

Iona Institute Submission
to Oireachtas Committee on Justice
Scrutiny of 'Dying With Dignity Bill 2020'

Table of content

Executive Summary	2
PART A:	
<u>Policy and Legislative Analysis</u>	
Policy and Legislative Context	3
Justifications for Assisted Suicide and Euthanasia	6
 <u>Implications and Implementation of the Kenny Bill's Provisions</u>	
'Qualifying Persons' (Eligibility Criteria)	11
Safeguards	22
Other Consequences in Overseas Jurisdictions	29
The Context of Palliative Care	35
Part B:	
<u>Legal Analysis</u>	
The Constitution of Ireland and European Convention on Human Rights	39
Conclusion	44

Executive Summary

- The 'Dying With Dignity Bill 2020' ('Kenny Bill') proposes to legalise physician assisted-suicide (PAS) and physician-administered euthanasia (PAE). The purpose of the current law against these practices is to:
 - Indicate fundamental social principles in favour of the value of individual human lives, and thereby help provide a cultural and legal framework for suicide prevention;
 - Provide necessary protections for the sake of public safety (in particular, to provide safeguards for patients, and sections of society who are particularly vulnerable).
- In accomplishing these purposes, the law fulfils a duty of the Irish State under Article 2 of the European Convention of Human Rights (right to life).
- Despite this, there are people who want to be enabled to end their own lives, or to have their lives ended, by a physician, because of the profound unhappiness they experience due to terminal illness.
- Claims that such enabling is a 'right to die' are made based on arguments from 'autonomy' and 'dignity'. These arguments suffer from the fact that provision of PAS / PAE is an entitlement, not a freedom, and the potential for PAS / PAE to cause undignified deaths.
- Aside from the problems with the arguments for PAS / PAE, the evidence base concerning European / U.S. jurisdictions that have for years experimented with legal frameworks for these practices finds that they remove important protections and actually *undermine* patient autonomy and dignity, as shown by the evidence of:
 - Involuntary PAE;
 - Patients pressured into PAS / PAE by their personal vulnerability;
 - Worsened suicide rates;
 - 'Bad deaths' due to ingestion of lethal drugs.
- In this light, the implications of the Kenny Bill's proposals are grave, in that they open up the possibility of the kind of abuses seen in other jurisdictions:
 - The eligibility criteria of the Bill provide scope for application to many more patients than just ones who are terminally ill in the colloquial sense. Those who are elderly, chronically ill, disabled, and in poor mental health (including those suffering from dementia), would all potentially fall under the Bill's definition of 'terminally ill'.
 - The premises justifying the Bill – 'autonomy', 'dignity', the 'right to die' – do not rationally allow for a limit to those who are 'terminally ill'. Either everyone (or at least everyone suffering) has a right to the enabling of our own suicide, or no-one does. The precedent introduced into law by this Bill would be a 'logical cliff' allowing incremental extension.
 - The proposed 'safeguards' of the Bill do not provide protection from undue influence or coercion, as no requirements exist that the two doctors certifying the voluntary nature of someone's application for PAS / PAE should have psychological training, or that they know the patient long enough and well enough to detect either coercion or more subtle pressure.
 - Jurisdictions with PAE / PAS, even with safeguards that are stronger on paper, have suffered serious abuses.
- The Kenny Bill would undermine the purpose of the law, and so far from extending patient autonomy, would worsen it.
- Better alternatives to legalising PAS / PAE exist in extensive palliative care reforms.
- The Kenny Bill and arguments for it are respectively incompatible with the Constitution of Ireland and European Convention on Human Rights, as well as recent jurisprudence in the Supreme Court and European Court of Human Rights.
- Whilst a perfect solution is impossible to all the problems raised by the issue of PAS / PAE, the best option is to follow the same approach typified by the response by the Irish Government and others to the COVID-19 pandemic: to err on the side of retaining social, medical, and legal protections for the most vulnerable members of society.

PART A: Policy and Legislative Analysis

Policy and Legislative Context

The ‘Dying With Dignity Bill 2020’ proposed by Deputy Gino Kenny¹ (hereafter, ‘the Bill’, or ‘the Kenny Bill’) would allow a doctor to prescribe a ‘qualifying person’ with “substance or substances” which they can orally ingest, or otherwise self-administer, to enable them to end their own life², and for another doctor or a nurse to assist in this action³. At minimum, the doctor attending the patient would prescribe these substances⁴, but also arrange the delivering⁵ and (where necessary) the provision of the means to self-administer them⁶, and would even be expected to administer the drugs directly to the patient if self-administration were impossible⁷.

The Bill would therefore not only introduce the assistance of a patient to end their own lives, but the killing of a patient who wishes to end his or her life but cannot do so themselves. The phrases used in academic literature to discuss the former practice is ‘physician-assisted suicide’ (PAS), and for the latter action, ‘physician-administered euthanasia’ (PAE)⁸ – more colloquially, ‘assisted suicide’⁹ and ‘euthanasia’.

¹ *Dying With Dignity Bill 2020* (‘Kenny Bill’): <https://data.oireachtas.ie/ie/oireachtas/bill/2020/24/eng/initiated/b2420d.pdf>

² *Ibid.*, sections 6(1), and 11(1)-(2).

³ *Ibid.*, section 6(2), and 11(6).

⁴ *Ibid.*, section 11(2)(a).

⁵ *Ibid.*, section 11(3)(a).

⁶ *Ibid.*, section 11(2)(b).

⁷ *Ibid.*, section 11(2)(c). This was recognised in the Dáil Second Stage debate by Tipperary TD Alan Kenny, the leader of the Labour party, who stated: ‘*This Bill is concerned with more than just providing assistance [in patient suicide]. It authorises in circumstances the direct administration of substances by the attending physician.*’

⁸ Precisely referring to ‘active’ and ‘voluntary’ euthanasia. This is as opposed to ‘passive’ euthanasia which involves ending someone’s life by withdrawal of treatment, either directly (so as to kill the patient) or indirectly (simply allowing them to die), and ‘involuntary’ euthanasia, when doctors take it upon themselves to choose to kill their patients.

⁹ Proponents of the Bill object to the use of the phrase, ‘assisted suicide’, despite its long-standing usage in international political and ethical discourse on this subject (‘assisted suicide’ is used in official reports on that practice in the Netherlands, Belgium, and Luxembourg, amongst other countries where it is licensed under a legal framework), preferring instead the phrase invented by those proposing the legal introduction of that practice in Anglophone countries: ‘assisted dying’. This is despite the fact that EXIT International uses the phrase, along with that of ‘rational suicide’ for ‘unassisted’ cases:

<https://exitinternational.net/about-exit/our-philosophy/>

In the Second Stage debate on his Bill, Deputy Gino Kenny (S-PBP; Dublin Mid-West) called it “*completely... [and] wholly inappropriate and irresponsible*” to “*conflate suicide and voluntary assisted dying*”, with Deputy Richard Boyd Barrett (S-PBP; Dún Laoghaire) arguing that the latter differed from the former in that it involved “*people who, like pretty much all of us, have wanted to live but whose choice about living is taken from them at the end, often in really awful circumstances*”. This point was repeated by Labour leader Deputy Alan Kenny (Lab; Tipperary) in the letter he read out by euthanasia campaigner Vicky Phelan: “*I do not want to die. I am not choosing between living and dying. My cancer is incurable. The option of living will no longer be available to me in the not too distant future*”.

Currently, both these practices are illegal in Irish law. Section 2(2) of the Criminal Law (Suicide) Act 1993¹⁰ explicitly prohibits assisted suicide by stating that, “[a] person who aids, abets, counsels or procures the suicide of another, or an attempt by another to commit suicide, shall be guilty of an offence and shall be liable on conviction on indictment to imprisonment for a term not exceeding fourteen years”. Euthanasia, as it involves a physician directly causing the death of (killing) their human patient, constitutes the Common Law crime of Murder (or potentially, Manslaughter), as further governed by section 4 of the Criminal Justice Act 1964¹¹.

The 1993 Act criminalised assisted suicide in statute at the same time as decriminalising the act of suicide itself, which had hitherto been a Common Law felony. This happened despite no-one having been prosecuted for suicide in living memory. The value of that law was that it formalised and properly established in statute a principle that already existed in the broader culture: that individuals who attempt to take their own lives should not be prosecuted for doing so, or stigmatised by their Government, but given the help and compassion that they need. This conviction has arguably become stronger as we have better come to understand the role and profound importance of mental health.

In a notebook in 1945, John F. Kennedy paraphrased G.K. Chesterton and wrote, “Don’t ever take a fence down until you know the reason why it was put up”. Applied to law, these words express how essential it is to understand the purpose of existing legal provisions in consideration of a Bill which aims to qualify them and reduce their application. In this context, it is necessary that we note the several important purposes which the legal injunctions against both assisted suicide and euthanasia serve.

Like much law, the laws against PAS and PAE serve a cultural purpose in indicating two fundamental social principles. The first is the value of human lives, and that deliberately ending a human

The Oxford English Dictionary definition for ‘Suicide’ is ‘[t]he action of killing oneself intentionally’, whilst to be ‘Suicidal’ means to be ‘[d]eeply unhappy or depressed and likely to commit suicide’. In neither definition are the motivating factors for suicide or being suicidal pertinent. To commit suicide is to intentionally end one’s own life; this fact does not depend on the motivations behind the intention, but merely that the intention and the action exist. To be ‘suicidal’ is to be so profoundly miserable that one could be in a position to commit suicide.

If someone desires and intends to end their life because of their unhappiness at how burdensome or painful they find their personal condition, then however understandable this may be, this is suicidal ideation by sheer definition. Our empathy and sympathy with a terminally ill person who wishes to expedite their death no more removes the suicidal nature of the desire, than it does in the situation of a person who has lost their family in a tragic accident, cannot imagine continuing without them, and therefore truly feels that their option to truly ‘live’, as they define it, has been taken away from them.

To insist on the term ‘assisted dying’ and thereby exclude the term ‘assisted suicide’, is to bowdlerise language and risk avoiding (and desensitising public debate to) the moral and practical gravity of what is being proposed for introduction into law, medicine, and society. For that reason, this submission will use the older standard terms.

¹⁰ Criminal Law (Suicide) Act 1993: <http://www.irishstatutebook.ie/eli/1993/act/11/section/2/enacted/en/html#sec2>

¹¹ Criminal Justice Act 1964: <http://www.irishstatutebook.ie/eli/1964/act/5/section/4/enacted/en/html#sec4>

life is, as a normative and *prima facie* moral and legal reality, wrong. The second is that suicide is therefore, again as a normative principle, a tragic and completely objectively negative phenomenon, and therefore not only something which nobody should encourage or assist in another, but which should be actively discouraged by each individual and by every institution in society, including Government.

These principles undergird the *suicide prevention* ethic and strategies of developed nations, including that of the Irish Government through its National Office for Suicide Prevention¹². These include maintaining emergency responses to attempted suicides, ‘suicide watches’ of those who may seek to harm themselves, and Government suicide prevention strategies. They also possess an important *public safety* role in providing and indicating the importance of appropriate social and legal protections to those who are psychologically vulnerable, from pressures to kill themselves both within and without. Through both these means, it is an expression of the Irish State’s obligation under Article 2 of the European Convention on Human Rights (the ‘right to life’) to take positive steps to safeguard human life¹³.

The Kenny Bill proposes to create an exception within current legal protections by introducing a legal framework licensing the practice of assisted suicide and euthanasia. In considering the Bill, it would be prudent to examine the experience of those overseas jurisdictions that have already introduced similar frameworks. There are 10 jurisdictions that have licensed assisted suicide, 9 of which are in the United States¹⁴, and 7 countries which have licensed both euthanasia and assisted suicide under legal frameworks¹⁵ such as that proposed by the Bill before the Dáil. In addition, there are 3 jurisdictions that have been left with indeterminate situations by high court-ordered full or partial decriminalisation of euthanasia and / or assisted suicide: Montana (2009; for assisted suicide)¹⁶, Italy (2019; partial assisted suicide)¹⁷, and Germany (full euthanasia and assisted suicide)¹⁸. Of these various jurisdictions, only 6 have legal frameworks which have been operating for longer than a decade. For assisted suicide-only systems

¹² National Office for Suicide Prevention: <https://www.hse.ie/eng/services/list/4/mental-health-services/nosp/preventionstrategy/>

¹³ See the Council of Europe’s Guide on *Article 2 of the European Convention on Human Rights*: https://www.echr.coe.int/Documents/Guide_Art_2_ENG.pdf We will discuss this further in Part B: Legal Analysis.

¹⁴ These being, by date of legislative or judicial introduction: Switzerland (1942), Oregon (1997), Washington (2008), Montana (2009; though through judicial decriminalisation without a formal legal framework), Vermont (2013), California (2016), Colorado (2016), the District of Columbia (2017), Hawaii (2019), Maine (2019), and New Jersey (2019).

¹⁵ These being, by date of legislative or judicial introduction: the Netherlands (2002), Belgium (2002), Luxembourg (2009), Colombia (2015), Canada (2016), Victoria (2017), and Western Australia (2019).

¹⁶ *Baxter v. State*, No. DA 09-0051 (Dec. 31, 2009), Montana Supreme Court: <https://www.courtlistener.com/opinion/888660/baxter-v-state/?q=cites%3A887957>

¹⁷ *Decision No. 242 of November 22, 2019*, Corte Costituzionale (Italian Constitutional Court): <https://www.gazzettaufficiale.it/eli/id/2019/11/27/T-190242/s1>

¹⁸ *Judgment of 26 February 2020 – 2 BvR 2347/15*, Bundesverfassungsgericht (Federal Constitutional Court): <https://www.bundesverfassungsgericht.de/SharedDocs/Pressemitteilungen/EN/2020/bvg20-012.html>

these are Switzerland and the American States of Oregon¹⁹ and Washington; those including euthanasia are the Netherlands, Belgium, and Luxembourg. With the exception of Luxembourg (the evidence from which is too small scale and scanty), these form the best evidence base for considering the Kenny Bill, and what effects we might reasonably expect from adoption of a similar system. Within this Submission we will chiefly focus on these jurisdictions in evaluating elements of the Bill. We shall also explore the limited results available for Canada, which has had a system of euthanasia and assisted suicide similar to that proposed in the Kenny Bill for almost half-a-decade, with notable results.

Justifications for Assisted Suicide and Euthanasia

The arguments in favour of the Bill's aims focus on two main points: 'autonomy' and 'dignity'. In the former, the concepts of 'autonomy' and 'choice' are invoked, such that it is asserted that individuals have a right to choose autonomously what happens to their own body, which extends to the ability to decide when their life has run its course and to end it on their own terms. At the Second Stage debate for the Kenny Bill, Labour leader Deputy Alan Kenny quoted a letter from assisted suicide campaigner Vicky Phelan: *"I just want to be allowed to have the choice to control the circumstances of my death much as I have made decisions about my own life... Allow people to make choices for themselves"*²⁰.

¹⁹ The Oregonian system is a popular model for many advocates for the licensing of physician involvement in causing the death of patients. This is despite (or arguably, may have something to do with) the fact that little can be said about it, due to the sheer paucity of data available.

The Oregon State Public Health Division publishes a 'Death With Dignity' Act Report every year, purporting to provide informed oversight of the implementation of the system of assisted suicide allowed by the act. This functions however, as minimal data collection. The law requires doctors to report any prescription they make of lethal drugs, but there are no penalties for those who fail to report, and so no enforcement of this requirement. Nor is noncompliance, underreporting, or any violation monitored by the State Health Division, which admitted in its first year that "[W]e cannot detect or collect data on issues of noncompliance with any accuracy", with other reports admitting that "[O]ur numbers are based on a reporting system for terminally-ill patients who legally receive prescriptions for lethal medications, and do not include patients and physicians who may act outside the law".

