

TERMINAL ILLNESS OR A “GRIEVOUS AND IRREMIABLE MEDICAL CONDITION” AND IN AN “ADVANCED STATE OF IRREVERSIBLE DECLINE IN CAPABILITY”

1. Clause 4 of the EOLC Bill sets out the eligibility criteria for accessing euthanasia or assisted suicide. These criteria will be interpreted and applied on a day to day basis by medical practitioners. Importantly, most of these practitioners are likely to be General Practitioners, rather than Palliative Care Specialists or specialists in the particular condition afflicting the person in question.

2. Clause 4 provides:

In this Act, **person who is eligible for assisted dying** means a person who—

- (a) is aged 18 years or over; and
- (b) is—
 - (i) a person who has New Zealand citizenship as provided in the Citizenship Act 1977; or
 - (ii) a permanent resident as defined in section 4 of the Immigration Act 2009; and
- (c) suffers from—
 - (i) a terminal illness that is likely to end his or her life within 6 months; or
 - (ii) a grievous and irremediable medical condition; and
- (d) is in an advanced state of irreversible decline in capability; and
- (e) experiences unbearable suffering that cannot be relieved in a manner that he or she considers tolerable; and
- (f) has the ability to understand—
 - (i) the nature of assisted dying; and
 - (ii) the consequences for him or her of assisted dying.

3. Euthanasia or assisted suicide is available to a person, possibly within a matter of days, if two doctors consider the criteria in cl 4 are met. The proposed doctors are:

3.1 the “attending medical practitioner” in cl 8, who is referred to in the course of this analysis as “**the first doctor**” or “**the first medical practitioner**” and who –

- (a) is the doctor to whom a person first expresses their wish for EAS;
- (b) may or may not be the person’s usual GP;¹
- (c) must (unless they exercise a conscientious objection) reach an opinion as to whether the person is eligible for EAS;²

3.2 the “independent medical practitioner” in cl 11, referred to in the course of this analysis as “**the second doctor**” or “**the second medical practitioner**” and who -

- (a) is appointed by the SCENZ Group as a doctor who is "willing to participate" in EAS;³
- (b) must read the person’s files, examine the person, and reach an opinion as to whether that person is eligible for EAS.⁴

¹ EOLC Bill, cl 3.

² Clauses 7 and 10.

³ Clauses 3 and 19.

⁴ Clause 11(3).

4. A breakdown of the eligibility criteria follows.

“18 years or over”

5. The EOLC Bill restricts access to assisted suicide to persons over the age of 18.⁵ The former Attorney General Chris Finlayson has opined that this age limit discriminates against eligible 16 and 17 year old New Zealanders who may also wish to be euthanised or be assisted to commit suicide:⁶

“Put another way, 16 and 17 year olds are disadvantaged vis-a-vis those aged 18 and over because they are ineligible for assisted dying.... I think the Bill appears to be inconsistent with the right to be free from discrimination on the grounds of age affirmed in s 19(1) of the Bill of Rights Act.”

6. The 18 year age limit is assessed separately (see the “Age Limit: 18 years or over” analysis).

“Suffers from.. a terminal illness .. or a grievous and irremediable medical condition”

7. Clause 4(c) of the End of Life Choice Bill legalises euthanasia or assisted suicide for anyone with a terminal illness that is likely to result in death within 6 months or who is experiencing the symptoms of a serious, irremediable medical condition and who is in an “advanced state of irreversible decline in capability”.⁷

“Terminal illness”

8. There are numerous problems arising out of the “terminal illness” formulation:

- 8.1 Medical diagnosis is a matter of probability, not certainty, and practitioners frequently refer to it as an “art not a science”. The word “likely” in the clause reflects this uncertainty. Medical misdiagnoses occur in New Zealand every year and include diagnoses of terminal illnesses that are later found to be misdiagnoses.⁸

- 8.2 It is difficult to accurately predict life expectancy in cases of terminal illness. Lecretia Seales, for example, was diagnosed in March 2011 with brain cancer. At that time, her doctors gave her “weeks to live”.⁹ She lived for more than three years, until June 2015.¹⁰

- 8.3 Even New Zealand’s Health Minister David Clark has told Parliament that it is not possible to determine with complete accuracy how long a person has to live and that even the term “terminally ill” is no longer commonly used. While introducing the Second Reading of the Misuse of Drugs (Medicinal Cannabis) Bill, he stated:¹¹

“I propose amending the bill via a Supplementary Order Paper at the committee of the whole House stage to increase the number of people eligible to use illicit cannabis under

⁵ Clause 4(a).

