Dying with Dignity Bill 2020

A Submission to the Oireachtas Committee on Justice
from the
Council for Life and the Consultative Group on Bioethics,
of the
Irish Catholic Bishops' Conference
26 January 2021

A. Introduction

We have been invited to make a submission to the Oireachtas Committee on Justice, regarding the 'Dying with Dignity Bill 2020' (hereinafter referred to as 'the Bill'). While there are many important things that can and should be said about the question of Euthanasia and Assisted Suicide, we understand that the role of the Committee is to assess this particular Bill. We acknowledge the request that submissions should focus on the provisions of the Bill in response to the twenty questions in the *Framework for Committee Scrutiny of PMBs.* The majority of these questions do not relate to the kind of ethical concerns which are the focus of our submission. We wish to present what follows as a response to just two of those questions:

Question 4: *How is the approach taken in the Bill likely to best address the policy issue?*, given that the stated policy issue is to '*make provision for assistance in achieving a dignified and peaceful end of life to qualifying persons*'.

Question 7: *What are the specific policy implications of each proposal contained within the Bill?*

The Council for Life is an advisory body established by the Irish Catholic Bishops' Conference. As part of its brief it is tasked with engaging in research on questions related to the dignity and protection of human life and monitoring legislative proposals. The Consultative Group on Bioethics is an academic working group, which advises the bishops on questions related specifically to the Ethics of Healthcare and Bioethics. Members of both groups were involved in the preparation of this submission.

The submission is rooted in our conviction that we have a moral responsibility to care for our 'neighbour' according to the Gospel image of the Good Samaritan. It draws on the insights of letter *Samaritanus Bonus*, on the care of persons in the critical and terminal phases of life.[1] Our view, essentially, is that the Bill's proposals, which provide for the medical facilitation of suicide, run radically counter to the common good, the promotion of which is a particular responsibility of the State.[2] If passed, the Bill would not only encourage the acceptance of assisted suicide but significantly weaken the protections against the non-consensual killing of particularly vulnerable classes of persons. We outline our reasoning in greater detail below.

IRISH CATHOLIC
BISHOPS' CONFERENCE
COMHDHÁIL EASPAG CAITLICEACH ÉIREANN

B. How the Bill Addresses the Policy Issue

(Question 4 of the Framework for Committee Scrutiny of PMBs)

1. The Policy Issue

The Bill is described as an '*Act to make provision for assistance in achieving a dignified and peaceful end of life to qualifying persons and related matters*'. Human dignity refers to individual worth and is inherent in every human person by virtue of his or her human nature. It is not something given or conferred by any institution, law, process, or standard of physical or mental well-being. Yet the Bill presupposes that human dignity can be lost and that a person can die 'without' dignity.

For many, though by no means all people, the end of life is marked by a period of declining capacity, sometimes directly related to sickness or disease and sometimes due simply to the frailty of old age. It becomes increasingly obvious, both to the person in question and to his or her immediate family and friends, that life is drawing to a close. In addition to the associated physical manifestations, this end stage of human life can give rise to a variety of emotions in the person who is dying: sadness, anxiety, depression, resignation, peace. Just as some people drift through life while others engage fully with it, so it is with the end of life.

2. Full and Free Participation in Decision-Making

It is possible to speak of the dying person as participating fully and freely in this closing stage of his or her life. In the midst of all the physical and emotional changes that happen, the identity of the dying person – and his or her status as a person - remains unchanged. To participate actively and freely in the end of one's life, in this sense, is to choose life, even while accepting the inevitability of death.

It is totally in keeping with the dignity of the person that a man or woman should wish to exercise his or her freedom by participating actively in decision-making about medical treatment or care which is proposed for him or her. This includes expressing certain preferences about how he or she might be cared for or treated at some future time, when he or she might not be competent to make a decision. The law already provides for people to refuse treatment which would be regarded as futile and/or unduly burdensome. The law already provides for advance care decisions and for assisted decision-making.[3]

3. The Achievement of the Policy Objective Through Palliative Care

Within existing law and medical practice, good palliative care, by upholding absolute respect for human life and, at the same time, acknowledging human mortality, offers terminally ill people the best possibility of achieving 'a dignified and peaceful end of life'. It does this by being sensitively truthful, by providing for the relief of physical and emotional pain and by ensuring that people have the opportunity to express fears and hopes and unresolved concerns and to be listened to, in a context where the focus is on care rather than on therapy or the artificial prolongation of life.