Since the information is voluntarily reported by doctors, no information is collected from patients, or their relatives, and there is no official means by which the public can complain about abuses of assisted suicide. There is thus no strong oversight of assisted suicide exercised by the State Government. An Oregon State official, Dr. Katrina Hedberg, when questioned by the UK House of Lords Select Committee on Lord Joffe's 'Assisted Dying for the Terminally Ill' Bill in 2004, acknowledged that even what data they do collect is ultimately lost, as the State Health Division destroys each year's underlying data records after it issues each annual report (see *House of Lords Select Committee Report on the Assisted Dying for the Terminally Ill Bill*, Volume II: Evidence, pg. 262, Question 592: <https://publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/86ii.pdf>). Little wonder then, that an editorial in *The Oregonian* pointed out after almost a decade of the law's operation that it established "a system that seems rigged to avoid finding" abuses (see *Living With the Dying Experiment*, *The Oregonian*, 08th March 2005). There may be many other abuses in Oregon, but the data the State Government releases is so limited, and so temporary, that is essentially hidden. Nonetheless, from what data is available, we can learn some very telling lessons from the Oregonian experience, particularly in consideration of safeguards and patient autonomy.

²⁰ Dáil Éireann Debate – Dying with Dignity Bill 2020: Second Stage [Private Members], Thursday, 01st October 2020, Vol. 998 No. 4: <https://www.oireachtas.ie/en/debates/debate/dail/2020-10-01/27/> All preceding and forthcoming quotations from Deputies in the Dáil debate may be found therein.

The word 'autonomy' is derived from the Greek αὐτός ('self'), and νόμος ('law'), and has the ordinary meaning of self-government, in the sense of the ability to act free from external control or influence. The philosopher Isaiah Berlin, in his essay *Two Concepts of Liberty*²¹, conceived of this as 'negative freedom', that is, 'freedom from' coercive interference, or exterior constraints.

This freedom, applied to one's own body, and even one's own life, is by necessity limited. If 'autonomy' were absolute on a bodily level, it would mean that someone who experiences body integrity dysphoria (BID) would be able to procure the removal of a healthy limb (such as a leg which they felt was superfluous). The legal reality however, is that a doctor who acceded to such a request would be prosecutable under the felony of assault causing serious harm, and certainly struck off the Irish Medical Council's Register of Medical Practitioners. This is because the actions of a medical practitioner are meant to be conditioned to the objective good of their patient, regardless of the subjective desires the patient may have about the condition of their body. Amputating a healthy leg, arm, digit, or any other appendage or organ, would be antithetical to the health and welfare of any patient. Instead, their dysphoria would be considered a pathology needing treatment.

The same logic applies in consideration over the autonomy of individuals who wish to decide the timing and nature of the end of their own life. On a social level, if personal autonomy in this area were absolute, then it would be considered a violation of individual sovereignty to rescue (prevent) someone attempting suicide from the ledge of a tall building, from a train platform, or from a waterway. Instead, we consider such actions heroic, not coercive.

The underlying principle here is well-illustrated by a more extreme example: the case of the voluntary victim, Bernd-Jurgen Brandes, a 43-year old German man who in 2001 answered the online advertisement of another man, 42-year old Armin Meiwes, for a "well-built male prepared to be slaughtered and then consumed". Brandes went to Meiwes's home, where Meiwes proceeded to kill and eat Brandes for their mutual sexual gratification. Brandes consented entirely 'voluntarily' to his own demise, so if autonomy were truly absolute such an arrangement would be entirely legal and morally uncontroversial. Indeed, the defence team in Meiwes's trial attempted a defence partially on the grounds that his actions formed a kind of euthanasia²². Instead, there is no jurisdiction on Earth where Meiwes

²¹ *Two Concepts of Liberty*, Isaiah Berlin, 1958: http://berlin.wolf.ox.ac.uk/published_works/tcl/

²² *German Cannibal Back on Trial*, Deutsche Welle, 12th January 2006: <https://www.dw.com/en/german-cannibal-back-on-trial/a-1853189>

would not be convicted of murder and (at least) sentenced to life imprisonment, as he eventually was in 2006 in his native Germany²³, as was ‘Detlev G.’ a former German police officer in a similar case in 2015²⁴.

Despite this reality, in 2020, the German *Bundesverfassungsgericht* (Federal Constitutional Court) ruled that the country’s laws against assisted suicide void because, they contended, the German Basic Law contained a ‘right to personality’, which involved that each individual has a “right to a self-determined death and to pursue and carry out the decision to end their life on their own terms”. In their view suicide is an “act of autonomous self-determination” which Government must give “sufficient space” to exercise. Aside from the inherent problems with this framing of suicide (as we have seen), and assisted suicide by implication (as we will discuss shortly), this decision raises the legal question in parallel to the moral one we have raised above: why should it be an “act of autonomous self-determination” to end one’s own life in suicide to which Government must “sufficient space”, but not if one were to offer oneself as a willing victim as in either of the two cannibal cases which Germany has seen? If ending one’s own life, or allowing or requesting someone else to end one’s own life, is an act of autonomy and part of a “right to personality”, then the reason for ending one’s life should be immaterial. That this leads to what most people would recognise as the dark nonsensicality of allowing voluntary cannibalism, acts as a *reductio ad absurdum* to the autonomy argument.

Clearly, individual autonomy is not (and cannot rationally be) seen as an absolute principle, whether in medicine or in any other sphere of social existence, but one which is heavily contingent on what is good for the health and broader personal welfare of the individual autonomous actor, let alone that of others.

Even if this were not true however, it would be ill-applied in the context of the Kenny Bill. Those employing it as a concept frame the argument for assisted suicide and euthanasia as the extension of a freedom. This is clearly misleading: as has been noted already, the Criminal Justice (Suicide) Act 1993 decriminalised suicide, and it is this statute which grants the pragmatic liberty for individuals to try end their own lives, even as society does everything it can to discourage them from doing so, such actions. We are already practically autonomous when it comes to trying to determine the span of our own lives (though circumstance may frustrate us), and neither physician assistance of suicide, or administration of euthanasia extends that legal reality at all.

²³ *German Cannibal Sentenced to Life in Prison*, Deutsche Welle, 09th May 2006: <https://www.dw.com/en/german-cannibal-sentenced-to-life-in-prison/a-2014515>

²⁴ *German ex-policemen jailed in cannibalism website killing*, Deutsche Welle, 01st April 2015: <https://www.dw.com/en/german-ex-policemen-jailed-in-cannibalism-website-killing/a-18354980>

Since the freedom already exists, what is being asked for on the basis of a 'right to die' is not allowing people to do something, but *giving them what they want*. The argument for assisted suicide is that those people who cannot end their own lives have the right to be enabled to do so. With euthanasia it goes even further – the 'right to die' is the right to be killed by your physician. These are not 'negative' liberties; they are 'positive' rights: not freedoms, but *entitlements*.

Another reason why 'autonomy' is inappropriately invoked in this context is that whilst autonomous choice involves one actor, assisted suicide (as with any medicalised interaction) involves two: the patient and the doctor. In medicine, just as the claim that 'autonomy' even means sovereign choice over one's body is simply untrue, the idea that it involves an ability to access any medical benefit at all simply is not a credible proposition.

To take a mild example, the reality of medical practice is that doctors have for decades frequently refused to prescribe antibiotics at a patient's request for relatively trivial conditions because to do so would produce general resistance to those drugs, which would prove profoundly injurious to people in the future, particularly those who seriously need antibiotic medication. This shows that the subordination of individual patient autonomy for the common good of the wider patient community is a normative principle in medicine. This is an important point which, in consideration of the dangers of assisted suicide to the most vulnerable of patients, we will return to in evaluating the eligibility criteria and alleged 'safeguards' in the Bill.

Meanwhile, 'compassion' and 'dignity' are also invoked in this subject in terms of relieving suffering, with the argument being that assisted suicide and euthanasia would kindly bring an end to the suffering of those who are, in the words of Deputy Mick Barry (S-PBP; Cork North-Central): "*[f]acing into an undignified death without control of their bodies or bodily functions and who make the choice to leave this world in a different way, namely, voluntary assisted death*".

It would surely be difficult not to empathise with the loss of personal dignity that serious illness can cause, and which Deputy Barry vividly described. This argument ignores however, the potential for assisted suicide and euthanasia as practices to compromise personal dignity (not to mention inherent human dignity), which again will be illustrated by our later evaluation of the Bill's contents and foreseeable effects. An immediate and direct example we can invoke for the general reality of the

practices the Bill proposes to license however, is the uncertain effects of the unnatural action of taking lethal drugs.

In 2011, the late British author Sir Terry Pratchett presented a documentary on the BBC called *Choosing To Die*, in which he advocated for legalisation of assisted suicide in the United Kingdom. One of the people he met in England was a 42-year old marine biologist called Andrew Colgan, who suffered from MS and was determined to travel to Switzerland and die in a Dignitas clinic. The programme did not follow Colgan's travel, but showed Pratchett raising a toast to Colgan at the time he was appointed to take the lethal drugs. What then went unreported in the documentary, was that so far from a quick death (5 minutes to fall unconscious; 20 minutes to die), Colgan took 90 minutes to die, with Dignitas staff even telling his grief-stricken mother Yvonne to stop embracing him as they feared her physical affection was keeping him alive²⁵.

In 2019, a study²⁶ in the journal *Anaesthesia* looked into the methods of achieving unconsciousness and death, usually through the use of barbiturates, the method of killing death row prisoners through lethal injection in the United States. The authors concluded:

"[F]or all these forms of assisted dying, there appears to be a relatively high incidence of vomiting (up to 10%), prolongation of death (up to 7 days), and re-awakening from coma (up to 4%), constituting failure of unconsciousness. This raises a concern that some deaths may be inhumane..."

If up to 1-in-10 deaths lead to vomiting, and almost 1-in-20 lead to prolonged death, this does not indicate that assisted suicide or euthanasia may necessarily lead to 'dignified deaths'. Even if it were possible that they could in all cases, the experience of jurisdictions in the European Union and the rest of the Europe, as well as the United States suggest that sufficient abuses occur that assisted suicide and euthanasia cause both personal autonomy and dignity to be undermined, particularly for the most vulnerable patients.

Unfortunately, similar conclusions can be drawn when we consider the further implications, we may reasonably expect in the practical implementation of the system the Bill proposes.

²⁵ 'My brother took 90 minutes to die at Dignitas': What the BBC didn't reveal in controversial Pratchett documentary, Nick Fagge, Daily Mail, 27th June 2011: <https://www.dailymail.co.uk/news/article-2008380/amp/Dignitas-What-BBC-didnt-reveal-controversial-Pratchett-documentary.html>

²⁶ Sinmyee S, Pandit VJ, Pascual JM, Dahan A, Heidegger T, Kreienbühl G, Lubarsky DA, Pandit JJ. *Legal and ethical implications of defining an optimum means of achieving unconsciousness in assisted dying*. *Anaesthesia*. 2019 May;74(5):630-637. doi: 10.1111/anae.14532. Epub 2019 Feb 20. PMID: 30786320. <https://onlinelibrary.wiley.com/doi/full/10.1111/anae.14532>

Implications and Implementation of the Kenny Bill's Provisions

'Qualifying Persons' (Eligibility Criteria)

The Kenny Bill licenses doctors to euthanise or assist in the suicide of their patients, only if they are 'qualifying persons' according to the eligibility criteria set down in sections 7 and 8. Section 7 requires that for someone to qualify for assisted suicide or euthanasia they must have a "clear and settled intention" to end their own life and made a declaration to that effect²⁷ (which we will discuss in considering the purported 'safeguards' within the Bill, and at the time of declaration be:

- 'Terminally ill'²⁸
- 18 years old or over²⁹
- Resident on the island of Ireland (therefore including residents in Northern Ireland) for not less than one year³⁰

The primary criterion of eligibility is that the person be "terminally ill". Deputy Kenny, in describing to the Dáil those who would so qualify for assisted suicide or euthanasia, summarised the Bill's ostensible extent and limitations:

'The Bill would allow a person, who must be over eighteen and suffering from a terminal illness, to... [request] assistance to end his or her life... The person seeking assistance must be diagnosed as having an incurable and progressive illness that cannot be reversed by treatment'.

The definition Kenny gave of 'terminal illness' reflects almost entirely that found within section 8 of the Bill, which states that a person is "terminally ill" if they are diagnosed by a registered medical practitioner as having an illness which is "**incurable**", "**progressive**", "**cannot be reversed by treatment**", and as a result of which "or complications relating thereto", the patient "**is likely to die**" (a "terminal illness").

Immediately, however, ambiguity obscures the scope of the Bill. The phrase "cannot be reversed by treatment" is not positively defined in the text of section 8 – which only excludes treatment being

²⁷ *Op. cit.*, Kenny Bill, section 7(b).

²⁸ *Ibid.*, section 7(a), 'terminally ill' being defined by section 8.

²⁹ *Ibid.*, section 7(c)(i).

³⁰ *Ibid.*, section 7(c)(ii).

understood as palliative or mitigating the symptoms of the illness³¹ – or the list of terms in section 2. Nor was this explained by Kenny in his description of the applicability and implications of the Bill in the Second Stage debate. This causes a clear problem of interpretation, given that the term ‘reversible’ is often used in medical discussions, as more broadly, as synonymous with ‘curable’. The Merriam-Webster Medical Dictionary defines a condition or medical intervention as ‘reversible’ if it is “capable of being corrected or undone: not permanent or irrevocable”, such that hypertension (a condition) can be undone, or a vasectomy (a procedure) can be corrected. The same dictionary defines its antonym, ‘irreversible’, when specifically referring to a pathological process such as a terminal illness, as “of such severity that recovery is impossible”³².

This leaves us with two potential interpretations of the Bill’s wording. That something “cannot be reversed by treatment” either means:

- That it is incurable, in which case it is a redundant phrase given the prior use of the word ‘incurable’ in the same sentence.
- That it means the *progression of the illness* cannot be reversed, such that the underlying condition cannot be alleviated permanently in its symptoms or other deleterious effects (since section 8(b) excludes any treatment which “relieves the symptoms of an inevitably progressive condition temporarily” from being regarded).

For the purposes of this paper, we shall assume the latter interpretation, although in the absence of clarification, it should be noted that the former interpretation obviously considerably widens the scope of those for whom the Bill would legalise assisted suicide or euthanasia considerably.

Another problem appears however, within the stipulation that the patient be “likely to die as a result of [the] illness or complications relating thereto”. Determinations that a person is likely to die of an illness or complication are *prognoses* (a medical professional’s opinion of the *probable* course of a medical condition), not *diagnoses* (proven identification of a given condition). The nature of prognosis moreover, is uncertain – they constitute predictions based on statistical averages, which in themselves are very unreliable in determining what will happen to any given individual patient.

³¹ *Ibid.*, section 8(b).

³² “Irreversible”. Merriam-Webster.com Dictionary, Merriam-Webster: <https://www.merriam-webster.com/dictionary/irreversible>

Research has shown³³ that clinicians' predictions are frequently inaccurate. Typically, only cancer patients show a predictable decline (with every other disease, prediction is unreliable), and even then, anything approaching surety only occurs in the last few weeks of life, as opposed to a year or even half a year³⁴. It is notoriously difficult to prognose a patient death from a particular condition or the complications relating to it, and a necessary and objectively demonstrable clinical judgement cannot reasonably be expected within anything more than a relatively short time-scale. Consequently, it is extremely common for medical prognoses of death outside of such a period to be mistaken, and many people prognosed with death, even within months or weeks, go on to live much longer and happier lives.

If applied in everyday medical practice therefore, sub-section 8(a) of the Bill would open up the premature death of many more cohorts of patients than Kenny proposed. The only way to avoid this would be to add a provision such as a fortnight or a few days, which raises the question as to why assisted suicide or euthanasia should be necessary at all, given the short time scale till death when this can be prognosed with reasonable certainty.