⁶ Christopher Finlayson *Report of the Attorney-General under the New Zealand Bill of Rights Act 1990 on the End of Life Choice Bill* (4 August 2017) at [24] and [36]; see also discussion below: “Discrimination in the Bill”.

⁷ EOLC Bill, cl 4(c), (d)

⁸ For example, there were 20 reported cases from July 2016 till June 2017 where initial assessments and diagnoses failed to find the key clinical issue; see Health Quality & Safety Commission Learning from adverse events: Adverse events reported to the Health Quality & Safety Commission 1 July 2016 to 30 June 2017 (2017) at 40; see also Eileen Goodwin “Dunedin Hospital’s cancer misdiagnosis” HealthCentral.nz (online ed, New Zealand, 21 December 2017); healthcentral.nz/dunedin-hospitals-cancer-misdiagnosis

⁹ Rebecca Macfie “Dying Wishes” *Noted* (online ed, New Zealand, 8 January 2015).

¹⁰ NZME “Right to die: Lecretia Seales dies hours after judgment” *NZ Herald* (online ed, New Zealand, 5 June 2015).

¹¹ Hansard Parliamentary Debate: Thursday, 29 November 2018.

the exception and statutory defence provisions. This change would remove the 12 month restriction and the term "terminally ill" from the provisions. It is not possible to predict with complete accuracy the progression of life-threatening conditions. In addition, terminally ill is no longer commonly used in palliative care and can be confronting for some patients..."

- 8.4 The problems the "terminal illness" formulation could generate are further illustrated by the experience in Washington in the United States, where to be eligible for assisted suicide, one needs to have a terminal illness.¹² Washington's law defines a terminal illness as "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months,"¹³ a definition that is similar and slightly narrower than that found in the End of Life Choice Bill.
- 8.5 Although the definition from Washington appears to be rigorous, it cannot be accurately enforced in practice. A government report found that as of 15 August 2017, 8 participants from 2016 were still alive. There were also four remaining participants from 2015, four from 2014, four from 2013, one from 2011, and one from 2009.¹⁴ This means that 22 terminally ill patients were alive more than 6 months after they were confirmed as having only months left to live. Potentially, other patients who could have survived in the same way ingested the prescribed pills and died.
- 8.6 The figures from Washington raise concerns but they are not unprecedented. Research has suggested that errors of this nature are prevalent and probably unavoidable. There are two reasons for this. Firstly, doctor's estimates of how long someone will take to die are often inaccurate.¹⁵ Secondly, doctors can misdiagnose at least 5% of patients; when a minor condition has been misdiagnosed as a serious condition, a doctor will give an excessively short prognosis.¹⁶
- 8.7 Finally, the 6 month life expectancy limit is arbitrary. The EOLC Bill provides no rationale for why only terminally ill people with 6 months to live should be eligible to be euthanized or assisted to commit suicide. Applying Lord Goff's conclusion in *Airedale NHS Trust v Bland*, there is no logical reason why the limit should not be **more** than 6 months.¹⁷ There are "Right to die" supporters who are critical of the 6 month limit and argue that it should not be so limited.¹⁸ Switzerland, The Netherlands, Belgium and (more recently) Canada, all have legislation that does not limit the right to euthanasia and assisted suicide to those with a prognosis of less than six months to live.

"A grievous and irremediable medical condition"

9. "A grievous and irremediable medical condition" is not further defined by the EOLC Bill. No list of conditions or specification of how advanced a particular condition must be is provided. The definition could include permanent intellectual or physical disability, a medical condition

¹² Wash Rev Code § 70.245.020(1) (2008).

