

Consultation Submission on the Dying with Dignity Bill 2020

January 2021

This document has been prepared in response to a call for submissions from the Oireachtas Committee on Justice on the *Dying with Dignity Bill 2020*.

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About the Royal College of Physicians of Ireland

The Royal College of Physicians of Ireland (RCPI) is a postgraduate medical training college dedicated to ensuring that doctors have the skills to provide patients with the best possible care. RCPI offers training programmes, examinations, diplomas and educational courses to equip doctors with the skills and knowledge they need to care for patients and run safe and efficient healthcare systems. RCPI has over 11,000 Trainees, Licentiates, Members and Fellows across 29 different specialities in over 90 countries.

RCPI is also a well-respected voice in public health debates. In recent years our Members and Fellows have led initiatives in policy and advocacy in the areas of alcohol, obesity, tobacco, physical activity, vaccinations and ageing.

An RCPI position paper on assisted suicide was published in 2017.¹ This paper was developed by a working group comprising representatives from a range of medical specialities within RCPI, including Geriatric Medicine, Neurology, Palliative Medicine, Psychiatry, Rehabilitation Medicine and Respiratory Medicine. The group reviewed research literature and the positions of medical professional bodies in Ireland and worldwide and made a recommendation to RCPI Council on the adoption of an RCPI position on assisted suicide in Ireland. The paper was approved and adopted as a College Position Paper at the RCPI Council meeting on 8th December 2017.

In October 2020, the working group published key updates to the 2017 RCPI position paper, referencing research and reports published worldwide on physician assisted suicide and euthanasia (PAS-E) since 2017.²

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Summary of RCPI position on assisted suicide

It is the position of RCPI that the potential harms of assisted suicide outweigh the arguments in favour of legislation for assisted suicide (such as provided for in the Dying with Dignity Bill). The RCPI position on assisted suicide is as follows:

- RCPI officially opposes the introduction of any legislation supportive of assisted suicide because it is contrary to best medical practice.
- RCPI promotes a considered and compassionate approach to caring for, and proactively meeting the needs and concerns of patients with any progressive or incurable illness who may be approaching the end of their life.
- RCPI promotes adherence to the Medical Council's current Guide on Professional Medical Conduct and Ethics for Registered Medical Practitioners guidance on End of Life Care.

The rationale for this position is described in this submission to the Oireachtas Committee for Justice, under questions set out in the *Framework for Committee Scrutiny of PMBs (Private Members' Bills)*. The response is based on previously published reports from RCPI. A response is provided for PART A only, Policy and Legislative Analysis.

Dying with dignity is already present in our healthcare system. Dying with dignity in our society is made possible by the delivery of compassionate and supportive and expert care by physicians, nurses, health & social care professionals and others working in hospitals, hospices, GP practices and other community settings across the country. These efforts are supported by specialist palliative care teams, by the efforts of families and friends, and by extension, the support of society. Legislating for assisted suicide threatens to undermine those efforts.

Introduction of legislation on assisted suicide has the potential for immense harm and unintended consequences. These consequences are not theoretical; they are based on experience in jurisdictions where assisted suicide/euthanasia has been introduced. They include:

- Expansion of groups included under legislation. For example, to infants and children, psychiatric patients, people with intellectual disability, with autism spectrum disorder, people living with dementia, and addiction disorders³ Expansion beyond an original

apparently restricted set of conditions has occurred in virtually all jurisdictions where physician-assisted suicide/euthanasia has been legalized.

- Inadequate safeguards for vulnerable members of society.
- Societal pressure and reduction in autonomy in relation to organ donation.
- Undermining of the practice of palliative care.
- Devaluation of the lives of persons with disabilities and certain medical conditions.
- Negative impact on the role of physicians and medicine/violation of medical ethics.
- Challenges in regulation and oversight: the Netherlands system does not focus on whether patients should have received PAS-E: to what extent this constitutes enforcement of strict safeguards, especially when cases contain controversial features, is not clear.⁴

We have grave concerns about how the assessment of capacity is dealt with in the Bill, about the implications of the legislation for conscientious objection and see serious challenges in oversight and regulation.

We highlight that complications may occur in process of death by assisted suicide, which in themselves can cause great suffering.

