

Houses of the Oireachtas: The Committee on Justice invites submissions on the Dying with Dignity Bill 2020.

Introduction

This submission is made on behalf of the Christian Medical Fellowship, an association of around 5,000 healthcare professionals across the UK and the Republic of Ireland, many of whom are involved in end of life decision-making on a regular basis.

Our aim is to unite and equip Christian doctors and nurses to live and speak for Jesus Christ. We represent members in the Republic of Ireland and the wider UK, including those in Northern Ireland who would be directly affected by the Bill's current scope. We also have close links with similar groups of healthcare professionals in many other nations, including those in jurisdictions that have already legalised assisted dying and have experienced the consequences of doing so.

We are pleased to respond to the Committee's invitation as they scrutinise this Private Member's Bill with the aim of ensuring that it is fit for its intended purpose and is legally sound.

We would be happy to be called to give verbal evidence if called upon.

Executive Summary

Policy and Legislative context

- 1. This Private Member's Bill attempts to introduce legislation that would permit doctors to assist the suicide of a patient at their request. The title of the Bill – *Dying with Dignity* – is misleading in that it does not describe its purpose. Neither does it supply evidence that current legislation is inadequate or that the Bill's provisions would 'ensure a dignified and peaceful end of life.' Terms such as 'terminal illness' and 'a clear and settled intention' are defined loosely, or not at all, and are open to different interpretations. Of greatest concern is that there is no requirement for a mental health assessment of the person requesting assistance to die. This omission is dangerous, making it likely that some whose mental health conditions are both treatable and reversible will instead receive assistance to die. We believe that, as drafted, this Bill is not fit for purpose.**
- 2. With a few exceptions, liberal democracies throughout Europe have resisted the legalisation of assisted suicide and voluntary euthanasia. Those, like Belgium and the Netherlands, who did make changes have seen incremental extensions to the laws they introduced, increasing the scope of qualifying persons to include chronically ill but not imminently dying persons, those (including children) who are simply weary of life and those who lack competence to decide for themselves. We look at the experience of jurisdictions where assisted suicide and/or euthanasia are already legal, and we also examine the outcomes of previous legal challenges to the existing law in Ireland. We find that the autonomous rights of the individual are, in practice, outweighed by the rights of vulnerable persons to the protection of the state.**

3. We look at the recommendations of The Joint Committee on Justice and Equality *Report on the Right to Die with Dignity*, from June 2018. The Committee could not agree to legislation that would have introduced assisted suicide but instead made various recommendations to Government, in particular that it review its policy on palliative care in the light of the Palliative Care Services Three Year Development Framework (2017 to 2019), and implement the Framework's recommendations in full. We note that physicians most closely involved in end of life care (palliative care specialists), and thus best placed to appreciate the needs and concerns of patients at the end of life, are strongly opposed to a change in the law, and we appeal to the Committee on Justice to recommend to the Irish Government that it resist any temptation to 'get rid of the problem by getting rid of the patient,' and instead invest in the training of a new generation of palliative care specialists.

Implications and implementation of the Bill's proposals

Under this heading we look in more detail at some of the issues already mentioned above. In addition, we suggest that the remedy (changing the law to permit assisted suicide) does not fit the problem – existential angst is not a terminal illness.

In section 6 we list our ethical concerns:

- the Bill strengthens the notion of 'a life not worth living' and undermines equality
- the Bill coerces vulnerable people to choose death
- the Bill undermines the doctor/patient relationship
- the Bill undermines respect for conscience
- the Bill holds out the lure of cutting costs
- the Bill's review policy is not sufficiently robust

Our submission ends with a brief Conclusion.

We suggest it is a mark of a civilised society that it provides for its most vulnerable and unproductive citizens extravagant care to the end of their natural lives. We believe this to be in keeping with the traditional values of the Irish people as well as with the convictions of those providing end of life care. We ask the Committee to consider recommending to Government that this Bill be dropped, not only because it is poorly drafted and dangerous, but because it flies in the face of the finest feelings and deepest instincts of the people on the island of Ireland.

1. Policy and Legislative context

a. Defining the problem

The Dying with Dignity Bill 2020 is a Private Member's Bill (PMB), sponsored by five members of the Dáil Éireann. It has completed its Second stage and is subject to scrutiny by the Committee on Justice prior to progression to the Committee stage.