¹³ § 70.245.010(13).

¹⁴ Washington State *2016 Death With Dignity Act Report* (Washington State Department of Health, DOH 422-109 201, September 2017) at 5.

¹⁵ Nicholas A Christakis and Elizabeth B Lamont "Extent and determinants of error in doctors' prognoses in terminally ill patients: prospective cohort study" (2000) 320 *BMJ* 469 at 471.

¹⁶ Hardeep Singh, Ashley N D Meyer and Eric J Thomas "The frequency of diagnostic errors in outpatient care: estimations from three large observational studies involving US adult populations" (2014) 23 *BMJ Qual Saf* 727 at 729.

¹⁷ *Airedale NHS Trust v Bland* [1993] AC 789, [1993] 1 All ER 821 (HL) at 867.

¹⁸ My Death My Decision "Why the 6 month "safeguard" is too limiting" <www.mydeath-mydecision.org.uk>.

for which there is no complete cure and which brings a more than minor level of permanent disability, and could extend to some serious psychological illnesses or mental health conditions.¹⁹

10. The definition is subjective, vague and unspecific, and ultimately not fit for use in medical practice. It could only lead to inconsistent application between practitioners and is capable of extending euthanasia and assisted suicide to conditions well beyond what most New Zealanders would tolerably expect under the EOLC Bill, including mental illness and disability.

Mental Illness

11. The architect of the EOLC Bill, Act MP David Seymour, has claimed that the Bill has been drafted so as to exclude those with mental illness. He has stated:

"A person with any kind of serious mental illness, by definition, has a distorted view of what ending their life means. If your argument is I'm depressed and I want assisted dying, the rules actually exclude you."²⁰

"There has been a lot of misinformation about the Bill. Some people have said it would affect mentally disabled people, which is just not the case"²¹

12. If this claim is correct, it would rule "out of scope" large numbers of terminally ill New Zealanders who might otherwise meet all of the cl 4 criteria, given that most independent reports show that somewhere between 25% and over 50% of terminally ill patients suffer from depression.²² In fact, patients who desire to die are statistically more likely to be suffering from mental illness.²³

13. In any event, on analysis of the EOLC Bill it is incorrect to assert that those suffering from mental illness would fall outside of its scope. Its provisions do not specifically exclude mental illness from the qualifying criteria, and a number of mental illnesses could fall within cl 4(c) of the EOLC Bill and qualify as "a grievous and irremediable medical condition". As for the other eligibility criteria in cl 4(d), (e) and (f):

- 13.1. Some mentally ill New Zealanders may also be considered to be "in an advanced state of irreversible decline in capability" and people who "experience unbearable suffering";

¹⁹ Segen's Medical Dictionary defines a medical condition as a "disease, illness or injury, any physiologic, mental or psychological condition or disorder (eg orthopaedic, visual, speech or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, coronary artery disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, TB, drug addiction, alcoholism", PMI *Segen's Medical Dictionary* (ebook ed, Farlex, 2012); see also the US Institute of Medicine's definition of 'serious medical condition' which encompasses conditions that cause serious disability, pain, discomfort or that require significant monitoring as well as conditions that are life threatening. This includes: cancer, heart disease, stroke, HIV/AIDS, stroke, closed head or spinal cord injuries, mental retardation, congenital malformations, arthritis, mobility disorders, blindness, Alzheimer's disease, dementia, chronic obstructive pulmonary disease, paraplegia, Down's syndrome, depression, diabetes, conditions requiring anticoagulation treatment, severe asthma, severe allergies, schizophrenia and others, Carole A Chrvala and Steven Sharfstein (eds) *Definition of Serious and Complex Medical Conditions* (National Academy Press, Washington, DC, 1999) at 19 and 20.

²⁰ Thomas Manch and Ruby Nyika "Catholic Church warns of euthanizing for gluten intolerance in push for submissions" *Stuff* (online ed, New Zealand, 9 February 2018).

²¹ Matthew Littlewood "Safeguards will protect End of Life Choice Bill, Seymour says" *Stuff* (online ed, Timaru, 15 March 2018).