4. The Failure of the Bill to Adequately Address the Policy Issue

Section 8 of the Bill fails to require care givers to provide adequate palliative care for the terminally ill person. Hence someone might decide to end his or her own life without ever having experienced what palliative care has to offer and, thus, making this decision without being fully aware of the other options available to them. If there is a perceived demand for assisted suicide, we would respectfully recommend that the Oireachtas should consider whether there is adequate provision for palliative care and, if so, whether there is sufficient energy invested in making its availability known and its purpose understood.

Another serious omission is the failure of the bill to recognise the reality that many patients who request assisted suicide are depressed. 'Depression, anxiety, and ambivalence about dying characterize both medical patients who attempt suicide and those who request assisted suicide. When the physical and psychological sources of the desperation that underlies requests for assisted suicide are addressed, the desire for death diminishes and patients are usually grateful for the time remaining to them. Improved psychiatric and medical care for those who are terminally ill offer significant possibilities for suicide prevention.'[4]

The desire to end one's life arises not so much from the fear of death as from fear of the symptoms associated with dying, be they physical, emotional or social. We find it unsatisfactory, therefore, that the Bill, in section 8, gives more weight to the irreversibility of the condition than to treatments which, even temporarily, relieve the symptoms. This leads to an unacceptably loose understanding of terminal illness.

5. Authorisation of Assisted Dying (Section 6)

For reasons best known to the drafters, the Bill does not make use of the term 'suicide', except with reference to amendments to the Criminal Law (Suicide) Act 1993. Notwithstanding this avoidance of the term, the Bill is essentially about making provision for a person who wishes to end his or her life, to make a formal declaration to that effect and to seek medical assistance in doing so. Section 11(2)(c) speaks of the provision of substances for the purpose of '*enabling that person to end his or her own life*.' It is therefore appropriate to refer to the Bill as an 'assisted suicide' bill. While palliative care already provides assistance to those who are dying, this Bill provides for the medical endorsement and facilitation of suicide. Legislators need to honestly recognise the difference and call things by their proper name.

The New Charter for Health Care Workers (2017), states: 'There is no right to arbitrarily dispose of one's life, so no doctor can be the executive guardian of a non-existent right'.[5] To participate in assisted suicide is to share in the intention of the patient to end his/her own life. The medical practitioner who formally or materially assists a patient in ending his/her own life is engaging in an act of homicide, which is always unlawful.[6]

The assumption underlying assisted suicide is that there is such a thing as a life without value; a life which is no longer worth living. This false assumption inevitably erodes the very basis of legal respect and protection, on a basis of equality, for every human life, regardless of age, disability, competence, or illness. The law already recognises that there are times when further treatment is futile and inappropriate, but to say that life itself is futile is fundamentally different. The legal endorsement of assisted suicide would ultimately lead to the acceptance of non-voluntary euthanasia, because the logic of assisted suicide is based on a rejection of the truth that all human lives are fundamentally equal in value and worthy of protection.

Compassion is often presented as a justification for assisted suicide, but having compassion means 'suffering with' someone. Assisted suicide reflects a failure of compassion on the part of society. It is a failure to respond to the challenge of caring for terminally ill patients as they approach the end of their lives.[7] Those who assist with a suicide, whatever their motives, co-operate with the self-destruction of another person. It is one thing when life is shortened as an unintended side effect of pain relief or the cessation of burdensome treatment. It is something else entirely, when one person actively and deliberately participates in ending the life of another.[8]

6. Assisted Suicide and Patient Autonomy

The Bill does not attempt to explore the question of patient autonomy, which is a well-established principle in healthcare. The principle of autonomy recognises the right of a person to be treated and cared for in a manner which reflects his or her own personal values, hopes and desires. Autonomy is not absolute, however, because as members of society our decisions can have serious implications for others. Medicine does not in fact suppose that patient choice is absolute, e.g., doctors can ethically refuse to administer treatments they judge to be harmful. So while autonomy is indeed a great good, as one highly regarded ethicist has said: 'its exercise should be consistent with the rights of others and all the other requirements of humane and decent behaviour. No man is an island. That is why it is important to understand the premises on which autonomous choices are made, to reflect on the implications of those premises. Exercises of autonomy, which proceed from premises which are both false [i.e., that some people are not of equal worth] and, in their implications, injurious to other members of society, can rightly be overridden by law.'[9]