The Bill does not define the problem it seeks to address. It does not make clear how existing legislation falls short or in what ways the proposed changes will benefit society. It appears to take for granted that change is needed. There is no attempt to quantify the scale of the problem that the

proposed legislation would address. No scientific evidence that this Bill would improve dying or 'ensure a dignified and peaceful end of life' is advanced.

The title of the Bill is misleading. Its purpose is to introduce legislation that would allow doctors to assist suicide or end the life of (euthanise) a patient at their request. It flies in the face of the opinion of those doctors with the most experience in caring for dying patients (palliative care specialists), the majority of whom do not support the proposed changes. In our opinion, the Bill would also recast the role of the doctor in a way that would undermine the trust essential to the doctor/patient relationship and thereby harm society in general.

b. Current policy and legislative context

There are no government Bills being considered at this time that would introduce similar measures.

c. The law as it stands

Both euthanasia and assisted suicide are illegal in Ireland. Suicide is not a crime in Ireland, and competent patients may refuse or decide to stop treatment, including feeding and hydration, even when this will result in their death.¹ Assisting suicide is illegal, however, with a penalty of up to fourteen years imprisonment.²

d. Wider EU/International context

Most liberal democracies in Europe continue to resist the legalising of euthanasia or assisted suicide. Exceptions are The Netherlands, Belgium, Switzerland and Luxembourg. In France, deep palliative sedation is legal, but not assisted suicide. Whatever the outcome of the Bill under discussion, there will therefore be implications for other States in the EU and beyond.

The Bill states, as one of its qualifying conditions for assisted suicide, that an applicant must have been 'resident on the island of Ireland' for at least a year. This would appear to include the population of Northern Ireland (NI).

The cross-border jurisdictional and constitutional issues are beyond our expertise, but the Bill fails to address the need to align the ethical frameworks of clinical practice provided by the General Medical Council (GMC) of the UK and the Irish Medical Council (IMC). There is a good deal of cross-border health provision. Would a doctor based in NI be guilty of assisting suicide under UK law if they provided clinical information to a patient seeking assisted suicide who then acquired the help they sought south of the border? These are complex issues, but the Bill ignores them.

It seems incredible that a piece of Irish legislation should so casually introduce a clause that would create a provision for Northern Irish residents to apply for assisted dying in the Republic. This would immediately cause a legislative crisis within the UK, introduce a highly controversial provision into a neighbouring jurisdiction and provoke an immediate clamour for similar legislation across the rest of the UK by campaigners who would decry the 'disparity of provision'. We can only imagine that this careless wording was an oversight in the drafting process, and recommend in the strongest possible

¹ Campbell, L (2013) Assisted dying: arguments for and against. Presentation to the Irish Medical Organisation, 4th April 2013.

² Section 2 of the Criminal Law (Suicide) Act 1993

terms that, should the bill as a whole proceed, reference to residency on the 'Island of Ireland' should be struck from the eligibility criteria.

e. Challenges to existing law

The law in Ireland banning assisted suicide has been challenged in recent years. 'In 2012, Marie Fleming took a legal action to be allowed assistance with dying. The case (*Marie Fleming v Ireland and the Attorney General*) was first heard in the High Court and subsequently, on appeal, in the Supreme Court. Ms. Fleming (the plaintiff) challenged the law criminalising assisted suicide.

The proceedings turned on the question of whether the plaintiff – in the final stages of multiple sclerosis and physically incapable of ending her own life – had a right to assisted suicide if this was the conscious decision she made. She claimed that the blanket ban on assisted suicide breached her constitutional rights and her rights under the European Convention on Human Rights (ECHR).³ Both courts rejected her claim. Ms. Fleming died in December 2013.⁴

The Supreme Court found that the right to die was not a corollary of right to life under Art 40.3.2, nor was the right to commit suicide or to have one's life terminated to be read into any other articles of the constitution. Specifically, the court held that the right to life does not entail a right to terminate life or have life terminated.

In coming to this conclusion, the court affirmed the distinction drawn by the Supreme Court in 1996 (*In Re a Ward of Court (withholding medical treatment) No 2*) between positive steps to end life and allowing nature to take its course. In that case the court held that the right to life included a right to die a natural death; and it consented to the withdrawal of all artificial nutrition and hydration of a patient in a near persistent vegetative state. The actions proposed by Marie Fleming would have amounted to positive action to end her life rather than dying a natural death and are therefore not within the boundaries of Art 40.3.2.