²² Robert L Fine "Depression, anxiety, and delirium in the terminally ill patient" (2001) 14 BUMC Proceedings 130 at 130; but see Ali Abbas Asghar-Ali, Kamal C Wagle, and Ursula K Braun "Depression in Terminally Ill Patients: Dilemmas in Diagnosis and Treatment" (2013) 45 JPSM 926 at 926.

²³ Keith G Wilson and others "Mental disorders and the desire for death in patients receiving palliative care for cancer" (2014) 0 BMJ Supportive and Palliative Care 1 at 1 and 6.

- 13.2. Many mentally ill New Zealanders will be able to satisfy the basic cl 4(f) test for "competence". The person is only required to have "the ability to understand the nature of assisted dying and the consequences for him or her of assisted dying". They merely need to understand that EAS involves taking or being given a lethal drug and that the consequence of this is that they will die.
14. The Disability Rights Commissioner also disagrees with David's Seymour's interpretation of the Bill. In her Submission to the Justice Select Committee on the EOLC Bill dated 7 March 2018, she stated:²⁴
- "This eligibility criteria captures a broad range of illnesses and conditions. It is possible that relatively common chronic health conditions, such as diabetes, heart disease, neurological disorders, intellectual disabilities, autism and other neuro-disabilities and regional pain syndromes, if advanced and sufficiently degenerative, could fall within the Bill's scope. Furthermore, the criteria is not expressly limited to physical conditions. It is possible that a person experiencing a mental health or psychological disorder, such as depression, anorexia or a bi-polar disorder could, in certain circumstances, be interpreted as fitting the criteria".*
15. The Canadian legislation regulating medical assistance in dying²⁵ contains the exact same phrase, "a grievous and irremediable medical condition, as cl 4(c) of the EOLC Bill in its definition of who is eligible for EAS.²⁶ The Government of Canada does not share Mr Seymour's interpretation of the exclusion of mentally ill persons from this criterion. Their website which contains information about accessing EAS now states:²⁷
- "If you have a mental illness or a physical disability and wish to seek medical assistance in dying, you may be eligible..."*
16. Of further relevance is a recent Report by the Canadian Institute for Research and Public Policy (IRPP) entitled "Interpreting Canada's Medical Assistance in Dying Legislation", the sole purpose of which is "to determine the most defensible interpretations of the [Canadian euthanasia] legislation, using the tools of statutory interpretation supported by relevant clinical and other forms of expertise".²⁸ Bearing in mind that the EOLC Bill's phrase "a grievous and irremediable medical condition" appears to have been taken directly from the Canadian euthanasia law, the following observations in the IRPP Report regarding mentally ill people are relevant (emphasis added):²⁹
- **"Persons with mental illness can be capable of making decisions** with respect to their health (even when the consequences of the decision are death).
 - Mental illness can be serious and incurable.
 - Persons with mental illness as their sole underlying condition can be in an advanced state of irreversible decline in capability caused by the mental illness.

²⁴ Paula Tesoriero "Submission of The Disability Rights Commissioner on the End of Life Choice Bill" at [10] (emphasis added).

²⁵ The Canadian legislature chose the phrase 'medical assistance in dying' or MAiD to describe euthanasia and assisted suicide.

²⁶ Criminal Code RSC 1985 c C-46, s 241.2(1)(c).

²⁷ Government of Canada "Medical assistance in dying" (26 October 2018) <www.canada.ca>.

²⁸ J Downie and JA Chandler, "Interpreting Canada's Medical Assistance in Dying Legislation", IRPP Report (March 2018), 23. The Report was drafted because "uncertainty about the meaning of specific terms in the Canadian MAiD legislation puts Canadians at risk in a number of ways". The authors have therefore identified "six key phrases in the current law that urgently need clarification" and "explain how these phrases are generating interpretive uncertainties, propose an interpretation for each phrase and justify each interpretation."

²⁹ Ibid, 29.

- Mental illness can cause enduring physical or psychological suffering that is intolerable to the person and that cannot be relieved under conditions that they consider acceptable.”