Assisted suicide is presented in this Bill as if it were a normal act befitting personal autonomy. The person who has decided to end his or her life is presented as the agent or actor, whilst the role of others involved is presented in terms of mere assistance. Those who 'assist' are also 'actors' and each is morally responsible for his or her own action. There is a very real paradox inherent in the fact that the act for which a doctor provides 'assistance', on the pretext of respect for autonomy, is the very same act which extinguishes the patient's autonomy once and for all. The Congregation for the Doctrine of the Faith says that: 'to end the life of a sick person who requests euthanasia is by no means to acknowledge and respect their autonomy, but on the contrary to disavow the value of both their freedom, now under the sway of suffering and illness, and of their life'.[10]

In making legal provision for assisted suicide, the Oireachtas – which is charged with the care of the common good – would effectively be conceding that, in circumstances of terminal illness, assisted suicide is in some sense 'good' or 'desirable'. Since law, of its nature, influences attitudes and behaviour, it is difficult to see how the availability of assisted suicide would not reduce end-of-life care to the level of a favour rather than a right.[11] Legalised assisted suicide would place the terminally ill, the disabled, and other vulnerable patients under emotional and social pressure to end their own lives in order to spare others the burden of caring for them. What begins as an abstract option becomes a specific societal 'duty' for many—a social pressure that no law, no matter how well intentioned, can regulate out of existence. In this way medically endorsed assisted suicide will stigmatise certain classes of vulnerable person. Medical endorsement of assisted suicide would also clash with wider societal efforts to address the scourge of suicide as something tragic, regrettable, and worthy of our efforts to fight against.[12]

For these reasons, the Bill's provisions run radically counter to the common good, to the equal worth of all human lives, and to the ethos of medicine.

C. Specific Policy Implications

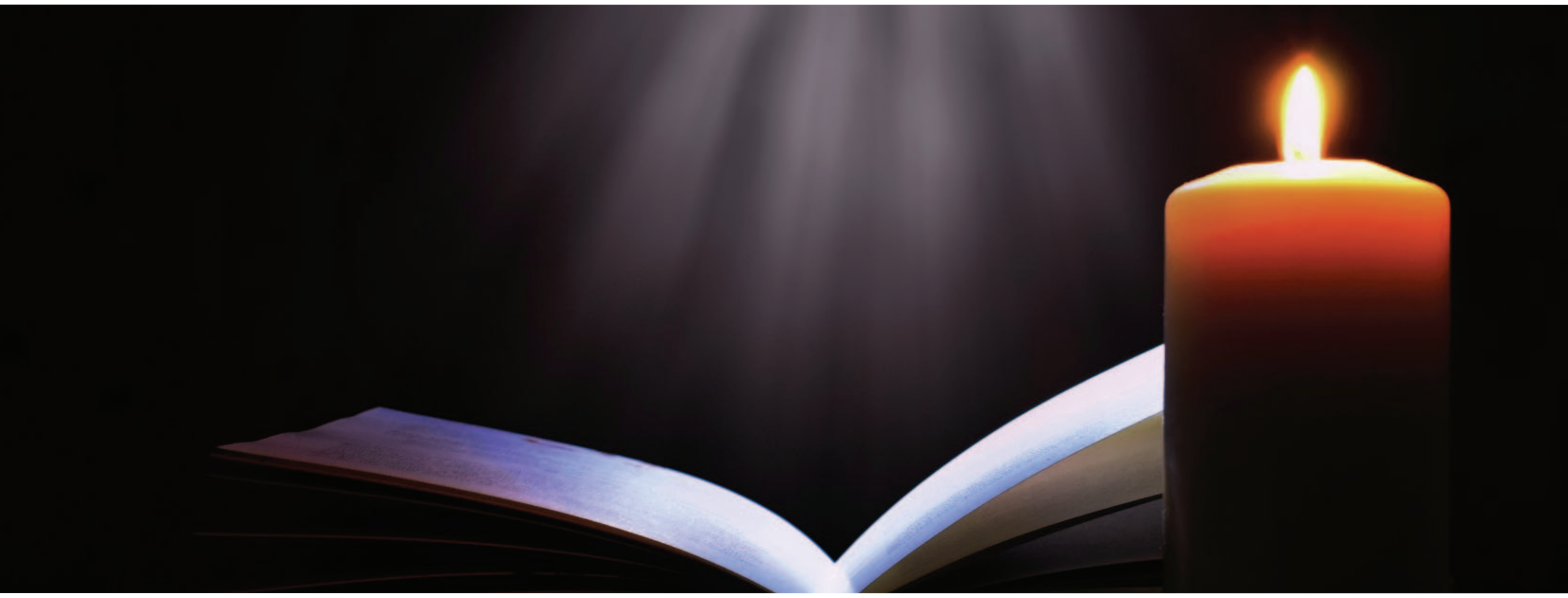
(Question 7 of the Framework for Committee Scrutiny of PMBs)