PART A: Policy and Legislative Analysis

Policy Issue and legislative context

1. Define the problem/the policy issue which the Bill is designed to address; to what extent is it an issue requiring attention? What is the scale of the problem and who is affected? What is the evidence base for the Bill?

Dying with dignity is already present within our healthcare system

The stated purpose of the Bill is “to make provision for the assistance in achieving a dignified and peaceful end of life in a qualifying person and to provide for other related matters”

We believe that dying with dignity is already present within our healthcare system. It is made possible by compassionate and supportive physicians, nurses, health & social care professionals and other healthcare staff, supported by the efforts of families and friends, and by extension, the support of society. Legislating for assisted suicide threatens to undermine those efforts. Instead, we argue for a focus on the right kind of compassionate support for people with advanced, progressive and often incurable illness, including at the end of life, for all who need it.

Human dignity is not a thing that can be lost through disability, disease, dependency, or suffering, although insensitive treatment or attitudes to those so affected can constitute undignified care. It is important that the healthcare professions promote a critical debate on the complexities of discourse relating to dignity and maintain care philosophies and routines that promote dignified care.

There have been major advances in promoting high-quality care at the end of life across the spectrum of healthcare provision in Ireland, and in particular through the provision of both palliative care services and increased training in palliative care across the professions. In addition, the professions have encouraged the development of advance care planning and provided assistance in ensuring that treatment at the end of life is proportionate to the goals of such advance healthcare plans.

Effective treatments at end of life are available

With advances in medicine, in palliative care and in mental health treatments, effective treatments at the end of life are available to the vast majority of people – to ensure that nobody should be suffering either mentally or physically.

Published research supports this view, for example

- In a 2017 Irish survey of bereaved relatives, most people reported that the end-of-life quality of care was outstanding, and that pain and care needs were met/relieved in the last days of life.⁵
- A 2020 Australian study looking at differences in severe symptom outcomes for palliative care patients receiving hospital care compared with those receiving care at home found that for over 25,000 people, all symptoms improved and over 85% of all patients had no severe symptoms prior to death.⁶
- There is a concern that a move towards assisted suicide would result in a shift in focus away from the development and the delivery of palliative care services and cure, and that research into palliative care may be discouraged.⁷
- In Ireland, as in Europe, palliative sedation in the context of palliative medicine is used to relieve the burden of otherwise intractable suffering at the end of life in a manner that is ethically acceptable to the patient, family and healthcare providers.⁸

The paradox of two forms of suicide

Suicide kills more people each year than road crashes, and is a source of grievous hurt to family, friends and those affected by the death. Much effort has been directed towards suicide prevention, and it is encouraging that the incidence of suicide has fallen from 13.5 to 9.7 per 100,000 between 2001 and 2015, albeit with persistently high rates among certain groups.⁹ Currently national suicide prevention policy is articulated in the national suicide prevention strategy 'Connecting for Life' which has been extended to 2024.¹⁰

That there might be two forms of suicide – one which is clearly upsetting and worthy of strenuous societal efforts to prevent, and one which might be tolerated and given the support and protection of law – is a challenging premise.¹¹

The acceptance of assisted suicide may also have had an adverse impact on non-assisted suicides. In Oregon between 1999 (two years after law providing for assisted suicide was introduced) and 2010 the suicide rate among those aged 35-64 increased by a massive 49%

in Oregon (compared to 28% nationally).¹² The incidence of 'unassisted suicide' in Oregon, where assisted suicide is legal, is 41% higher than the national average and is the second leading cause of death in those aged 10-34. In the Netherlands, there has been a 30% increase in the suicide rate in the general population between 2008 and 2012.^{13 14}

Complications/methods used in assisted dying

We feel that it important to highlight the following data relating to the process of death for patients electing for assisted suicide.¹⁵

Data from the Dutch protocols, and other similar methods used elsewhere, suggest that after oral drug sedative ingestion, patients usually lose consciousness within five minutes. However, death takes considerably longer. Although cardiopulmonary collapse occurs within 90 minutes in two-thirds of cases, in a third of cases death can take up to 30 hours. Other complications include:

- difficulty in swallowing the prescribed dose (in up to 9%)
- vomiting thereafter (in up to 10%), both of which prevent suitable dosing,
- and re-emergence from coma (in up to 2%)

Each of these potentially constitutes a failure to achieve unconsciousness, with its own psychological consequences, and it would seem important explicitly to acknowledge this in suitable consent processes.

