[19] *Ibid* at X85.

[20] *Ibid* at XY35.

[21] *Ibid* at Y35.5.

[22] *Ibid* at X60-X84.

[23] *ICD 2016*, *supra* note 15 at 4.2.3B(m).

[24] Births, Deaths and Marriages Registration Act 1995 (NSW) s 39, online: <https://legislation.nsw.gov.au/view/html/inforce/current/act-1995-062#sec.39>.

health-related procedure", which includes the administration of a drug.[25]

I.55 Medical practitioners required to provide a death certificate for a patient whom they believe has died by EAS are required to include that information in the certificate [§87(6)a] but are also required to "identify" the cause of death as "the disease, illness or medical condition" that made the person eligible for EAS [§87(7)b]. Here the wording of the Act is somewhat coy; it says only that practitioners must "identify" the underlying condition. However, this can only be 'identified' in NSW death certificates by explicitly attributing the cause of death to the underlying condition.[26]

I.56 The Act defines "voluntary assisted dying" only as "the administration of a voluntary assisted dying substance" and reasonably related steps [Schedule 1]. However, it elsewhere defines "voluntary assisted dying substance" (VAD substance) as "a poison" to be used "for the purpose of causing a patient's death" [§7]. VAD substances are prescribed for that purpose [§28(1)d] and must be "of a sufficient dose to cause death" [§59(2), §60(2)]. Eligible patients must be advised that death is the expected outcome of being administered a VAD substance [§28(1)e] and how long that is expected to take [§73(2)i].

I.57 It is thus clear that the Act requires falsification of the cause of death by medical practitioners and by the Registrar of Births, Marriages and Deaths [Schedule 1A.1(1)], and it requires the Registrar to conceal the actual cause of death in EAS cases when issuing death certificates [Schedule 1A.1(2)]. Falsification of death certificates is contrary to international standards for identifying causes of death that are acknowledged by the Australian government.[27] The contradiction becomes apparent if one compares death by lethal injection administered by legally authorized practitioners (EAS-trained medical and nurse practitioners) and death by by lethal injection by unauthorized practitioners (non-EAS trained practitioners or pharmacists) in identical circumstances following exactly the same procedural guidelines and otherwise in accordance with the Act. The death of a patient from a lethal injection would be

> a) an unreportable death, classified as a natural death caused by the underlying illness, if the injection were given by an EAS trained nurse practitioner in accordance with the Act [§60(6)];
>
> b) a reportable death classified as homicide caused by injection of a toxic substance, if the injection were given by a registered nurse who was not EAS-trained, or by a pharmacist [Schedule 1A.2, 41B].

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[25] Coroners Act 2009 No. 41 (NSW) s 6, online: <https://legislation.nsw.gov.au/view/html/inforce/current/act-2009-041#sec.6>.

[26] In "Part III: Cause of Death." NSW Dept. of Justice, Registry of Births, Marriages and Deaths, "Medical Certificate of Cause of Death" (Undated), Government of NSW (website), online: < https://www.wnswphn.org.au/uploads/documents/ePAF/27 - NSW Health - MCCD (new).pdf>.

[27] *ICD 2016*, *supra* note 15 at 4.1.2.

I.58 Falsification of death certificates was one factor enabling a British medical practitioner, Dr. Harold Shipman, to murder at least 215 and as many as 260 patients between 1974 and 1998.[28] The Chairman of the Shipman Inquiry commented unfavourably upon practitioner "modification" of the cause of death in death certificates so as not to "distress relatives" or "involve the coroner."[29]

Voluntary assisted dying care navigator service (VADCNS)

I.59 The government plans to approve a service "to provide support, assistance and information" about euthanasia and assisted suicide [§179]. Given this specific focus, VADCNS will not be comparable to an agency or service that provides information and assistance in relation to a variety of government and health services. It will be a euthanasia/assisted suicide enabling service. VADCNS will be dedicated specifically to enabling euthanasia and assisted suicide.

Institutions

I.60 "Residential facilities" are nursing homes, hostels or other facilities where "accommodation, nursing or personal care is provided to persons on a residential basis who, because of infirmity, illness, disease, incapacity or disability, have a need for nursing or personal care." The term includes "residential aged care facilities" [Schedule 1]. The key point is that residential facilities, as defined in the *Act*, provide "residential aged care": nursing or personal care that includes accommodation, staff, meals, cleaning services and furnishings and equipment [§88].

I.61 "Health care establishments" include public hospitals and any private health facility to which anyone "is admitted, provided with medical, surgical or other prescribed treatment and then discharged" or which provides anyone with "services or treatments" prescribed by regulation [§88].[30] Health care establishments provide "health care", which is defined as "medical, surgical or nursing care" [§88].

I.62 An "entity" is a person (presumably individual or corporate) and an unincorporated body [Schedule 1]. "Health entities" own or operate "health care establishments." The term "relevant entities" excludes individuals; relevant entities provide "relevant services" - "personal care service" or "residential aged care service." [§88]

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[28] United Kingdom, The Shipman Inquiry, *First Report: Death Disguised* (London: HMSO, 19 July 2002) vol 1 (Dame Janet Smith) at para 14.2, online: <https://webarchive.nationalarchives.gov.uk/ukgwa/20090809051504/http://www.the-shipman-inquiry.org.uk/fr_page.asp?ID=187>

[29] United Kingdom, The Shipman Inquiry, *Third Report. Death Certification and Investigation of Deaths by Coroners* (London: HMSO, 14 July 2003) (Dame Janet Smith) at 5.39—5.40, online: <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/273227/5854.pdf>.

[30] *Private Health Facilities Act 2007 No. 9* (NSW) s 4, 33A, online: <https://legislation.nsw.gov.au/view/html/inforce/2022-03-24/act-2007-009>.

I.63 Hence, the *Act* effectively divides institutions into two categories: "residential facilities" like nursing homes, hostels, group homes, etc. operated by "relevant entities" (excluding individuals) [Part 5, Division 2] and "health care establishments" like hospitals or hospices operated by "health care entities" (including individuals) [Part 5, Division 3]. In this review (not in the *Act*), "governing entity" refers to the entity operating a facility, whether a health care or relevant entity.

I.64 The reason for this division is that the legal occupancy status of persons in residential facilities is different from that of persons in health care establishments, and this is suggestive of the obligations imposed by the *Act* upon governing entities.

Institutional freedom

I.65 The *Act* states that residential facilities and health care establishments may decide that they will not provide EAS related services [§89(1)],and it implies that they may refuse to provide even information about EAS [§90,§99]. In particular, they may refuse to participate in any stage of the EAS process, store a VAD substance or be present at euthanasia or assisted suicide, and may also refuse to allow anyone to be employed "by or at the facility or establishment" to participate in such activities [§89(2)]. However, this acknowledged freedom to refuse is merely an exercise of institutional autonomy. The *Act* does not recognize institutional freedom of conscience.

Institutional obligations

Notice

I.66 Governing entities operating residential care facilities or health care establishments where EAS related services are not provided must publish notice of the fact in order to make people receiving or seeking services at those facilities aware of it [§98, §107].

Access to EAS information

I.67 If a patient in a residential facility or health care establishment asks the governing entity (i.e., facility staff or an institutional representative) for information about EAS services and the information is not provided by the entity, the entity must not hinder the patient from accessing information. It must allow someone or a member or employee of the official navigator service “reasonable access” to the person in the facility or establishment to provide the information [§90,§99].

Access to EAS services

I.68 A person receiving services at a residential facility or health care establishment that does not provide euthanasia or assisted suicide can advise the governing entity (i.e., facility staff or an institutional representative) that he wishes to request EAS [§92(1), §101(1)]. When this occurs, the *Act* imposes obligations on governing entities related to the request and assessment process.

I.69 **Non-participating health care establishments**: Governing entities “must take reasonable steps to facilitate" patient transfers to and from a place where the EAS process can take place. This includes all requests [§101(2)] assessments [§102(2),§103(2)], declarations [§104(2)], administration decisions [§105(2)] and actual provision of euthanasia/assisted suicide [§106(2)]. However, the *Act* requires governing entities to consider whether or not a transfer would likely cause “serious harm” to the EAS candidate, adversely affect access to euthanasia/assisted suicide (eg, through loss of capacity), cause "undue delay and prolonged suffering", and whether the transfer location can receive the person. Possible financial loss or costs incurred by the candidate must also be considered [§102(3), §103(3), §104(3) §105(3), §106(3)]. Transfer decisions are the sole responsiblity of the governing entity, but these provisions in the Act enables them to be legally challenged.

I.70 **Non-participating residential facilities**: The *Act* distinguishes between requests (first and final) and all other steps in the EAS process in residential facilities, presumably because the first and final requests require only a conversation between an institutional occupant and EAS practitioner and nothing more.

> a) In the case of first and final requests, governing entities of non-participating residential facilities must allow medical practitioners eligible to accept and act upon EAS requests "reasonable access" to all institutional occupants, regardless of their legal occupancy status [§92(2)]. If the requested medical practitioner is unable to attend, the governing entity "must take reasonable steps to facilitate the transfer of the occupant to and from a place" where the requests may be accepted [§92(3)].
>
> b) All permanent residents must be allowed to have EAS assessments, make declarations and administration decisions and have euthanasia/assisted suicide provided in the facilities [§93(2)a, §94(2)a, §95(2)a, §96(2)a, §97(2)a], unless EAS practitioners are unable to attend. In that case, the entities "must take reasonable steps to facilitate" patient transfers to and from locations where the services can be provided [§93(2)b, §94(2)b, §95(2)b, §96(2)b, §97(2)b].
>
> c) In the case of institutional occupants who are *not* permanent residents, the governing entity "must take reasonable steps to facilitate the transfer of the person to and from a place" where the services can be provided [§93(3)a, §94(3)a, §95(3)a, §96(3)a, §97(3)a]. However, if such a transfer "would not be reasonable in the circumstances," the entity must allow a medical practitioner "reasonable access" to provide the services at the facility [§93(3)b, §94(3)b, §95(3)b, §96(3)b, §97(3)b]. Decisions about the reasonableness of transfers cannot be made by governing entities; they must be made solely by the coordinating practitioner or by a medical practitioner nominated by the patient [§88].