17. The IRPP Report concluded:

“It should be noted here, before closing, that few patients with mental illness as the sole underlying medical condition will meet all of the eligibility criteria. In particular, few will meet the criterion of their natural death being “reasonably foreseeable.” Some, **but not all**, will fail to meet the legal standard of mental capacity. For some, their condition may be curable and their suffering remediable. However, some may meet all the criteria and, if they do, then the legislation does not otherwise exclude them.”

18. In any event, in 2016 the Canadian government appointed the Council of Canadian Academies to examine whether mentally ill Canadians should be able to access euthanasia and assisted suicide “where mental illness is the sole underlying medical condition”, and the Council tabled its Report on this (and other issues) in Parliament in December 2018.³⁰ The Report is now under consideration and no doubt the issue will come up for consideration during Canada’s parliamentary review of its euthanasia legislation in 2021.

19. In Belgium, where euthanasia legislation uses a similar phrase (“serious and incurable condition”³¹) mental illness has become a rapidly growing ground for euthanasia. Two observations may be made regarding its practice of euthanising Belgians with mental illness:

19.1 Belgium regularly euthanises citizens suffering from mood disorders. A 2015 study by Belgian psychiatrist Dr Lieve Thienpont examined the cases of 100 of her psychiatric patients who requested euthanasia for their suffering. It found that 58 of the patients suffered from a treatment-resistant mood disorder (including 48 with major depressive disorder and 10 with bipolar disorder) and/or a personality disorder (50), while 29 patients had both. In total, 48 of the euthanasia requests were accepted and 35 were carried out.³²

19.2 Both Belgian academics and international “right to die” advocates argue the exact opposite of David Seymour’s claim that depressed or mentally ill persons are incapable of consenting to euthanasia. A recent report, published (amongst others) by the World Right to Die Federation, concluded (emphasis added):³³

“The increase [in Belgium] in euthanasia cases in people with a diagnosis of psychiatric disorder or dementia has given rise to some concerns, one of which relates to the specific competencies of physicians. Dealing with euthanasia requests is a challenging task for physicians, especially so when a request is based on psychological suffering. Assessment of decision-making capacity in people with psychiatric disorders is a

³⁰ Government of Canada “Medical assistance in dying” (26 October 2018) <www.canada.ca>; and An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying) SC 2016 c 3, s 9.1(1).

³¹ Loi relative à l’ euthanasie [Euthanasia Act] of 28 May 2002, Moniteur Belge [MB] [Official Gazette of Belgium], 22 June 2002, 28515, art 3 § 1.

³² Dr Lieve Thienpont and others “Euthanasia requests, procedures and outcomes for 100 Belgian patients suffering from psychiatric disorders: a retrospective, descriptive study” (2015) 5 *BMJ Open* 1 at 5; according to the study other psychiatric diagnoses included 14 psychotic disorders, 11 anxiety disorders, 10 eating disorders, 10 substance use disorders, 9 somatoform disorders, 1 attention deficit hyperactivity disorder, 7 obsessive-compulsive disorders, 7 dissociative disorders, 6 with complicated grief and 23 with somatic illnesses.

³³ Sigrid Dierickx, “Euthanasia practice in Belgium A population-based evaluation of trends and currently debated issues”, July 5, 2018 (published at https://www.worldrtd.net/sites/default/files/newsfiles/Sigrid_Dierickx.pdf), citing Cairns R, Maddock C, Buchanan A, David AS, Hayward P, Richardson G, et al, “Reliability of mental capacity assessments in psychiatric in-patients”, *Br J Psychiatry* 2005; 187:372–8 and Trachsel M, Irwin SA, Biller-Andorno N, Hoff P, Riese F, “Palliative psychiatry for severe and persistent mental illness”, *BMC Psychiatry BMC Psychiatry*. 2016;16.

complex undertaking. **However, studies of mental capacity in psychiatric patients show that mental capacity can be reliably assessed....**

Despite all existing and novel treatments for mood disorders, euthanasia may still be the only option available for certain people suffering from severe treatment-resistant depression. Given the complex nature of euthanasia requests expressed by people with mental illness, it is essential to develop practice guidelines for evaluating and responding to these requests.”