The Court also rejected the argument that s2(2) of the Criminal Law (Suicide) Act 1993 was incompatible with the constitution on the ground of equality, as it had the effect of indirectly discriminating against those who are unable to commit suicide without assistance. It was held that the fact that an objectively neutral provision affects able bodied and disabled bodied individuals differently does not amount to a breach of the constitutional principle of equal treatment under Art 40.1.

Finally, the court was called upon to decide upon the compatibility of s2(2) of the 1993 Act with the European Convention on Human Rights, particularly Article 8 of the Convention, with the court again finding against Ms Fleming. The court relied heavily on a decision of the European Court of Human Rights in a case taken by Diane Pretty (*Pretty v United Kingdom*), a woman suffering from motor neuron disease. The Court held it was primarily for individual States to assess whether an interference with the right to private life under Article 8 was proportionate, bearing in mind the risks of abuse if the law on assisted suicide was relaxed.⁵

³ Her key argument was that Section 2(2) of the Criminal Law Suicide Act 1993 should be declared invalid under the Constitution and incompatible with the ECHR.

⁴ Joint Committee on Justice and Equality Report on the Right to Die With Dignity June 2018, p 15.

⁵ Spain, E. (2013) 'Fleming and the Right to Die' [blogpost], on *humanrights.ie* (accessed 18.01.21)

However, The Supreme Court did make it clear that the Oireachtas is not precluded by the Constitution from legislating to decriminalise assisted dying in limited circumstances, and subject to appropriate safeguards.⁶

This case, like similar ones in other jurisdictions, illustrates how the autonomous rights of the individual are, in practice, outweighed by the rights of vulnerable persons to the protection of the state.⁷

f. Previous attempts to change the law

A previous attempt to introduce a similar Bill (The Right to Die with Dignity Bill, 2015) was moved by Deputy John Halligan. The Bill passed first stage and order was made for second stage in Dáil Éireann. However, as a Minister, Deputy Halligan could not progress the Bill himself.

Following this, the Joint Committee on Justice and Equality conducted hearings and produced their *Report on the Right to Die with Dignity* in June 2018.⁸ The Committee was unable to reach clear consensus and therefore did not recommend legislative change. They did, however, make several recommendations, including:

- that the issue be referred to the Citizens' Assembly for deliberation
- that the Minister for Health publicise the importance of Advance Healthcare Directives
- that the Government review its policy on palliative care in the light of the Palliative Care Services Three Year Development Framework (2017 to 2019), and implement the Framework's recommendations in full
- that palliative care provision be extended to vulnerable groups including disabled persons and those suffering from mental illness or chronic physical conditions

2. The Dying with Dignity Bill 2020 – Implications and implementation of the Bill's proposals

Concerns

1. The Bill as framed is not 'fit for purpose'

The Dying with Dignity Bill 2020 seeks to '*make provision for assistance in achieving a dignified and peaceful end of life to qualifying persons.*' It is the latest attempt to change the law in Ireland. A person is a qualifying person if they are terminally ill, has a clear and settled intention to end their own life, is aged 18 or older, is a resident on the island of Ireland and has been so for not less than one year.

⁶ Fleming -v- Ireland & ors [2013] IESC 19; para.108.

⁷ Campbell, L (2016) 'The limits of autonomy: an exploration of the role of autonomy in the debate about assisted suicide,' in M Donnelly and C Murray (Eds.) *Ethical and Legal Debates in Irish Healthcare*. Manchester: Manchester University Press, p.56.

⁸https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/joint_committee_on_justice_and_equality/reports/2018/2018-06-25_report-on-the-right-to-die-with-dignity_en.pdf (accessed 18.01.2021)

A 'terminal illness' is defined loosely as an incurable and progressive illness which cannot be reversed by treatment, and the person is likely to die as a result of that illness or its complications. No time within which death is expected to occur is included in the definition. 'Terminal' could therefore be interpreted in a most elastic way.