Oversight

I.71 The operation of the *Act* is to be overseen by a Voluntary Assisted Dying Board consisting of five paid members jointly appointed by the Minister of Health and the Attorney General Ambulance Services for a term of not more than three years. A member must have "knowledge, skills or experience relevant to the Board's functions." At least two members must be medical practitioners [§143, §149].

I.72 The Board is to monitor the operation of the *Act* and maintain a list of registered health practitioners willing to be involved in EAS servcies. The Board is to provide advice, information and recommendations to the government, record at least 17 kinds of statistical information, conduct analyses and research, rule on requests for residency exemptions, and give prior approval for the provision of EAS in each case. It may refer information to a number of state authorities, including the Commissioner of Police, Registrar of Births, Deaths and Marriages, the State Coroner, Health

Secretary, Australian Health Practitioner Regulation Agency and the Commissioner appointed under the *Health Care Complaints Act*. It must report annually on its operations. [§136, §170, §173].

Judicial review of practitioner decisions

I.73 The New South Wales Supreme Court is empowered to review and overturn decisions about residency, decision-making capacity, voluntariness and pressure or duress (not diagnosis or prognosis) by coordinating and consulting practitioners [§109]. An appeal to the Court may be made by the patient, patient's agent or another person "who has a sufficient and genuine interest in the rights and interests" of the patient [§108].

I.74 If the Court decides the patient does not satisfy the conditions of residency, capacity or voluntariness, or is acting under pressure or duress, the patient is ineligible for EAS and the service may not be provided; otherwise, the EAS process will resume [§113-115]. A review decision can be appealed to the Supreme Court and dealt with as a new hearing of the case [§109(2)].

I.75 Coordinating practitioners may refuse to continue in their roles if the Supreme Court overturns their decision that a patient is ineligible for EAS on grounds of capacity, voluntariness, pressure or duress, but must then transfer the patient to someone eligible and willing to act as coordinating practitioner. [§116, §175].

Statutory principles

I.76 The Act identifies eleven principles underpinning the statute [§4]:

> (a) human life has equal value;
>
> (b) a person's autonomy, including autonomy in relation to end of life choices, should be respected;
>
> (c) a person has the right to be supported in making informed decisions about the person's medical treatment and should be given, in a way the person understands, information about medical treatment options, including comfort and palliative care and treatment;
>
> (d) a person approaching the end of life should be provided with high quality care and treatment, including palliative care and treatment, to minimise the person's suffering and maximise the person's quality of life
>
> (e) a therapeutic relationship between a person and the person's health practitioner should, wherever possible, be supported and maintained,
>
> (f) a person should be encouraged to openly discuss death and dying, and the person's preferences and values regarding the person's care, treatment and end of life should be encouraged and promoted,
>
> (g) a person should be supported in conversations with the person's health practitioners, family, carers and community about care and treatment preferences,
>
> (h) a person is entitled to genuine choices about the person's care, treatment and end

of life, irrespective of where the person lives in New South Wales and having regard to the person's culture and language,

(i) a person who is a regional resident is entitled to the same level of access to voluntary assisted dying and high quality care and treatment, including palliative care and treatment, as a person who lives in a metropolitan region,

(j) there is a need to protect persons who may be subject to pressure or duress,

(k) all persons, including health practitioners, have the right to be shown respect for their culture, religion, beliefs, values and personal characteristics.

I.77 The principles can be grouped into four cateories.

- Six (a, c, d, e, h and j) are commonplaces that can be accepted by anyone, regardless of views about euthanasia and assisted suicide.
- Three (b, g, k) are ambivalent because interpretation depends upon how "respect" is understood.
- One (f) is contestable because it can be understood to mean that a choice in favour of euthanasia/assisted suicide or some other morally contested option (like suicide by starvation and dehydration) should be "encouraged and promoted." This would be an unacceptable imposition on anyone opposed to a "preference" in principle or in a particular case.
- One (i) is unacceptable because it requires agreement that everyone should be able to have access to euthanasia and assisted suicide. Those opposed to the procedures in principle could not agree to this, and those who may be opposed in particular cases could give only qualified agreement.

The illusion of neutrality

"Rights balancing"

I.78 The six commonplace principles are irrelevant to conflicts of conscience in relation to supporting or participating in euthanasia/assisted suicide. The remaining five may be relevant but are subject to morally partisan interpretations. Since the *Act* seems to give equal weight to all of the principles, an adjudicator can impose subjective and contested views about the meaning and importance of each principle during an ostensibly neutral "rights balancing" analysis. For example, a belief that euthanasia or assisted suicide is immoral (in prinicple or in particular cases) could be overridden because an adjudicator believes that patient autonomy or culture deserves more respect, or that the beliefs of practitioners or collectives are less important than access to euthanasia and assisted suicide. An adjudicator with different underlying beliefs about belief, autonomy, and freedom could be expected to reach different conclusions.

I.79 For present purposes it does not matter which conclusion is "correct." The point is that no one should be under the illusion that the principles identified in the *Act* can be fairly and objectively applied in a "rights balancing" exercise when there is fundamental disagreement about what they mean.

Therapeutic homicide and suicide

I.79 People reasonably disagree about whether or not it is morally acceptable to kill people and help them to kill themselves at a time of their choosing under conditions specified in the *Act*. Further, even if it is held to be morally acceptable under the conditions specified in the *Act*, there is disagreement about whether or not euthanasia and assisted suicide are health care or part of medical practice. The New South Wales law largely reflects Queensland's Voluntary Assisted Dying Act 2021. Queensland's Law Reform Commission ("the Commission") recognized both issues.[31] With respect to the latter, it said:

> Views differ as to whether voluntary assisted dying is health care. It is an end of life option governed by medical assessments and prescriptions by medical practitioners and designed to minimise suffering and maximize quality of life. In that context, many, including Queensland Health, consider it to be a form of health care. . . Others take an entirely different view, including various entities, some palliative care specialists, other health practitioners and individuals from many walks of life. They fundamentally object . . . on ethical, health policy or other grounds. The right of individuals and entities to take these different views should be respected.[32]

I.80 However, New South Wales' Act, like Queensland's law, simply assumes that euthanasia and assisted suicide are morally acceptable forms of healthcare and demands that they be characterized as death by natural causes rather than homicide or suicide [I.53-I.57]. This does not demonstrate respect for different views. On the contrary, it effectively imposes a chokehold on public discourse, suppressing the words needed by objecting practitioners - and even judges - to express their reasoning.33 Canadian physicians have explained the problem:

!.81 By redefining euthanasia and assisted suicide as therapeutic medical services, the [Canadian Medical Association] made physician participation normative for the medical profession; refusing to provide them in the circumstances set out by law became an exception requiring justification or excuse. That is why public discourse in Canada has since centred largely on whether or under what circumstances physicians and institutions should be allowed to refuse to provide or collaborate in homicide and suicide (notes not included).[33] Canadian physicians have explained the problem:

> By redefining euthanasia and assisted suicide as therapeutic medical services, the [Canadian Medical Association] made physician participation normative for the medical profession; refusing to provide them in the circumstances set out by law became an exception requiring justification or excuse. That is why public discourse in Canada has since centred largely on whether or under what circumstances

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[31] *QLRC 2021*, *supra* note 6 at 420, n 2-3.

[32] *Ibid* at para 15.218.

[33] Sean Murphy, "To kill - or not to kill? That is the question. An answer for a Dying with Dignity Clinical Advisor" (27 Jan 2020) *Protection of Conscience Project* (website) online: <https://www.consciencelaws.org/law/commentary/legal105.aspx>.

> physicians and institutions should be allowed to refuse to provide or collaborate in homicide and suicide (notes not included).[34]

Summary

I.82 People seeking euthanasia/assisted suicide (EAS) must be adults with an advanced, progressive disease or medical condition that is causing suffering (of any degree or kind) and that is expected to cause death within 12 months (in the case of neurodegenerative conditions) or within 6 months in all other cases. They must be acting voluntarily, without pressure or duress, and be capable of making and communicating medical decisions. They can be mentally impaired or have dementia or a disability, but EAS cannot be provided for mental impairment, dementia or disability alone. Decision-making capacity is presumed in the absence of evidence to the contrary if a patient appears to understand the consequences of a decision. The *Act* acknowledges that capacity can be temporarily or permanently lost. It imposes residency requirements that can be waived for compassionate reasons.

I.83 Only EAS-trained medical practitioners with least ten years general practice experience or specialist credentials can act as EAS coordinators and consultants. Other EAS trained medical practitioners and and nurse practitioners may administer euthanasia.

I.84 It appears that NSW legislators muddled the wording of the provision about discussions with patients while attempting to modify the comparable provision in Queensland's *Voluntary Assisted Dying Act 2021*. All health care workers, contracted care service workers and medical practitioners can initiate discussion about or suggest euthanasia/assisted suicide to patients, even if patients have not expressed an interest, as long as they provide other information required by the *Act*. If a patient asks about EAS, contracted care service workers and health care workers other than medical practitioners can provide EAS information, but need not provide information about available options or suggest that the patient talk to a medical practitioner. However, none are required to suggest or initiate discussion about EAS.