20. Once again applying Lord Goff’s conclusion in *Airedale*, there is no logical reason why euthanising or helping those with “a grievous and irremediable medical condition” to commit suicide would not also be extended to many mentally ill New Zealanders. There is no truth to any claim that it would not. Clearly it has been the experience in those few jurisdictions which have legalised EAS to date.

Disabilities

21. The same logic applies to disabled New Zealanders, who also fall within the EOLC Bill's scope. Nevertheless, Mr Seymour has made a number of confusing public statements over whether the EOLC Bill extends to disabled people or not:

I would never write a bill that somehow discriminated against someone with a disability ... this is not about them, it is about people who are in a state of decline and have been for a long time.³⁴

She’s got two concerns, one that somebody with a disability might be somehow euthanised because of their disability – that’s impossible.³⁵

Disabled people should be given the same rights as anyone else to choose to end their lives, but ... the bill’s drafting [is] clear that only people with terminal illnesses, whether disabled or not, could make use of euthanasia services ... the bill as drafted grant[s] equal access to end of life choices, while safeguarding against vulnerable people making use of the law unnecessarily.³⁶

22. The Disability Rights Commissioner is in no doubt over the extension of the EOLC Bill to disabled New Zealanders. In concluding that the EOLC Bill “should not be passed into law”, the Commissioner stated:³⁷

Taking into account the [Human Rights] Commission’s position above, and my specific statutory responsibility to the disability community, my position is that:

- a. this Bill undermines the position of disabled and vulnerable members of our community and poses significant risks to them, as individuals and as a group;
- b. the proposed safeguards in the Bill are deficient, both procedurally and substantively, for both terminal and non-terminal conditions;

³⁴ Adele Redmond “End of Life Choice Bill ‘not about disability’, David Seymour says” *Stuff* (online ed, New Zealand, 26 April 2018).

³⁵ “ACT’s David Seymour defends End of Life Choice Bill after Disability Commissioner’s criticism” *1 News Now* (online ed, New Zealand, 8 March 2018).

³⁶ Thomas Coughlan “Seymour’s bill ‘woefully inadequate’: Disability Rights Commissioner” *Newsroom* (online ed, Wellington, 12 March 2018).

³⁷ Paula Tesoriero “Submission of The Disability Rights Commissioner on the End of Life Choice Bill” at [4].

- c. It is not possible to consider the issue of legalising assistance in dying in isolation from palliative care service provision and the current services and resources available to those who experience serious but non-terminal conditions.
23. The Canadian assisted suicide legislation also defines a “grievous and irremediable medical condition” as “a serious illness, disease or *disability*”.³⁸ Thus although the EOLC Bill does not define what a “grievous and irremediable medical condition” is, there is an indication that the Courts of New Zealand will include disability in any interpretation of the phrase.

“Is in an advanced state of irreversible decline in capability”

24. The next eligibility criterion states that the applicant must be “in an advanced state of irreversible decline in capability”.³⁹ This criterion is unclear. The EOLC Bill provides no guidance on what this phrase means or how it should be interpreted. Given the EOLC Bill’s focus on personal autonomy and a person’s own perception of their situation, it is likely to be interpreted as relating to any state of permanent physical or mental disability, so long as it is more than minor.
25. In recent public comments, David Seymour has argued that this criterion is adequately drafted and should be interpreted in the following way:⁴⁰
- “You’ll get people who say ‘hang on a minute ... what about people in wheelchairs? What about ... somebody who’s in a car crash and is upset that they have lost their legs...? But the reason you have to get through the [advanced state of irreversible decline in capability requirement] is that this is not actually about your level of capability... this is about people who are in decline, who are getting worse and have been for some time. So that’s why we talk about an “advanced state of irreversible decline in capability.”
26. Mr Seymour’s statement provides one possible interpretation. However, it is not supported by the EOLC Bill’s own formulation and, in any event, even if it were the preferred interpretation it is problematic: if the requirement is that a person should be actively ‘deteriorating’ or ‘advancing’ in their loss of capability, the question is from what starting point is the comparison to be made, both in terms of time and in terms of capability. It is also not clear what the policy objective would be for allowing assisted suicide for persons with degenerative conditions, such as Huntington’s, but excluding it for static conditions, such as paraplegia. Further, his interpretation could also raise issues of discrimination under s 19 of the New Zealand Bill of Rights Act 1990.
27. The phrase “an advanced state of irreversible decline in capability” appears to have been taken directly from the criteria of Canada’s Bill C-14, which also legalises euthanasia and assisted suicide in Canada for “grievous and irremediable medical conditions” that involve “an advanced state of irreversible decline in capability”. The recent Report by the Canadian

