Introduction: Doctors for Life welcomes the opportunity to contribute to the review of the "Dying with Dignity Bill 2020".

Doctors for Life is an organisation for doctors who wish to uphold the practice of medicine as a service to human life at all stages. It is open to medical practitioners and health care professionals of every specialty, both working and retired. It aims to provide evidence-based and factual information to doctors and others who are concerned about the ethical questions relating to patient care and practitioner responsibility at all stages of life. It is not affiliated to, or part of, any other organisation. Doctor for Life has a broad membership and includes doctors working in General Practice, Medicine for the Elderly and Psychiatry.

This submission follows the format of questions as per guidelines.

SUBMISSION TO THE OIREACHTAS

1. The "policy issue" and the policy and legislative context:

1.1. The stated aim of the Bill is *"to make provision for assistance in achieving a dignified and peaceful end of life"* to certain persons. As such, the Bill is unnecessary. The development and expansion of Palliative Care services in Ireland already provides this much-needed service to all terminally ill patients who wish to avail of it and could do so to an even greater extent if more funds were provided by the State. There is a risk that legalising physician-assisted suicide will mitigate the imperative to provide (and fund) high quality palliative care. We cannot hope to confer on people the dignity in their disabilities and their dying that they deserve when support services for community nursing, out of hours care, occupational therapy, the provision of aids in the home and continuing care packages remain at the current inadequate levels.

1.2. The real aim of the Bill is to make provision for medical assistance in ending the life of certain persons. It is significant that the word "euthanasia" does not appear in the proposed legislation which covers both euthanasia and physician assisted suicide in the "softer" but confusing term "assisted dying." This Bill is actually about medical help to end life, since it is about both the prescription and possibly administration of lethal doses of medication, i.e., assisted suicide and euthanasia. It is about deliberate acts to end life, not about assisting in the natural dying process which the term "assisted to die" could be taken to mean.

1.3. There is no national evidence of a medical requirement for this as a means of managing terminal illness, even under the unacceptably loose definition proposed by this Bill.

2. Assisted suicide is currently illegal in Ireland and there is no basis in the Irish Constitution for the right to die[1]. The Bill proposes to confer a right which does not exist in the Constitution and then to restrict that right to a particular cohort of "qualifying" people.

3. Physician assisted suicide and euthanasia have been legalised in several jurisdictions, i.e., Belgium, the Netherlands, New Zealand, Canada, the state of Victoria in Australia and some states of USA (Oregon, Washington, Vermont, California, Colorado, Washington DC, Hawaii, New Jersey, Maine and Montana). Physician-assisted suicide was legalised first in countries with poorly-developed palliative care services.[2]

4. Implications and implementations of the Bill's proposal

4.1 The Bill contains medical and legal terms which it has not defined or which it has defined badly, thus giving rise to confusion and inevitable misinterpretation. The definition of a terminal illness given in Section 8, a) can equally be applied to illnesses which are compatible with good quality of life, such as diabetes, heart failure, chronic obstructive airways disease, asthma, to name but a few. Clinical evidence shows that consultants are often inaccurate in their estimation of a patient's prognosis. Defining the terminal phase is often much more difficult than people might imagine, particularly in patients with non-malignant disease such as cardiac or respiratory failure.[3]

4.2. Some provisions in the Bill are flatly contradictory. Section 9, (6) which states that a person may revoke their decision at any time, is undermined by Section 10, (4), which could lead to a denial of the right to revoke because of fluctuating capacity. Similarly, Section 10, (2), (b) undermines Section 10, (4).

5. No alternative and/or additional policy, legislative and non-legislative proposals were considered.

6. Not relevant.

[1] Supreme Court Judgement in Marie Fleming v Ireland, April 2013

[2] Ten Have H *et al* Ed *The Ethics of Palliative Care: European Perspectives*. 2002. Open University Press. Buckingham.

[3] Glare P *et al*. *Predicting survival in patients with advanced disease*. In *Oxford Textbook of Palliative Medicine* 3rd Edition Ed Doyle D, Hanks G, Cherny N, Calman K Oxford University Press Oxford 2004 pp 29-40.