I.85 The EAS process begins with a “clear and unambiguous” first request to a medical practitioner made personally by a patient (not a third party). After discussing alternative options, the medical practitioner must accept or reject the request and promptly notify the patient. A practitioner who rejects a request must advise the patient that others may be able to assist and provide information about them or the Voluntary Assisted Dying Care Navigator Service. An EAS-qualified medical practitioner who accepts a request becomes the coordinating practitioner, responsible for supervising the EAS request, assessment and administration process.

I.86 A medical practitioner who accepts a request must assess the patient's eligiblity. Patients deemed eligible must be referred to a consulting practitioner to confirm the assessment, and can be referred repeatedly to consulting practitioners until eligibility is confirmed. Referrals to specialists are optional, and their opinions are not binding.

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[34] Rene Leiva et al, “Euthanasia in Canada: a Cautionary Tale” (2018) World Med J 64(3): 17 at 19, online: <https://www.wma.net/wp-content/uploads/2018/10/WMJ_3_2018-1.pdf>.

I.87 A patient deemed eligible by two medical practitioners and who wishes to proceed must make a second EAS request, a written declaration witnessed by two people, then a final request, and then, with the coordinating practitioner's assistance, an administration decision: to opt for assisted suicide or euthanasia. Assisted suicide is less reliable than euthanasia, and experience elsewhere demonstrates that very few choose assisted suicide when both euthanasia and assisted suicide are available.

I.88 The second request, final request, and administration decision could all occur during the same consultation, although a final request cannot be made until the day after the completion of the second (consulting) assessment, and cannot normally be made within five days of a first request; the latter requirement can be waived if the patient may lose capacity or die before EAS can be provided. Subject to Australian national laws, the *Act* explicitly allows the use of audiovisual communication for first and final requests and administration decisions. The Act does not explicity prohibit audiovisual communication for EAS assessments. Australia's *Criminal Code* currently prevents this. Should the *Code* be amended to allow it, videoconferencing for first and final requests and administration decisions would immediately be allowed, and it appears that professional regulators in New South Wales would be able to permit videoconferencing for EAS assessements.

I.89 Coordinating practitioners must be authorised by the Voluntary Assisted Dying Board (the Board) to prescribe a lethal substance for each patient, whether it is to be practioner-administered or self administered. A practitioner providing euthanasia must have an adult witness present and ensure that the patient has decision-making capacity and is acting voluntarily. A patient can self-administer lethal medication at any time and place, without notifying anyone. Neither a witness or confirmation of decision-making capacity or voluntariness is required. It is thus possible for death by self-administration to occur in public or inconvenient places or remain undiscovered for some time. If the patient is incapacitated but does not die after being administered or ingesting the lethal substance, it does not appear that an additional lethal dose can be given to kill the patient unless the patient regains capacity and consents.

I.90 The wording of the *Act* seems to leave open the possibility that a friend, family member, agent or contact person could put the substance to or into the mouth of a patient who needs help to self-administer it, which, in some circumstances, would be indistinguishable from administering it. A required statutory instruction to patients that they are not obliged to self-administer the lethal substance could contribute to this outcome.

I.91 The *Act* requires the cause of death be falsified by reporting it as the disease or medical condition for with EAS was approved. Falsification of the cause of death on death certificates is contrary to international standards for identifying causes of death that are acknowledged by the Australian government. Falsification of death certificates contributed to the murder of over 200 patients by a British medical practitioner and led to unfavourable comments by the chairman of the subsequent inquiry into the murders.

I.92 The New South Wales government will establish the Voluntary Assisted Dying Care Navigator service to assist those seeking "support, assistance and information" about EAS services. VADCNS will be a service dedicated to enabling euthanasia/assisted suicide, so it will not be equivalent to a service providing information and assistance related to a variety of government and health services.

I.93 Institutions are categorized as "residential facilities" like nursing homes, hostels, group homes, etc. operated by "relevant entities" (excluding individuals) and "health care establishments" like hospitals or hospices operated by "health care entities" (including individuals). They may decide not to provide EAS related services and information.

I.94 The *Act* imposes obligations on residential facilities and health care establishments if a person in their care requests EAS information or services that they do not provide. They must allow a VADCNS employee or someone else “reasonable access” to anyone in their to provide the information. Generally speaking, governing entities are expected to facilitate the transfer of patients in health care establishments to and from a location where EAS services can be provided. On the other hand, they are expected to allow all EAS services in residential facilities for all permanent residents, and for all occupants who are not permanent residents if an EAS practitioner decides that transferring them "would not be reasonable in the circumstances."

I.95 The operation of the *Act* is to be overseen by an appointed Voluntary Assisted Dying Review Board. It must approve each EAS application and residency exemption, maintain a list of registered health practitioners willing to be involved in EAS services and monitor the and report annually upon operation of the Act. The Supreme Court of New South Wales is empowered to review and overturn decisions about residency, capacity, and voluntariness (not diagnosis or prognosis). Coordinating practitioners may refuse to continue if the Court overturns a decision about capacity or voluntariness, but must then transfer the patient to the consulting practitioner or someone eligible to act as coordinating practitioner.

I.96 The *Act* identifies eleven principles underpinning the statute and seems to give equal weight to all of them. Six are irrelevant to conflicts of conscience in relation to supporting or participating in euthanasia/assisted suicide and five are subject to morally partisan interpretations. This enables an adjudicator to impose subjective and contested views about the meaning and importance of each principle during an ostensibly neutral “rights balancing” analysis. No one should be under the illusion that the principles identified in the *Act* can be fairly and objectively applied in a “rights balancing” exercise when there is fundamental disagreement about what they mean.

I.97 The provision of euthanasia or assisted suicide under the *Act* is not considered palliative care, which is clearly distinguished as an alternative option. People hold different views about the moral acceptability of euthanasia and assisted suicide and whether or not the procedures are forms of health care or medical practice. However, the *Act* assumes that euthanasia and assisted suicide are morally acceptable forms of healthcare and must be characterized as death by natural causes rather than homicide or suicide. This does not demonstrate respect for different views. On the contrary, it effectively imposes a chokehold on public discourse, suppressing the words needed those opposed to the *Act* to express their reasoning.

PART II: INDIVIDUAL FREEDOM OF CONSCIENCE

Introduction

II.1 Part I assumed the willing participation of health care practitioners and facilities with the provisions of the *Act*. We now consider provisions of the *Act* that have an impact on practitioners who, for reasons of conscience, are unwilling to participate in euthanasia and assisted suicide (EAS) or comply with other requirements of the law.

II.2 It is important to recognize that, with respect to EAS, the health care professions are not divided into sharply defined groups of objecting and non-objecting practitioners. An undetermined number may object absolutely to the procedures for reasons of conscience, but the position of many practitioners is more fluid, depending upon the nature of the illness or condition said to justify EAS. Their support or opposition is also likely to reflect their opinions about a patient's decision-making capacity, voluntary consent, or other issues they consider relevant in certain cases or certain kinds of cases. This is one reason why a policy of registering conscientious objectors is unfair and ill-advised, and why Part II considers the relevance of the *Act*'s provisions about eligibility, capacity, discussion with patients, etc. — not just provisions specific to conscientious objection.

Eligibility

II.3 In general, the broader the grounds for euthanasia and assisted suicide, the more likely it is that conflicts of conscience will arise among health care practitioners. Those willing to provide euthanasia or assisted suicide for terminally ill patients may be much less willing to end the lives of people with chronic illness, and many more would be inclined to resist calls to kill or assist in the suicide of physically or cognitively disabled patients. By restricting eligibility for EAS to competent adults with terminal illnesses or conditions, and by explicitly ruling out EAS for mental health impairment, dementia and disability, the *Act* reduces the number of practitioners likely to experience conflicts of conscience when it comes into force.

Capacity assessments

II.4 Practitioners not opposed to euthanasia and assisted suicide in principle may object to providing the services for patients whose decision-making capacity is questionable. Two factors relevant to assessing decision-making capacity are of particular interest: limited capacity and fluctuating capacity.

Limited capacity

II.5 Queensland's *Voluntary Assisted Dying Act* explicitly acknowledges that a person may be capable of making some decisions but not others.[35]35 This is not acknowledged in the New South Wales law, but the absence of statutory recognition does not prevent practitioners from taking this into account in assessing patient capacity. Applying this to euthanasia and assisted suicide introduces

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[35] *Voluntary Assisted Dying Act 2022* (Qld) s 11(3), online: <https://www.legislation.qld.gov.au/view/html/asmade/act-2021-017>.

a problem apparently unrecognized by Queensland and Canadian legislators and by the Canadian judges who ordered the legalization of the procedures in the case of *Carter v Canada (Attorney General)*.[36]

II.6 The ability of practitioners to perform capacity assessments for euthanasia and assisted suicide is disputed. On the one hand, it is argued that assessing patient competence for these procedures requires expertise that is not necessarily possessed by the majority of physicians.[37] On the other, the plaintiffs convinced the *Carter* trial court judge (and ultimately the Supreme Court of Canada) that obtaining informed consent for assisted suicide and euthanasia is no more difficult than obtaining informed consent for customary medical treatment.[38] It is instructive to set side by side the comments about capacity later made by an objecting physician (Physician D) and evidence accepted on this point by the trial court judge in *Carter*:

Madam Justice Lynn Smith	**Physician D**
Dr. Ganzini, a geriatric psychiatrist and Professor of psychiatry and medicine. . . cites the decision whether to undergo a neurosurgical procedure as an example of a cognitively demanding one, since the risks, benefits, and various trade-offs between short-term and long-term gains can be very complex and challenging to understand.	The decision to have medical aid in dying requires significant "meta" thought and reflection. It is more complex than even a decision about level of care, antibiotic treatment for pneumonia, or blood pressure pills. It is even at a different level than the choice to take chemotherapy or not.
In contrast, she says, *the risks and benefits of a lethal prescription are straightforward and not cognitively complex. The risk is that the prescription might not work; the benefit is that the patient's life will end at a time of her choosing*.[39](emphasis added)	All of our patients are vulnerable, many of them have concomitant psychiatric disorders, and almost all of them are demoralized to a certain extent that is normal in the context of a life-threatening illness. These issues make the determination of competence very difficult *because of the gravity of deciding to end one's own life.*[40](emphasis added)

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[36] *Carter v Canada (Attorney General)*, 2015 SCC 5, [2015] 1 SCR 331, online: <https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/14637/index.do>.