The colloquial understanding of someone being 'terminally ill' is that they have a condition that will very soon lead to their passing³⁵, a situation which affects a limited number of people who are at the very end of their life. An illustrative example is provided by Vicky Phelan, whose tragic personal situation has been central to both the CervicalCheck screening scandal and now in the lobbying efforts for assisted suicide, and who in the aforementioned letter read to the Dáil mentioned that, *"My cancer is incurable. The option of living will no longer be available to me in the not too distant future"*. As no time limit exists in the Bill however, the criteria within it would encompass a profoundly broader range of people than those whose death could be prognosed in the near future, including almost every group Kenny mentioned as being expressly excluded, when he said:

This Bill does not allow for assisted [suicide / euthanasia] in cases where a person looking for help does not suffer from a terminal illness. People suffering from depression or any mental health issues could not access this law. People suffering from life-threatening physical illnesses could not avail of assisted

³³ White N., Reid F., Harris A., Harries P., Stone P. *A systematic review of predictions of survival in palliative care: how accurate are clinicians and who are the experts?* PLoS One. 2016;11(8) doi: 10.1371/journal.pone.0161407.

³⁴ This has been the reality for the 20 years in which legal assisted suicide structures have been in place (cf. *Terminal Uncertainty*, Nina Shapiro, Seattle Weekly, 13/01/09: <https://www.seattleweekly.com/news/terminal-uncertainty/>).

³⁵ As illustrated by Table 1 of Hui *et al*, 2014. *Concepts and Definitions for "Actively Dying", "End of Life", "Terminally Ill", "Terminal Care", and "Transition of Care": A Systematic Review*, Journal of Pain and Symptom Management 47(1):77-89. <https://doi.org/10.1016/j.jpainsymman.2013.02.021>

[suicide / euthanasia]. *People of advanced age could not avail of this law. It applies only to those suffering from a terminal illness*'.

Taking this into account, and even on the most restrictive understanding of 'irreversibility', so far from forming a basis for thinking the Bill would be limited in its scope, the criteria it contains provide the opposite.

That this is the case is best illustrated by the most obvious condition that fits all of the Bill's criteria. Though Kenny stated that "[p]eople of advanced age could not avail of this law", human aging itself is altogether incurable, progressive, irreversible in its progression, and could at any stage of life be prognosed as more than likely to lead to the death of those experiencing it, either from its normal inevitable terminus (natural death) or from the wide spectrum of age-related complications.

Similarly, Kenny stated that "[p]eople suffering from life-threatening physical illnesses could not avail" of the procedure to access physician assisted suicide or administered euthanasia his Bill would legalise. Once again however, a wide variety of chronic illnesses as well, many of which constitute disabilities, are covered by the four criteria it sets down. Diabetes, for example, a condition with which many people live relatively long lives happily even with limitations on their diet and with necessarily regular insulin injections, is commonly incurable, progressive, and cannot be reversed by treatment in its progression. Moreover, as a result of it "or complications relating thereto", the patient could well be prognosed as "likely to die". It therefore fits the definition of "terminal illness" under the Bill. Similarly, Down's syndrome (especially in its severer forms) even more so: it is certainly incurable, progressive, irreversible in its progression, and will almost certainly cause, either in itself or complications related to it, the death of the person has it. The Bill would therefore license assisted suicide for patients with these and other conditions which are not remotely normally considered 'terminal illnesses'.

Indeed, many very common incurable and progressive illnesses, which can be kept at bay for years by effective treatments and involve long and happy lives for those suffering from it, might be included:

- Severe COVID-19
- Many cancers
- Hypertension (high blood pressure)
- Ischaemic Heart Disease (which can cause heart attacks, heart failure, and arrhythmias)
- Chronic Obstructive Respiratory Disease (CORD)
- Cerebrovascular disease (strokes)

- Inflammatory Bowel Disease (Ulcerative Colitis, Crohn's disease)
- Parkinson's Syndrome
- Multiple Sclerosis (MS)
- Chronic Schizophrenia
- Asthma
- *Osteogenesis imperfecta* ('Brittle Bone Disease', a disability)
- HIV
- Renal failure

More examples could be added, and they arguably include most of the diseases that cause most deaths globally. Whilst many on this list might well be envisaged by those who conceived, drafted and have proposed and sponsored the Bill, many surely fall outside their own goals, and certainly the common understanding of what conditions for which assisted suicide and euthanasia might be understandably enabled.

Demonstrably then, the definition of 'terminal illness' given in the Bill encompasses not only illnesses such as advanced cancers, which might be expected to result in death in the short or medium term, but also fluctuating long-term conditions, such as earlier stage cancers, Multiple Sclerosis, Parkinson's and heart disease, and a number of conditions that more properly constitute disabilities. People with these and other inevitably progressive conditions can live for many years but, where they are frail or have other medical problems, they could be reasonably expected to die within six months. Bills that limit the applicability of euthanasia to patients who are expected to die within a relatively short (e.g. six-month) time frame therefore bring within their eligibility criteria a wider range of people than just those with end-stage terminal illness.

So, like the definition of 'terminal illness' within the Bill, the potential reach of assisted suicide is broader than the supposedly narrow group its proponents claim. This could affect many people who may be mistakenly diagnosed as terminal but who have many meaningful years of life ahead of them.

Even if the Bill as written did not go further than its ostensible intentions, the precedent set by granting the premises of the legislation itself in allowing euthanasia and assisted suicide, would establish a means by which euthanasia could be extended. We have seen that those arguing for the Bill's passage grounded their effort on autonomy and dignity, both of which it was argued, constitute a 'right to die'. Given this, the obvious question arises as to why such a right (necessitating in particular, the entitlement

to a legal process by which individuals might acquire physician assistance or administration so as to determine the time and manner in which they will die) should be at all restricted to the terminally ill.




If you grant the premise that every person has the right to access physician assistance in or direct administration the means of their death on the basis of autonomy, and also on the basis that personal dignity requires the ending of those suffering from a debilitating condition, then there are no rational grounds upon which this right should be limited. That this is the case is most easily appreciated when we consider the cases of those who suffer from conditions – again, more accurately thought of as severe disabilities – such as paraplegia as in the high profile case of Tony Nicklinson³⁶, who was left ‘locked-in’ his own body after a Rugby accident. The profound personal suffering involved in such situations show that many of the ‘hardest’ of cases do not actually fall under the category of terminal illness, but with those who are suffering from such extreme non-terminal conditions. As such a condition does not potentially or actually lead to the death of the person suffering from it, such an individual would not be catered for by the restrictions of the Kenny Bill, and this would leave demands to form for a new extension of the law, for which no argument in principle against such a development would exist if the premise of the justifications for assisted suicide and euthanasia were granted by this Bill.

The legislation under current consideration therefore contains the seeds of its own incremental extension; the limitation to terminal illness could not possibly last either legislatively or judicially. To limit the current Bill to terminal illness is a short term compromise tactic, and not a line that could be preserved in the medium to long term. This is not a merely ‘slippery slope’ but a necessary ‘logical cliff’ to which there is little if any potential limitation once the fundamental grounds on which euthanasia is introduced have been granted.

This is sadly illustrated by the evidence we see from the nearest (both geographically and legislatively) analogous systems of euthanasia and assisted suicide to that of the Kenny Bill: the Netherlands and Belgium. Both of which licensed assisted suicide and euthanasia only for the terminally ill, but have since seen a series of non-terminal cases to which euthanasia has been extended. Both Belgium and the Netherlands have introduced euthanasia not only for people who are terminally ill, but also for those who request it for ‘mental suffering’. This has had serious consequences, as there have been a number of cases in the last few years in which people who in Ireland currently would have been

³⁶ *Tony Nicklinson dies six days after losing ‘right to die’ case*, Sarah Boseley, The Guardian, 22nd July 2012: <https://www.theguardian.com/uk/2012/aug/22/tony-nicklinson-right-to-die-case>

given the help they need to heal the mental health problems from which they suffer, have in the Low Countries been euthanised:

 A portrait of Godelieva De Troyer, a 64-year-old Belgian woman with short blonde hair, smiling. She is wearing a white top.	<p>Godelieva De Troyer³⁷, a 64-year old healthy Belgian woman who was living with depression, was killed by lethal injection at her own request in a Brussels hospital in 2012, despite at least two of the experts who assessed not agreeing that she was beyond treatment. Her son was not contacted until after his mother had been euthanised, when a hospital rang asking him to retrieve her body from the morgue.</p>
 A side-by-side portrait of Marc and Eddy Verbessem, 45-year-old deaf twins. They are both bald, wearing glasses, and have a serious expression. A small logo for 'LE JOURNAL RTL-TVI' is visible in the bottom left corner.	<p>Marc and Eddy Verbessem³⁸, 45, a pair of deaf twins, were euthanised in 2013 due to the fear that with the onset of blindness they would be unable to communicate with each other.</p>
 A portrait of Ann G, a 44-year-old Dutch woman, seen from the back. She has dark hair and is wearing a dark top.	<p>Ann G³⁹, a 44-year old Dutch woman who asked for euthanasia for psychological pain in 2016 after being sexually exploited by her psychiatrist who was treating her for anorexia.</p>

³⁷ *Son challenges Belgian law after mother's 'mercy killing'*, Bruno Waterfield, Daily Telegraph, 02nd February 2015: <https://www.telegraph.co.uk/news/worldnews/europe/belgium/11382843/Son-challenges-Belgian-law-after-mothers-mercy-killing.html> See also *The Death Treatment*, Rachel Aviv, The New Yorker, 22nd June 2015: <https://www.newyorker.com/magazine/2015/06/22/the-death-treatment>

³⁸ *Marc And Eddy Verbessem, Deaf Belgian Twins, Euthanised After Starting To Turn Blind*, Eline Gordts Huffington Post, 14/01/13: https://www.huffingtonpost.co.uk/entry/marc-eddy-verbessem-belgium-euthanasia_n_2472320

³⁹ *Sex abuse victim in her 20s allowed to choose euthanasia in Holland after doctors decided her post-traumatic stress and other conditions were incurable*, Steve Doughty, Daily Mail, 10th April 2016: <https://www.dailymail.co.uk/news/article-3583783/Sex-abuse-victim-20s-allowed-choose-euthanasia-Holland-doctors-decided-post-traumatic-stress-conditions-uncurable.html>



Nathan⁴⁰, born Nancy, and also 44-years old, was euthanised in 2013, after a series of failed gender reassignment surgeries.



Mark Langedijk⁴¹, a 41-year old Dutch alcoholic, ended his life in 2016 by fatal injection as a means of escaping his condition.



Tine Nys⁴², a 38-year old who had experienced the break-up of a relationship, was euthanised in 2009 on the basis that she had autism. Her family have recently complained about the 'nonchalant' way she was treated.



An unnamed Dutch woman in her 20s⁴³, who had suffered sexual abuse from the age of five to 15 and suffered from post-traumatic-stress disorder (PTSD) and chronic depression amongst other mental health problems, was euthanised in 2016. Doctors judged her to be "totally competent" and that there was "no major depression or other mood disorder which affected her thinking".

⁴⁰ Nathan Verhelst Chooses Euthanasia After Failed Gender Reassignment Surgeries, Eline Gordst, Huffington Post, 10th May 2013: https://www.huffingtonpost.co.uk/entry/nathan-verhelst-euthanasia-belgium_n_4046106

⁴¹ Dutch euthanasia law is used to kill alcoholic, 41, who decided death was the only way to escape his problems, Steve Doughty, Daily Mail, 29th November 2016: <https://www.dailymail.co.uk/news/article-3980608/Dutch-euthanasia-law-used-kill-alcoholic-41-decided-death-way-escape-problems.html>

⁴² Controversial case re-opens euthanasia debate, Andy Furniere, Flanders Today, 04th February 2016: <http://www.flanderstoday.eu/politics/controversial-case-re-opens-euthanasia-debate>

⁴³ Sex abuse victim in her 20s allowed by doctors to choose euthanasia due to 'incurable' PTSD, Matt Payton, Independent, 11th May 2016: <https://www.independent.co.uk/news/world/europe/sex-abuse-victim-her-20s-allowed-dutch-doctors-undergo-euthanasia-due-severe-ptsd-a7023666.html>



Noa Pothoven⁴⁴, a 17-year old girl who suffered from PTSD after being raped, and consequent depression and anorexia, was allowed to starve herself to death in the Netherlands in 2019. As such, hers was not a case of active euthanasia, but one of her complaints before she died was that the Netherlands does not have specialised institutions or clinics where teenagers can go for psychological aid. Here then, is where a medical and general culture allows a young person to experience a failure in care, but allows her to take her own life in a context of normalised suicide.

More such cases exist and include people who have been given permission to be euthanised for borderline personality disorder, and chronic-fatigue syndrome⁴⁵. Others have publicly called for or almost had access to euthanasia:

- A then 52-year old Belgian serial rapist and murderer Frank Van Den Bleeken⁴⁶ was meant to be euthanised in prison in 2015. Van Den Bleeken claimed that was experiencing “unbearable psychological suffering” in prison, where he had already spent 30 years. His wish was initially granted, but the decision was reversed⁴⁷.
- A 39-year old gay man in Belgium pseudonymously called ‘Sébastien’⁴⁸, tried to end his life in 2016 because he could not accept his sexuality. He had said of euthanasia, “For me, it's just a kind of anaesthesia”.

⁴⁴ *Noa Pothoven: The complicated death of a little girl who didn't want to grow up*, Image, 20th December 2019: <https://www.image.ie/life/noa-pothoven-complicated-death-little-girl-didnt-want-grow-151150>

⁴⁵ *Op. cit., The Death Treatment*, by Rachel Aviv. See excellent account, further information, and cases discussed therein: <https://www.newyorker.com/magazine/2015/06/22/the-death-treatment>

⁴⁶ *Belgian rapist Frank Van Den Bleeken 'to be euthanised' in prison this week*, Roisin O'Connor, Independent, 05th January 2015: <https://www.independent.co.uk/news/world/europe/belgian-rapist-frank-van-den-bleeken-be-euthanised-prison-week-9957302.html>

⁴⁷ *Belgian serial rapist will not be euthanised*, Bruno Waterfield and Andrew Marszal, Daily Telegraph, 06th January 2015: <https://www.telegraph.co.uk/news/worldnews/europe/belgium/11327541/Belgian-serial-rapist-will-not-be-euthanised-as-planned.html>

⁴⁸ *Man seeks euthanasia to end his sexuality struggle*, Jonathan Blake, BBC News, 09th June 2016: <https://www.bbc.co.uk/news/world-europe-36489090> An interview with ‘Sébastien’ can be found here on the Victoria Derbyshire Show, 09th June 2016: <https://www.bbc.co.uk/programmes/p03xrcz3>

- Emily⁴⁹ (who went under the pseudonym 'Laura' when her story was being reported) was approved for lethal injection in 2015⁵⁰, even though she was physically healthy and only 24-years-old. She said, "*Leven, dat is niets voor mij*" ("Life, that's not for me"). Thankfully, she changed her mind.

All this has happened despite the on-paper 'safeguards' in the Belgian⁵¹ and Dutch⁵² laws that a patient presenting for euthanasia be in a "medically futile condition of constant and unbearable... mental suffering that cannot be alleviated", or be experiencing suffering that is "lasting and unbearable". Such is the situation in the Netherlands that, whilst voluntary euthanasia is defined as ending life *on request*, euthanasia has been extended to occurring without request to newborn infants with disabilities⁵³. Cases where children have been euthanised have also occurred in Belgium⁵⁴, a development which has caused international concern⁵⁵. Both exemplify example of how initially voluntary euthanasia laws can slip into the gradual allowing of horrifying involuntary forms due to the steady corruption of medical culture.

The incremental extension of such laws away from the situations they were initially conceived to cover illustrates the fundamental problem with laws permitting medicalised killing: if we grant that there exists a 'right to die' such that people have the right to have their doctors not only enable their death, but be agents of that death, then it is logically impossible to limit that right only to one sort of person.