The conditions that could qualify as 'terminal' include chronic illnesses such as diabetes and heart and lung disorders. The term could also include neurodegenerative conditions that are incurable though not terminal (in the sense that they will necessarily lead to death within a period of six or even 12 months), such as multiple sclerosis, muscular dystrophy and dementia. The Institute of Public Health of Ireland estimates almost 30% of the population have a chronic condition which could fit the definition in this Bill of a terminal illness.⁹

The lack of a clearer definition of 'terminal illness' increases the likelihood that, in practice, assisted suicide will be offered to anyone with a chronic and debilitating illness who is tired of life or who, in the opinion of their clinicians, has a life 'not worth living.'

The person seeking assistance to die must sign a declaration, stating that they have a clear and settled intention to end their own life. That signature must be witnessed, the witness countersigning the declaration in the presence of the person. Finally, the declaration must also be countersigned by two registered medical practitioners.

The Bill does not clarify how a 'clear and settled intention' is to be assessed. Is it a matter of time and, if so, how long a time? Would a week be long enough, a year too long? How is the attending doctor to be 'satisfied' that his patient's intention is a 'settled' one? It appears to be left entirely to his or her subjective discretion. Given that in recent polls a majority of doctors have indicated their unwillingness to be personally involved in assisting suicide, the attending physician is likely not to know very well the patient being assessed.

There is no requirement in this Bill for a formal assessment of mental health. This is a glaring omission, that reinforces the impression of a poorly conceived Bill driven more by ideology than clinical necessity or compassionate concern. The rudimentary capacity assessment tool recommended in the Bill amounts to little more than a tick-box exercise, falling far short of the depth required to safeguard the most momentous decision anyone can ever make – the taking of their own life.

The incidence of mental health issues in Ireland is one of the highest in Europe.¹⁰ The lack of a mandated mental health assessment means that some people with potentially reversible mental health disorders, who request assistance to end their lives, will not be offered appropriate treatment but assessed as having a settled intention to end their own lives. This is as dangerous as it is outrageous.

Our preference is that this Bill fail. If however it should progress, then our appeal would be that any legislation permitting assisted suicide in the island of Ireland should impose a statutory responsibility upon the attending medical practitioner to ensure that a psychiatric assessment is carried out by a qualified specialist in every case, and that a sufficient period of time be allowed for any medication prescribed as a result to take effect, before a declared wish to end a life is considered settled.

⁹ http://www.publichealth.ie/files/chronic_executive.pdf (Visited 25.01.2021)

¹⁰ <https://www.irishtimes.com/news/health/ireland-has-one-of-the-highest-rates-of-mental-health-illness-in-europe-report-finds-1.3707073> 22.11.2018

The only stipulation attached to the Attending and Independent Medical Practitioners is that they be registered. In theory, a doctor just two years out of medical school could be the one responsible for assessing the eligibility of the patient to receive a cocktail of lethal drugs. That is a fearful responsibility to give to someone lacking much in the way of clinical experience. When looking for the second signature, it would be natural for the attending physician to seek out, as the Independent Practitioner, someone known to be supportive of assisted suicide. In this way, the system as drafted is seen to be open both to inexperience and unconscious bias.

We conclude that the Bill, in its present form, is not fit for purpose.

2. The remedy does not fit the problem – existential angst is not a terminal illness

Studies of the factors that contribute to the desire to end one's life reveal that pain is not the issue – purpose and meaning are. The three main factors causing someone to turn to suicide are:¹¹

- a perception (usually mistaken) that they are alone in the world and that no one really cares about them
- a feeling (again, usually mistaken) that they are a burden on others and that people would be better off if they were dead
- fearlessness towards pain and death

Contrary to common perception, the main reason given for requesting medical assistance to die is not uncontrolled pain, nor even the fear of such pain, but the fear of loss of dignity, of becoming a burden to others, or of becoming dependent. In Oregon in 2013, such existential reasons were by far the most common ones given for seeking assisted dying – 93% cited 'loss of autonomy,' 89% 'loss of enjoyment of life' and 73% 'loss of dignity.'¹² 'Pain' did not figure in the top five reasons given. The 2019 figures¹³ tell the same story, with 86%, 90% and 72% respectively, 'pain' again outside the top five reasons given.

