COMPETENCY CRITERIA: THE ABILITY TO UNDERSTAND THE NATURE AND CONSEQUENCES OF ASSISTED DYING

1. The final criterion that those requesting euthanasia or assisted suicide under the End of Life Choice Bill must meet is that they have the ability to understand the nature of assisted dying and the consequences of assisted dying.[1]

2. The required competence – the ability to understand and to make informed choices – is fundamental to the concept of the exercise of informed consent, and underpins the Code of Patient Rights established under the Health and Disability Act 1994.

3. The Explanatory Note to the End of Life Choice Bill claims that it "outlines a stringent series of steps to ensure the person is mentally capable of understanding the nature and consequences of assisted dying".[2] That is not correct. The competency test is very limited and offers no 'stringent steps' for ascertaining whether a person is competent. For a person to be deemed competent under the Bill, it is required that the person:[3]

> (f) has the ability to understand—
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> (i) The nature of assisted dying; and
>
> (ii) the consequences for him or her of assisted dying

4. The Bill's competence criterion sets a lower standard than the assessment for informed consent (used to assess consent for routine medical treatment). Given the presumption of competency in New Zealand, this criterion would exclude only an extremely small group of people who were unable to understand the very basic proposition that euthanasia or assisted suicide involves the administration of a lethal drug and that the consequences of euthanasia and assisted for them is death.[4] It would not exclude large numbers of people who are depressed or mentally ill.

5. This definition lacks a number of essential components. For example, it fails to refer to the person also needing to have the ability to retain or to weigh and balance that information. It does not refer to the need for the person to understand other key information relevant to their decision, such as the nature of their condition and prognosis, alternative treatments and supports that may be open to them, or any of the other matters referred to in cl 4 of the End of Life Choice Bill. New Zealand case law recognises that informed consent requires that the patient must be able to use the information provided in order to come to a decision, and as part of that must have competence or capacity. In *S v Attorney-General*, the High Court noted that the orthodox definition of capacity requires:[5]

> (a) the ability to understand relevant information;
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> (b) the ability to appreciate the nature of the situation and its likely consequences;
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> (c) the ability to manipulate the information rationally; and
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> (d) the ability to communicate choice.

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1 EOLC Bill, cl 4(f).
2 EOLC Bill (explanatory note) at 1.
3 Clauses 3 and 4(f).
4 Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, sch 1 Right 7(2); and Protection of Personal and Property Rights Act 1988, s 5.
5 *S v Attorney-General* [2017] NZHC 2629 at [777].

6. The prescriptive nature of the regime set out in the End of Life Choice Bill, which is discussed further below, requires a medical practitioner to approve a person as eligible for euthanasia or assisted suicide, provided that the applicant meets the criteria in cl 4 and has the level of capacity required in cl 4(f). The Bill provides for no exception for situations where the attending medical practitioners may have other concerns about the patient's competency or understanding.

7. The second medical practitioner is limited by the same framework. If either practitioner doubts that the application is incapable of understanding the nature and consequences of assisted dying, the applicant will be referred to an expert psychologist. However, they are also limited to assess whether the applicant meets the limited definition of competence. If they deem the person to meet it, they are obliged to confirm the person as eligible for EAS.

8. The competence test which has been discussed is strictly limited to its own narrow criteria. It does not incorporate many of the various other mandatory steps a doctor must follow in cl 8, once a patient has communicated their wish to be euthanised or to be assisted to commit suicide. These include giving the patient information regarding their condition's prognosis, information about the irreversible nature of assisted dying, and the impacts of assisted dying. They must also ensure that the person understands his or her other options for end of life care.[6]

9. Under the End of Life Choice Bill, a person's competence is to be assessed by whichever doctor that person first approaches, whether they know the person or not, and regardless of that doctor's expertise or experience in assessing competence.[7] The Bill does not provide for a specialist assessment of competence unless this first doctor (or the doctor providing the second opinion) considers that the person is not competent.[8] Consequently, a specialist has no role in re-assessing or reviewing a positive assessment of competence by the non-specialist first and second doctors. The specialist's involvement is thus facilitative rather than gate-keeping or protective: the apparent intent of their role is to ensure that persons are not wrongfully excluded from access to euthanasia or assisted suicide. They have no role in ensuring that persons are not wrongfully included.