Other complications reported

- difficulties with intravenous access which preclude proceeding (3%);
- prolonged time to death (up to 7 days from drug administration in up to 4%);
- and failure to induce coma (with patients re-awakening, even sitting up, in up to 1.3%), which is more common in those who are not frail. The incidence of 'failure of unconsciousness' is approximately 190 times higher when it is intended that the patient is unconscious at the time of death as when it is intended, they later awaken and recover after surgery (when accidental awareness is approximately 1:19,000).

2. What is the current policy and legislative context, including are there any proposed Government Bills or general schemes designed to address the issue? Have there been previous attempts to address the issue via legislation?

Criminal Law (Suicide) Act

The Criminal Law (Suicide) Act 1993 decriminalised suicide, but assisting a suicide remains illegal. The 1996 Supreme Court decision in *Re a Ward of Court* established that the rights to privacy and personal autonomy conferred a right to refuse medical treatment, even where this would lead to death. The court also stated that “right, as so defined, does not include the right to have life terminated or death accelerated and is confined to the natural process of dying. No person has the right to terminate or to have terminated his or her life, or to accelerate or have accelerated his or her death.”

3. Is there a wider EU/international context?

Positions of relevant professional bodies in Ireland, UK and worldwide

A small number of countries have legislated for assisted suicide and euthanasia. However, such action presents many concerns for physicians and other healthcare professionals. These concerns are so great that, for example in the UK, most of the professional medical bodies have expressed their opposition to introduction of legislation on assisted suicide. In Ireland also, a number of professional healthcare/medical bodies have also expressed opposition. In most cases, the bodies in question have arrived at this position through reviews from expert groups, and through survey(s) of their membership.

The working group looked at the positions of medical professional bodies throughout the world

- World Medical Association
- Royal College of Physicians (RCP)
- Royal College of General Practitioners (RCGP)
- British Medical Association (BMA)
- Academy of Medical Royal Colleges (AOMRC)
- British Geriatric Society
- British Society of Rehabilitation Medicine (BSRM)

- Association for Palliative Medicine of Great Britain and Ireland (APM)
- Irish Palliative Medicine Consultants' Association
- Irish Association for Palliative Care (IAPC)
- European Association for Palliative Care
- Royal Dutch Medical Association (KNMG)
- Swiss Academy of Medical Sciences
- Swiss Medical Association
- Royal Australian College of General Practitioners (RACGP)
- Royal Australasian College of Physicians (RACP)
- Australian Medical Association
- American Psychiatric Association Position
- American College of Physicians
- American medical association

Many of these bodies were not in favour of assisted dying in any form. Some had not taken a position, and many expressed that the view that physicians should not have a role in assisted suicide.

Issues in jurisdictions where assisted suicide and/or euthanasia has been introduced

At the time of writing the RCPI 2017 position paper, assisted suicide or euthanasia was legal in six countries (Belgium, Colombia, Canada, The Netherlands, Switzerland, and Luxembourg). It was also legal in seven US States (California, Colorado, Montana, Oregon, Vermont, Washington and Washington DC).^{16 17}

Since 2017, PAS-E has been introduced to the state of Victoria in Australia: individuals whose life expectancy is 6 months or less can seek assisted PAS-E. Patients with certain progressive neurodegenerative conditions, such as multiple sclerosis or motor neuron disease, can apply within 1 year of their expected death. People with conditions that might hinder their decision-making capacity, such as advanced Alzheimer's disease, are excluded, as are people who have a mental illness or disability, without a terminal illness: healthcare practitioners must not initiate or suggest discussion of assisted suicide/euthanasia to patients.¹⁸

Germany's supreme court in 2020 lifted a law which outlawed the provision of assisted-suicide services. These services could range from signing a prescription for a lethal overdose

of sedatives, to providing consultation to terminally ill patients on how they could travel outside of Germany to end their lives legally.¹⁹

In jurisdictions where assisted suicide or euthanasia have been legalised, a number of issues raise concerns. These include euthanasia of those with dementia, mental illness, depression and non-terminal conditions; the extension of eligibility to allow euthanasia of children; and an increase in 'unassisted' suicide rates (see also page 9).