1. Qualifying Persons (Section 7)

The present Bill limits the availability of assisted suicide to terminally ill adults who are judged competent to make the required declaration. If, however, it is considered legitimate in principle for one person to participate in the deliberate ending of the life of another, then there is no principled reason why the same 'civil right' to assisted suicide ought not to be extended to other categories of competent adults who, for some reason or other, have come to the conclusion that life is futile or unduly burdensome.

Legalised assisted suicide is based on the false premise that quality of life confers human dignity, and on a rejection of the truth that all lives are of equal worth. There would, logically then, be no principled reason either, why legalised killing ought not to be extended to the killing of persons whose quality of life is deemed to be poor and who have not 'asked' to have their lives ended. The logic of assisted suicide propels the widening of the practice towards extremely vulnerable groups and towards non-consensual killing.

International data confirms this. The introduction of assisted suicide/euthanasia on 'limited' grounds inevitably tends towards the widening of those grounds to include the medicalised killing of persons with non-terminal illnesses,[13] persons with psychological conditions and disorders,[14] persons with disabilities,[15] and persons who do not voluntarily request being killed (e.g., persons, including children, who lack mental capacity due to, e.g., being comatose).[16] Our own High Court in its judgement in the case of *Fleming v. Ireland* commented on the last point thus, 'the fact such a strikingly high level of legally assisted deaths without explicit request occurs in countries such as Belgium, The Netherlands and Switzerland without any obvious official or even popular concern speaks for itself as to the risks involved in any such liberalisation.'[17]



International data also demonstrates enormous increases in year-on-year assisted suicides after the initial introduction of the practice. For example, in Oregon assisted suicides have increased by 218% over the last ten years[18] and the most recent estimates are that assisted suicide/euthanasia in Canada accounts for 2% of *all* deaths[19] and in Belgium and The Netherlands accounts for 4.6% of *all* deaths, including the deaths of children and vulnerable people.[20] Our own High Court and Supreme Court have expressly acknowledged much of the above evidence and considered it very good reason to reject the idea of a right to assisted suicide.[21]

We ask legislators not to ignore this data and not to shirk the very serious responsibility they have to reflect on the logic underpinning it. To repeat: when medicalised killing is accepted as legitimate in principle, when the truth that all human lives are of equal value is abandoned, then there is no principled limit on medicalised killing and no principled way to support the application to all people of the norm against deliberate killing. This is not a speculative slippery-slope 'argument' – it is honest recognition of the logic underpinning hard data.

2. Declaration (Section 9)

Section 9 presents the process which is to be followed by the terminally ill person in making a valid declaration to end his or her own life. The Bill (9.1) makes provision for two medical practitioners, described as the '*attending medical practitioner*' and the '*independent medical practitioner*' to countersign the declaration made by the person who has chosen to end his or her life. Before countersigning the declaration, the two medical practitioners are required, among other things, to satisfy themselves that the person making the declaration;

- has the capacity to make the decision (9.3 a)
- has a clear and settled intention to make the decision, which has been reached voluntarily (9.3 c)
- has been fully informed, regarding the care options that are available to him or her (9.4).