[37] *Carter v. Canada (Attorney General)*, 2012 BCSC 886 (CanLII) [*Carter 2012*] at para 770–774, online: <https://canlii.ca/t/frpws> .

[38] *Ibid* at para 831.

[39] *Ibid* at para 775.

[40] Response of Physician D to Administrator, Protection of Conscience Project (9 September, 2016). The response was an anecdotal report received as a result of a request from the Project Administrator for details about adverse effects experienced by Canadian health care practitioners attributable to the legalization of assisted suicide and euthanasia. The respondents identified

II.7 The italicized passages demonstrate that a life-or-death decision has, for Physician D, a completely different significance than it has for Dr. Ganzini. The risk perceived by Physician D is that the patient might die. The risk perceived by Dr. Ganzini is that the patient might live (at least, for a time). Here we see that different underlying philosophical or ethical views about life and life-ending acts can significantly affect one's views about the existence and nature of risk. The problem of *a priori* inescapable biases in favour of an outcome is intrinsic to capacity assessments and cannot be avoided in euthanasia and assisted suicide.

II.8 According to a knowledgeable and experienced physician, each capacity assessment must be made within the context of the kind of decision-making contemplated. It is also influenced by the risks involved in the decision, life-or-death consequences calling for the highest level of capacity.[41] A cognitively impaired patient may be considered competent to decide whether to take an aspirin for a headache, but not to make a decision about neurosurgery because of an inability to understand a complex procedure and evaluate its potential consequences.

II.9 In Dr. Ganzini's opinion, the only thing the patient needs to understand is that a lethal injection will end her suffering by causing her death, and that, if it fails, a second dose may be required. On this view, it is possible that patients might be deemed capable of choosing to die by lethal injection even if they would be considered incapable of making challenging medical decisions about alternative treatments and palliative care. Closely related to this, the burden of illness may make it easier to understand the euthanasia/assisted suicide process than to understand alternative treatment options, inclining a patient to choose what is more easily understood than what may offer satisfactory relief. In either situation, practitioners otherwise willing to provide euthanasia/assisted suicide may be unwilling to do so, even if colleagues deem the patient legally capable of making the decision.

Fluctuating capacity

II.10 In its careful articulation of the effect of a "permanent" loss of capacity on eligibility for EAS the Act implicitly recognizes that capacity may be temporarily lost and regained [§16(3),(4)]. This issue was considered by the Supreme Court of Canada in relation to approving euthanasia for patients suffering from clinical depression (major depressive disorder). The Court accepted the plaintiffs' argument that depression undermining capacity should be treated, and, if the patient recovers sufficient capacity (even temporarily), his decision for EAS should be accepted.

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themselves to the Administrator, who promised to preserve their anonymity in discussion of the reports at a symposium at the J. Reuben Clark Law School of Brigham Young University. Discussion of the methodology of capacity assessments here is drawn from an earlier version at Sean Murphy, "Legalization of Assisted Suicide and Euthanasia: Foundational Issues and Implications" (2017) 31:2 BYU J Pub Law 333 at 350–353, online: <https://digitalcommons.law.byu.edu/jpl/vol31/iss2/3> [Murphy 2017].

[41] Physician H, explanation offered in the presence of the Administrator, Protection of Conscience Project, on 10 October, 2015: verified by the Administrator prior to publication in Murphy 2017, *supra* note 40 at 352.

> **Sheila M. Tucker:** The evidence . . . was that you can have major depressive disorder and still be competent as a medical decision maker. What the further question was, if you are to make the further judgement about whether or not, even though you are competent, the major depressive disorder is influencing your decision about wanting to end your life, that that's a very fine judgement. And so, the recommended answer to her from the witness, and which she agreed with, was, it's too fine of a judgement. Simply exclude people who are actively suffering from major depressive disorder.
>
> **Justice R.S. Abella:** Even if it results from the very suffering that is what you want to be able to alleviate by the decision to end your life.
>
> **Sheila M. Tucker:** Yes, because you cannot rely on their decision. . . But that's a very high threshold . . . of major depressive disorder, because she also said, it's expressed in the context of active suffering. She said such people should be treated . . . for major depressive disorder, and if they could recover *enough* to reliably make a decision — they weren't actively suffering from it *to the same degree* — then they should be allowed to make the decision (emphasis added).[42]

II.11 Even medical practitioners willing to provide or facilitate euthanasia or assisted suicide for clear-headed patients may not be confident that they can safely act upon a request made when the clouds of major depressive disorder part for a time, or if the patient recovers what a colleague considers "enough" capacity to make a valid request.

Disagreements about eligibility

II.12 The Supreme Court of New South Wales can overturn decisions by coordinating and consulting practitioners about residency, capacity and voluntariness. A coordinating practitioner whose decision about eligibility is overturned by the Court can refuse to continue in the role. If he withdraws, he must transfer the patient file to the consulting practitioner (if there is one) or to someone who can act as a coordinating practitioner. It is highly unlikely that such situations would involve practitioners absolutely opposed to euthanasia/assisted suicide because one would expect them to refuse to accept a first request (see II.17-19).

II.13 It is possible that a practitioner willing to consider EAS might accept a request but assess the patient as ineligible because of doubt (rather than conviction) about voluntariness or capacity. In such a case, reversal by the Court might be accepted by the practitioner as resolving the doubt, allowing him to proceed.

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[42] Supreme Court of Canada, "35591, Lee Carter, et al. v. Attorney General of Canada, et al (British Columbia) (Civil) (By Leave) Webcast of the Hearing on 2014-10-15" (22 January, 2018), Supreme Court of Canada (website), online: <https://www.scc-csc.ca/case-dossier/info/webcastview-webdiffusionvue-eng.aspx?cas=35591&id=2014/2014-10-15--35591&date=2014-10-15&fp=n&audio=n> at 144:32/491:20 to 145:57/491:20.

II.14 Only if a practitioner were certain that the patient lacked capacity or was not acting freely would reversal by the Court cause a conflict of conscience. The provision permitting the practitioner to withdraw recognizes and resolves this problem [§116(1)]. However, the *Act* also requires the withdrawing practitioner to transfer the patient to a colleague who can proceed with the EAS process [§116(2)]. Indeed, if the Court reverses a practitioner's settled conclusion about capacity or voluntariness, the *Act* requires the practitioner to continue as if he had actually confirmed the patient's eligibility [cf §116(2), §175(1)]. This certainly implies that the onus is on the withdrawing practitioner to find someone willing to kill or assist in the suicide of a patient, nothwithstanding a conviction that the patient lacks capacity or is acting involuntarily. A practitioner may find this requirement unacceptable, and it is completely unnecessary.

II.15 The Voluntary Assisted Dying Board will be a powerful and well-connected state instrument with a list of willing EAS practitioners. The *Act* should be amended to require the Court to direct the Voluntary Assisted Dying Board to find a new coordinating practitioner should the coordinating practitioner withdraw in these circumstances. The new practitioner could then request the transfer of the patient from the original practitioner in the customary way. In the Project's experience, objecting physicians are typically willing to cooperate in patient-initiated transfers in such situations, but not to initiate the transfers themselves.

Discussion with patients

II.16 We have seen that all health care workers, contracted care service workers and medical practitioners can initiate discussion about or suggest euthanasia/assisted suicide to patients, even if patients have not expressed an interest [I.11-I.14]. What is significant within the context of freedom of conscience is that they are not required to do so. Many health care workers — not just those opposed to EAS — are unwilling to introduce the subject absent some expression of interest by the patient. Their approach reflects concern that a patient who would not normally consider EAS might be induced to ask for it if a health care worker gratuitously initiates discussion. By explicitly making discussion optional the Act supports both health care workers who want to initiate discussion about EAS and those who think it best to let patients take the lead, responding to their enquiries or apparent interests.

Objecting registered health practitioners

II.17 Subsection 9(1) of the *Act* states that registered health practitioners who object to euthanasia/assisted suicide for reasons of conscience may refuse to

- "participate in the [EAS] request and assessment process"
- "prescribe, supply or administer" a lethal substance
- "be present" when a lethal substance is administered.

II.18 Subsection 9(2) adds what is purported to be a clarification: that subsection 9(1) "does not limit the circumstances in which a registered health practitioner may refuse to do any of the things" identified. However, the vague reference to "circumstances" is not at all equivalent to a statement that a practitioner cannot be obliged to indirectly participate (by referral, for example) or support or assist in euthanasia or assisted suicide. This kind of ambivalent wording is often the outome of struggles between those demanding referral or some other kind of positive support for morally contested procedures and those resisting such demands. When neither group can obtain the wording it actually wants, they may settle on an ambiguous formula that each will try to apply in practice to achieve their desired outcome (i.e., suppression or protection of practitioner freedom of conscience).