90% of those who end their lives by suicide suffer from some form of mental illness including depression, bipolar disorder, borderline personality disorder and alcohol or drug misuse.¹⁴ The 2013 Oregon figures show that less than 3% of cases were referred for a formal psychiatric assessment, although 26% met the criteria for depression.¹⁵ Baroness Sheila Hollins, former president of the UK Royal College of Psychiatrists, comments: *'Researchers have found that some patients who have ended their lives under the terms of Oregon's assisted suicide law had been suffering from clinical depression. Depression impairs decision-making capacity; it is common in elderly people and it is treatable. But in some cases in Oregon, it has not been diagnosed by the doctor who assessed the patient's capacity and prescribed lethal drugs. Oregon's law requires referral for psychiatric examination in cases of doubt but in some cases that has not happened.'*

It is inevitable that many people suffering a terminal illness will also experience depression, anxiety and perhaps other psychological conditions. What will not be immediately clear is the degree to

¹¹ <http://www.nhs.uk/Conditions/Suicide/Pages/Causes.aspx>

¹² <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year16.pdf>

¹³ <https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf>

¹⁴ <http://www.nhs.uk/Conditions/Suicide/Pages/Causes.aspx>

¹⁵ Levene I, Parker M. Prevalence of depression in granted and refused requests for euthanasia and assisted suicide: a systematic review. JME 2011;37:205

which those mental health conditions may account for the settled intention to end their own lives. It can be fiendishly difficult, even for well-acquainted family doctors, to assess the contribution that loneliness, depression or the desire not to be 'a burden' may be making to their patient's request for assisted dying. Even apparently settled wishes can change unaccountably, and apparently irreversible conditions can remit.

Successfully treating depression may change a person's outlook significantly, even if it doesn't change their prognosis. But it would appear from the experience in Oregon, for example, that routine psychiatric assessment is being overlooked. It is almost as if the declared wish to end one's life trumps all therapeutic considerations.

The British Geriatrics Society (BGS) in July 2015 stated that much of the public demand for assisted dying stems from 'the fear of a prolonged death with increasing disability, sometimes associated with unwanted, burdensome medical care'.¹⁶

i) They express concern that vulnerable older and disabled people will feel a duty to die:

The BGS see it as their job not to 'prolong life at all costs' but to 'improve quality of life' to its natural end. They express deep concern that many requests to end life come directly or indirectly from the patients' families and not from the older person themselves: *'Often such requests are then forgotten if such degrading symptoms as urinary and faecal incontinence, depression and unremitting pain are relieved. The BGS is concerned with protecting the interests of vulnerable older and disabled people who already feel pressure to give up their lives to reduce the burden they feel they cause to others.'*

ii) They argue for a change of focus:

Suffering at the end of life can be prevented *'by a change in the focus of care – from prolonging life to addressing the individual's own priorities and symptoms, and by the involvement of medical professionals skilled in palliative and end of life care'*.

iii) They warn about the negative impact on doctor-patient relationships:

'Crossing the boundary between acknowledging that death is inevitable and taking active steps to assist the patient to die changes fundamentally the role of the physician, changes the doctor-patient relationship and changes the role of medicine in society.'

iv) They appeal for a prohibition of intentional killing:

Legalising assisted dying, they conclude, *'will lead to a change in attitude to death in society and also within the medical profession. The prohibition on intentional killing is the cornerstone of society and it is worth preserving the notion that all lives are precious.'*

3. Inadequate palliative care provision exacerbates the problem

In our opinion, giving lethal drugs to people who feel their lives no longer have meaning and purpose is the wrong treatment option. Existential angst is not best treated by 'removing' the person, but by helping that person to rediscover their sense of worth and purpose. Dignity is not lost simply by losing control of some bodily function. Surely dignity and value are conferred upon even the most disabled of persons by the sensitivity, expertise and kindness of caregivers. The remedy is to improve standards of care, especially palliative care, rather than to assist dying.

¹⁶<http://www.bgs.org.uk/index.php/specialinterest-main/ethicslaw-2/4067-position-assisted-suicide>

This was the mindset, championed by Dame Cicely Saunders, that helped to launch the hospice movement – ‘*You matter because you are you, and you matter to the end of your life. We will do all we can not only to help you die peacefully, but also to live until you die.*’ The UK has benefitted enormously from the pioneering work of the hospice movement. Symptoms accompanying dying are less to be feared than at any time in history, because of medical advances and the expertise of hospice and palliative care teams.