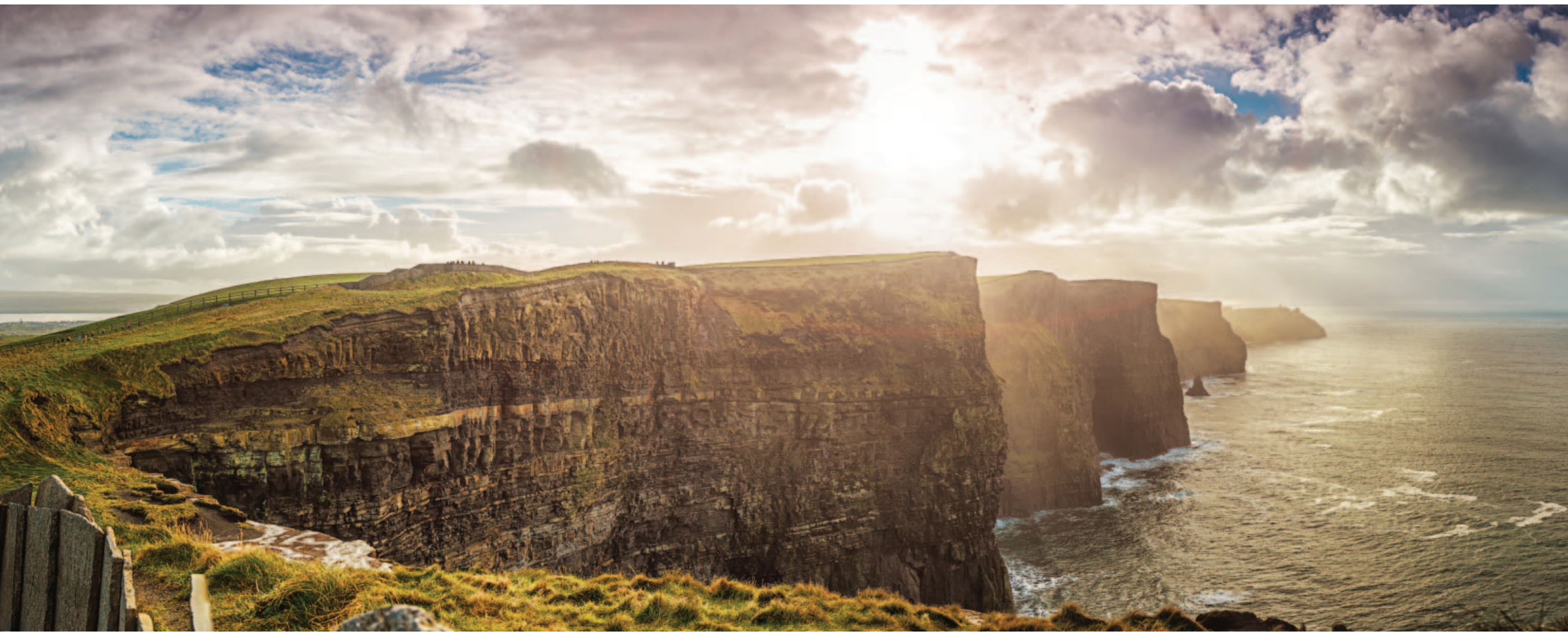
Similar requirements apply in other jurisdictions. These medical practitioners are, by definition, willing to participate in taking a human life. How, then, can they be trusted to make a decision that is in the best interests of a vulnerable patient?

We also note that the Bill does not require the medical practitioners providing the information to have any specific training in care of the dying or palliative care.

3. Assessment of Capacity (Section 10)

This section of the Bill deals with the assessment of capacity, previously referred to in Section 9. The Bill states (10.1) that *'the person's capacity shall be assessed on the basis of his or her ability to understand the nature and consequences of a decision to be made by him or her in the context of the available choices at the time the decision is made'*.