The 2017 RCPI position paper noted the following concerns that had been documented in relation to what was actually happening in some jurisdictions where assisted suicide or euthanasia has been legalised¹⁴:

- In the Netherlands, a 2013 review showed that 97 people with dementia were 'euthanised' in that year, along with 42 people with mental illness, and that euthanasia without explicit request from the patient was increasing.
- Between 2011 and 2014 in Belgium the euthanasia of two deaf adults was approved on the basis that they were going blind, and another adult in his 30s was approved on the basis of autism. A clinic that 'euthanised' a woman suffering from tinnitus was reprimanded for being 'careless'.
- Belgium also now allows euthanasia of children, while the Netherlands allows euthanasia of children over the age of 12 and babies under a different protocol. There are also proposals in the Netherlands to extend this to children between 1 and 12 years of age.²⁰
- Euthanasia in Belgium and the Netherlands and assisted suicide in Oregon is increasing significantly as the practice is normalised.
- The incidence of 'unassisted suicide' in Oregon is 41% higher than the national average and is the second leading cause of death in those aged 10-34. In the Netherlands, there has been a 30% increase in the suicide rate in the general population between 2008 and 2012.

Some additional issues noted in the 2017 RCPI paper:

In the State of Oregon:

- Out of 18 patients given clearance for physician assistance in dying, three were depressed at the time of requesting medical assistance in dying but that this was neither investigated nor treated.²¹

- Contrary to suggestions, the highest resort to physician assistance in dying in Oregon is among the elderly. ²¹
- In 2000, those who delayed in taking the medications survived for as long as ten months to 2.7 years (6/12 survival an eligibility criterion). Reporting of this data ceased in 2005. ²¹
- In 2014, the median time to death was 25 mins but varied up to 104 hours; six patients woke up and none of those re-attempted assisted suicide.²²

And in the Netherlands:

- Between 1990 and 2010 the ratio of euthanasia to assisted suicide in the Netherlands increased from 141:18 to 475:21 (66).²³ Where both assisted suicide and euthanasia are legalised, the rate of increase in Euthanasia is far greater than assisted suicide. That is, proportionately more doctors end lives than supply medicines so people can end their lives themselves. The challenge is that psychologically even more pressure is placed on doctors to actively participate in euthanasia, although morally the acts are probably equivalent.
- Difficulties were reported in administering the drugs in 10% of cases of physician assisted suicide and 5% of euthanasia, with vomiting in 7% and 3% of cases respectively. Deaths also took a long time of up to 7 days in 15% and 5% of cases respectively.²⁴

Implications and implementation of the Bill's proposals

4. How is the approach taken in the Bill likely to best address the policy issue?

We believe that dying with dignity is already present within our healthcare system. It is made possible by compassionate and supportive specialist palliative care teams, by the efforts of families and friends, and by extension, the support of society. Legislating for assisted suicide threatens to undermine those efforts. Instead, we argue for a focus on the right kind of compassionate support at the end of life, for all who need it.

5. What alternative and/or additional policy, legislative and non-legislative approaches were considered, including those proposed by the Government and what, does the evidence suggest, are the differences between and the merits of each?

We believe that what is needed is a focus on ensuring the right kind of compassionate care and support is in place for people with progressive or incurable illness who may be approaching, or is at the end of their life, for all who need it. This includes better palliative care including symptom control, psychological support and adequate treatment for depression and pain including the implementation in full of existing national policy focused on providing this support, such as:

- Palliative Care Three Year Development Framework 2017 – 2019²⁵
- National Cancer Strategy 2017 -2026²⁶
- Mental Health Strategy, including
 - Sharing the Vision: A Mental Health Policy for Everyone²⁷
 - Connecting for Life, Ireland's National Strategy to Reduce Suicide, 2015-2020²⁸

An argument for the introduction of assisted suicide is that despite the best available palliative care, a small number of terminally ill patients suffer unbearably. It has been argued that the absence of legislation supporting assisted suicide is leading to some patients having to take their own lives earlier in order to do so while they are still physically able to do so in anticipation of disability.