II.19 In any case, the *Act* states that practitioners may refuse to accept a first request [§21(2)a] or a referral for a consulting assessment [§31(2)a] and must immediately inform the patient or the coordinating practitioner, as the case may be [§21(5), §31(5)]. They must also record the refusal and the reason for it in the patient's medical record [§22,§33] and report the refusal and reason for it to the Board [§23,§34]. They are not obliged to do anything else, so the starting point for objecting practitioners pressured by regulators or others to do more should be that the *Act* not only does not require it, but (interpreting §9 in a fully protective sense) affirms that they need not do so. Note that objecting practitioners who refuse to do something (such as referral) are protected from disciplinary action by regulators if they act in good faith and reasonably believe that the refusal is in accordance with the *Act* [§131(3)-(4)]. Subsection 9(2) can be cited in support of good faith and reasonable belief by practitioners unwilling to refer patients or otherwise facilitate euthanasia/assisted suicide by means other than those specified in subsection 9(1).

II.20 The likelihood of conflicts of conscience is reduced by the provision that forbids coordinating and administering practitioners to delegate responsibility for administering a lethal substance to another health professional [§85(2)].

Other objecting care workers

II.21 The protection for individual freedom of conscience offered by the *Act* is limited to registered health care practitioners. No protection is provided for the many people involved in the provision of health care, personal care and aged care who are not registered health practitioners, even though the *Act* explicitly recognizes their work [§10]. For example, nothing in the *Act* prevents employers from requiring a personal care worker or social worker to actively support the provision of EAS or to be present when lethal medication is administered.

Falsification of death certificates

II.22 New South Wales legislators apparently believe that legal euthanasia and assisted suicide are beneficial forms of medical treatment. However, beneficial medical treatments do not require a bureaucracy of medical deception. Deception increases the likelihood of conflict and controversy. Indeed, some EAS supporters may worry that mandating deceptive practices is counterproductive.

II.23 Medical practitioners not responsible for euthanasia and assisted suicide deaths and who object to the procedures for reasons of conscience are likely to object to falsifying the cause of death in death certificates; so, too, may physicians who support but do not act as EAS practitioners. They may be uncomfortable lying or dissembling to families about how their loved ones died, which would seem to be unavoidably associated with falsifying causes of death. Some may be concerned that falsifying records and lying to families is likely to undermine the trust essential to the practice of medicine. Others may have principled objections to falsifying documents, lying, dissembling and other forms of deception under any circumstances. Finally, some may consider falsification ill-advised because it is likely to compromise important epidemiological data. EAS practitioners may share these concerns.

II.35 If the state insists that death certificates must be falsified, unwilling practitioners should not be compelled to participate in or support what they consider to be deceptive, unethical or professionally ill-advised practices. Since all EAS deaths must be reported to the Voluntary Assisted Dying Review Board [§87(1)-(3)], the *Act* should be amended to make a medical member of the Board responsible for completing EAS death certificates (assuming that a Board member's objection to doing so would also be accommodated).

Summary

II.25 The health care professions are not divided into sharply defined groups of objecting and non-objecting practitioners. The position of many practitioners depends upon the nature of the illness or condition, opinions about decision-making capacity, voluntariness, or other issues they consider relevant.

II.26 The broader the grounds for euthanasia and assisted suicide, the more likely it is that conflicts of conscience will arise. By restricting eligibility to competent adults with terminal illnesses or conditions, and by explicitly ruling out EAS for disability, dementia or "mental health impairment" alone, the *Act* reduces the number of practitioners likely to experience conflicts of conscience when it comes into force.

II.27 The ability of practitioners to perform capacity assessments for euthanasia and assisted suicide is disputed, and assessment of limited, fluctuating and episodic capacity can be particularly troublesome. Patients could be deemed capable of choosing euthanasia/assisted suicide even if they are considered incapable of challenging medical decisions about alternative treatments and palliative care. The burden of illness may make it easier to understand the EAS process than alternative treatment options, and to choose what is more easily understood rather than what might offer significant symptom relief. Even practitioners willing to facilitate euthanasia for clear-headed patients may not be confident that they can safely act upon a request made when the clouds of major depressive disorder part for a time, or if the patient recovers what another colleague considers "enough" capacity to make a valid request.

II.28 Risk assessments by EAS supporters, uncommitted practitioners and EAS opponents may reflect significantly different views about life-or-death decisions based on different underlying philosophical or ethical views. A priori biases in favour of an outcome cannot be avoided in EAS assessments.

II.29 The New South Wales Supreme Court can overturn a coordinating practitioner's conclusion that a patient is ineligible for EAS because of involuntariness or lack capacity. This can cause a problem for practitioners who are certain of their conclusion because, though they can withdraw, the *Act* requires them to transfer the patient to a colleague willing to continue the EAS process. They may well consider this unacceptable, and it is completely unnecessary. The *Act* should be amended to require the Voluntary Assisted Dying Board to find a new coordinating practitioner should the coordinating practitioner withdraw in these circumstances.

II.30 All health care workers, contracted care service workers and medical practitioners can initiate discussion about or suggest euthanasia/assisted suicide to patients, even if patients have not expressed an interest, but they are not required to do so. By explicitly making discussion optional, the *Act* supports both practitioners who want to initiate discussion about EAS and those who think it best to let patients take the lead, responding to their enquiries or apparent interests.

II.31 All registered health practitioners who conscientiously object to EAS may refuse to participate in any part of the EAS process and refuse to be present when EAS is provided. The wording of the relevant provision is ambivalent, but the *Act* does not require objecting practitioners to do anything other than record the refusal and the reason for it in the patient's medical record and report the refusal and reason for it to the Voluntary Assisted Dying Board. Further, objecting practitioners who refuse to do something (such as referral) are protected from disciplinary action by regulators if they act in good faith and reasonably believe that the refusal is in accordance with the *Act*. Hence, the starting point for objecting practitioners pressured by regulators or others to do more should be that the *Act* not only does not require it, but (interpreting the ambivalent provision in a fully protective sense) affirms that they need not do so.

II.32 The protection for individual freedom of conscience offered by the *Act* is limited to registered health care practitioners. No protection is provided for the many people involved in the provision of health care, personal care and aged care who are not registered health practitioners, even though the *Act* explicitly recognizes their work. For example, nothing in the *Act* prevents employers from requiring a personal care worker or social worker to actively support the provision of EAS or to be present when lethal medication is administered.

II.33 Regardless of their views about euthanasia and assisted suicide, some medical practitioners are likely to object to falsifying the cause of death in death certificates. They may be uncomfortable about lying or dissembling to families about how their loved ones died or concerned that falsifying records and lying is likely to undermine the trust essential to the practice of medicine. Others may have principled objections to falsifying documents, lying, dissembling and other forms of deception under any circumstances. Finally, some may consider falsification ill-advised because it is likely to compromise important epidemiological data. If the state insists that death certificates must be falsified, the *Act* should be amended to make a medical member of the Voluntary Assisted Dying Review Board responsible for completing EAS death certificates (assuming that a Board member's objection to doing so would also be accommodated).

PART III: INSTITUTIONAL & COLLECTIVE FREEDOM OF CONSCIENCE

Introduction

Institutional freedom of conscience

III.1 The concept of institutional freedom of conscience or religion has been examined and challenged repeatedly since at least the early 1970's. Claims that facilities like hospitals and hospices cannot rely on constitutional guarantees of freedom of conscience *because* they are not individuals are untenable because they are contradicted by legal history and widespread practice. At best, they provide superficial camouflage for efforts to compel unwilling institutions to provide morally contested services favoured by the claimants, or anti-religious discrimination, or both. [43]

III.2 The *Act* is is concerned with two kinds of institutions: "residential facilities" like nursing homes, hostels, group homes, etc. operated by "relevant entities" (excluding individuals), and "health care establishments" like hospitals or hospices operated by "health care entities" (including individuals) [see I.60-I.64]. In this review (not in the *Act*), "governing entity" refers to the entity operating a facility, whether a health care or relevant entity. Regardless of structure, an "institution" in the sense relevant here always manifests a collective enterprise by individuals, so the term "entity/collective" is used in this Part to keep this in mind.

III.3 The *Act* admits the possibility of conscientious objection by individuals [§9] —] — but not by entities/collectives [§89-90, §99]. It addresses only the obligations of entities/collectives that do not participate in euthanasia or assisted suicide — for any reason.

III.4 It is likely that one of the reasons underlying this strategy was a desire to avoid even implicitly acknowledging an institutional right to refuse to participate in euthanasia and assisted suicide for reasons of conscience. Consistent with this, the *Act's* statement of underlying principles acknowledges the need to respect individuals' culture, religion, beliefs, values and personal characteristics, but — not those of entities/collectives [§4].

III.5 Thus, while the *Act* explicitly states that entities/collectives can refuse to participate in euthanasia and assisted suicide [§89-90, §99], it places refusals based on moral/ethical objections to killing people on the same level as refusals based on pragmatic considerations like lack of trained personnel. Its message is that guarantees of freedom of conscience or religion are irrelevant to decision-making by entities/collectives about involvement in killing people, and, if entities/collectives defend refusals on that basis, the *Act* puts them at a disadvantage.