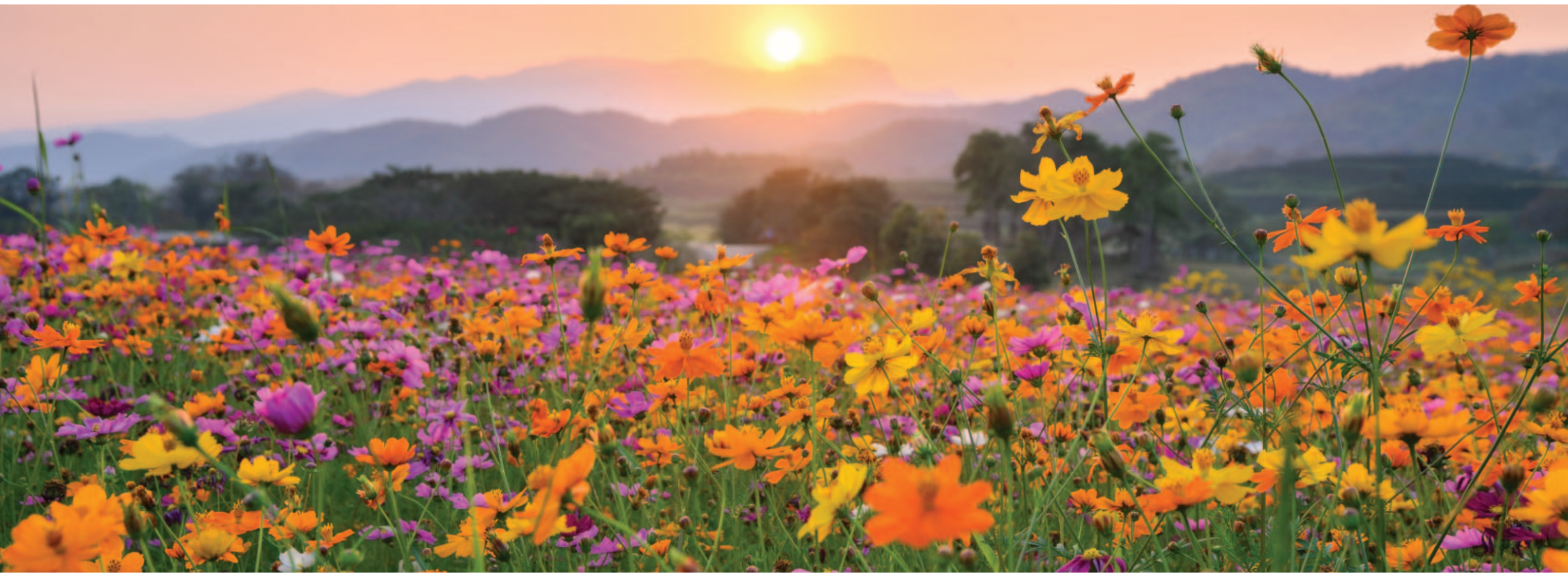
In this context the Bill provides (10.4) that *'the fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him or her from being regarded as having the capacity to make the decision'*. We would be particularly concerned about the implications of this provision for people with dementia who can be quite lucid and rational for periods of time but who also suffer from short-term memory loss and who often change their minds and their feelings about themselves and others in the space of a few moments. It is arguable that a medical practitioner, especially one who doesn't really know the patient, may not always be the best person to assess a person's capacity to understand. Given the significance the Bill attaches to mental capacity, we find it surprising that there is no requirement in the Bill for one of the medical practitioners to have expertise in the area of mental health.



4. Assistance in Dying - Healthcare Professionals (Section 6 & 11)

The right to assisted suicide presupposes that somebody with the requisite skills would be available to 'assist'. The Bill presumes (6.1 & 6.2) that this assistance will be provided by a medical practitioner, who may be assisted by an 'assisting healthcare professional'. The Bill further provides (11.5d) that the attending medical practitioner '*in the event that the qualifying person cannot self-administer the substance or substances may administer the substance or substances* *but the decision to self-administer or have administered the substance or substances must be taken by the person for whom the substance or substances has been prescribed*'. This is a grave injustice to healthcare professionals in that it implicates them in an act which repudiates the authentic value of life.[22]

Healthcare professionals are given privileged access to the human body and to drugs for the express purpose of healing and alleviating pain. In doing otherwise, they are in breach of the trust placed in them by society. While we would, clearly, be opposed to assisted suicide *per se*, we also believe that this identification of healthcare professionals as those who would assist and, under certain circumstances, actually perform the act in accordance with the instructions of their client, is seriously damaging to the ethos and the credibility of the healthcare professions. It radically changes the meaning of healthcare.