This descent down the 'logical cliff' of the 'right to die' is affected not just by the reason of the grounds for euthanasia and assisted suicide, but by the cultural effect such legalisation brings about. A study in 2013 that looked at opinions of health care professionals and the public after eight years of euthanasia legislation in the Netherlands found an increase in support for euthanasia or assisted suicide

⁴⁹ 24 and Ready to Die, The Economist, 10th November 2015: <https://www.youtube.com/watch?v=SWWkUzkfJ4M&feature=youtu.be>

⁵⁰ *Right to die: Belgian doctors rule depressed 24-year-old woman has right to end her life*, Rose Troup Buchanan, The Independent, 02nd July 2015: <https://www.independent.co.uk/news/people/right-die-belgian-doctors-rule-depressed-24-year-old-woman-has-right-end-her-life-10361492.html>

⁵¹ *Euthanasia Act 2002* (Belgium): <https://apmonline.org/wp-content/uploads/2019/01/belgium-act-on-euthanasia.pdf>

⁵² *Termination of Life on Request and Assisted Suicide (Review Procedures) Act 2002* (Netherlands): <https://publications.parliament.uk/pa/ld200405/ldselect/ldasdy/86/4121603.htm>

⁵³ A description of the 'Groningen Protocol', through which this extension took place, is given by two authors who helped develop this practice in *End-of-Life Decisions in Newborns: An Approach From the Netherlands*, A. A. E. Verhagen and P. J. J. Sauer, *Pediatrics* (September 2005), 116(3):736-739: <https://pediatrics.aappublications.org/content/116/3/736>

⁵⁴ *Belgium Approved Euthanasia of 3 Minors, Report Finds*, Arya Hodjat, VOA News, July 25th 2018: <https://www.voanews.com/europe/belgium-approved-euthanasia-3-minors-report-finds>

⁵⁵ Siegel AM, Sisti DA, Caplan AL. *Pediatric Euthanasia in Belgium: Disturbing Developments*. *JAMA*. 2014;311(19):1963–1964. doi:10.1001/jama.2014.4257 Brian S. Carter, *Why Palliative Care for Children is Preferable to Euthanasia*, *The American Journal of Hospice & Palliative Care* 33(1), July 2014. DOI: 10.1177/1049909114542648

for non-terminal conditions. Among professionals, a significant number (24%-39%) were found to be in favour of ending the lives of individuals who experience mental suffering due to loss of control, chronic depression or early dementia. Further, a third of doctors and 58% of nurses were in favour of euthanasia in the case of severe dementia, given the presence of an advance directive⁵⁶.

A similar situation has developed in Canada, where in just five years, the original limitation of the law there to those with conditions which are incurable, irreversible, causing them grievous suffering, and where death is 'reasonably foreseeable', is already been objected to, with efforts to expand it to those not at the end of life⁵⁷, who cannot⁵⁸ or are too young to consent⁵⁹, or who suffer from psychiatric disorders⁶⁰ such as Alzheimer's⁶¹.

Even outside the strict construction of the law, Canada has seen euthanasia approved for a 77-year old woman with osteoarthritis⁶², a man with Motor Neurone Disease who ended his life due to the poor hospital care he was receiving⁶³, and a 90-year old woman who could not accept the prospect of another COVID-related lockdown in her retirement home⁶⁴.

This tendency to incremental extension was illustrated further in March 2012, when the Dutch introduced mobile units to deal with what they call the 80% of people with dementia or mental illness

⁵⁶ *Opinions of health care professionals and the public after eight years of euthanasia legislation in the Netherlands: A mixed methods approach*, Palliative Medicine (March 2013), 27:3:273-280: <https://journals.sagepub.com/doi/abs/10.1177/0269216312448507>

⁵⁷ *Montrealers file legal action contesting restrictions on medical aid in dying*, Global News, 14th June 2017: <https://globalnews.ca/news/3526916/montrealers-file-legal-action-contesting-restrictions-on-medical-aid-in-dying/>

⁵⁸ *Quebec appoints experts to weigh in on expanding assisted-dying law*, Global News, 24th March 2017: <https://globalnews.ca/news/3333418/quebec-appoints-experts-to-weigh-in-on-expanding-assisted-dying-law/>

⁵⁹ *Young patients, their parents now asking for medical aid in dying: pediatricians' group*, Keith Gerein, Edmonton Journal, 26th October 2017: <http://edmontonjournal.com/news/local-news/embargoed-pediatricians-group-weighs-in-on-extending-medical-aid-in-dying-to-minors>

⁶⁰ *Adam Maier-Clayton's death renews debate on assisted-dying access for those with mental illness*, Catrina Franzoi, Globe and Mail, 16th April 2017: <https://www.theglobeandmail.com/news/national/adam-maier-claytons-death-renews-debate-on-assisted-dying-access-for-those-with-mental-illness/article34718194/>

⁶¹ *Most caregivers favour assisted dying for Alzheimer's patients: survey*, Aaron Derfel, Montreal Gazette, 22nd September 2017: <https://montrealgazette.com/news/local-news/most-caregivers-favour-assisted-dying-for-alzheimers-patients-survey>

⁶² *Woman, 77, with osteoarthritis approved for euthanasia in Canada after confusion over wording of assisted dying law*, Mia De Graaf, Daily Mail, 27th June 2017: <https://www.dailymail.co.uk/health/article-4644228/Woman-arthritis-approved-euthanasia-Canada.html>

⁶³ *One man committed suicide to not go back: Doctors quit Montreal hospital after allegations of shoddy care*, Vancouver Sun, 08th October 2016: <https://vancouversun.com/news/canada/one-man-committed-suicide-to-not-go-back-doctors-quit-montreal-hospital-after-allegations-of-shoddy-care>

⁶⁴ *Facing another retirement home lockdown, 90-year-old chooses medically assisted death*, Avis Favaro, CTV News, 19th November 2020: <https://www.ctvnews.ca/health/facing-another-retirement-home-lockdown-90-year-old-chooses-medically-assisted-death-1.5197140>

currently being “missed” – their words – by the country’s euthanasia laws⁶⁵. Similarly, the 2011 annual report of the five Dutch Regional Euthanasia Review Committees⁶⁶ found that 13 psychiatric patients were killed by euthanasia in 2011, up from 2 in 2012. This again, despite a notional legal requirement that the patient should be mentally competent.

That moves from voluntary to involuntary euthanasia, and from autonomy for patients to autonomous decisions for patients by doctors, cannot be stopped by ostensible ‘safeguards’ put into place, can be seen by the further experiences not just of the Benelux countries, but Oregon and Washington as well, and from evaluating those that have been included into the Kenny Bill itself.

Safeguards

In further describing his Deputy Kenny stated the existence within his Bill of “*safeguards and protections to ensure the person seeking help can make a decision independently and not under duress of any kind*”. Other than the eligibility criteria, this refers to the procedure set forth in sections 9 and 10, ostensibly intended to obviate possible abuse. Section 9 requires that:

- A patient applying for assisted suicide or euthanasia must sign a valid declaration that he or she “has a clear and settled intention to end his or her own life”⁶⁷, in front of a witness who is not a beneficiary of the patient’s estate⁶⁸;
- This declaration must be countersigned by two doctors, neither of whom may be the witness to the patient’s declaration⁶⁹:
 - the “attending medical practitioner” from whom the person has requested assistance in suicide or administration of euthanasia⁷⁰;
 - another ‘independent medical practitioner’, who is independent in that he or she has no familial or professional connection to the attending medical practitioner⁷¹.
- The two countersigning doctors must first separately assess and be satisfied that the patient:

⁶⁵ *Go-ahead for world's first mobile euthanasia unit that will allow patients to die at home*, by Simon Caldwell, Daily Mail, 10th February 2012: <https://www.dailymail.co.uk/news/article-2099089/Go-ahead-worlds-mobile-euthanasia-unit-allow-patients-die-home.html>

⁶⁶ Regional Euthanasia Review Committees Report (2011): <https://www.euthanasiecommissie.nl/binaries/euthanasiecommissie/documenten/jaarverslagen/2011/nl-en-du-fr/nl-en-du-fr/jaarverslag-2011/rte.jv2011.engels.def-36.pdf>

⁶⁷ *Op. cit.*, Kenny Bill, clause 9(1)(a).

⁶⁸ *Ibid.*, clause 9(1)(b).

⁶⁹ *Ibid.*, clause 9(c)(iii).

⁷⁰ *Ibid.*, clause 9(c)(i).

⁷¹ *Ibid.*, clause 9(c)(ii).

- Is indeed ‘terminally ill’ as defined within the Bill⁷²;
- Has the capacity to procure the ending of his or her own life⁷³, which the Bill specifies means verifying his or her ability to:
 - Understand the nature and consequence of the decision they make making “in the context of the [immediately] available choices”⁷⁴;
 - Understand⁷⁵ and retain⁷⁶ decision-relevant information, if only for a short period⁷⁷, which includes data concerning the reasonably foreseeable consequences of all of the immediately available choices and “failing to make the decision”⁷⁸;
 - Use and weigh the same information in making the decision⁷⁹;
 - Communicate his or her decision whether physically or instrumentally⁸⁰.
- Has made a decision which is informed, voluntary (un-coerced), and expresses a “clear and settled intention” to procure the ending of his or her own life⁸¹.

The problem with the system as laid out in this provision is that it relies on the witness and two countersigning doctors having the ability to discern correctly whether the person presenting for assisted suicide or euthanasia is making a choice that is truly ‘autonomous’, when this is defined as ‘voluntary’ and “without coercion or duress”. This fails as a safeguard both because it lacks the strength to discern undue influence in its various forms, and because it leaves open the possibility of premature deaths due to the compromised personal autonomy of the patient themselves. We see both these problems illustrated by the second area of the evidence base relevant to the Bill: the experience of assisted suicide in the American States of Oregon and Washington.

Nothing in the Bill sets out *how* either of the two doctors might go about evaluating the patient to discern that they are not acting under any form of inordinate pressure in relation to his or her wish to request assisted suicide or euthanasia. Indeed, there is no requirement that they have the psychological training that might begin to allow them to do so.

⁷² *Ibid.*, clause 9(3)(a).

⁷³ *Ibid.*, clause 9(3)(b).

⁷⁴ *Ibid.*, sub-section 10(1).

⁷⁵ *Ibid.*, clause 10(2)(a); *cf.* sub-section 10(3).

⁷⁶ *Ibid.*, clause 10(2)(b).

⁷⁷ *Ibid.*, sub-section 10(4).

⁷⁸ *Ibid.*, sub-section 10(5).

⁷⁹ *Ibid.*, clause 10(2)(c).

⁸⁰ *Ibid.*, clause 10(2)(d).

⁸¹ *Ibid.*, clause 9(3)(c).

Even if they did have such training, the ‘safeguard’ also relies on both physicians knowing the patient well enough, their families, and their overall situation, to be able to evaluate the patient’s intentions, mental capacity, and freedom from duress such as pressure (however subtle) felt by an individual from unscrupulous relatives wanting to remove the burden of care the patient constitutes for them or to access their estate upon inheritance, still less that of medical staff at the very least wanting to free up a bed given their tightened finite resources, or a series of other potential situations. Given that anything approaching such a close relationship, if it exists at all, would be restricted to that between patients and their General Practitioners (GPs), and even this for a substantial number of people is much less familiar than it used to be, this is incredibly unrealistic.

Further, the experience of Oregon suggests that the sorts of doctors who would be willing to take part in the process for assisted suicide and euthanasia, would not likely be someone whom the patient knows. One study looking at Oregon’s system between 2001-2007 showed a majority (61%, 165 out of 271) of the lethal prescriptions were written by a minority (18%, 20 out of 109) of the participating physicians. More striking still, just 3 physicians were responsible for 23% of lethal prescriptions (62 out of 271)⁸². Given the approximately 10,000 licensed physicians in Oregon at the time, a large proportion of lethal prescriptions were written by a small number of physicians. A similar problem may exist in Canada, the euthanasia system in which jurisdiction has operated since 2016. According to the First Annual Report on Medical Assistance in Dying (MAiD) in Canada in 2019, of the 91,375⁸³ doctors then operating in Canada, 1,196⁸⁴ engaged in euthanasia of their patients. That’s 1.3% of Canadian doctors. Of the 439,975 Canadian nurses, 75 were engaged in euthanasia procedures – 0.017% of nurses in Canada. What all this suggests is that the few doctors (and nurses) who are willing to engage in the majority of euthanasia and assisted suicides, tend to be the least scrupulous minority in their profession, yet it would potentially be such as these who would be responsible for ensuring that the patient applying for assisted suicide or euthanasia would be making a *voluntary* decision.

⁸² K. Hedberg, D. Hopkins, R. Leman, and M. Kohn, *The 10-Year Experience of Oregon’s Death with Dignity Act: 1998-2007*, *The Journal of Clinical Ethics* 20, no. 2 (Summer 2009): 124-32. (Concentration of Oregon’s Assisted Suicide Prescriptions & Deaths from a Small Number of Prescribing Physicians, Kenneth R. Stevens, Jr. MD, Revised 18/03/2015, Physicians for Compassionate Care Education Foundation)

⁸³ *Physicians in Canada, 2019*, Canadian Institute for Health Information: <https://www.cihi.ca/en/physicians-in-canada#:~:text=Doctors%3A%20In%202019%2C%20there%20were,increase%20over%20the%20previous%20year>

⁸⁴ *First Annual Report on Medical Assistance in Dying (MAiD) in Canada*, Health Canada (July 2020), p. : <https://www.canada.ca/content/dam/hc-sc/documents/services/medical-assistance-dying-annual-report-2019/maid-annual-report-eng.pdf>

Further attempted safeguards might possess a similar attraction on paper, but they would likewise fail to ensure proper patient consent to their own death. We see this illustrated by the amendments that Sinn Féin have stated their intention to propose⁸⁵, and which they hope might strengthen this area of the Bill:

- A “waiting period for reflection”;
- “[P]sychiatric evaluations”;
- “[C]onfirmation that criteria are met by a:
 - High Court Judge,
 - ‘Medical person’
 - ‘Layperson’.

There is nothing about a period of further reflection that would necessarily remove the pressures already identified on a patient. Indeed, the pressure might build up rather than recede. Further, whilst a psychiatrist might have the training that the two doctors would lack, it is unclear as to how he or she might have the time or develop the depth of knowledge of the patient, and their families, to be able to evaluate the patient’s intentions, mental capacity, daily circumstance, and freedom from duress such as subtle pressure from others, so as to be able to discern the undue influence of the people surrounding a patient or the situation in which the patient finds him or herself in, in a single or even a series of evaluations (the more of which there are, the more the process defeats the purpose of assisted suicide and euthanasia to enable someone to control the timing of the end their life).

In light of all this, Sinn Féin’s stated proposal of having a High Court Judge, ‘medical person’ (of what kind, is not yet clear), and a ‘layperson’ to confirm that the criteria within the Bill for an assisted suicide or euthanasia to proceed have been met, is a useless added layer of bureaucracy. Since the process is inherently flawed, the so-called ‘safeguards’ in the Bill as they exist are effectively toothless, and lack the detail and power to protect vulnerable people. What more then, could a High Court Judge, yet another medical professional, and a layperson (none of whom are likely to know the patient or have the time or training to discern the voluntary state of their decision even if they were asked to do so) add to this? Certainly, to ask them to merely confirm that a weak process has been followed, would in no way provide extra strength and safety to the proceedings.

⁸⁵ *Op. cit.*, Dáil Éireann Second Stage Debate – Dying with Dignity Bill 2020, see remarks by Deputy David Cullinane (SF; Waterford).

Further, the assumption here is that the assessment is looking to confirm a voluntary decision, regardless of what is motivating the free choice of the individual. Here, 'voluntary' simply means 'choosing', but this masks the possibility that someone might, to all intents and purposes, seem to be making an entirely 'autonomous' decision, yet might be inwardly motivated by factors that make this a choice despite their profoundly compromised personal autonomy.