Critical presumption

III.6 Contrary to the position taken by the *Act*, this paper presumes that entities/collectives are entitled to rely upon constitutional guarantees of freedom of conscience, notwithstanding differences

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[43] Sean Murphy, "Institutional freedom of conscience in relation to euthanasia and assisted suicide" (14 May, 2022) Protection of Conscience Project (website) [Murphy 2022] at para I.9–I.12, online:<https://www.consciencelaws.org/law/commentary/legal114.aspx>.

between individuals and collectives in the exercise of that freedom. Individuals and entities/collectives are equally concerned to avoid complicity in perceived wrongdoing. This obviously includes taking part directly in what they deem to be a wrongful act, but also causally contributing to by collaboration or contingent cooperation. However, factors relevant to moral decision-making by entities/collectives are not necessarily identical to those affecting the exercise of freedom of conscience by individuals, nor do they play out in the same way. The concept of individual freedom of conscience is applied analogically to collectives, so some differences are to be expected.[44]

Scope

III.7 The focus here is the effect of the Act upon institutions in New South Wales that refuse to provide or facilitate euthanasia/assisted suicide (EAS) for reasons of conscience. It is specific to the exercise of *preservative* freedom of conscience.[45,46] The policy of such institutions typically reflects desire to preserve institutional moral integrity by refusing to be complicit in, cooperate in or otherwise support or encourage the killing of patients and a desire to prevent harm to others. Institutional religious integrity is not addressed in this review.

Institutional challenges

Participation, collaboration and cooperation

III.8 The *Act* does not require entities/collectives to provide euthanasia or assisted suicide or even (apparently) to provide information about the procedures [see I.65], so it does not threaten institutional freedom of conscience in relation to direct participation in EAS services.

III.9 However, objecting individuals and entities/collectives also want to avoid contributing to EAS in morally significant ways: ordering, recommending or encouraging it and other forms of collaboration or facilitation, such as helping patients connect with someone willing to kill them or help them kill themselves. Beyond collaborative conduct entailing complicity, individuals and entities/collectives also wish to avoid forms of cooperation that they may consider morally wrong in certain circumstances [“contingent cooperation”].[47]

III.10 The problem of contingent cooperation is especially troublesome for institutions.[48] Providing advance notice of institutional policies is an important strategy for avoiding conflicts with patients and difficulties associated with contingent cooperation. Hence, the *Act’s* requirement that

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[44] Murphy 2022, *supra* note 43 at I.13–I.14.

[45] Introduced in Sean Murphy & Stephen Genuis, “Freedom of Conscience in Healthcare: Distinctions and Limits” (2013) 10(3) J Bioethical Inquiry 347 [Murphy & Genuis], online: <https://link.springer.com/article/10.1007%2Fs11673-013-9451-x>.

[46] Discussed and applied in Sean Murphy et al, “The Declaration of Geneva: Conscience, Dignity and Good Medical Practice” (2020) 66(4) World Med J 41 [Murphy et al], online: <https://www.wma.net/wp-content/uploads/2020/12/wmj_4_2020_WEB.pdf>.

[47] Murphy 2022, *supra* note 43 at para II.5.

[48] *Ibid* at para II.6–II.9.

entities/collectives provide such notice furthers the accommodation of both patients who may want EAS services and entities/collectives unwilling to provide them [I.66].

III.11 Ideally, people who may want EAS services will avoid facilities operated by entities/collectives unwilling to provide or facilitate them. However, this may not always work out in practice, so the *Act* has been designed to enable the state to compel unwilling entities/collectives to at least cooperate in killing people in their care or helping them kill themselves.

III.12 Obligations to cooperate imposed on objecting entities/collectives by the *Act* arise only if patients notify institutional staff or representatives that they want EAS information, want to make EAS requests, have EAS assessments, etc. Requests directed to non-institutional staff would not create institutional obligations. This is reasonable, since only entities/collectives aware of a request could be expected to act on an obligation, and they can become aware of requests only through their employees or representatives. But it also means that patients and practitioners cannot proceed with EAS in an objecting institution unless they notify institutional authorities at each stage in the EAS process [§90, §92(1),§99, §101(1)].

III.13 The *Act* requires two kinds of cooperation; enabling access to information about EAS and facilitating access to EAS services. The extent of cooperation demanded in relation to EAS services (requests, assessments, provision of euthanasia/assisted suicide) is sometimes related to the legal occupancy status of the person in care.

Legal occupancy status

III.14 The *Act* groups EAS candidates into two classes based on legal occupancy status: those who are "permanent residents" and those who are not. It implies that those residing temporarily in health care establishments (like hospitals or hospices) are not permanent residents; it assumes that occupants of residential facilities may or may not be permanent residents. Those who are not "permanent residents" are identified here (not in the *Act*) as "institutional occupants."[49]

III.15 For present purposes, it is assumed that, apart from the *Act*, permanent residents have legal status analogous to residential tenants in relation to the institutional space they occupy, but institutional occupants do not.[50] It is further assumed that an entity/collective may not be able to include a no-EAS-on-premises condition in a permanent residency agreement, but can include such a condition in institutional occupancy agreements.[51]

III.16 To the extent this is correct, permanent residents would seem to be free to have visitors come and go as they choose, to communicate privately with visitors, and to do as they wish inside the premises they occupy, even if the premises is part of a larger facility. Owners and managers of a residential facility have no authority to manage or interfere in permanent residents' affairs without

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[49] *Ibid* at para V.1–V.9.

[50] The assumption is consistent with the differential treatment of permanent residents and institutional occupants by the *Act* .

[51] The assumption is consistent with the *Act's* requirement that an objecting entity/collective give advance notice of such limitations.

their consent, except to the extent necessary to protect the entity/collective's legitimate interests (including freedom of conscience), other residents and facility staff. Assuming these further inferences are correct, it is obvious that permanent residents would be able to arrange for and obtain EAS services *in their own premises*, notwithstanding opposition by owners of the facility, even if the *Act* did not address the issue. This would *not* be true of institutional occupants.

III.17 The facilities to which the *Act* pertains encompass a broad range of designs and living arrangements. A permanent resident may have a self-contained private apartment or merely a small private room and bathroom (much like a private hospital room). Institutional occupants are more likely to share a room with one or more others, separated from them only by curtains. However, this may also be true of permanent residents in residential facilities.

III.18 It is obvious that, from the perspective of an entity/collective, facility staff and other occupants, the provision of EAS services in a private apartment in a residential facility would be radically different from providing them behind a curtain in a room shared with others, but the *Act* does not distinguish between the two situations. Fortunately, nothing in the *Act* prevents entities/collectives from imposing conditions on EAS-related activities that they are required to permit in order to protect other patients,[52] staff[53] and institutional moral integrity. For example: a nursing home that is unable to prevent EAS in a resident's room may refuse to take custody of EAS drugs, refuse to allow celebrations associated with anticipated EAS elsewhere in the facility, prohibit employees from participating in or supporting the procedure, and limit the provision of EAS to times when other residents are likely to be absent or sleeping.

Access to information

III.19 The *Act* imposes an institutional obligation to provide access to EAS information for all institutional occupants, regardless of legal occupancy status. however, the institutional obligation to provide access to EAS information arises *only* if a patient receiving treatment or care in a facility asks *institutional staff or representatives* about euthanasia or assisted suicide [I.67]. It does *not* apply when patients seek information from *non-institutional* medical or health care practitioners visiting the facility.

III.20 Independent practitioners are governed by other provisions in the *Act* [I.11-I.15] and professional regulations. If asked, they would be expected to provide information necessary to enable informed medical decision making. It is likely that most information sought by most patients would be provided in this way.

III.21 Were a patient to ask *institutional staff* for EAS information, the *Act* requires entities/colllectives to permit and enable the patient to obtain information about the services

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[52] YouTube, "Allow Me to Die: Euthanasia in Belgium" (15 September, 2015) at 00h:40m:00s to 00h:43m:30s, online: <https://youtu.be/hCRpuTRA7-g>.

[53] "Nurse diagnosed with PTSD after interaction with patient seeking euthanasia: Tribunal rules 'her own convictions' caused her injury. Denies claim for compensation" (10 October, 2017), Protection of Conscience Project (website), online: <https://www.consciencelaws.org/law/commentary/legal089-001.aspx>.

regardless of their legal occupancy status [I.67]. Objecting entities/collectives, like individual practitioners, may well be willing to provide patients with information necessary to enable them to make an informed decision about euthanasia and assisted suicide, as long as they can avoid doing so in a manner that causally connects them to killing their patients or makes it appear that they support or recommend the procedures [III.8–III.13].

III.22 To conform to the *Act*, objecting entities/collectives could require that all patient enquiries about EAS received by institutional employees be directed to staff members trained to provide patients with information necessary to enable informed decision-making without compromising institutional moral integrity. The policy could also require that discussion and communication of information take place in private, and could operate seamlessly with responses to first requests for EAS [III.28-III.31]. Note that an objecting entity/collective that provides EAS information in this way is not required by the *Act* to admit anyone else for the purpose of providing information [I.67].

III.23 However, a patient may ask for specific information that an entity/collective is unwilling to provide even through a designated employee, such as the name and contact information for an EAS practitioner or EAS enabling service like VADCNN [I.59].[54] Here the text of the *Act* is critical. It specifies that an entity/collective must allow a medical practitioner or a member of VADCNN reasonable access to the patient to provide "the information *that has been requested*" (§90(1)c and (2)b, emphasis added). It does not, however, require an objecting entity/collective to arrange for this: only that it not obstruct arrangements made by the patient. Like individual practitioners, objecting entities/collectives could comply with the *Act* by directing patients seeking EAS practitioner contact information to a service able to facilitate contact with practitioners or health services generally (like NSW Health)[55] and not obstructing the arrangements subsequently made by a patient or patient's representative to connect with someone willing to provide the information.