7. Specific policy implications of each proposal contained in the Bill:

7.2. The Bill proposes that medical and other health personnel should participate in the deliberate ending of a patient's life. This is a complete subversion of medical ethics and one to which very many doctors, nurses and allied health care professionals would strongly object.

7.3. It also proposes that, despite his/her conscientious objection to physician-assisted suicide, the doctor must facilitate transfer of care to a service which will comply with the patient's wishes (Section 13, Subsection 3). This undermines the right to conscientious objection because it attempts to compel healthcare professionals to facilitate an act with which they disagree on principle and on grounds of conscience.

7.4. There has been no consultation of medical, nursing or allied healthcare personnel to establish whether or not the changes to their practice proposed in the Bill are acceptable.

8. Unintended policy consequences if enacted:

8.2. The international evidence would support the concept that once physician-assisted suicide is legalised, criteria are gradually changed so as to manage suffering in broader contexts. Belgium and the Netherlands in the past six years have changed their laws to allow for physician-assisted suicide of some minors with terminal illness. The Netherlands now allow physician-assisted suicide for new-born babies with terminal illnesses. Belgium allows it for children of all ages[4],[5]. The UN Human Rights Committee has expressed shock at the operation of the law in the Netherlands due to the large numbers involved and the inclusion of new-born handicapped infants[6]

8.3. International experience also shows that clinical criteria for physician-assisted suicide are gradually broadened to include psychiatric illness and dementia. In those countries where physician-assisted suicide has been legalised for more than ten years, the numbers of deaths have increased exponentially.[7]

8.4. No contingency plans have been included in the proposed Bill for physician-assisted suicide in the event of the inevitable refusal by large numbers of healthcare professionals to participate in the procedure. This would have implications for health-care institutions, particularly hospices and nursing homes, and professional specialties, mainly Palliative Care, Neurology, Medicine for the

[4] APM Euthanasia of Minors in Belgium https://apmonline.org/wp-content/uploads/2019/01/belgium-en-euthanasie-minors.pdf

[5] Sharrif, M.J., Assisted Death and the slippery slope –finding clarity amid advocacy. Convergence and complexity. Current Oncology, June 2012, 19 (3), 143-154

[6] UN Human Rights Committee, "Concluding Observations of the Human Rights Committee, the Netherlands", UN doc CCPR/CO/72/NET, 2001

[7] Belgium – Commission Federale de Controle et d'Evaluation de l'Euthanasie; Bi-annual Report 2019.

Older Person, Psychiatry, General Practitioners, Public Health and institution-based nurses.

8.5. No mention is made in the Bill of any specialist qualifications or experience required in order to qualify as an assisting health care professional, an attending medical practitioner or an independent medical practitioner. There is nothing to specify how long the attending medical practitioner has been attending the patient, as the only stipulation is that of being the registered medical practitioner "from whom a qualifying person has requested assistance to end their life". There is nothing to ensure that patients are not mismanaged by poorly qualified personnel. The Bill also makes no provision for disagreements in physicians' assessments of a patient's condition.[8]

8.6. The Bill does not refer to the financial remuneration to be offered to physicians who elect to participate in physician-assisted suicide. As the process outlined in Section 11, (5, 6) is a lengthy one, there would be implications for the physician's work-load and other patients. There is no mechanism proposed in the Bill to prevent pecuniary motives from being a factor in the involvement of physicians in ending the life of a qualifying patient.

9. The opinion of the European Central Bank is not relevant.

10. How would be Bill, if enacted, be implemented?

10.2. This is covered in considerable detail in Section 11 of the Bill.

10.3. Ref 11, (6); the absence of the attending physician or assisting healthcare professional from the same room as the person means that they cannot confirm that the procedure was carried out in accordance with the Act. The attending physician or assisting healthcare professional should remain in the same room as the patient from the time of administration of medication until death has occurred.