Looking again at the evidence from Oregon, we see that choices to end life are not simple matters, but complicated by a range of motivating factors that challenge being simplistically framed as 'autonomous'. The Oregon State Public Health Division brings out an Annual Report each year, which includes whatever data has been returned concerning the motivations for those opting for assisted suicide. In 1998, the year in which the 'Death with Dignity' Act licensing assisted suicide in Oregon took effect, it reported that 13% of patients applying for medication to commit suicide did so because they were frightened of being a burden on their families⁸⁶. This percentage has substantially increased since, even whilst fluctuating, to the extent that in 2014 almost four times more patients (40%) were opting for assisted suicide for this reason⁸⁷. In 2019 (the most recent figures), it was 59%⁸⁸. Meanwhile, in Washington State, which also uses a similar system, the most recent figure for this reason cited by those opting for assisted suicide is 51%⁸⁹. In Canada, the first annual 'MAiD' report in 2019 adopted a similar system of noting motives for euthanasia and assisted suicide, and found the figure to be 34%⁹⁰. Consistently across jurisdictions, between a third and a half of those presenting to end their lives, have fear of being a burden as a reason for doing so.

This illustrates the degree to which a so-called 'right to die' (more accurately a right to be killed) can in fact become a '*duty to die*', and those of us in other jurisdictions must ask ourselves whether we

⁸⁶ Oregon Public Health Division Death with Dignity Act Report (1998), Table 3: 'Characteristics of case patients and matched controls', sub-heading 'End of Life Concerns', page 16:

<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year1.pdf>

⁸⁷ Oregon Public Health Division Death with Dignity Act Report (2014), Table 1: 'Characteristics and end-of-life care of 857 DWDA patients who have died from ingesting a lethal dose of medication as of February 2, 2015, by year, Oregon, 1998-2014', sub-heading 'End of Life Concerns', page 5:

<http://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year17.pdf>

⁸⁸ *Op. cit.*, Oregon Public Health Division Death with Dignity Act Report (2019), Table 1: 'Characteristics and end-of-life care of 1,657 DWDA patients who have died from ingesting a lethal dose of medication as of January 17, 2020, Oregon, 1998-2019', sub-heading 'End of Life Concerns', page 12:

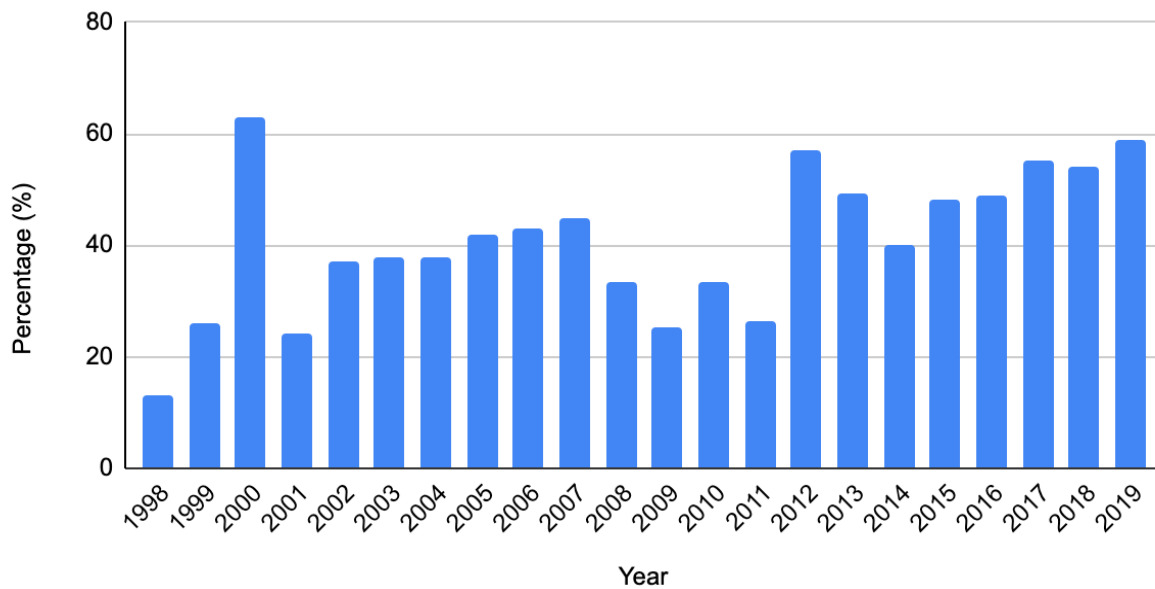
<https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf>

⁸⁹ Washington State Department of Health 2018 Death with Dignity Act Report, Table 2: 'End of life concerns of participants who died, 2016-2018', page 11: <https://www.doh.wa.gov/Portals/1/Documents/Pubs/422-109-DeathWithDignityAct2018.pdf>

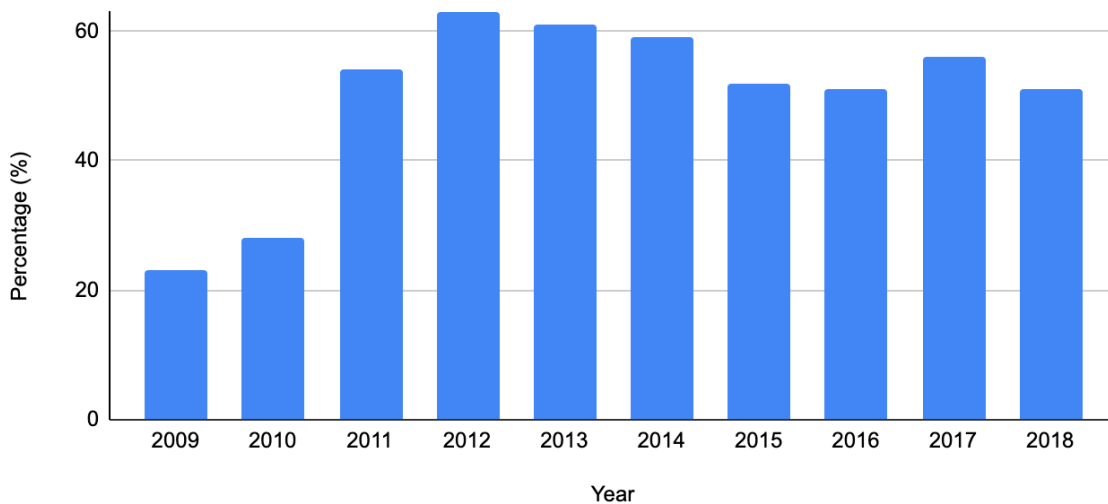
⁹⁰ *Op. cit.*, First Annual Report on MAiD in Canada 2019, p. 32.

really want to live in a society where this is the attitude engendered in the elderly and the terminally ill. Sadly we see the figures for this motivation stay higher in both Oregon and Washington over the periods of the operation of their assisted suicide laws:

Proportion of Those Seeking PAS Who Reported Feeling a Burden on Friends, Family, Caregivers, et al (Oregon, 1998-2019)



Proportion of Those Seeking PAS Who Reported Feeling a Burden on Friends, Family, Caregivers, et al (Washington State, 2009-2018)



Moreover, reports of individual assisted suicide cases show that patients are receiving assisted suicide in Oregon who suffer from depression and dementia, and 2008 study published in the British Medical Journal examined 58 Oregonians who sought information on assisted suicide. Of them, 26% met the criteria for depressive disorder, and 22% for anxiety disorder. Three of the depressed individuals

received and ingested the lethal drugs, dying within two months of being interviewed. The study's authors concluded that Oregon's law "may not adequately protect all mentally ill patients"⁹¹.

In 2006, having compiled the available evidence, the UK's Royal College of Psychiatrists advised that "many doctors do not recognise depression or know how to assess for its presence in terminally ill patients"⁹². As noted already, the Kenny Bill's proponents have not explained how a doctor should go about assessing mental capacity for suicide, the decision to end one's life.

It might be thought that the psychiatric evaluations Sinn Féin intend to introduce by amendment might avert such a problem from being seen in Ireland, but this depends not only on what the psychiatrist is being asked to evaluate, but to what extent an evaluation of poor mental health would be allowed to override patient autonomy. Some might wish to argue that depression and anxiety can co-exist with a truly autonomous decision, whereas others might argue that decisions made under depression and anxiety. If the former, then what would psychiatric evaluations accomplish in relation to this issue? If the latter, then how many people who want to end their own lives through having their suicide assisted or through being euthanised, would realistically be allowed to make that choice?

This problem of the 'autonomous' choice of assisted suicide / euthanasia is not an accidental bug, it is an essential and very dark feature of the very concepts of physicians assisting the suicide of, or euthanising, their patients. Those whose physical and mental condition leads them to wish to die are *by definition*, those with poorer mental health. Their personal autonomy is at its very weakest, precisely because they are compromised by their medical situation, and this may very well be even more pronounced if they live in a culture where the inability to autonomously act and enjoy life is seen as a failure to have a life worth living. Such an attitude might not only be self-defeating, but be present in and therefore reinforced by those around them.

The situation was put well by Rowan Williams, the former Archbishop of Canterbury, when in a 2010 Presidential Speech to the Anglican General Synod⁹³: "*The freedom of one person to utilise in full consciousness a legal provision for assisted suicide brings with it a risk to the freedom of others not to be manipulated or harassed or simply demoralised when in a weakened condition. Once the possibility is*

⁹¹ *Prevalence of depression and anxiety in patients requesting physicians' aid in dying: cross sectional survey*, Ganzini, Goy, and Dobscha, BMJ 2008;337:a1682: <https://www.bmj.com/content/337/bmj.a1682>

⁹² *Statement from the Royal College of Psychiatrists on Physician-Assisted Suicide* (2006), para. 2.4.

⁹³ *Full text: Archbishop of Canterbury's presidential speech*, The Guardian, 09th February 2010: <https://www.theguardian.com/uk/2010/feb/09/full-text-archbishop-canterbury-speech>

there, it will not only be utilised by the smallish number of high-profile hard cases but will also create an ethical framework in which the worthwhileness of some lives is undermined by the legal expression of what feels like public impatience with protracted dying and ‘unproductive’ lives”.

No ‘safeguard’ can overcome these inherent problems, as external checks can provide (and hitherto have only provided) a bureaucratic box-ticking procedure that does not within itself carry the time or ability to truly know with anything approaching proper confidence that a person is truly ‘voluntarily’ making a decision without pressure from others, or with sufficiently good mental health.

Other Consequences in Overseas Jurisdictions

If Belgium and Holland have given the best illustration of how eligibility criteria are elastic and subject to the ‘mission creep’ of incremental extension by the logic of licensing assisted suicide and euthanasia, and the Oregonian system has illustrated the failure and inherent problems with alleged ‘safeguards’, then both sadly show the broader abuses that can follow from introducing these practices into healthcare, by the effect it has not only on the broader medical system (including the doctor-patient relationship which sits at the very centre of medicine), but wider society.

The first and most concerning consequence shown in European euthanasia practice has been the existence of involuntary euthanasia killings. Not only does the ‘Groningen Protocol’ for disabled infants already described illustrate this point, but recorded past practice on adults. In the Netherlands during the 1990s, the initial evidence of a number of deaths without explicit patient request; the rates were 0.8% and 0.7%, being equivalent to 1,000 and 900 deaths per year⁹⁴. A 2007 study also found that again in 2005, 500 patients were given a lethal injection without request⁹⁵. For such reasons the law and

⁹⁴ *Euthanasia, physician-assisted suicide, and other medical practices involving the end of life in the Netherlands, 1990–1995*, P J Van der Maas *et al*, *New England Journal of Medicine* 335.22 (1996): 1699-1705: <https://www.nejm.org/doi/full/10.1056/NEJM199611283352227> *Euthanasia in the Netherlands: Sliding down the Slippery Slope*, J Keown, *Notre Dame Journal of Ethics & Public Policy* 407 (1995): <https://scholarship.law.nd.edu/ndjlepp/vol9/iss2/3/> *Reports from the Netherlands. Dances with data*, J M van Delden, L Pijnenborg, and P J van der Maas, *Bioethics* 7 (1993), 4:323-329: <https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1467-8519.1993.tb00222.x> *Non-voluntary and involuntary euthanasia in The Netherlands: Dutch perspectives*, R Cohen-Almagor, *Issues in Law and Medicine* 18.3 (2003): <https://heinonline.org/HOL/LandingPage?handle=hein.journals/ilmed18&div=30&id=&page=>

⁹⁵ *End-of-Life Practices in the Netherlands under the Euthanasia Act*, Van der Heide *et al*, *New England Journal of Medicine*, 10/05/07: <https://www.nejm.org/doi/full/10.1056/NEJMsa071143#t=article>

practice of euthanasia and assisted suicide in the Netherlands has been criticised twice by the United Nations Human Rights Committee, in 2001⁹⁶, and in 2009⁹⁷.

The nature of regulation for what constitutes a truly ‘voluntary’ euthanasia has also been a matter of concern: in 2017, a case was reported of a Dutch doctor who was cleared of any wrongdoing after asking the family of a woman due to be euthanised who was resisting her to hold her down whilst the lethal injection was administered⁹⁸.

As a result, the Dutch system has been met with renewed criticism and opposition, even from past supporters. Professor Theo Boer, who for nine years was a member of one of the five Regional Review Committees that assess the compliance of euthanasia cases with Dutch law, has written about how the Committees have been insufficient to stop a series of developing abuses, such as subtle pressure being put on people who present for euthanasia by relatives⁹⁹. More prominently, the late Dr. Els Borst, who was formerly the Health Minister and Deputy Prime Minister who guided legalisation of legalised euthanasia through the Dutch parliament, stated that legalised euthanasia has led to a severe decline in the quality of care for terminally-ill patients in Holland, and that ‘safeguards’ haven’t been sufficient, in an interview with anthropologist Dr Anne-Mei The for a book on the history of euthanasia¹⁰⁰.

In Belgium, a June 2010 study of assisted suicide/euthanasia examined 208 euthanasia deaths in the region of Flanders. The study found that 66 (32%) of the euthanasia deaths were done without explicit request or consent, and the life-ending drugs were sometimes administered by nurses (as opposed to physicians) in some of the cases of euthanasia, operating “beyond the legal margins of their profession”¹⁰¹. More recent research has even shown that organ donors (including 23.5% of all lung donors) had been euthanised, raising concerns that patients may be given an emotional inducement to

⁹⁶ UN Human Rights Committee (HRC), UN Human Rights Committee: Concluding Observations: Netherlands, 27 August 2001, CCPR/CO/72/NET: <https://www.refworld.org/docid/3be1202a4.html>

⁹⁷ UN Human Rights Committee (HRC), Concluding observations of the Human Rights Committee: Netherlands, 25 August 2009, CCPR/C/NLD/CO/4: <https://www.refworld.org/docid/4aa7aa642.html>

⁹⁸ *Panel clears Dutch doctor who asked family to hold patient down as she carried out euthanasia procedure*, Daily Telegraph, 28/01/17: <https://www.telegraph.co.uk/news/2017/01/28/panel-clears-dutch-doctor-asked-family-hold-patient-carried/#a-c64d6b89-41a0-400a-a282-0c11164c7f73>

⁹⁹ *Dutch Ethicist – “Assisted Suicide: Don’t Go There”*, Professor Theo Boer, Euthanasia Prevention Coalition Blog, 16/07/14: <http://alexschadenberg.blogspot.com/2014/07/dutch-ethicist-assisted-suicide-dont-go.html>

¹⁰⁰ *Now the Dutch turn against legalised mercy killing*, Simon Caldwell, Daily Mail, 09/12/09: <https://www.dailymail.co.uk/news/article-1234295/Now-Dutch-turn-legalised-mercy-killing.html>

¹⁰¹ *Physician-assisted deaths under the euthanasia law in Belgium: a population-based survey*, Chambere et al, Canadian Medical Association Journal 182(9):895-901 (2010): <https://pubmed.ncbi.nlm.nih.gov/20479044/>

be killed, believing that they can be better use being euthanised and harvested¹⁰². This prospect of voluntary euthanasia as a source of organ donation, despite the instrumentalisation and exploitation of patients this may often involve, has prompted concerns from north American doctors¹⁰³, as the possibility opens up in Canada (the CMAJ having released guidance on the issue¹⁰⁴, just as others have anticipated this new source¹⁰⁵.