III.24 In sum, the cooperation required of objecting entities/collectives by the *Act* in relation to providing information about EAS does not appear to undermine institutional freedom of conscience.

Access to euthanasia and assisted suicide

III.25 The *Act* requires three requests (one witnessed), two assessments by different practitioners (and possibly assessments by determiners), and an administration decision before EAS is actually provided. From start to finish, New South Wale's EAS process involves at least seven steps, and each has to take place somewhere. Had the *Act* been designed to accommodate institutional freedom of conscience, objecting entities/collectives seeking to avoid moral entanglement in the process would have had three options (subject to the legal occupancy status of a patient): permanent transfer of patients seeking EAS, temporary transfers for some or all of the steps in the process, and no transfer: i.e., allowing the full EAS process to take place in a facility, but without support or

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[54] Not all objecting entities/collectives would exclude VADCNN as a source of information: *QLRC 2021*, *supra* note 2 at para 15.233.

[55] NSW Government, "Public" , NSW Health (website) [NSW Health], online: <https://www.health.nsw.gov.au/public/Pages/default.aspx>.

participation by facility staff.[56]

III.26 However, the *Act* effectively denies institutional freedom of conscience. It imposes a number of constraints and requirements on objecting entities/collectives specifically to compel their cooperation and even collaboration, some of which go beyond legal constraints arising from legal occupancy status.

Requests for EAS

First and final requests

III.27 The *Act* requires that a first request for euthanasia/assisted suicide be accepted or refused by a medical practitioner. Refusal does not prevent EAS because a patient remains free to ask other medical practitioners to accept the request. This arrangement underpins the provisions protecting practitioner freedom of conscience [II.17-II.19] and could have been applied to protect institutional freedom of conscience, but the *Act* does not do this.

III.28 The *Act* contemplates a patient's requests only within the context of an EAS delivery process, not within the context of caring for patients. In reality, patients can request euthanasia/assisted suicide at any time, even where the procedures are illegal. For example, palliative care patients experiencing grave pain and suffering sometimes ask for EAS. Experienced palliative care practitioners consider this an expression of anguish and respond by attempting to identify and ameliorate the source of distress rather than by simply ignoring the request or shutting down the conversation. It is highly unlikely that objecting entity/institutions would be interested in suppressing this kind of request or patient-practitioner exploration, as it can lead to remediation of patients' distress and relieves them of inclinations toward euthanasia.

III.29 This kind of dialogue remains possible notwithstanding the *Act* because it requires a patient request to be "clear and unambiguous" [§19(2)a] and also requires practitioners to discuss alternatives [§10(2)]. Only if a practitioner concludes that a request is clear and unambiguous (which must surely imply an understanding of alternatives) do the obligations imposed by the *Act* in relation to a first request become relevant. That conclusion need not be reached the same day the patient initiates the discussion.

III.30 Objecting health care establishments and residential facilities would naturally instruct their medical staff to refuse a first request that is found to be "clear and unambiguous." They could instruct them to comply with the Act by (i) informing the patient that other health practitioners or health service providers may be able to assist them, (ii) providing information about services (like NSW Health) that can connect them with EAS services, and (iii) recording in the patient's medical record the refusal and information provided to the patient [§22]. They could also require that such consultations with patients must occur in private. It appears that non-institutional medical practitioners could be required through the credentialing process to conform to these policies.

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[56] *Murphy 2022*, *supra* note 493 at para V.10–V.16.

III.31 By exploring, documenting and refusing first requests and providing information that enables patients to seek EAS elsewhere it would be possible for objecting entities/collectives (like individual practitioners) to respond compassionately to patients and manage first requests without compromising institutional moral integrity. What happens next would be up to the patient. A patient could arrange to consult with an EAS-qualified medical practitioner willing to accept a request and begin the EAS process by assessing his eligibility.

III.32 No issue would arise if the *Act* were to state only that an entity/collective must not obstruct patients who make such arrangements. However, it does more. It requires objecting institutions (both health care establishments and residential facilities) to cooperate by letting EAS practitioners accept first and final requests *in their facilities* [§92(2)]. Accepting requests (i.e., agreeing to act upon them), especially final requests, is more directly supportive of and causally related to euthanasia and assisted suicide than merely receiving and responding to requests. It is thus more significant in moral evaluation of collaboration and contingent cooperation and more likely to be problematic for objecting entities/collectives. This is ignored by the Act.

III.33 Further, when an EAS practitioner cannot attend, objecting entities/collectives must "take reasonable steps to facilitate the transfer" of the patient to a location where first and final requests can be accepted [§92(3)]. It is not clear if this is means that the entity/collective must initiate the transfer rather than merely cooperate in a transfer arranged by the patient or others. If the former, it is arguably a demand for active collaboration rather than passive cooperation that may be unacceptable to some objecting entities/collectives.

Declarations, EAS assessments, administration decisions, and administration of lethal substance

Objecting health care establishments

III.34 Objecting hospitals, hospices and other health care establishments “must take reasonable steps to facilitate" patient transfers to and from a place where the EAS process can take place. This includes all requests [§101(2)] assessments [§102(2),§103(2)], declarations [§104(2)], administration decisions [§105(2)] and actual provision of euthanasia/assisted suicide [§106(2)]. Again, it is unclear if objecting entities/collectives must *initiate* the transfer rather than merely cooperate in a transfer arranged by the patient or others. If the former, it is arguably a demand for active collaboration rather than passive cooperation that may be unacceptable to some objecting entities/collectives.

III.35 In addition, the *Act* requires governing entities to consider whether or not a transfer would likely cause “serious harm” to the EAS candidate, adversely affect access to euthanasia/assisted suicide (eg, through loss of capacity), cause “undue delay and prolonged suffering”, and whether the transfer location can receive the person. Possible financial loss or costs incurred by the candidate must also be considered [§102(3), §103(3), §104(3) §105(3), §106(3)]. Patients cannot dictate transfer decisions; they are the sole responsiblity of the governing entity. However, these provisions in the *Act* exposes objecting entities/collectives that transfer patients to legal challenges and litigation.

Objecting residential facilities

III.36 **Permanent residents:** Objecting nursing homes, assisted living facilities and other residential facilties must allow all permanent residents to have all EAS services in their facilities, including all requests, declarations, assessments, consultations administration decisions and the provision of euthanasia/assisted suicide [§93(2)a, §94(2)a, §95(2)a, §96(2)a, §97(2)a]. This is unlikely to result in a conflict if the resident has a self-contained suite similar to an apartment, but may well be problematic when the resident shares accommodation with other residents.

III.37 **Institutional occupants:** Objecting nursing homes, assisted living facilities and other residential facilties "must take reasonable steps to facilitate the transfer" of institutional occupants who are not permanent residents to and from a place" where the services can be provided [§93(3)a, §94(3)a, §95(3)a, §96(3)a, §97(3)a]. However, if such a transfer "would not be reasonable in the circumstances," the entity must allow a medical practitioner "reasonable access" to provide the services at the facility. Moreover, a decision to transfer a patient can be vetoed by the coordinating EAS practitioner or a medical practitioner nominated by the patient [§93(3)b, §94(3)b, §95(3)b, §96(3)b, §97(3)b].

Comment

III.38 The *Act* appears to leave objecting entities/collectives with a choice between two potentially objectionable alternatives. If transfers must be initiated by objecting entities/collectives, some may object on the grounds that initiating rather than merely cooperating in a transfer demands active collaboration rather than passive cooperation. On the other hand, they may find allowing EAS services in the facility also ethically unacceptable.

III.39 It is doubtful the New South Wales legislators would find it difficult to understand why entities/collectives might refuse to allow their facilities to be used to enable eugenic sterilization of people described as "human wreckage,"[57] "degenerates"[58] and "defectives."[59] The would likely concede that it is reasonable, prudent and consistent with the best traditions of liberal democracy to honour collective refusal to cooperate or collaborate in such practices, notwithstanding popular

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[57] Emily Murphy, "Sterilization of the Insane." The Vancouver Sun (3 September 1932), Wayback Machine (website), online: <http://wayback.archive-it.org/2217/20101208161436/http://www.abheritage.ca/famous5/achievements/reading/sterilization_insane.html>.

[58] Richard Cairney,"Democracy was never intended for degenerates": Alberta's flirtation with eugenics comes back to haunt it" (1996) 155(6) CMAJ 789 at 791, online: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1335257/pdf/cmaj00102-0185.pdf>.

[59] Marie Stopes, Roman Catholic Methods of Birth Control (London: Peter Davies, 1933) at 197-215.

opinion and the views of prominent establishment influencers. In contrast, their *Act* reflects the view that it can be unreasonable to refuse to allow homicide or suicide in one's premises, and that dissent from this position should not be tolerated.

III.40 One might argue that the *Act* simply extends rights and freedoms associated with residential tenancy: that residential facilities are the homes of people in care, and that objecting entities/collectives, like landlords, should not be able to prevent them from having euthanasia/assisted suicide in their own homes.[60] However, landlords are not required to help tenants travel to see EAS practitioners who are unable to make home visits, so the analogy does not support an expectation that objecting entities/collectives must actively facilitate patient transfer to obtain the services elsewhere.