There are several challenges to this position, including a paper showing that in psychiatric patients, symptoms of unbearable suffering may start at an early age and may further progress because of insufficient and/or poor patient-physician communication and inefficient treatment practices.²⁹

Research has also highlighted the following³⁰:

- Lack of self-determination: Psychological and social motives characterize requests for PAS-E more than physical symptoms or rational choices; many requests disappear with improved symptom control and psychological support;

- Inadequate palliative care: Better palliative care makes most patients physically comfortable. Many individuals requesting PAS-E don't want to die but to escape their suffering. Adequate treatment for depression and pain decreases the desire for death;

We also know that the process of adaptation to change means that a patient's level of distress may fluctuate significantly at different points of their health journey. As a result, the anticipation of intolerable suffering may be transformed in experience and meaning, given time and appropriate support.

Financial issues are also relevant – for example, in the context of economic arguments about a health service overly concerned with “waste” of resources, disabled people may be seen as a drain, as may older people. We also know from the US that some people have been denied life-extending treatments because they are too costly while the cheaper assisted suicide option has been offered as an alternative.³¹ In addition, all major UK advocacy groups for disability have rejected assisted suicide.

6. Are there Government-sponsored Bills (or General Schemes) which are related to and/or broadly aim to address the same issue? Are there merits in combining them?

See above on existing national policy

7. What are the specific policy implications of each proposal contained within the Bill (environmental/economic/social/legal)? Has an impact assessment (environmental/economic/social/legal) been published (by Government or a third party) in respect of each proposal contained within the Bill?

Challenges in assessment of capacity

The assumption of mental capacity and freely given consent is based on a subjective clinical judgment, including the patient's ability to understand, believe and weigh up the implications of their decision. There are a range of emotional as well as cognitive factors which influence mental capacity. Evidence presented to the UK Commission on Assisted Dying noted that judgements about mental capacity relating to assisted suicide were inconsistent and sometimes at variance with the UK Mental Capacity Act 2005. It found that a consensus had not yet been established on what constitutes capacity for this decision.³²

Conscientious objection

Provision 13 of the Bill states that "a person with objection shall make arrangement for transfer of care to enable the qualifying person to avail of assistance in ending their own life in accordance with this act."

It has been argued in the literature that there should be protections for patients from doctors' personal values and there should be more severe restrictions on the right to conscientious objection, particularly in relation to assisted dying. Of note is the Swedish approach where individual healthcare professionals have no recognised right of conscientious refusal – but there are legal cases challenging this in the European Court of Human Rights.³³

Healthcare professionals are thus concerned regarding their right to conscientiously object to authorise or perform certain lawful services. A 2015 UK case may provide some parallels. In UK- Doogan (2015) the Supreme Court determined that two senior midwives who objected to abortion were, nevertheless, obliged to provide administrative and supervisory assistance to other healthcare professionals who were providing abortions.³⁴

Concerns have been expressed from within the medical profession that physicians may not be allowed to conscientiously object to provide assisted suicide.³⁵ Similarly, there is concern that the duty of a healthcare professional to refer or to provide a patient with information may undermine the professional's conscientious objection.³⁶ It remains unclear under what

circumstances there would be an ethical obligation to inform terminally ill patients about assisted dying as an end-of-life option – and whether conscientious objection would be allowed.³⁷

Inadequate overview and regulation

Concerns have been raised about the overview process in the Netherlands: in substantive criteria cases, the focus of the regional ethics overview was procedural. The cases were more about unorthodox, unprofessional or overconfident physician behaviours and not whether patients should have received assisted suicide/euthanasia³⁸.

