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Manatū Hauora | Ministry of Health  
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Tēnā koe

## **Re: Review of the End-of-Life Choice Act 2019**

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) welcomes the opportunity to provide feedback on the End-of-Life Choice Act 2019 (the Act) as part of the review of the legislation.

The RANZCP is the principal organisation representing the medical specialty of psychiatry in Aotearoa New Zealand and Australia and is responsible for training, educating, and representing psychiatrists. The RANZCP has over 8400 members, including more than 5900 qualified psychiatrists and is guided on policy matters by a range of expert committees. This submission has been prepared in consultation with Tu Te Akaaka Roa, the New Zealand National Committee, and other Aotearoa New Zealand based Committees, including the Faculty of Old Age Psychiatry.

Tu Te Akaaka Roa acknowledges the wide range of views regarding voluntary assisted dying and supports medical practitioners to make their own ethical decisions regarding their involvement with voluntary assisted dying, in line with relevant legislation and the RANZCP's [Position statement 67: Voluntary assisted dying](#). Tu Te Akaaka Roa considers the Act to have sufficient clarity regarding the roles, responsibilities, and processes of assisted dying services. However, we suggest several changes to ensure the Act is implemented in an equitable way and with sufficient safeguards in place. Specifically, we recommend:

- Providing additional training and supervision for clinicians to ensure capacity assessments are completed to an appropriate standard, including the impact of mental disorders on capacity,
- Amending Section 10 of the Act to permit health practitioners provide person-centred end-of-life care,
- Introducing a standardised approach for assessing, managing, and monitoring suicide risk,
- A streamlined approach to data collection, and
- Addressing the resource limitations within the palliative care and health care sectors.

### **Training and supervision for health professionals conducting capacity assessments**

The issue of capacity is central to the discussion on assisted dying. Any voluntary assisted dying scheme must include important safeguards to ensure patients have both the capacity to make the decision and do so freely and voluntarily.

Capacity assessments for voluntary assisted dying are complex and require a nuanced approach. The RANZCP strongly recommends that capacity assessments for assisted dying services only be conducted by medical practitioners who are specifically trained in this field. An assessment of capacity does not necessarily require a psychiatrist. However, we have received feedback that the standard for capacity assessments is not always met, which is also reflected in complaints received by the Health and Disability Commissioner (HDC). [1-3] Research suggests significant shortfalls in knowledge of capacity assessments amongst doctors, including geriatricians and general practitioners which may contribute to the observed inconsistencies of assessment standards. [4, 5] Additionally, non-psychiatrically trained clinicians often lack confidence in recognising underlying mental health conditions and evaluating their impact on decision-making capacity. [4, 11, 12]

Psychiatric conditions, such as clinical depression or anxiety disorders are prevalent among palliative care patients. [6, 7] However, in situations where a patient has a terminal condition causing enduring and unbearable suffering, symptoms of mental ill health may be mistaken for an ‘understandable’ reaction to their condition. [8] While it can be difficult to differentiate between the symptoms, understanding the underlying causes is critical for providing optimal care and conducting capacity assessments. Clinical depression can significantly impact someone’s physical and psychological wellbeing, as well as their social connections and cognitive processes, including decision-making and capacity. [9, 10]

The current Act does not require routine screening for mental health conditions which may pose a risk for tāngata whai ora. While the rights to autonomy and self-determination are equally owed to people with mental illness and a psychiatric diagnosis does not automatically imply incompetence, the potential impacts of comorbidities must be considered during an assessment for assisted dying. Due to shortages of psychiatrists across the motu, a timely comprehensive psychiatric assessment is not always possible, nor is it necessary if the wider health workforce is provided with appropriate training and guidance.

Tu Te Akaaka Roa recommends the development of clear guidance and provision of equitable workforce training and supervision to ensure capacity assessments, including the impact of mental disorders on decision-making, and other treatment/care decisions are well informed and in line with relevant legislation, acknowledging the ongoing review of the Protection of Personal and Property Rights Act 1988 Mental Health (Compulsory Assessment and Treatment) Act 1992.

### **Amending Section 10 of the Act**

Any legislation, including the End-of-Life Choice Act 2019, must enable medical practitioners to provide high-quality, comprehensive, and person-centred healthcare. We believe palliative care should strive to achieve the best quality of life during the final stages of a person’s illness and allow patients to make their own decisions and die with dignity.