Not only has the wording and intention of the law been ineffective as a safeguard for such practices, but nor have the procedural elements. A study in the British Medical Journal¹⁰⁶ found that only half of euthanasia cases in Flanders had been reported to the Federal Control and Evaluation Commission. There were no repercussions for failing to report euthanasia deaths to the commission, a situation likely aided by the fact that nearly half of the sixteen members on the commission are affiliated with 'right-to-die' associations.

Another matter of concern from the same report is the steep rise in cases of continuous deep sedation (12.3% of deaths in 2010). This may account for the rise in deaths by an 'intensified alleviation of symptoms' (from 18.8% of deaths in 1990, to 36.4% of deaths in 2010). This may cover more deaths ending without request.

The state of euthanasia in the Netherlands, and Belgium, despite attempted 'safeguards' into the law, shows how the human reality can follow the law of unintended consequences and be very different from the good intentions of the framers of laws that purport to 'assist dying'. When medical professionals get used to the idea that they can kill their patients at their request, it is not too difficult to see medical culture corrupted into accepting euthanasia according to the doctor's own judgement, or the extension of the principle to other less 'autonomous' groups of people.

Turning to Oregon, there have been concerns that licensing assisted suicide there has led to 'suicide contagion'. In Oregon, between 1999 (two years after assisted suicide was introduced) and 2010

¹⁰² *Initial experience with transplantation of lungs recovered from donors after euthanasia*, Van Raemdonck et al, Applied Cardiopulmonary Pathophysiology 15:38-48 (2011): http://www.applied-cardiopulmonary-pathophysiology.com/fileadmin/downloads/acp-2011-1_20110329/05_vanraemdonck.pdf

¹⁰³ See for example, Ely, E.W. *Death by organ donation: euthanizing patients for their organs gains frightening traction*. Intensive Care Med 45, 1309–1311 (2019). <https://doi.org/10.1007/s00134-019-05702-1>

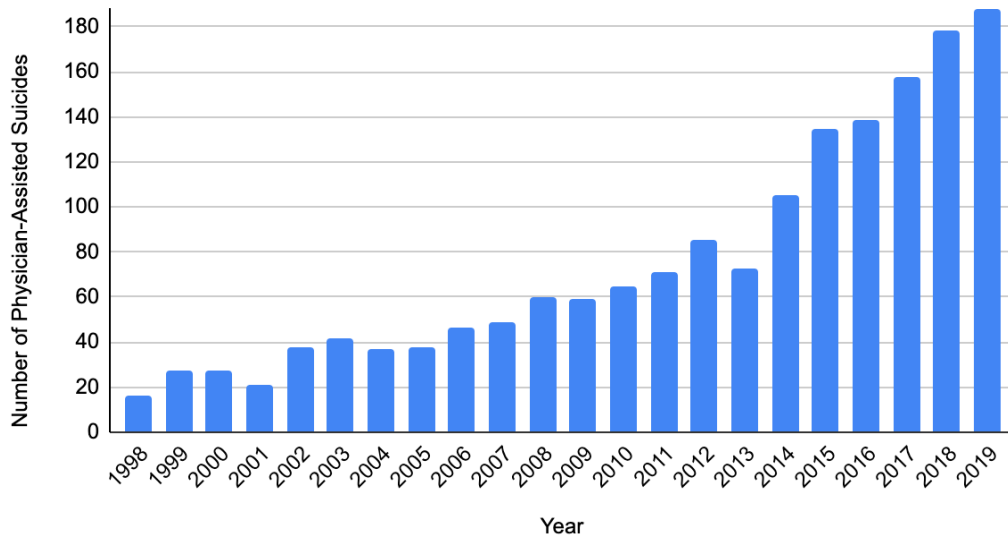
¹⁰⁴ CMAJ 2019 June 3;191:E604-13. doi: 10.1503/cmaj.181648

¹⁰⁵ N Engl J Med 2018; 379:909-911 DOI: 10.1056/NEJMp1804276

¹⁰⁶ Reporting of euthanasia in medical practice in Flanders, Belgium: cross sectional analysis of reported and unreported cases, Smets et al, BMJ 341:5174 (2010): <https://www.bmj.com/content/341/bmj.c5174>

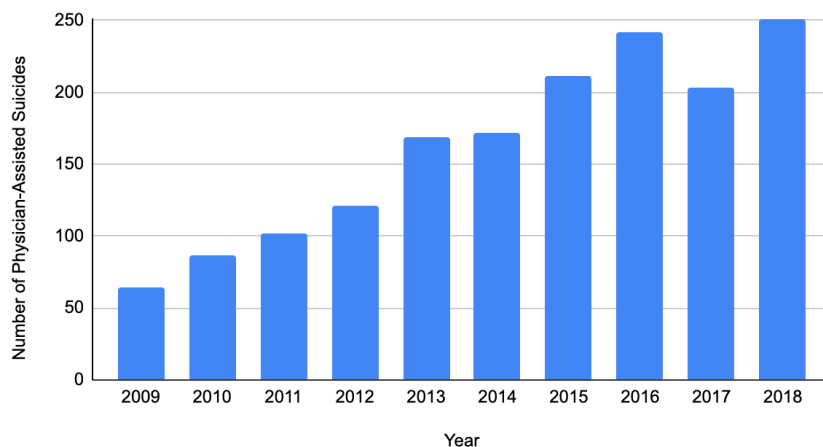
the suicide rate among those aged 35-64 increased by almost 50% (compared to 28% nationally)¹⁰⁷. Oregon's largest city, Portland also sees high levels of suicides¹⁰⁸. What this has suggested is that assisted suicide exacerbates the number of suicides, as the idea of ending one's own life becomes normalised. The latest Oregon figures¹⁰⁹ show that the numbers of assisted suicides have risen from 16 in 1998, to 188 in 2019, an increase of over 1000%. In 2016 alone, the numbers of assisted suicides increased by 30%:

Assisted Suicides, Oregon (1998-2019)



Sadly, we see have also seen this kind of increase across the various jurisdictions discussed:

Assisted Suicides, Washington (2009-2018)

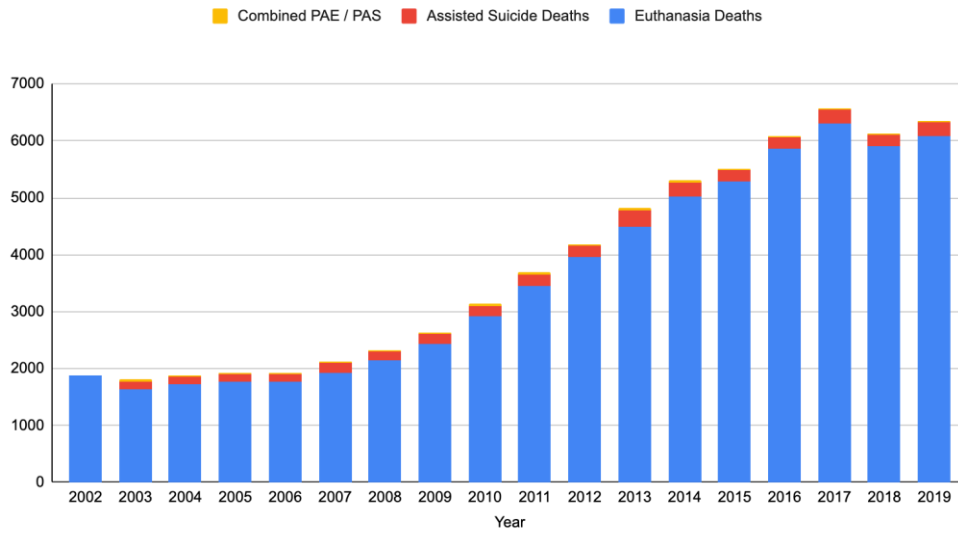


¹⁰⁷ *Suicide Among Adults Aged 35–64 Years — United States, 1999–2010*, Mortality and Morbidity Weekly Report Centres for Disease Control and Prevention, 03/05/13: <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6217a1.htm>

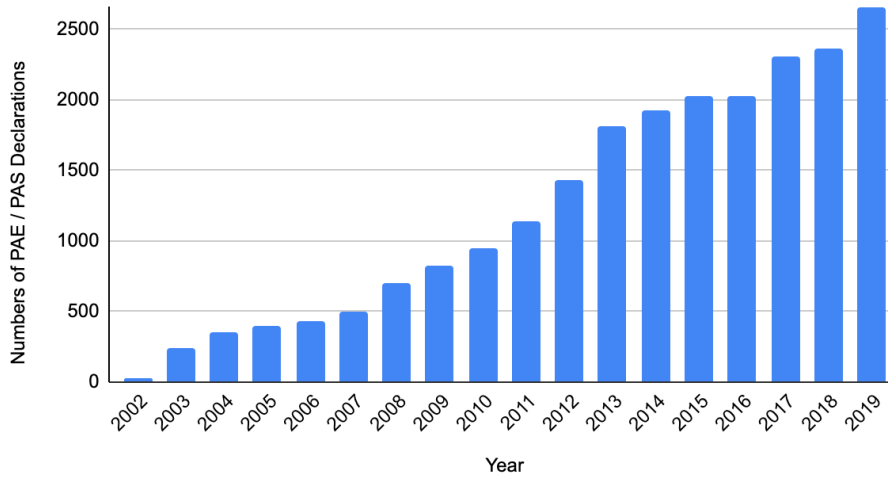
¹⁰⁸ *An Analysis of Completed Suicides: April 2011-June 2013*, Frank Silva, Portland Police Bureau Behavioural Health Unit, 30/09/13: <https://www.portlandoregon.gov/police/article/465339>

¹⁰⁹ Oregon Public Health Division Death with Dignity Act Report (2015): <https://www.oregon.gov/oha/ph/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Documents/year18.pdf>

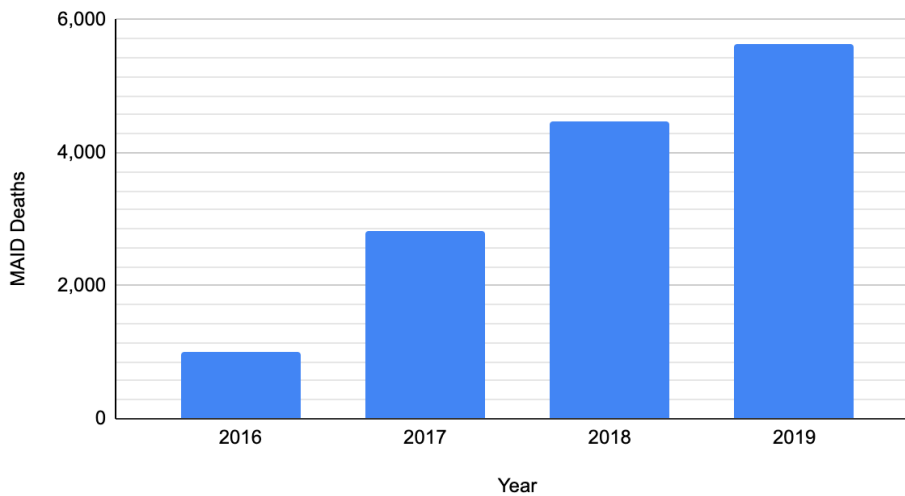
Euthanasia / Assisted Suicide Numbers, Netherlands (2002-2019)



Euthanasia / Assisted Suicide Numbers, Belgium (2002-2019)



Reported 'MAiD' Deaths in Canada (2016-2019)



It is important to note how this would translate to Ireland. In 2019, the Dutch *Regionale Toetsingscommissies Euthanasie* (RTEs; Regional Euthanasia Commissions) received 6,361 notifications

of euthanasia¹¹⁰. This is 4.2% of the total number of people who died in the Netherlands in that year (151,813¹¹¹). That same year, there were 2,656 euthanasia deaths in Belgium¹¹², out of 108,783 deaths¹¹³ (2.44%). Canada, which as we have seen on paper has a more restrictive system than those in Holland and Belgium, but which has already seen the internal logic of euthanasia start the beginnings of incremental extension to its law's eligibility criteria, has also experienced a rise in euthanasia deaths swifter and steeper than what the Benelux countries have experienced, going from 0.8% in 2016 (1,015¹¹⁴ out of 267,213 deaths¹¹⁵) to 2% in 2019 (5,631¹¹⁶ out of 284,082 deaths¹¹⁷), almost at the Belgian level already. A *pro rata* calculation of the number of deaths Ireland could expect a year from adopting euthanasia and assisted suicide (based on the 31,134 deaths in Ireland in 2019¹¹⁸), would be between almost 770 to just over 1,300 a year.

There are signs that the provision of assisted suicide has also effected the nature and extent of healthcare provision. In 2008, ABC News reported that a 64-year-old Oregon woman, Barbara Wagner, whose lung cancer had been in remission, learned the disease had returned and would likely kill her. Her last hope was a \$4,000-a-month drug that her doctor prescribed for her, but the insurance company refused to pay. It might be a temptation to blame that on a system of predominating private health insurance governed by the profit motive, which is operative in the United States. Yet the cost-cutting and cost-saving motive in public health insurance programmes can also lead to inhumane consequences, as Oregon itself demonstrates. In Barbara Wagner's case, what the Oregon Health Plan – the state's 'Medicaid' (state-provided healthcare) programme – agreed to cover, were drugs for a physician-assisted death. Drugs which then costed about \$50¹¹⁹.

Indeed, under the Oregon Health Plan, some necessary services and medicines – including some analgesic drugs to relieve pain – are not covered, but assisted suicide (which is cheap to provide) is

¹¹⁰ Regional Euthanasia Review Committees Annual Report (2019), p. 10-11: <https://www.euthanasiecommissie.nl/binaries/euthanasiecommissie/documenten/jaarverslagen/2019/april/17/index/Annual+report+2019.pdf>

¹¹¹ Dutch Mortality Numbers: <https://countryeconomy.com/demography/mortality/netherlands>

¹¹² *Commission fédérale de Contrôle et d'Évaluation de l'Euthanasie Neuvième rapport aux Chambres législatives* (2018-2019): https://organesdeconcertation.sante.belgique.be/sites/default/files/documents/9_rapport-euthanasie_2018-2019-fr_0.pdf

¹¹³ Belgian Mortality Numbers: <https://countryeconomy.com/demography/mortality/belgium>

¹¹⁴ Op. cit., *First Annual Report on MAiD*, 2019 (pp. 18-19).

¹¹⁵ *Mortality: Overview, 2004-2016*, Statistics Canada: <https://www150.statcan.gc.ca/n1/pub/91-209-x/2018001/article/54957-eng.htm>

¹¹⁶ Op. cit., *First Annual Report on MAiD*, 2019 (pp. 18-19).

¹¹⁷ *Deaths, 2019*, Statistics Canada: <https://www150.statcan.gc.ca/n1/daily-quotidien/201126/dq201126b-eng.htm>

¹¹⁸ Vital Statistics Yearly Summary (2019), Central Statistics Office: <https://www.cso.ie/en/releasesandpublications/ep/p-vs/vitalstatisticsyearlysummary2019/>

¹¹⁹ *Death Drugs Cause Uproar In Oregon*, ABC News, 06th August 2008: <https://abcnews.go.com/Health/story?id=5517492>

covered. According to Oregon's 'Prioritised List of Health Services 2021', cancer treatment was limited according to relative life expectancy: *"treatment with intent to prolong survival is not a covered service for patients who have progressive metastatic cancer..."*¹²⁰. By contrast, *"[i]t is the intent of the Commission that services under ORS 127.800-127.897 (Oregon Death with Dignity Act) be covered for those that wish to avail themselves to [sic] those services. Such services include but are not limited to attending physician visits, consulting physician confirmation, mental health evaluation and counselling, and prescription medications"*¹²¹.