11. Performance indicators and formal review mechanisms:

Section 15, (2) of the Bill refers to the establishment of a body known as the "Assisted Dying Review Committee". It does not specify how this body will be composed, what its terms of reference will be, whether it will have access to patient records and what will be its powers. This Committee should be charged with ensuring compliance, reviewing data and publishing information concerning physician-assisted suicide in Ireland. It should have powers to refer to the Irish Medical Council or to the Nursing and Midwifery Board of Ireland any concerns or complaints about participating doctors and/or nurses.

12. Will there be enforcement or compliance costs?

This is covered in Section 5 of the Bill.

[8] Kissane DW *et al* Seven Deaths in Darwin; Case studies under the rights of Terminally ill Act. Northern Territory Australia *Lancet* 1998; 352; 1097-102.

12.2. A person guilty of an offence under section 10 (capacity) of the Act has ended the life of a patient without their consent and should receive a much more severe penalty than that proposed.

12.3. A person guilty of an offence under section 14 (obligation to keep and provide records) of the Act should also receive a much more severe penalty in order to ensure compliance.

13. What are the likely financial costs of implementing the proposals of the Bill and what is the likely overall fiscal impact on the exchequer?

13.2. Payments to participating physicians, nurses, pharmacists for time spent with the patient prior to the procedure and for maintaining and providing records

13.3. Costs of medication and their delivery

13.4. In the expected event of large numbers of physicians refusing to refer patients, it will be necessary to have an intermediary agency run by the State which would be accessible to patients who wish to end their lives with the assistance of a third party.

13.5. Costs of Assisted Dying Review Committee.

14. Have cost-benefit analyses been provided?

No. It is therefore not possible to calculate the financial impact on the State's Health Services, although it can be conjectured that medical and nursing indemnity fees, medication costs, legal challenges and a possible intermediate "agency" would impose considerably on the national exchequer.

15. Is the draft PMP compatible with the Constitution?

The Constitution does not acknowledge a right to die (cf. footnote 1).

16. Is the draft PMP compatible with EU legislation and human rights legislation (ECHR)?

The ECHR ruled against the right to assisted suicide in the case of Pretty vs United Kingdom in 2015.[9]

17. Is there ambiguity in the drafting which could lead to the legislation not achieving its objectives and/or to case law down the line?

17.2. Section 8: The definition of "terminally ill" is weak and open to interpretation. The time of death cannot be accurately predicted.

[9] https://hudoc.echr.coe.int/eng#{%22itemid%22:[%22001-60448%22]}

17.3. Section 10: see section 4.2 above. Consent is crucial to this procedure and the ambiguities contained in this Bill will lead to legal challenges from interested parties.

17.4. The stated aim of the Bill is false and should be amended to "Assisted Suicide Bill", as it is the Criminal Law (Suicide) Act 1993 that would require amendment.

17.5. There will be legal challenges to the lack of provision of true conscientious objection.

18. Are there serious drafting deficiencies or technical drafting errors (e.g., incorrect referencing to Acts, etc.)

Unknown.

19. Are there any potential unintended legal consequences which may stem from the PMP as drafted?

Yes. See Section 17 above.

20. Are there appropriate administrative and legal arrangements necessary for compliance and enforcement of the provisions of the Bill included?

These are included but are not appropriate as they are not sufficiently severe as to ensure compliance.

Summary:

Doctors for Life would like to raise objections to the Bill on the following grounds:

1. The title of the Bill is misleading and should be: "Assisted suicide".
2. Vague and inaccurate definition of term "terminal illness".
3. Self-contradictory proposals regarding consent.
4. Presumption of a right which does not exist in the Constitution.
5. Disregard for societal implications of physician-assisted suicide.
6. Disregard for personal, ethical and professional impact on the medical and nursing professions.
7. Disregard for effects on patients who may NOT wish to commit physician-assisted suicide.
8. Disregard for the right to conscientious objection.
9. Disregard for financial implications for the State.
10. The proposed regulatory mechanism is weak.
11. The proposed punitive measures are so weak as to positively encourage non-compliance.

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