5. Conscientious Objection (Section 13)

Under the heading of conscientious objection the Bill provides (13.1) that '*nothing in this Act shall be construed as obliging any medical practitioner or assisting healthcare professional to participate in anything authorised by this Act to which he or she has a conscientious objection*'. It goes on, however, to state (13.3) that '*A person who has a conscientious objection referred to in subsection (1) shall make such arrangements for the transfer of care of the qualifying person concerned as may be necessary to enable the qualifying person to avail of assistance in ending his or her life in accordance with this Act*'.

This very limited provision for conscientious objection fails to acknowledge the right to freedom of conscience for healthcare professionals who judge any significant cooperation with suicide to be morally wrong. Central to freedom of conscience is the right not to do what one regards as seriously immoral. The Bill would coerce the consciences of objecting healthcare providers in order to facilitate something they know to be gravely immoral and utterly incompatible with their vocation to heal. This burdening of conscience is unnecessary, disproportionate and seriously unjust.

D. Conclusion

Over the past year the governments, the healthcare services and the populations of the world have struggled to supress the COVID-19 pandemic and to protect those in society who are most vulnerable. We have been deeply moved by the level of generosity and tenderness that has been shown by so many healthcare professionals and the sacrifices that have been made by so many to protect those who are most at risk. Alongside that positive manifestation of genuine compassion, we note, however, that some of the written protocols which relate to the difficult and essential task of prioritising critical care resources, are shot through with language which is essentially utilitarian in its assessment of the value of human life.

Whatever our prognosis and however limited our capacity, our value as persons is rooted in who we are rather than in our life-expectancy or our ability to reach certain standards of physical or mental performance. Pope Francis recalls that 'the current socio-cultural context is gradually eroding the awareness of what makes human life precious. In fact, it is increasingly valued on the basis of its efficiency and utility, to the point of considering as 'discarded lives' or 'unworthy lives' those who do not meet this criterion.'[23] We contend that, the Committee would best serve humanity and the common good of society by recommending to the Oireachtas that this Bill should not be passed for all the reasons given above.

E. Recommendations

1. That the Oireachtas should consider whether there is adequate provision for palliative care and, if so, whether there is sufficient energy invested in making its availability known and its purpose understood.
2. That the Committee would recommend to the Oireachtas that this Bill should not be progressed further.

Notes

[1] Cf. Congregation for the Doctrine of the Faith, *Samaritanus Bonus: On the Care of Persons in the Critical and Terminal Phases of Life.* Rome: Libreria Editrice Vaticana, 2020 (http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20200714_samaritanus-bonus_en.html).

[2] Cf. *Bunreacht Na hÉireann*, Preamble (and passim.).

[3] Cf. Assisted Decision-Making, (Capacity) Act 2015.

[4] Herbert Hendin, 'Suicide, Assisted Suicide, and Medical Illness', *The Journal of Clinical Psychiatry*, 60(Suppl. 2), 1999, 46–50.

[5] Pontifical Council for Pastoral Assistance to Healthcare Workers, *New Charter for Healthcare*, Philadelphia: NCBC, 2017, 169.

[6] Cf. *Samaritanus Bonus*, V(1).

[7] Ibid., III. Cf. also Robert D. Orr. 'Pain Management Rather Than Assisted Suicide: The Ethical High Ground', *Pain Medicine*, 2(2), 2001, pp. 131–137 (downloaded from https://academic.oup.com/painmedicine/article/2/2/131/1859790).

[8] The analysis here relies on the well-established principle of double effect. The principle has been acknowledged by, inter alia, the Parliamentary Assembly of the Council of Europe (Recommendation 779: On the Rights of the Sick and Dying, 1976), the House of Lords Select Committee on Medical Ethics (Report on Medical Ethics ,1994, paras 242, 243), and the United States Supreme Court (*Vacco* v. *Quill* [1997] 521 US 793, 801-2).

[9] John Finnis, 'Misunderstanding the Case Against Euthanasia,' in John Keown (ed.), *Euthanasia Examined: Ethical, Clinical and Legal Perspectives*, Cambridge: Cambridge University Press, 1995, 70–1.