³⁸ Criminal Code RSC 1985 c C-46, s 241.2(2).

³⁹ EOLC Bill, s 4(d).

⁴⁰ David Seymour “Public Consultation Meeting on End of Life Choice bill held by Paula Bennett MP” (Upper Harbour Electorate, 10 July 2018); In comments to Newsroom in response to the Disability Commissioner’s report on the bill, Seymour also stated: “A person cannot access an assisted death unless they are in ‘an advanced state of irreversible decline in capability.’ This means that a person cannot access an assisted death because of their level of capability, it is being in an advanced state of decline that counts”, Thomas Coughlan “Seymour’s bill ‘woefully inadequate’: Disability Rights Commissioner” *Newsroom* (online ed, New Zealand, 8 March 2018); However, Mr Seymour’s hand-out at Paula Bennett’s consultation meeting entitled “End of Life Choice Bill – Eligibility Criteria” did not make that claim, stating that the bill’s reference to an advanced state of irreversible decline in capability “limits access to medically assisted dying to those who experience significant loss of capability as a result of their illness. That means they have lost the ability to live a full life, such as by a combination of a loss of mobility, loss of senses, and loss of ability to eat, drink or speak”.

Institute for Research and Public Policy entitled “Interpreting Canada’s Medical Assistance in Dying Legislation” (discussed above) points to “multiple areas of uncertainty” regarding the “advanced state of irreversible decline in capability” criterion.⁴¹ The IRPP Report, geared solely at determining “the most defensible interpretations of the legislation, using the tools of statutory interpretation supported by relevant clinical and other forms of expertise” goes on to highlight all of the ambiguities in the “advanced state of irreversible decline in capability” phrase:

“First, is “capability” limited to physical function, or does it also include cognitive function?

Second, do the terms “advanced state” and “decline” mean that the loss of capability must be a gradual, protracted process? If so, a patient who has a sudden, precipitous loss of capability would be ineligible for MAiD. If meeting this criterion requires only a substantial loss of capability, no matter the speed of the decline, a patient who experiences a precipitous loss would still be eligible.

Third, can the decline in capability have stabilized, or must it be continuing?

Fourth, is the decline in capability assessed according to a subjective or an objective standard — that is, by the patient or by the practitioner?

Fifth, is the decline in capability assessed relative to the patient’s prior capability or relative to the general population’s capability?”

28. The IRPP Report arrives at the following “proposed interpretation” of the criterion for Canadian doctors:⁴²

“Advanced state of irreversible decline in capability” includes declines in cognitive as well as physical functions; sudden as well as gradual losses of capability; and ongoing as well as stabilized declines in capability. It is assessed by the medical or nurse practitioner, and it is assessed relative to the patient’s prior capability.”

29. Additionally, the IRPP Report notes that “persons with mental illness as their sole underlying condition can be in an advanced state of irreversible decline in capability caused by the mental illness.”⁴³

⁴¹ J Downie and JA Chandler, “Interpreting Canada’s Medical Assistance in Dying Legislation”, IRPP Report (March 2018), 23. The Report was drafted because “uncertainty about the meaning of specific terms in the Canadian MAiD legislation puts Canadians at risk in a number of ways”. The authors have therefore identified “six key phrases in the current law that urgently need clarification” and “explain how these phrases are generating interpretive uncertainties, propose an interpretation for each phrase and justify each interpretation.”

⁴² Ibid, 24.

⁴³ Ibid, 29.