A similar situation has also developed in Canada. Reports that an Ontario hospital tried to discharge a chronically-ill man, Roger Foley, or else charge him \$1,800 a day, and suggested that he might end his life via euthanasia as an alternative to treatment, combined with studies taking place as to the savings the healthcare system could enjoy through the practice of MAiD¹²², suggest that the healthcare system in Canada is already becoming corrupted. Thinking of patients in terms of the savings made or the better allocation of resources secured by ending their lives, leads to the kind of undue material pressure being put on a Barbara Wagner or a Roger Foley, to end their lives sooner.

Surely instead, we would rather want a compassionate society in which people are valued for who and what they are – human beings with inherent dignity, who are always valued – and which consequently invests in good quality palliative care? It is on this point that we should consider the final element to this debate, one that is critical in finding the real answers to terminal illness and patient suffering.

The Context of Palliative Care

Ireland has one of the best palliative care systems in the world. In 2015, the Economist Intelligence Unit (EIU) published its 'Quality of Death Index'¹²³, which in its global ranking of 80 countries put Ireland's provision of end-of-life care at 4th place, behind only the UK, New Zealand, and Australia.

¹²⁰ Oregon Health Authority *Prioritized List of Health Services*, Guideline Note 12, Patient-Centred Care Of Advanced Cancer (2021): <https://www.oregon.gov/oha/HPA/DSI-HERC/PrioritizedList/1-1-2021GL.docx>

¹²¹ Statement of Intent 2: Death With Dignity Act, *Prioritized List of Health Services*, Oregon Health Authority, p. SI-1: <https://www.oregon.gov/oha/HPA/DSI-HERC/PrioritizedList/1-1-2021%20Prioritized%20List%20of%20Health%20Services.pdf>

¹²² CMAJ 2017 January 23;189:E101-5. doi: 10.1503/cmaj.160650: <https://www.cmaj.ca/content/cmaj/189/3/E101.full.pdf>

¹²³ *The 2015 Quality of Death Index*, Economist Intelligence Unit: <https://eiperspectives.economist.com/sites/default/files/2015%20EIU%20Quality%20of%20Death%20Index%20Oct%202015%20FINAL.pdf>

The EIU's country profile for Ireland¹²⁴ stated that the nation "provides some of the world's best palliative care services", noting (*inter alia*) that the "voluntary hospice movement has long been active in the development and provision" of these, and praising the country's "clear strategy", "comprehensive support from public institutions", and monitoring enabling "consistent high quality across all hospital and hospice units"¹²⁵.

No system can become complacent however, and the latest experience of Ireland's closest neighbour is instructive. The country rated by the EIU as having the best palliative care was the United Kingdom, due to its "*comprehensive national policies, the extensive integration of palliative care into its National Health Service [NHS], and a strong hospice movement*"¹²⁶. The UK ranked highest quality in palliative and healthcare environment, human resources, as well as affordability and quality of care. Despite this, separate reviews over the last decade have found the UK's system still struggles with under-supply, limited application outside of a hospice setting, and sometimes poor organisation.

The UK Government commissioned an independent review¹²⁷ into palliative care funding, which reported in 2011 that of the over 470,000 people who die in England each year, 355,000 require palliative care, yet only 171,000 receive specialist palliative care. It also found a postcode lottery of palliative care that led to gross inequities, with only 56% of the NHS's Primary Care Trusts providing 24-hour community nursing.

This "unacceptable variation" and other similar problems were further confirmed in 2016 both by a Commons Health Committee report¹²⁸, and by researchers at the London School of Economics (LSE), in a report commissioned by the hospice charity Marie Curie¹²⁹, which found that more than 100,000 people a year who would benefit from palliative care were not getting it, leaving them without the sufficient

¹²⁴ The 2015 Quality of Death Index: Country Profiles, Economist Intelligence Unit (p. 35): https://eiuperspectives.economist.com/sites/default/files/images/2015%20Quality%20of%20Death%20Index%20Country%20Profiles_Oct%206%20FINAL.pdf

¹²⁵ The EIU conclusions came from the analysis in Centeno, C., T. Lynch, O. Donea, J. Rocafort and D. Clark, 'Ireland', *EAPC Atlas of Palliative Care in Europe 2013*.

¹²⁶ *Op. cit.*, EIU 2015 Quality of Death Index Country Profiles, UK (p. 75).

¹²⁷ Palliative Care Funding Review, 'Funding The Right Care and Support for Everyone', Hughes-Hallett *et al* (July 2011): https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/215107/dh_133105.pdf

¹²⁸ End of Life Care: Fifth Report of Session 2014–15, House of Commons Health Committee (March 2015): <https://publications.parliament.uk/pa/cm201415/cmselect/cmhealth/805/805.pdf>

¹²⁹ *Equity in the Provision of Palliative Care in the UK: Review of Evidence*, Dixon *et al*, Marie Curie (April 2015): <https://www.mariecurie.org.uk/globalassets/media/documents/policy/campaigns/equity-palliative-care-uk-report-full-lse.pdf>

pain relief they needed. Groups most likely to be so affected were the “oldest old” (aged 85 and over), people living alone, people living in deprived areas, and those from ethnic minorities.

In May the same year, a report¹³⁰ by the Parliamentary and Health Service Ombudsman into complaints about end of life care found serious issues with the provision of that service. This included poor communication with families – tragically, meaning that some reported losing a chance to say goodbye to a dying loved one – and poor pain management resulting in unnecessary suffering of patients. The report also reported what the independent review, Health Committee, and LSE reports identified: poor planning and fragmented, uncoordinated care, often compounded by inadequate out of hours services.

In response to these structural problems, pathways to proper reform were prescribed, not only promising to fix these deficits, but in doing so to save money rather than lead to a greater strain on the public purse. The Commons report recommended access to palliative care in community settings and hospitals, as well as hospices. The 2011 review estimated that provision of more community-based services could reduce the number of hospital deaths by 60,000 a year, calculating that the annual saving to hospitals would be £180 million. The LSE report came to similar conclusions, finding that providing palliative community care to those that need it could improve the quality of life for thousands of patients and save millions in NHS money by preventing unwanted and distressing hospital treatment.

Following this, Professor Ilora Finlay, a Welsh cross-bench member of the UK’s House of Lords, a former President of the British Medical Association, a patron of both the hospice charity Marie Curie and the Motor Neurone Disease Association, and one of Britain’s leading experts in palliative care medicine, tabled an ‘Access to Palliative Care Bill’¹³¹ in the 2015-2016 session of the UK Parliament. As a Private Member’s Bill, it has yet to be passed, and so has been re-tabled in its various forms¹³² in all three Parliamentary sessions since. The Bill has sought to amend the deficits in the UK’s current structure of palliative care provision, by extending access to specialist palliative care from hospices to hospitals,

¹³⁰ *Dying Without Dignity: Investigations of the Parliamentary and Health Service Ombudsman into complaints about end of life care*, Parliamentary and Health Service Ombudsman, May 2015: https://www.ombudsman.org.uk/sites/default/files/Dying_without_dignity.pdf

¹³¹ *Access to Palliative Care Bill 2015-16*, House of Lords: <https://services.parliament.uk/bills/2015-16/accesstopalliativecare.html>

¹³² *Access to Palliative Care Bill 2016-17*, House of Lords: <https://services.parliament.uk/bills/2016-17/accesstopalliativecare.html> *Access to Palliative Care Bill 2017-19*, House of Lords: <https://services.parliament.uk/Bills/2017-19/accesstopalliativecare.html> Currently the *Access to Palliative Care and Treatment of Children Bill 2019-21*: <https://services.parliament.uk/bills/2019-21/accesstopalliativecareandtreatmentofchildren.html>

community care, and places of usual residence (personal, as well as residential homes). This has also meant ensuring equal access to palliative care by ensuring:

- Necessary education and training for all health and social care providers (including the handling of sensitive communications between themselves, dying patients, and their loved ones, for provision of psychological and emotional support);
- The priority and duty of analgesic requirements for all patients for all medical professionals;
- Consistent and complete access to essential palliative medication for healthcare workers and their patients at all times, and to the specialist advice needed to properly care for those with complex conditions.

Many of the issues these reforms seek to address were noted by the EIU Index Report as applicable globally, which noted that “[q]uality of care depends on access to opioid analgesics and psychological support... In many countries access to opioids is still hampered by red tape and legal restrictions, lack of training and awareness... The best care also includes inter-disciplinary teams that also provide psychological and spiritual support and physicians who involve patients in decision-making and accommodate their care choices”.

Indeed, similar ideas to those already discussed in the UK have already been proposed in Ireland. Point 3 of the Model of Care for Adult Palliative Care Services promulgated by the National Clinical Programme for Palliative Care in April 2019¹³³ is, “[a]n enabling environment is created where hospital, community and primary healthcare providers are supported to provide a palliative care approach as part of their normal service provision”, showing the cross-border concern to integrate palliative care beyond hospices and further into community care and throughout the health and care systems. Public and media discussions have also centred around making palliative care more accessible, and moving away from its stereotype of being bound to hospices, and more as a part of general medical provision, including being brought into residential homes¹³⁴.

If such deficits exist to varying extents in all countries, and proposed solutions such as those above are thought to be proper to the best palliative care system in the world UK, it would certainly be worth considering they, or other reforms more suited to the Irish context, should be pursued by the Oireachtas.

¹³³ *Adult Palliative Care Services Model of Care for Ireland* (26th April, 2019), p. 20: <https://rcpi-live-cdn.s3.amazonaws.com/wp-content/uploads/2019/04/NCP-Palliative-Care-Model-of-Care-24.04.0219.pdf>

The National Clinical Programme for Palliative Care is a joint initiative of the Health Services Executive (HSE), and the Royal College of Physicians of Ireland (RCPI).

¹³⁴ See for example, *Moving palliative care from hospitals to the home*, RTÉ, 06th May 2020: <https://www.rte.ie/brainstorm/2020/0506/1136802-palliative-care-hospitals-home/>

When Irish palliative care is not yet the best that it could be, to introduce a system of assisted suicide and euthanasia that as we have seen possesses the profound danger of pushing hundreds of vulnerable Irish citizens into premature deaths, to which inadequate palliative care might well end up as a contributing if not key factor (reports from Quebec already support this thesis¹³⁵), would be grossly irresponsible. Before the Oireachtas even considers licensing physician assistance of suicide or euthanising of patients (which would be dangerous in any case) therefore, it should first implement consider reforms that lead to Ireland overtaking the UK to become the country which provides the greatest access to the best quality palliative care in the world.

To adopt reforms in particular that would improve access to analgesics, and enhance psychological support and patient involvement in their choices of authentic care (rather, that is, than enable their own suicide) would be especially valuable. These would reduce the perceived need for the extreme measures of assisted suicide and euthanasia, rooted as they are in appeals to ‘autonomy’ and ‘dignity’, by better providing a comforting sense of control back to vulnerable patients at one of the most uncertain times of their lives.

Ireland’s ambition should not be to remove important protections for vulnerable patients in law, but to extend the most efficient, humane, and universal system of palliative provision possible, one which would have the flexibility and trust essential to putting patient decisions about their treatment at the core of medical care. This would magnify the necessary harmony between medical and social compassion and legal strength and protection rooted in the principles of the Constitution. By grasping the opportunity to cement Irish global leadership in the provision of end-of-life care, the Oireachtas could transcend the dangerous distraction of the assisted suicide debate by providing for the world an example of how, without endangering the most vulnerable of citizens, or compromising fundamental medical ethics, true dignity in dying can be achieved.

Part B): Legal Analysis

The Constitution of Ireland and European Convention on Human Rights

Given what we have already noted about the demonstrable dangers of euthanasia and assisted suicide, it should be clear that those practices are antithetical to the principles of the Constitution.

¹³⁵ Lack of palliative care pushing Quebecers toward medically assisted death, College of Physicians says, CBC News, 31st May 2018: <https://www.cbc.ca/news/canada/montreal/lack-of-palliative-care-pushing-quebecers-toward-medically-assisted-death-college-of-physicians-say-1.4685470>

Specifically, clauses 1° and 2° of section 3 of Article 40, and clauses 1° and 2° of section 1 of Article 41, which respectively involve the State guaranteeing “*in its laws to respect, and, as far as practicable, by its laws to defend and vindicate the personal rights of the citizen*”, and “*by its laws protect as best it may from unjust attack and, in the case of injustice done, vindicate the life, person, good name, and property rights of every citizen*”.

Any law which allows patients at the greatest ebb of their personal autonomy due to their compromised physical and mental state, to be subject either to overt personal pressure by unscrupulous relatives or medical staff, or covert pressure from insufficiently caring medical and general culture, would be a failure to secure public safety, and therefore to defend and vindicate the personal rights of the citizen, or best protect citizens from unjust attack. By compromising existing legal protections, it would also undermine the law’s proper ability to vindicate the lives of citizens so abused through euthanasia or assisted suicide in cases of genuine coercion or pressure, and therefore lethal injustice.

By contrast, the ‘right to die’ asserted by those who propose licensing assisted suicide and euthanasia, which they have in the past identified as present in the same sections of the Constitution as those mentioned above, does not exist. This was established well by the Supreme Court of Ireland in *Fleming v. Ireland* case in 2013, in the judgement¹³⁶ of which, the Justices stated that “*there is no constitutional right to commit suicide or to arrange for the ending of one’s life at a time of one’s choosing*”. The court also found that the prohibition on assisted suicide was not discriminatory and was not contrary to the European Convention on Human Rights.

This latter judgement was largely based on consideration of the fact that the European Court of Human Rights has consistently refused to find a right to end one’s own life or to have it ended by a physician in any of the Articles in the European Convention. The most important case cited for this, *Pretty v. United Kingdom*¹³⁷, saw claims made that such grounds exist in five particular articles, all of which were rejected:

- Article 2 (Right to Life) – Corresponding to Article 40 in particular but also Article 41 by implication in the Constitution, the Court defined this in its judgement in the *Pretty* case as “*enjoin[ing] States not only to refrain from the intentional and unlawful taking of life, but also to take appropriate steps to safeguard the lives of those within its jurisdiction*”, including “*in certain well-defined*

¹³⁶ *Fleming v. Ireland* (2013): https://www.courts.ie/viewer/pdf/a998a535-6045-4d81-9aaa-54e42dfaa343/2013_IESC_19_1.pdf/pdf#view=fitH

¹³⁷ *Pretty v. United Kingdom* (2002): <https://hudoc.echr.coe.int/eng-press#%22itemid%22:%22003-542432-544154%22>

circumstances a positive obligation on the authorities to take preventive operational measures to protect an individual whose life was at risk from the criminal acts of another individual". All of this would surely entail State's duties to have laws against euthanasia and assisted suicide, given the role such laws play in safeguarding the lives of citizens, and the protection of individuals whose lives might be at risk from unscrupulous persons. What the Court excluded absolutely was the idea that a right to life could actually be construed as a right to death. This would take the negative right to life (the right not to be lethally attacked), and confuse it with a positive right to end one's life, a concept absent from the concept of the right to life itself, and the text of the Convention. Noting "the emphasis on the obligation of the State to protect life" the Court had always maintained, it stated boldly that the Article 2 right to life could not "*without a distortion of language, be interpreted as conferring the diametrically opposite right, namely a right to die [later: "whether at the hands of a third person or with the assistance of a public authority"]; nor could it create a right to self-determination in the sense of conferring on an individual the entitlement to choose death rather than life*".