[10] *Samaritanus Bonus*, III.

[11] Ibid., VI.

[12] There is some evidence that legalising assisted suicide is associated with an increase in wider suicide rates. See David Jones and David Paton, 'How Does Legalization of Physician Assisted Suicide Affect Rates of Suicide?', *Southern Medical Journal*, 180(10), 2015, 599–604.

[13] Seen in the increases in euthanasia from non-terminal conditions in the Netherlands and Belgium and in the removal of the requirement that death be 'reasonably foreseeable' for 'medical assistance in dying' in Quebec in *Truchon c. Procureur Général du Canada*, 2019 QCCS 3792 (CanLII); (https://d3n8a8pro7vhmx.cloudfront.net/dwdcanada/pages/4439/attachments/original/1574891049/truchon_v_canada_-_text.pdf?1574891049) and in the C-7 Bill to extend this to the whole of Canada.

[14] This is legal in Belgium, the Netherlands, Luxembourg and Switzerland and the Justice Minister in Canada is proposing that the C-7 Bill be amended to include this.

[15] See for example Irene Tuffrey-Wijne, Leopold Curfs, Ilora Finlay, and Sheila Hollins, 'Euthanasia and Assisted Suicide for People with an Intellectual Disability and/or Autism Spectrum Disorder: An Examination of Nine Relevant Euthanasia Cases in the Netherlands (2012–2016)', *BMC Medical Ethics*, 19(1), 2018, 1–21; Kevin Fitzpatrick and David Albert Jones, 'A Life Worth Living? Disabled People and Euthanasia in Belgium' in David Albert Jones, Calum MacKellar and Chris Gastmans (eds.) *Assisted Suicide and Euthanasia: Lessons from Belgium* Cambridge: Cambridge University Press, 2017, 133–149.

[16] The High Court in *Fleming v. Ireland* found that between 0.4% and 1.9% of *all* deaths in Switzerland, Belgium and Netherlands were cases of non-consensual euthanasia. *Fleming v. Ireland* [2013] IEHC 2, 96-99. Since *Fleming* the law in Belgium has been extended to children (in 2014), while the law in the Netherlands has extended euthanasia to children over 12 (in 2014) and to children under 12 (in 2020) and to patients with dementia who are no longer able to consent (by a Dutch Supreme Court ruling 2020).

[17] *Fleming v. Ireland* [2013] IEHC 2, 104.

[18] Increase from 59 to 188 deaths. See Death with Dignity National Center's 'Oregon Death with Dignity Act: Annual Reports' for years 12 (2009) and 22 (2019) respectively (available at https://www.deathwithdignity.org/oregon-death-with-dignity-act-annual-reports/).

[19] 'In 2019, there were 5,631 cases of euthanasia or assisted suicide reported in Canada, accounting for 2.0% of all deaths ... This an increase of 26.1% over 2018.' See Health Canada, *First Annual Report on Medical Assistance in Dying in Canada 2019*, Ontario: Health Canada, 2020 (https://www.canada.ca/en/health-canada/services/medical-assistance-dying-annual-report-2019.html). Note this only includes officially reported figures. The actual rate may well be higher.

[20] Figures from 2013 and 2015 respectively, Kenneth Chambaere, Robert Vander Stichele, Freddy Mortier, Joachim Cohen and Luc Deliens 'Recent Trends in Euthanasia and Other End-of-Life Practices in Belgium', *New England Journal of Medicine*, 372, 2015, 1179–1181 (https://www.nejm.org/doi/full/10.1056/nejmc1414527); Agnes van der Heide, Johannes J.M van Delden, and Bregje D. Onwuteaka-Philipsen, 'End-of-Life Decisions in the Netherlands over 25 Years', *New England Journal of Medicine* 377, 2017, 492–494 (https://www.nejm.org/doi/full/10.1056/nejmc1705630).

[21] *Fleming v. Ireland* [2013] IEHC 2 and *Fleming v. Ireland* [2013] IESC 19.

[22] Cf. *Samaritanus Bonus*, V(1).

[23] Pope Francis, Address to the Participants of the Plenary Session of the Congregation for the Doctrine of the Faith, 30 January 2020, English Trans. in *L'Osservatore Romano*, 31 January 2020, 7.