8. Could the Bill, as drafted, have unintended policy consequences, if enacted?

The unintended consequences of the bill are many and are highlighted with reference to examples from the literature in both RCPI reports. We are concerned with unintended consequences that have been seen in other jurisdictions where assisted suicide/euthanasia has been introduced. These include:

- The expansion of groups included (to groups for which the legislation was not originally foreseen): this has occurred in virtually every jurisdiction where PAS-E has been legalized
- Inadequate safeguards for vulnerable members of society
- Societal pressure and reduction in autonomy in relation to organ donation
- Undermining of the practice of palliative care
- Devaluation of the lives of persons with disabilities
- Negative impact on the role of physicians and medicine
- Impracticability and ineffectiveness of oversight and regulatory measures

At the same time, the possibility for other forms of harm cannot be discounted. One unintended consequence for example, would be that a person may choose euthanasia based on mistaken medical diagnosis or prognosis.

Expansion of groups included in Physician Assisted Suicide-Euthanasia (PAS-E)

The process of extension of PAS-E to age groups and conditions is extremely concerning. We noted the following extensions of PAS-E in the 2020 paper published by this group.

- **Newborn infants:** newborn infants in the Netherlands four years after the introduction of assisted suicide/euthanasia.³⁹
- **Children:** over the age of 12 in the Netherlands (There are also proposals in the Netherlands to extend this to children between 1 and 12 years of age.⁴⁰) and any age in Belgium.⁴¹
- **Psychiatric patients:** euthanasia of patients with psychiatric illness with an increase in the estimated number of requests from 320 in 1995 to 500 in 2008 and then to 1,100 in 2016 in the Netherlands⁴² and Belgium⁴³. This creates enormous ethical dissonance with the ethos and practice of suicide prevention.⁴⁴

- **Intellectual disability and/or autism spectrum disorder:** There was a lack of detail on social circumstances and how patients were informed about their prognosis: capacity tests in these cases did not appear sufficiently stringent.⁴⁵
- **Tired of living:** The Dutch government intends to create a separate legal framework for PAS-E for those who are “tired of living”.⁴⁶
- **Chronic disease:** Ongoing court challenges in Canada to legislative requirements for PAS-E have resulted in its approval for individuals with chronic illnesses such as osteoarthritis, dementia, and physical disability.⁴⁷
- **Advance directives for dementia:** The inclusion of requests for euthanasia in advance directives for dementia in the Netherlands has been of concern in terms of over-riding patients’ right to change their mind characterized in a particularly troubling case where a woman was euthanized after indicating that she did not want to be euthanized, and was sedated covertly and physically restrained for the euthanasia to be carried out.⁴⁸

Inadequate safeguards

There is concern that legalising assisted suicide would lead to significant unintended consequences for the healthcare system and society and that societal attitudes would gradually change; that there would inevitably be a creep from restrictive to permissive eligibility and potentially to include non-voluntary and involuntary euthanasia.⁴⁹ With that, there is the possibility that life would be devalued in society, particularly concerning for vulnerable people-sick, disabled and elderly. This argument includes the idea that people who are very ill or with severe disabilities may feel pressured to request assisted suicide or euthanasia to avoid being a burden to their families.

The United Nations Human Rights Committee and the United Nations Committee on the Rights of Persons with Disabilities have expressed concerns about the impact on the disabled and the vulnerable in countries where assisted suicide is legal. The fear is that at the heart of arguments for assisted suicide is a belief that some lives- lives that are physically or intellectually compromised - are not worth living, and that the legislation undermines the rights of the disabled, both directly but also by implying lesser values of certain types of life. It has been argued that it is impossible to enforce sufficient safeguards, and in particular that there are no safeguards that can truly protect the vulnerable.

For example, there is evidence that safeguards in the Netherlands and Belgium are ineffective and violated, including administering lethal drugs without patient consent, absence of terminal illness, untreated psychiatric diagnoses, and nonreporting.⁵⁰

Organ donation – respect for autonomy

Organ donation in the context of PAS-E raises ethical issues regarding respect for autonomy, societal pressure, conscientious objections and the dead-donor rule.⁵¹ A number of proposals have been made suggesting reversing the accepted principle of organ donation after death to ‘death by donation’.^{52 53} Belgian physicians have noted that an estimated maximum of 10.1% of all patients undergoing euthanasia could potentially donate at least 1 organ, and that if even if only a small percentage of the patients undergoing euthanasia donated an organ, donation after euthanasia could potentially help reduce the waitlists for organ donation: this may add pressure to promote living organ donation which causes death.⁵⁴

