

## Submission on the “Dying with Dignity Bill 2020” by the Royal College of Surgeons in Ireland.

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### **PART A: Policy and Legislative Analysis**

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

Caring for patients for whom a cure is not possible and death is imminent and ensuring that death is as dignified as possible is a fundamental principle on which the practice of medicine is based. RCSI believes that, for the vast majority of patients, dignity in dying is best ensured by the provision of timely access to good nursing, good palliative care including access to a hospice or home hospice care, and appropriate social support for patients and those close to them. Access to such services should be a right and be guaranteed by the State for all its residents.

For those patients for whom death is not imminent but who have incurable illness likely to lead to death in a relatively short period of time, RCSI believes that access to the services required to maintain the best possible quality of life for as long as possible should equally be a principle which underpins the care of those with a terminal illness.

RCSI believes that the proposed legislation is not in accord with best medical practice. The introduction of doctor assisted suicide is not in the best interests of patients and does not address the real issues of death with dignity. Much better that the State would not persist in this but instead support the neglected area of palliative care which has been so beneficial but could be undermined by doctor assisted suicide.

Recent high profile cases in the public domain have identified particular circumstances in which individuals found their quality of life intolerable, had a limited life expectancy and sought the legal relief to allow others assist them in ending their life. RCSI believes such cases are rare and would be rarer still if there were better access to high quality end of life supports.

RCSI believes that the introduction of euthanasia will have a harmful effect upon society. As long as human dignity is not based simply on usefulness to society, people such as the mentally ill, the severely handicapped, the very young and the incurably sick must be treated with respect and their lives safeguarded. An acceptance even of voluntary euthanasia and/or physician assisted suicide would seem to involve a weakening of this basic position.

In the event the Oireachtas chooses to legislate for assisted suicide in such rare circumstances, it is important to include significant safeguards to ensure that assisted suicide does not become the default option; that patients at the most vulnerable stage of their life would feel their choices are constrained; and that vulnerable patients would feel an obligation to end their lives to relieve the “burden” their life may represent for their families or others.

RCSI supports the detailed analysis published by our sister college the Royal College of Physicians in Ireland in 2017<sup>1</sup> and updated in 2020<sup>2</sup>. RCSI shares the concerns of the College of Psychiatrists of Ireland that legalisation of assisted suicide might have an adverse impact on the recent success in reducing the levels of suicide in the Irish population.

RCSI believes that the risks of introducing a legal structure to allow assisted suicide as set out in this bill would do more harm than good and, on this basis, that the bill should not be progressed. It is feared that legalisation of voluntary euthanasia and physician assisted suicide would create a precedent to

extend the practice to handicapped and sick individuals also, who do not suffer so much themselves, but rather are a perceived burden to society. Whether or not there is such a danger depends on the basic approach of those who are in favour of euthanasia and physician assisted suicide. Although many supporters of voluntary euthanasia base their case on respect for individual autonomy, it may well be that their understanding of who qualifies for the category of 'human being' depends on the quality of human life present. If this were so, it would be logical for them to regard the State as an institution whose duty it was to safeguard and promote the common good of 'good quality human beings' and dispose of those who do not meet the agreed criteria.

Notwithstanding the above, if the Oireachtas is minded to progress this or similar legislation, given the fundamental social impact of these proposals, RCSI proposes that it should be the subject of a structured national conversation such as has been employed in the recent past informing the legislature the context of difficult ethical issues.

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

This issue has been addressed elsewhere. Currently, assisting a patient with suicide is a crime under the Criminal Law (Suicide) Act 1993. In addition, the Medical Council's "Guide to Professional Conduct and Ethics for Registered Medical Practitioners 2019" explicitly forbids doctors from participating in killing a patient (Section 46.9 You must not take part in the deliberate killing of a patient).<sup>3</sup>

*3. Is there a wider EU/international context?*

There is no "right to die" under the European Convention on Human Rights. In *Pretty vs the United Kingdom*<sup>4</sup>, The European Court of Human Rights (ECHR) has found that Article 2 (right to life) of the Convention could not, without a distortion of language, be interpreted as conferring the diametrically opposite right, namely a right to die. The court also found that there is no obligation on the state to sanction actions intended to terminate life under Article 3.<sup>5</sup>

In other judgements, the ECHR has determined that States have a wide margin of appreciation in determining whether to legislate to allow assisted suicide.

The World Medical Association (WMA) is firmly opposed to euthanasia and physician-assisted suicide. No physician should be forced to participate in euthanasia or assisted suicide, nor should any physician be obliged to make referral decisions to this end.<sup>6</sup>

In a submission to the UK parliament on a similar bill in 2015, the Royal College of Surgeons of England stated that they believe the law in the UK as it currently stands should not be changed and no system should be introduced to allow people to be assisted to die<sup>7</sup>. In their submission, they highlighted the risks that such legislation would fundamentally alter the role of doctors and their relationship with patients; greater availability of palliative care expertise would address the issue for the vast majority of patients; and the danger that a "right to die" may become a "responsibility to die" making already vulnerable people even more vulnerable<sup>7</sup>.

## **Implications and implementation of the Bill's proposals**

### **Policy implications/implementation**

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

RCSI believes that the provisions as proposed in the bill will not meet the apparent policy objective and would create a liberal and poorly regulated regime of assisted suicide that could place increased

pressures on patients to avail of the option when they would be better served by investment in holistic palliative and end of life care.

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

RCSI believes that, for the vast majority of patients, dignity in dying would best be ensured by providing timely access to good nursing care, good palliative care including access to a hospice or home hospice care, and appropriate social supports for the patient and their families. Access to those services should be a right and should be guaranteed by the State for all its residents.