In their Report on the Right to Die with Dignity, 2018, The Joint Committee on Justice and Equality stated that ‘*assisted dying should never be contemplated due to inadequate or insufficient supports or as a substitute for a holistic framework of care. The Committee supports the recommendations contained in the Palliative Care Services Three Year Development Framework (2017 to 2019) and urges the Minister for Health to ensure the recommendations are implemented in full*’ (recommendation 4, p.57). They also noted regional discrepancies in the provision of palliative care and recommended these should be addressed as soon as possible (recommendation 5, p. 57).

Good palliative care, whether in the community or in hospices, has long demonstrated that it is possible to control discomfort and distress effectively – killing the pain, not the patient.¹⁷ In 2009 the British Medical Association (BMA), recognising that requests for assisted suicide and euthanasia are very rare when patients are being properly cared for, called for better training of doctors and education of the public about palliative care.¹⁸ Whilst some effects of disease, such as paralysis, might not be reversible, with effective care people are still able to lead meaningful lives. The love and support of family, friends and clinical staff will affirm their value, regardless of the limitations of their condition.

4. Palliative care physicians oppose the Bill

It is notable that recent surveys of palliative care physicians in Ireland, as elsewhere, show that those doctors most closely associated with the care of the dying do not want to see a change in legislation to allow assisted suicide or euthanasia. The Irish Palliative Medicine Consultants Association (IPMCA) aligns with the position of the Royal College of Physicians of Ireland (RCPI), which states:

‘That RCPI officially opposes the introduction of any legislation supportive of assisted suicide because it is contrary to best medical practice. That RCPI promotes a considered and compassionate approach to caring for, and proactively meeting the needs and concerns of patients who may be approaching the end of their life. That RCPI would as a body promote adherence to the Medical Council’s current Guide on Professional Medical Conduct and Ethics for Registered Medical Practitioners guidance on End of Life Care.’¹⁹

Similarly, The Irish Association for Palliative Care (IAPC) – an all-Ireland body with the aim of promoting palliative care nationally and internationally – has recommended there be no change in the law.

¹⁷Hearn J, Higginson I. Do specialist palliative care teams improve outcomes for cancer patients? A systematic literature review. *Palliat Med* July 1998,12; 5:317-332

¹⁸http://bmaopac.hosted.exlibrisgroup.com/exlibris/aleph/a21_1/apache_media/VITJEQ4TGE1SQBYUCDDQ2T93SAHVT.pdf

¹⁹ <https://rcpi-live-cdn.s3.amazonaws.com/wp-content/uploads/2020/02/Assisted-Suicide-Position-Paper-2017.pdf> (Visited 25.01.2021)

In 2014/15 the Association of Palliative Medicine polled its members²⁰ on their views and 82% voted against a change in the law, an overwhelming majority. This isn't just a desperate attempt to validate their own work, but a conviction, born of experience, that better is possible, and that enabling patients to live well until their natural death gives them greater dignity than affirming the implication that human dignity departs when a person can no longer contribute more than they consume, or give more than they receive?

We urge the Irish Government to resist the temptation to 'get rid of the problem by getting rid of the patient,' and instead invest in the training of a new generation of palliative care specialists. We suggest this would be much more in keeping with the traditional values and convictions of the Irish people, of whom a commitment to the 'sanctity of life' principle has been such a distinctive characteristic, and with the views of the overwhelming majority of palliative care physicians.

5. The inevitability of incremental extension – evidence from other jurisdictions

There is evidence from all the jurisdictions where assisted suicide or euthanasia have been legalised of incremental extension in application. Returning to the example of Oregon, details of patients dying under the Act²¹ show a substantial number do not have terminal illnesses. In 2013 16.9% of those receiving assistance to die under the Act did not have cancer, heart disease, chronic lung disease or motor neurone disease but were classified as having 'other illnesses.' A footnote in the 2013 Oregon Public Health Division report on compliance with the Act explains that this *'includes deaths due to benign and uncertain neoplasms, other respiratory diseases, diseases of the nervous system (including multiple sclerosis, Parkinson's disease and Huntington's disease), musculoskeletal and connective tissue diseases, viral hepatitis, diabetes mellitus, cerebrovascular disease, and alcoholic liver disease'*. Whilst many of these conditions might be considered life-shortening, it is not credible that all these cases were terminal. They fell outside the terms of the Oregon Act.