- Article 3 (Prohibition of Torture) – This forbids State actors from inflicting ill-treatment on citizens, or as the Court put it, it was "*first and foremost a prohibition on the use of lethal force or other conduct which might lead to the death of a human being*". Pretty had argued that the prohibition on assisted suicide in UK law, and the refusal of the UK's Director of Public Prosecutions to give an undertaking not to apply that law by prosecuting her husband if he assisted her to commit suicide, both constituted "inhuman and degrading treatment" on behalf of the British State. Once again, then, an implausibly wide reading of an article that ill-fitted what the Court noted as "*the fundamental objectives of the Convention and its coherence as a system of human rights protection*". As with Article 2, an essentially 'negative right' not to be interfered with was being invoked as a "positive obligation on the part of the State which... would require that the State sanction actions intended to terminate life". Construing Article 3 in harmony with Article 2 however, there is no right to commit suicide itself (merely, as we discussed earlier, a pragmatic liberty), and neither article conferred "any claim on an individual to require a State to permit or facilitate his or her death". By forbidding one person to assist in another person's self-destruction, and refusing to commit not to impose legal penalties on those who do so, the State is not torturing either of those two individuals either by commission or omission. Simply because the person wanting to end their own life finds their aim frustrated does not mean that the unhappiness caused by this can be called 'torture'. The Court found such a reading "*placed a new and extended construction on the concept of treatment*", and thus it was "*beyond dispute that the respondent*

Government had not, themselves, inflicted any ill-treatment on the applicant. Nor was there any complaint that the applicant was not receiving adequate care from the State medical authorities”.

- Article 8 (Right to Respect for Privacy and Family Life) – Here, the Court came closest to finding something approaching a right to euthanasia or assisted suicide, stating that “[t]he applicant was prevented by law from exercising her choice to avoid what she considered would be an undignified and distressing end to her life. The Court was not prepared to exclude that this constituted an interference with her right to respect for private life as guaranteed under Article 8 § 1”. This is dubious reasoning, as the Court appeared to open themselves to the possibility of falsely construing, as the applicant’s legal representatives had already also in relation to Articles 2 and 3, a negative right (a right not to be interfered with by the State or others) as a positive right (the right to do something, including potentially to be enabled to do it). In this case however, it was not the law which prevented the applicant, Diane Pretty, from exercising a choice she wished to make. Rather, it was the Motor Neurone Disease from which she suffered. The law did not ‘interfere’ with a choice of hers; her condition prevented it. As we discussed in Part A (pp. 7-8) whilst someone might have the pragmatic legal liberty to ‘privately’ do something to themselves, it does not follow that this entails a right to do it, still less an entitlement for the State to help them do it. The Court did not ‘canonise’ that interpretation however, but left it an open question. Instead, they recalled that Article 8 § 2 allowed for States to interfere with private activity in any case, if “such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others”. The question was whether such interference was necessary in its ends and proportional in its means. In this, they found in favour of the United Kingdom in both regards. As to ends, they state their agreement with (what was then) the Judicial Committee of the House of Lords, that “States were entitled to regulate through the operation of the general criminal law activities which were detrimental to the life and safety of other individuals. The law in issue in this case [against assisted suicide] was designed to safeguard life by protecting the weak and vulnerable and especially those who were not in a condition to take informed decisions against acts intended to end life or to assist in ending life”. As to means, they found it was not “arbitrary for the law to reflect the importance of the right to life, by prohibiting assisted suicide while providing for a system of enforcement and adjudication which allowed due regard to be given in each particular case to the public interest in bringing a prosecution, as well as to the fair and proper requirements of retribution and deterrence”. The Court therefore found no Article 8 right had been violated, but that laws against assisted suicide are proportional means to

necessary ends: in this case, we can rightly point out, both “public safety” and the “rights... of others”. The Court came to similar conclusions in the case *Haas v. Switzerland*¹³⁸.

- Article 9 (Freedom of Thought, Conscience, and Religion) – The Court here noted that “not all opinions or convictions constituted beliefs as protected by Article 9 § 1”, and that included Pretty’s commitment to the principle of personal autonomy in her passionate support for assisted suicide. The Court concluded that there had been no violation of Article 9.
- Article 14 (Prohibition of Unjust Discrimination) – Here, the applicant contended that there was an unjust difference in treatment between those who were and who were not capable of committing suicide. This too did not follow, as the situation was not that those who were able were enabled to commit suicide, and those who were not lacked such support. Rather, the law does not distinguish at all between those two groups, and does not support either. That some people are not able to achieve an aim which they have (as established) no right to access in the first place, and others are, is not State discrimination. Even if there were, the Court found that there would be a proportional reason to make no distinction between the two groups, as to “*seek to build into the law an exemption for those judged to be incapable of committing suicide would seriously undermine the protection of life which the 1961 Act was intended to safeguard and greatly increase the risk of abuse*”. Consequently, there had been no violation of Article 14.

To conclude then, the Supreme Court and the European Court of Human Rights have rejected the idea that there can be any human rights to euthanasia or assisted suicide either (in the former case) in the Constitution, or (in the latter case) the European Convention on Human Rights. Even where the European Court has been open to the (implausible) possibility that Article 8 could be construed as a right to commit suicide, it has balanced this against other State obligations, such as those relating to the State’s duties to protect the right to life of its citizens, and given state actors a wide berth of operation in laws concerning them.

So far from being the kind of acts the procurement of which could be thought of as a ‘right’ then, euthanasia and assisted suicide undermine important constitutional and human rights duties on the part of the State towards the right to life of its citizens by removing vital protections, and indeed their implementation in multiple jurisdictions show that they actually constitute threats to that primary right given the abuses they engender, contrary both to genuine human autonomy and dignity.

¹³⁸ *Haas v. Switzerland* (2011): <https://hudoc.echr.coe.int/eng-press#%7B%22itemid%22:%5B%22003-3405698-3821885%22%7D>

Conclusion

We find ourselves considering the issues surrounding euthanasia and assisted suicide during the COVID-19 pandemic, a crisis that will cost millions of lives worldwide. Our attitude and response to that problem should be instructive as to how we react to the challenges of end-of-life care. Over the last year since the outbreak began, countries across the world have been taking measures to minimise deaths of at-risk groups (especially the chronically ill, disabled, and elderly). These measures have taken the form of lockdowns, social distancing, mandatory face coverings, and heightened hand hygiene. All of these proceedings, whether they prescribe or proscribe human behaviour, in some way suppress human autonomy in a variety of ways for the sake of every citizen, and most especially the most vulnerable members of our society. Whilst there might be controversy over the forms these measures have taken, and their effectiveness, few people would doubt that the fundamental moral approach, one of compassion and solidarity, putting people before personal profit and even satisfaction and enjoyment, has been the right one.

With this consensus in mind, we should extend the same logic, and consistent humanity, to the issue of end of life care. A proper concern for the most vulnerable is exactly the response that should be applied in medicine and law in the proscription of physician involvement in enabling or causing the death of their patients. Laws against euthanasia and assisted suicide are a vital part of the social framework that protects vulnerable people from harm. They operate with a strength that can protect, and yet also the flexibility that can show compassion. If there is a deficiency in either of those areas it can be addressed by better prosecutorial guidelines, but when these protections are abandoned, the evidence from foreign jurisdictions shows the abuse that can occur.

The experience of European countries that are, like Ireland, developed, liberal, and democratic, is that the introduction of voluntary euthanasia and assisted suicide enables the violation of the right to life of some of the most vulnerable human beings. It corrupts medical culture, worsens society's view of dying and illness as well as those who are dying and ill, retards and undermines the development of palliative care, and leads society off of an easily foreseeable 'logical cliff', in which those particularly who suffer mental illness become the victims of a coarsened culture. In all this, so far from extending or respecting personal autonomy and dignity, doctor-enabled or administered death undermines both.

It is for this reason that opposition to physician-assisted suicide and euthanasia are opposed across the world by a host of voices from a cohort of sectors in civil society, on the grounds that both

practices are antithetical to public safety and social justice due to the damaging effects both have on patients who need the greatest protection.

In Ireland, the Royal College of Physicians of Ireland opposes the license of euthanasia and assisted suicide¹³⁹, as have leading members of the Irish Palliative Medicine Consultants' Association (IPMCA)¹⁴⁰. Similarly in the UK, medical bodies such as the Royal Colleges of Physicians¹⁴¹, Surgeons¹⁴², and General Practitioners¹⁴³, the Association of Palliative Medicine, Hospice UK¹⁴⁴, the British Medical Association¹⁴⁵ and the World Medical Association¹⁴⁶, as well as by organisations that represent and campaign for the welfare of the disabled and elderly, such as the British Geriatric Society¹⁴⁷, Scope¹⁴⁸, the UK Disabled People's Council¹⁴⁹, Disabled People Against Cuts (DPAC)¹⁵⁰, and Not Dead Yet UK¹⁵¹.

The same has been the case in other jurisdictions. The Australian Medical Association actively opposes euthanasia¹⁵², as do leading disability rights activists there such as Craig Wallace, the President

¹³⁹ *Assisted Suicide Position Paper; Key Updates and Literature Review – October 2020*, RCPI: <https://www.rcpi.ie/news/releases/assisted-suicide-position-paper-key-updates-and-literature-review-october-2020/#:~:text=Following%20careful%20consideration%20of%20the,contrary%20to%20best%20medical%20practice>

¹⁴⁰ *Palliative medicine and dying with dignity*, Irish Times, 05th October 2020: <https://www.irishtimes.com/opinion/letters/palliative-medicine-and-dying-with-dignity-1.4371686> See also, *Doctors come out against assisted dying bill*, Daniel McConnell, Irish Examiner, 04th October 2020: <https://www.irishexaminer.com/news/arid-40059278.html>

¹⁴¹ *RCP Briefing: Assisted Dying Bill 2015-16*: <http://bit.ly/2ewhCpe> The RCP has since decided to adopt a neutral position on the issue, without having consulted its members.

¹⁴² *Royal College of Surgeons, House of Lords Briefing: Assisted Dying Bill*: <http://bit.ly/2eFJOTc>

¹⁴³ *Royal College of GPs remains opposed to change in the law on assisted dying*, 21st February 2020: <https://www.rcgp.org.uk/about-us/news/2020/february/royal-college-of-gps-remains-opposed-to-change-in-the-law-on-assisted-dying.aspx>

¹⁴⁴ *Position Statement on Hospice Care and Assisted Dying*, Hospice UK: <https://www.hospiceuk.org/docs/default-source/default-document-library/position-statement-on-hospice-care-and-assisted-dying.pdf?sfvrsn=2>

¹⁴⁵ *The BMA's position on physician-assisted dying*, British Medical Association, 28th September 2020: <https://www.bma.org.uk/advice-and-support/ethics/end-of-life/the-bmas-position-on-physician-assisted-dying>

¹⁴⁶ *WMA Statement on Euthanasia and Physician-Assisted Suicide*, adopted September 1992; and reaffirmed October 2019: <https://www.wma.net/policies-post/declaration-on-euthanasia-and-physician-assisted-suicide/>

¹⁴⁷ *Physician-Assisted Suicide – BGS Position Statement*, 10th July 2015: <https://www.bgs.org.uk/policy-and-media/physician-assisted-suicide>

¹⁴⁸ *Scope concerned by reported relaxation of assisted suicide guidance*, SCOPE, 20th January 2018: <https://www.scope.org.uk/media/press-releases/scope-concerned-by-reported-relaxation-of-assisted-suicide-guidance/>

¹⁴⁹ *UKDPC Position Statement: Assisted Suicide* (2015).

¹⁵⁰ See: <https://dpac.uk.net/tag/assisted-dying/>

¹⁵¹ *About Not Dead Yet UK*: <http://notdeadyetuk.org/about/>

¹⁵² "The AMA believes that medical practitioners should not be involved in interventions that have as their primary intention the ending of a person's life", *Position Statement on the Role of the Medical Practitioner in End of Life Care 2007 (amended 2014)*, section 10.5 :

https://ama.com.au/sites/default/files/documents/ps_on_the_role_of_the_medical_practitioner_in_end_of_life_care_2007_amended_2014_0.pdf

of People with Disabilities Australia¹⁵³, as well as groups such as Lives Worth Living¹⁵⁴. The situation was similar in New Zealand, where euthanasia has sadly recently been legalised. The New Zealand Medical Association¹⁵⁵, the Australian & New Zealand Society of Palliative Medicine (ANZSPM)¹⁵⁶, Hospice New Zealand¹⁵⁷, New Zealand Health Professionals Alliance¹⁵⁸, Palliative Care Nurses New Zealand¹⁵⁹, and Not Dead Yet Aotearoa¹⁶⁰, are all examples of organisations that opposed euthanasia.

This alliance of those who care about the welfare of the most vulnerable members of the human family is surely in itself instructive. They have all listened to the same stories and looked at the same evidence. They know on objective medical and humanitarian grounds that euthanasia does not promote or extend patient choice; it invites and enables coercion. This is not mere speculative hypothesis; it is evidenced reality. This risk of even subtle coercion of vulnerable people is precisely why Irish law, as UK law, exists as it does. As Elizabeth Butler-Schloss, the former President of the High Court Family Division, once put it, *“Laws, like nation states, are more secure when their boundaries rest on natural frontiers”*. This is about asserting a fundamental principle of law that serves to protect vulnerable people from lethal coercion: the medical and legal Rubicon that doctors preserve the lives of their patients, and emphatically do not involve themselves in taking those lives, or even enabling them to take their own lives.

In saying this, and in laying out the evidence of the harms that assisted suicide and euthanasia cause, we do not ignore the difficult and often heart-rending stories of those who wish their own lives to end. As much as possible must be done to create a culture in which as few people as possible feel that their condition, and inability to move and look after themselves as once they did, renders their life without meaning or value. Any social structure or situation that makes people whose autonomy has been compromised by illness feel that they are better off dead, is one that is antithetical to all our efforts of suicide prevention, and proper medical care.

¹⁵³ *Euthanasia: let's look at the bigger picture*, Craig Wallace, ABC, 21st January 2013: <http://www.abc.net.au/rampup/articles/2013/01/21/3673497.htm>

¹⁵⁴ Lives Worth Living: <http://livesworthliving.com.au/>

¹⁵⁵ *NZ Medical Association warns against euthanasia*, Radio New Zealand: <https://www.rnz.co.nz/news/political/313347/nz-medical-association-warns-against-euthanasia>

¹⁵⁶ *Australian and New Zealand Society of Palliative Medicine Position Statement: The Practice of Euthanasia and Physician-Assisted Suicide*: <https://www.anzspm.org.au/c/anzspm?a=sendfile&ft=p&fid=1491523669&sid=>

¹⁵⁷ *Euthanasia – Our Opinion*, Hospice NZ: <https://www.hospice.org.nz/resources/end-of-life-choice-act-our-concerns/euthanasia-our-opinion/>

¹⁵⁸ *Unpacking the End of Life Choice Act*, September 27th 2020: <https://www.nzhpa.org/unpacking-the-end-of-life-choice-act-2019/>

¹⁵⁹ *PCNNZ Position statement on euthanasia and assisted dying*: <https://pcnnz.co.nz/wp-content/uploads/2016/05/Euthanasia-position-statement-2012.pdf>

¹⁶⁰ See: <https://notdeadyet.org/tag/not-dead-yet-aotearoa>

The simple and unavoidable truth however, is that there is no such thing as a perfect world. Neither the law as it currently exists, nor the introduction of euthanasia, would serve everyone. What we can know, however, is that euthanasia can and does compromise the right to life and welfare of those who most need the safeguarding of the law. Instead of aiming for a false utopia, it is important for Government to try to deal with the reality as it is of legal and medical necessity. The current legal situation in Ireland, like that in the UK, when practiced properly, allows for the best balancing of justice and mercy, protection and compassion; introducing euthanasia would destroy this balance and endanger those whom the law has a duty to soundly protect.

There are better answers to the problems of terminal illness and patient pain, and they lie in serious-minded and comprehensive palliative care reform, not in the introduction of a practice that will abuse the elderly, the disabled, the terminally and severely ill, and many others whom the law owes protection. We would urge members of the Oireachtas to be fully cognisant of the value and importance of the current laws, to think imaginatively about how any deficiencies in end-of-life care can be resolved without removing vital protections, and to stand for a legal and medical framework that best serves true social justice and the common good.