10. Moreover, the Bill as drafted does not require any further assessment of competency after the decision is made by the first doctor (and confirmed by the SCENZ doctor) that the person is eligible to be euthanised or assisted to commit suicide. As no time limits are specified in the Bill, years may pass between that initial decision and the administration of the lethal drug. At the point of selecting (cl 15) and administering (cl 16) the lethal drug, possibly many years later, the attending medical practitioner is not required by the End of Life Choice Bill to assess competency. The practitioner is merely directed to "ask the person to choose one of the methods" for receiving the lethal drug and "ask the person if he or she chooses to receive the medication". There is no clarity as to what level of capacity the medical practitioner is expected to require from the patient at these stages of the process.

11. The issue that then arises (and which the End of Life Choice Bill fails to address) is whether a person who was competent at the time of a request but who has suffered a reduction in their competence by the time of scheduling the timing and/or consenting to the final administration of the lethal drug could be euthanised or helped to commit suicide. In its current form there is no clarity in the End of Life Choice Bill for medical practitioners, or for

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6 EOLC Bill, cl 8(2).
7 EOLC Bill, cl 10(2).
8 Clauses 10(2)(c) and 12.

people contemplating euthanasia or assisted suicide, and their families and whānau, on whether and under what circumstances the regime will allow this.

12. Nor is it clear whether a person's initial request for euthanasia or assisted suicide under cl 8, or the various EAS arrangements that must be made between a medical practitioner and a person whose request has received a "positive decision" under cl 14, might be regarded as constituting an "advance directive" for the purposes of the Code of Health and Disability Consumers' Rights, to be executed at a later stage when that person is no longer competent.[9] This is discussed in a separate analysis.

13. The risks highlighted above are that:

    13.1. mentally ill and depressed New Zealanders could satisfy the low-threshold competency test for euthanasia or assisted suicide, and doctors must facilitate their requests;

    13.2. other New Zealanders who are otherwise medically incompetent could satisfy the low-threshold competency test for euthanasia or assisted suicide, and doctors must facilitate their requests;

    13.3. the lack of any subsequent competence checks means that New Zealanders who had requested and were approved for EAS many months or years earlier could have lost the capacity to understand and make informed choices over their own best interests by the date of their death, making it virtually impossible at that time to determine if they are competent to choose EAS or not (though not necessarily impossible for a doctor to proceed with euthanising them regardless).[10]

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[9] The Code states that every health care consumer has a right to use advance directives in accordance with the common law, Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, sch 1 Right 7(5); the Code defines advance directives as a written or oral directive by which a consumer makes a choice about future health care decisions that is intended to be effective when they are no longer competent, sch 1 cl 4.

[10] A doctor could proceed with euthanasia in reliance on an advance directive, or on an instruction by a welfare guardian or person holding a power of attorney, or even in reliance on their own judgment (protected with immunity) that euthanasia is "in the best interests" of the patient; see also Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, sch 1 Rights 7(4) and 7(5), Right 7(4) provides that if a patient is not competent to make an informed choice and give informed consent; and no person entitled to consent on behalf of the patient is available, a doctor may provide services without obtaining the informed consent of the patient when: (a) it is in the best interests of the patient; and (b) reasonable steps have been taken to ascertain the views of the patient; and either (c) the provider believes, on reasonable grounds, that the provision of the service is consistent with the informed choice that the patient would have made if he or she were competent; or (d) if the patient's views have not been ascertained, the provider takes into account the views of other suitable people who are interested in the welfare of the patient and available to advise the provider".