In 1984, the Supreme Court in the Netherlands established a set of criteria that should be followed for a physician to cause the death of a person by euthanasia without fear of prosecution. From 1984 to 2002 a series of legal decisions led to a widening application of euthanasia for the hard cases, including people living with chronic depression (mental pain) to children who were born with disabilities. This led in 2001 to Parliament officially legalising euthanasia, the law coming into effect in April 2002; over the next decade the rate of euthanasia deaths increased three-fold. By 2007, voluntary euthanasia (1.7%), non-voluntary euthanasia (0.4%) and terminal deep sedation accompanied by withdrawal of nutrition and hydration (8.2%), accounted for nearly one in ten Dutch deaths.²²

In the same year (2002), Belgium's law came into effect permitting euthanasia for those in a 'medically hopeless' situation – the 'hard' cases. Over the next ten years the rate of euthanasia in Belgium increased eight-fold.²³ In 2010, 954 Belgians were killed by euthanasia; in 2019, the figure had risen to 2,655. Today, Belgium has some of the world's most liberal euthanasia laws, which are not restricted to the terminally ill or to competent adults. Children of any age are also eligible, as

²⁰ <https://apmonline.org/wp-content/uploads/2019/01/press-release-apm-survey-confirms-opposition-to-physician-assisted-suicide-2.pdf> (Visited 25.01.2021)

²¹ <http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year16.pdf>

²² Saunders P. <https://www.carenotkilling.org.uk/press-releases/dutch-euthanasia-stats/>

²³ Euthanasia and assisted suicide laws around the world. Guardian 17 July 2014 bit.ly/WmgaXm

long as they ask for it themselves and have the agreement of parents, and people with psychiatric conditions are also eligible.

Despite the extent of the laws already in place, lawmakers in The Netherlands are currently inquiring into how further to expand legislation in order to permit euthanasia based on having a 'completed life,' allowing people to be killed if they are tired of life and feel it is complete, but have no serious illness.²⁴ This would mark a fundamental shift in the purpose of medicine – from preserving life to ending it – that would result in an equally fundamental change in the nature of the doctor/patient relationship.

In practice, once any so-called 'right' is established in law, experience shows that incremental extension takes place over time. There is a steady increase in absolute numbers of cases and a gradual inclusion of those who are outside the stated boundaries of the law. There is also pressure to extend the law as activists bring new cases to the courts using the same general arguments of autonomy and compassion.

If this Bill becomes law, it will only be a matter of time before someone with a non-terminal but life-controlling condition claimed to have a settled conviction that he or she wished to end their life, and that the law unfairly discriminated against them by denying them the right extended to those with a terminal condition. It would be very difficult to hold the line; sooner or later a 'hard' case would come before a judge who would rule in favour of extending assistance to die to someone who was not terminally ill. A precedent would have been set in case law; the line would have been crossed.

6. Ethical concerns

- a. The Dying with Dignity Bill 2020²⁵ strengthens the notion of 'a life not worth living' and undermines equality

There is, of course, a significant financial cost to the provision of high quality, widely accessible palliative care. But we would humbly suggest that the cost to society of legalising assisted suicide is much greater.

It would inevitably strengthen the perception that people with certain types of disease or disability have lives 'not worth living', that they would be 'better off dead', and that the costs of their care would be better directed towards healthcare provision for the more socially or economically 'productive' members of society. The quotient of compassion in the caring professions and respect for human life in society in general would inevitably ebb.²⁶ Little wonder that organisations representing disabled people are among the most vociferous opponents of this Bill and others like it.

The calibre of a civilised society can be measured by the investment it is willing to make in the care of its most vulnerable and least 'productive' members. **We appeal to the Committee on Justice to withhold their support from a Bill that, if passed, will recalibrate the general notion of a life worth living and leave many, whose lives are already a struggle, without compassionate, extravagant care.**

²⁴ <https://www.houseofrepresentatives.nl/news/plenary-session-about-citizens-initiative-%E2%80%98completed-life%E2%80%99> (Visited 28.01.2021)

²⁵ Hereinafter referred to in headings simply as 'The Bill'