Risk of devaluation and disinvestment in palliative care

Palliative care is a recognized component of the right to the highest attainable standard of health, which is protected in article 12 of the International Covenant on Economic, Social and Cultural Rights, and in article 24 of the Convention on the Rights of the Child.⁵⁵

It has been noted that while PAS-E was determined as a right in Canada, no similar right was determined for access to palliative care, and less than 30% of Canadians have access to any form of palliative care and less than 15% have access to specialized palliative care.⁵⁶ A Quebec study found that in patients requesting euthanasia, 32% of those who received a palliative care consultation had it requested less than seven days before euthanasia provision and another 25% of palliative care consults were requested the day of or the day after the euthanasia request.⁵⁷

The use of the euphemistic terminology of Medical Assistance in Dying (MAID) to refer to PAS-E in Canada is considered by palliative care physicians to have exacerbated this confusion in both the public and health care spheres. Canadian palliative care organizations have argued against the use of such language, affirming that palliative care provides support or “assistance” in dying to help people live as fully as possible until their natural death, but does not intentionally hasten death.⁵⁸ This assertion is also supported by the longstanding World Health Organization definition of palliative care.

Fear of being a burden to others is a real concern in terms of seeking assisted suicide/euthanasia and should be addressed by relieving it through positive pro-active palliative measures to address and remedy this fear.⁵⁹

Hospices that do not engage with assisted suicide/euthanasia are being defunded in Canada and the number of registrars entering palliative care in Quebec dropped after MAID legalisation.⁶⁰

Devaluation of the lives of persons living with disabilities

As mentioned above, the United Nations Human Rights Committee and the United Nations Committee on the Rights of Persons with Disabilities have expressed concerns about the impact on the disabled and the vulnerable in countries where assisted suicide is legal, as well as concerns over PAS-E being promoted as a cost-saving measure⁶¹ instead of providing the care needed for a good quality of life. A January 2021 statement from UN human rights experts in response to a growing trend to enact legislation on medically assisted dying, said

“when life-ending interventions are normalised for people who are not terminally ill or suffering at the end of their lives, such legislative provisions tend to rest on - or draw strength from - ableist assumptions about the inherent ‘quality of life’ or ‘worth’ of the life of a person with a disability.”

and

“even when access to medical assistance in dying is restricted to those at the end of life or with a terminal illness, people with disabilities, older persons, and especially older persons with disabilities, may feel subtly pressured to end their lives prematurely due to attitudinal barriers as well as the lack of appropriate services and support.”⁶²

Another report from the Special Rapporteur on the rights of persons with disabilities to the UN 17th Dec 2019 highlights the importance of ensuring access to appropriate palliative care support:

“... access to appropriate palliative care, rights-based support (see A/HRC/34/58), home care and other social measures must be

guaranteed; decisions about assisted death should not be made because life has been made unbearable through lack of choices and control”⁶³

The 2020 RCPI paper, referenced commentary which draws on both the literature and on case examples from Canada. Specifically, it considered the issue of assisted suicide/euthanasia as an alternative to, or substituted for, appropriate disability supports. It also considered the issue of the devaluation of disabled lives in general and within health care practice and ethics. It concluded that current safeguards are inadequate and that as PAS-E regimes become more permissive the risk to disabled persons will increase.⁶⁴

Also, in societies where a negative public discourse related to living with dementia is tolerated, despite evidence of maintained quality of life for those so affected, assisted suicide or voluntary active euthanasia (VAE) may undermine the collective will to improve services and supports for those living with dementia, as noted in a case in the Netherlands where a woman with dementia was euthanized against her wishes, and this was tolerated by the professions and the courts.^{65 66}

Impact on physicians and medicine - violation of medical ethics

Consideration of medical ethics implies that legalising assisted suicide would be in violation of the medical ethics requirement for respect for human life, and incompatible with the doctor’s role as healer and to preserve human life: although generally implicit in professional ethics discourse, it is a central tenet that doctors should not kill their patients. In addition, it would be in direct contravention of the Irish Medical Council’s Guide on Professional Conduct and Ethics and guidance on End of Life Care.⁶⁷ It would also be a paradigm shift in the role of the physician and could lead to irreparable damage to the patient-doctor relationship.

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