Practitioner credentialing (privileges: scope of practice)

III.41 Medical practitioners who visit health care establishments in New South Wales are expected to have their scope of practice (also known as credentials/privileges) specified in written service contracts.[61] In 2002 the Ministry of Health stated that "adequate formal appointment and credentialling processes" was mandatory;[62] this is presumed though not stated in updated guidance[63] and a current policy directive.[64] Residential care facilities are not part of the NSW public health system, but national legislation requires them to ensure that their employees are “competent” and have “qualifications and knowledge to effectively perform their roles.”[65] This provides a legal mandate for residential care credentialing.

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[60] For example, *QLRC 2021*, *supra* note 6 at para 15.174.

[61] Health Services Act (NSW) at Chapter 8, online: <https://legislation.nsw.gov.au/view/whole/html/inforce/current/act-1997-154#ch.8>

[62] NSW Ministry of Health Statewide Services Development Branch,"Guide to the Role Delination of Health Services, 3rd ed" (July, 2002), NSW Government (website) at i, online: <https://www.health.nsw.gov.au/services/publications/guide-role-delineation-health-services.pdf >.

[63] NSW Ministry of Health Strategic Reform and Planning Branch, "Guide to the Role Delineation of Health Services, 5th ed" (December, 2021), NSW Government (website), online: < https://www.health.nsw.gov.au/services/publications/role-delineation-of-clinical-services.PDF>.

[64] NSW Ministry of Health, "Policy Directive: Visiting Practitioner Appointments in the NSW Public Health System" (16 Nov 2016) NSW Government (website), online: < https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2016_052.pdf>.

[65] Aged Care Quality Standards, Standard 7(3)c (27 May 2022), Aged Care and Quality Safety Commission (website), online: <https://www.agedcarequality.gov.au/sites/default/files/media/Guidance and resources_Standard 7.pdf>.

III.42 Since the *Act* requires EAS practitioners to have special training [I.10] one would expect EAS to be specifically identified when a facility recognizes practitioners' credentials and defines their scope of practice. On the other hand, one would expect objecting entities/collectives to refuse to include EAS in granting credentials because that would explicitly affirm the acceptability of euthanasia/assisted suicide and authorize the procedures, blatantly contradicting their moral commitments.

III.43 The *Act* is silent about credentialing, but it demands that entities/collectives allow qualified practitioners to provide EAS services to patients in their facilities. This poses a dilemma for objectors.

> i) They could refuse to grant credentials that permit EAS, and refuse to allow uncredentialled practitioners access to their facilities. However, this would leave objecting entities/collectives liable to legal action for non-compliance with the *Act*. Further, EAS practitioners may surreptitiously circumvent the prohibition, which, given the requirements of the *Act*, would leave the entities/collectives without legal recourse, and may have other adverse affects.[66]
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> ii) They could grant *other* privileges to non-facility EAS practitioners, and then tolerate their provision of EAS services if they abide by restrictions imposed [III.18]. However, allowing practitioners to provide services not permitted by institutional credentials may give rise to legal liability. Moreover, it would require entities/collectives absolutely opposed to euthanasia/assisted suicide to make a policy explaining how euthanasia/assisted suicide should be provided in their facilities: an absurd or at least hopelessly convoluted approach.
>
> iii) They could grant credentials explicitly authorizing EAS, making clear their opposition to the procedures and setting out conditions and restrictions on provision of the service in order to protect other patients, staff and mitigate harm to institutional moral integrity. This may be the only way to ensure that restrictions can be enforced.

III.44 Driving objecting entities/collectives into a trap from which they can only escape by explicitly authorizing something they find morally abhorrent is a clever but ugly example of coerced expression, but consistent with the bias previously noted [III.40].

Summary

III.45 Factors relevant to moral decision-making by entities/collectives are not necessarily identical to those concerning individuals, and the concept of individual freedom of conscience is applied

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[66] Kelly Grant, "Vancouver doctor cleared of wrongdoing in probe into assisted death at Orthodox Jewish nursing home", *The Globe and Mail* (7 August, 2019), online: <https://www.theglobeandmail.com/canada/article-bc-doctor-cleared-of-wrongdoing-in-probe-into-assisted-death-at/>.

analogically to collectives, so some differences are to be expected. This paper presumes that entities/collectives are entitled to rely upon constitutional guarantees of freedom of conscience, notwithstanding differences between individuals and collectives in the exercise of that freedom. Individuals and entities/collectives are equally concerned to avoid complicity in perceived wrongdoing. This obviously includes taking part directly in what they deem to be a wrongful act, but also causally contributing to by collaboration or contingent cooperation.

III.46 The *Act* does not admit the possibility of conscientious objection by entities/collectives. Consistent with this, the *Act* acknowledges the need to respect individuals' culture, religion, beliefs, values and personal characteristics, but not those of entities/collectives. It imposes a number of constraints and requirements on objecting entities/collectives specifically to compel their cooperation and even collaboration, some of which go beyond legal constraints arising from legal occupancy status. Refusal to participate in or facilitate killing people for moral reasons is placed on the same level as refusals based on pragmatic considerations like lack of trained personnel or management of institutional branding. The *Act* thus implies that guarantees of freedom of conscience or religion are irrelevant to decision-making by entities/collectives about involvement in killing people, and, if they defend refusals on that basis, the Act puts them at a disadvantage.

III.47 The *Act* is is concerned with two kinds of institutions: "residential facilities" like nursing homes, hostels, group homes, etc. operated by "relevant entities" (excluding individuals), and "health care establishments" like hospitals or hospices operated by "health care entities" (including individuals). In applying the *Act* one can distinguish between health care establishments and residential facilties. Regardless of structure, an “institution” in the sense relevant here always manifests a collective enterprise by individuals, so the term “entity/collective” is used here to keep this in mind.

III.48 The *Act* does not require entities/collectives to provide euthanasia or assisted or even to provide information about the procedures, so it does not threaten institutional freedom of conscience in relation to direct participation in EAS services. Instead, the *Act* is designed to enable the state to compel unwilling entities/collectives to cooperate and perhaps collaborate in killing people in their care or helping them kill themselves, and to disadvantage any that resist by appeals to freedom of conscience.

III.49 However, patients and practitioners cannot proceed with EAS in an objecting institution unless they notify insititutional authorities at each stage in the EAS process. This is fortunate, because providing EAS services in a private apartment in a residential facility would be radically different from providing them behind a curtain in a room shared with others, and the *Act* does not distinguish between the two situations. Nothing in the *Act* prevents objecting entities/collectives from imposing conditions on EAS-related activities that they are required to permit once they have been notified.

III.50 Objecting entities/collectives must allow all institutional occupants access to EAS information. They could direct all patient enquiries about EAS to staff members trained to provide patients with information necessary to enable informed decision-making without compromising institutional moral integrity. Hence, the cooperation required in providing information about EAS does not appear to undermine institutional freedom of conscience.

III.51 The *Act* leaves room for objecting entities/collectives to direct staff to fully and compassionately explore and document first requests, refuse those found to be clear and unambiguous, and provide information enabling patients to seek EAS elsewhere. They can thus comply with a number of the *Act's* provisions without compromising institutional moral integrity. However, the *Act* also requires objecting entities/collectives to allow EAS practitioners to accept first and final requests from anyone in their health care establishments and residential facilities. Accepting requests (i.e., agreeing to act upon them), especially final requests, is more directly supportive of and causally related to euthanasia and assisted suicide than merely receiving and responding to reqests, and thus more likely to be problematic for objecting entities/collectives.

III.52 Moreover, the *Act* demands that objecting entities/collectives allow EAS practitioners to provide all EAS assessments, consultations and euthanasia/assisted suicide for permanent residents in residential facilities. Contingent cooperation of this kind is likely to be problematic, especially in relation to patients who share rooms with others. If EAS practitioners cannot attend, objecting entities/collectives must "take reasonable steps to facilitate the transfer" EAS candidates to a location where they can receive EAS services, including lethal injection. This suggests that active collaboration might be expected, and it goes well beyond merely granting the equivalent of a residential tenancy right to service delivery at home. Landlords are not forced to help tenants travel to see EAS practitioners who can't make home visits.

III.53 Objecting entities/collectives may refuse to allow the EAS process for institutional occupants in health care establishments and residential facilities only if, once more, they "take reasonable steps to facilitate" transfers to enable the procedures elsewhere. If that means initiating rather than simply cooperating in a transfer requested by others, the purported compromise may amount to a choice between two objectionable alternatives. In addition, the *Act* allows legal action against objecting entities/collectives that require transfers from their health care establishments for EAS procedures (including euthanasia and assisted suicide) if transfer “would not be reasonable in the circumstances.” It also enables patients and EAS practitioners to veto transfers of institutional occupants from residential facilities, thus forcing objecting entities/collectives to cooperate.

III.54 The *Act's* demands that qualified practitioners be allowed to provide EAS services to patients in facilities poses a dilemma for objecting entities/collectives in granting credentials. Granting credentials for EAS would explicitly affirm the acceptability of euthanasia/assisted suicide and authorize the procedures, thus contradicting their moral commitments. However, granting credentials may be necessary to avoid legal liability, and it may be the only way for objecting entities/collectives to impose enforceable conditions and restrictions on provision of the service in order to protect other patients, staff and mitigate harm to institutional moral integrity.

III.55 The provisions of the *Act* suggest that NSW legislators not only believe that it is morally acceptable to kill patients or help them kill themselves in accordance with their law, but are unable to imagine or unwilling to concede that others could reasonably and collectively hold and live in accordance with the contrary view, and should be entitled to do so in a democratic state. This demonstrates a lack of moral imagination or unreflective and entrenched authoritarianism inconsistent with the best traditions of liberal democracy.