²⁶ Wyatt J. Matters of Life and Death. Nottingham, England: IVP, 2009 (2nd Edn):207

b. The Bill coerces vulnerable people to choose death

The pressure on vulnerable people to end their lives, to 'do the decent thing' perhaps in order to liberate finances for other members of the family, or to relieve pressure on a beleaguered health system, becomes almost irresistible in an environment where assisted suicide becomes normal. It is impossible to draft legislation that incorporates effective safeguards against this unintended pressure. A 'right to die' is effectively replaced by a 'duty to die'.²⁷

c. The Bill undermines the doctor/patient relationship

There are also concerns about the effect on the doctor-patient relationship of assisted dying legislation, as raised by the BGS (see above). Trust is crucial to this relationship. The patient's confidence that the doctor will always act in such a way as to do no harm is foundational to the relationship. Giving doctors the power deliberately to end the lives of their patients will inevitably redefine the nature of the relationship and risks undermining that essential trust and confidence. The long-term effect on doctors themselves could be equally damaging. Doctors could become hardened to causing death, and even begin to see their most vulnerable patients as 'disposable'.²⁸ Such patients might then decide not to ask for medical help, for fear that they be encouraged to consider assisted suicide by doctors whom they feel they can no longer fully trust.

Lord McColl of Dulwich described this change in medical conscience as 'chilling'. In a speech in the House of Lords in 2003, reporting on a visit to the Netherlands, he said: *'Noble Lords will be aware that the Select Committee visited Holland. When we inquired of a doctor what it was like doing the first case of euthanasia, he said, "We agonised all day. It was terrible". But he said that the second case was much easier and the third case – I quote – "was a piece of cake". We found that very chilling indeed.'*²⁹

d. The Bill undermines respect for conscience

Section 13 appears to respect conscientious objection but in truth does nothing of the sort, because it mandates onward referral to another physician who is known to be in favour of assisted suicide. It obliges the doctor who objects to assisting suicide on the grounds of conscience to be complicit in what they regard as an unethical act. This is unacceptable and contravenes Medical Council (Ireland) guidance.³⁰

e. The Bill holds out the lure of cutting costs

Killing is cheaper than caring. At times of national financial restraint, and with the high cost of in-patient care, the temptation for authorities to 'stretch' the scope of application would be ever-present. In the UK it costs upwards of £5000 a week to provide in-patient hospice care, but just a one-off cost of around £5 to pay for the drugs which would help a person commit suicide. Cancer treatments like chemotherapy, radiotherapy or surgery cost much more.

There is clearly a financial incentive to encourage assisted suicide – does the Irish Government really wish to place that temptation before families, health ministers and local healthcare managers?

²⁷ <http://www.telegraph.co.uk/comment/personal-view/4736927/Right-to-die-can-become-a-duty-to-die.html>

²⁸ Keizer B in Ross W. Dying Dutch: Euthanasia spreads across Europe. Newsweek, 12 February 2015

²⁹ McColl I. Lords Hansard, 6 June 2003: Column 1681

³⁰ <https://www.medicalcouncil.ie/news-and-publications/reports/guide-to-professional-conduct-and-ethics-8th-edition-2016-.pdf>. Para 49 (Visited 25.01.2021)

f. The Bill's review policy is not sufficiently robust

The review procedure is essentially a database exercise. It assumes that every doctor will have acted perfectly, that eligibility criteria will have been properly assessed, that coercive factors and unconscious bias played no part. Given that lives are at stake, a more robust scrutiny process is appropriate. Concerns expressed by family members or other clinicians should be fully explored in a judicial process.

Conclusion

We are grateful to the Committee on Justice for this opportunity to comment on the Dying with Dignity Bill 2020. In its present form, we consider the Bill not fit for purpose. It defines neither the problem it seeks to address nor how current legislation is inadequate. In our view, the need for such a Bill has not been demonstrated. It is hard to escape the conclusion that the authors are motivated more by ideology than by evidence.

The Joint Committee on Justice and Equality studied these same matters comparatively recently, publishing their *Report on the Right to Die with Dignity* in June 2018. They did not recommend a change of legislation but made some far-reaching recommendations, notably to improve the availability of high-quality palliative care in all parts of Ireland, in keeping with the Palliative Care Service's Three Year Development Framework (2017 to 2019).

End of life care concerns us all – one in one die. Our contention is that dignity in dying is not to be found through legislation that permits us to avoid discomfort or dependence on others by being assisted to end our own lives. Dignity and value are conferred upon others, in all their frailty and vulnerability, by the sensitivity, kindness and expertise of caregivers, at home, in hospital or in a hospice. The need is surely to improve standards of care, especially palliative care, rather than to assist dying.

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