Section 10 of the Act prohibits health practitioners from initiating any discussion with a person about assisted dying under the Act, or from making any suggestion to the person that they exercise the option of receiving assisted dying. This clause was enacted to protect people from undue influence and ensure end-of-life choices are reached voluntarily. In Australia, similar clauses have been included in assisted dying laws in Victoria and South

Australia, while the remaining four states allow specific health practitioners to discuss assisted dying under certain conditions, provided that palliative care and other alternatives are also explored. [18] In contrast, Canadian law allows healthcare professionals to bring up the topic of medically assistance in dying and discuss it with eligible patients. [19]

While it is important to protect patients from undue influence, Tu Te Akaaka Roa is concerned that Section 10 has inadvertent consequences and prevent medical practitioners from providing high-quality, patient-centred care. Open, effective, and honest communication, and the provision of relevant medical information is a critical component of holistic, patient-centred care and supports patients to make informed choices about their care. The HDC (Code of Health and Disability Services Consumers' Rights) Regulations 1996 (the Code) highlights the centrality of open communication in the provision of high-quality health care through Right 5: The Right to effective communication, Right 6: The Right to be fully informed, and Right 7: The Right to make an informed choice and give informed consent.

Section 10 of the Acts is at odds with Rights 5, 6, and 7 of the HDC Code and may pose an ethical dilemma for health care professionals. Importantly, comprehensive discussions about a person's end of life, including alternative treatment options such as assisted dying, are a crucial part of holistic patient care. End-of-life conversations provide an opportunity for tāngata whai ora to express their fears, expectations, and preferences, and allows people to make a fully informed choice regarding their care. While it can be difficult, this discussion can provide relief and support psychological wellbeing. [13-16] International data suggest that people often seek eligibility for therapeutic means but ultimately decide not to proceed with it. [15, 17]

As of March 2024, 1847 New Zealanders applied for a formal assessment under the Act, 738 (40%) progressed to have an assisted death, while 71 (4%) were still awaiting a decision. [1-3] While the data lacks clarity, it suggests that most applicants did not progress to have an assisted death, in line with international findings. Notably, between April 2022 and March 2024, 460 (28%) of applicants (out of 1629 which reached an outcome during that period) died while awaiting a decision and 101 (6%) lost competence during the process. [1, 3] The relatively high number of applicants who died during the assessment process might indicate that discussions around end-of-life choices are initiated at an advanced stage and may prevent some people from accessing the care they desire, particularly those who may be less familiar with public policies and rely on health professionals to provide relevant information.

We recommend amending Section 10 permit practitioners to provide information on assisted dying as part of the wider discussion on available treatment options. We recommend the provision of clear guidance on the process and communication, and addition of further safeguards, to prevent undue influence, ensure a high standard is met consistently, and protect clinicians from erroneous complaints.

### **Assessing, managing, and monitoring suicide risk**

Case studies of persons who died by suicide after being deemed ineligible for assisted dying have raised concern about the significant distress experienced by individuals unable to access assisted dying services. [20] While it is unclear how widespread this issue is, due to a lack of follow-up data, it is critical to communicate any decision regarding eligibility for

assisted dying in a safe and effective manner and provide ongoing support.

We recommend the introduction of an evidence-based approach of suicide risk assessment and management for those individuals who are deemed ineligible for assisted dying in NZ and the provision of ongoing support. Additionally, we recommend the provision of clear information and guidelines for patients and the broader health workforce to increase the understanding of what support is available to ease individuals suffering at all stages of the process.

Additionally, we recommend a streamlined approach to data reporting to facilitate service improvements. The information provided in the annual reports is inconsistent and lacks clarity due to different information being included in annual report and data being included across multiple domains (e.g., application outcomes). Further information regarding the experiences and outcomes for whānau whai ora would help to advance our understanding of service need and success and opportunities for service improvements.

### **Addressing resource limitations**

It is crucial that the implementation of a voluntary assisted dying framework is accompanied by increased supports to the palliative care sector. Without adequate resourcing and accessibility of palliative care and psychological supports, the legalisation of voluntary assisted dying may present a perverse incentive for patients suffering enduring and unbearable suffering caused by a serious and incurable condition to choose to end their life, rather than have their pain alleviated. Alongside the general health sector, palliative care services and mental health services are underfunded. The psychiatry workforce is experiencing severe workforce shortages and with increasing demand, access to assisted dying services will soon be limited. Additional funding for psychiatrists to complete assisted dying services needs to be considered to ensure will service can be provided in a safe and equitable way, as intended by the Act.

Thank you for the opportunity to provide feedback; we look forward to working with Manatū Hauora in the future. If you have any further questions regarding this letter, please contact the New Zealand National Office - Tu Te Akaaka Roa via [nzoffice@ranzcp.org](mailto:nzoffice@ranzcp.org) or on +64 (0)4 472 7247.

Ngā manaakitanga



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