This would require additional legislation.

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

No

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

The introduction of assisted suicide in other jurisdictions has resulted in a significant societal impact. Data from the Netherlands indicate that 2.9% of all deaths in the Netherlands and between 3.5 and 5.6% in some age groups were by assisted suicide. In Flanders (Belgium), 4.2% of deaths in those under 64 were by assisted suicide<sup>8</sup>.

No formal impact assessment has been published on the likely effects of the proposed legislation in Ireland. In other jurisdictions it is not known how many patients are pressured into obtaining prescriptions or engage in 'doctor shopping,' to find a practitioner who will agree to their request if turned down by a given physician. Little is known about the after-effects on practitioners and families, although there are reports of post-traumatic stress disorder and preliminary reports suggest increased rates of suicide in the general population of states that have legalized physician assisted suicide<sup>9</sup>.

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

If the Oireachtas chooses to legislate for assisted suicide in such a way, the current legislative proposals do not include sufficient safeguards to ensure that this does not become the default option in many circumstances and that vulnerable patients may feel an obligation to end their lives to relieve the "burden" their life may represent for their families or others.

*9. Has the Committee taken due consideration of the opinion of the European Central Bank (ECB) on the Bill, if applicable?*

No comment

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

RCSI believes that more robust provisions are required to ensure that doctors involved in the process are on the specialist register (rather than be just registered practitioners), should have an established practice base in the jurisdiction, should have satisfied the Medical Council that they have completed appropriate training as laid down by the Council and are maintaining their competence. These provisions should fall under the responsibility of the Minister for Health.

There should be a more robust process for assessing the validity of the decision by a patient to avail of the provisions of the bill as provided, for example, in the Health (Regulation of Termination of Pregnancy) Act 2018 and the Mental Health Acts 2001-2018 for mental health tribunals which are independent and there to protect patients' rights.

*11. Are there appropriate performance indicators which the Department, or whoever is ultimately charged with implementing the Bill, can use to assess the extent to which it meets its objective? Does it include formal review mechanisms?*

Specific provisions should be made in the bill to specify the format for the registration of deaths that occur under the Act. Notification of all deaths that occur under the provisions of the bill should be notified to a separate specific registry maintained by the Department of Health should also be required. An annual report should be laid before the Oireachtas and published.

### **Cost evaluation**

*12. Will there be enforcement or compliance costs?*

There will be costs attached to regulation, training and oversight of the bill.

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

The Bill addresses issues of the criminal law but what of the obligations owed by hospitals and doctors to patients in civil law? Such a fundamental recalibration of medical ethics is likely to have consequences in legal liabilities. The views of the State Claims Agency should be ascertained by the committee.

*14. Have cost-benefit analyses (CBA) been provided/published (by Government or a third party) in respect of each proposal contained within the Bill? Will benefits/costs impact on some groups/stakeholders more than others?*

No cost benefit analysis has been published in relation to the implementation of the bill.

### **PART B - Legal Analysis**

*15. Is the draft PMB compatible with the Constitution (including the 'principles and policies' test)?*

It is at least doubtful that the Bill is compatible with the Constitution. Whilst suicide is no longer unlawful, it is a very different matter when the assistance of others may be invoked in circumstances which are far from clear because of the Bill's lack of specificity and where the conscientious objection protection is illusory.

If the Bill were to be the subject of a reference to the Supreme Court under Article 26 of the Constitution it is hard to see how it could survive such scrutiny. How could the Court even begin to understand how it might work in practice given the lack of specifics ?

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

There is no "right to die" under the European Convention on Human Rights. In *Pretty vs the United Kingdom*<sup>4</sup>, The European Court of Human Rights (ECHR) has found that Article 2 (right to life) of the Convention could not, without a distortion of language, be interpreted as conferring the diametrically opposite right, namely a right to die. The court also found that there is no obligation on the state to sanction actions intended to terminate life under Article 3<sup>5</sup>

In other judgements, the EHCR has determined that States have a wide margin of appreciation in determining whether to legislate to allow assisted suicide.

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

The Bill, introducing as it does a fundamental reversal of a medical ethic that has sustained the welfare of patients for centuries, is surprisingly short and lacking in detail thus making comment on it difficult. It compares very unfavourably with, for example, its equivalent in the State of Victoria Australia, namely the Voluntary Assisted Dying Act 2017 particularly in the area of statutory protections and conscientious objection<sup>10</sup>. It contains little or no detail of how it will operate in practice leaving all of that to be dealt with by statutory instruments. That is not an appropriate way to legislate for such an important issue and makes informed comment doubly difficult.

**Title:** The title of the Bill is misleading in at least two ways. It is a Bill to provide for doctor assisted suicide and euthanasia and it would be more honest to describe it for what it is. It may also imply that it is not possible to die with dignity at present or that such is possible only by means of the procedure envisaged by the Bill. Both are false.

**Section 2:** This Bill deals with a topic which is much more appropriate to the functions of the Minister for Health than the Minister for Justice. Apart from the repeal of certain criminal statutory provisions and the creation of new ones, everything else to be dealt with involves medical professionals and the care and health of their patients.

The definitions ought to be changed so as to involve only doctors on the specialist register, based in this jurisdiction (to avoid fly-in practitioners), who have completed training to the satisfaction of the Medical Council and who maintain their competence.

**Section 3:** This section is framed in very wide terms and far too much of the detail as to how the Act will operate can only be the subject of speculation.

The Bill should set out in detail (and thus be the subject of parliamentary debate and scrutiny) precisely how it will operate and the protections, if any, that will apply.

**Sections 7 and 8:** The definition of “terminally ill” is far too vague and covers many long term conditions. In the absence of some temporal limitation or a much more specific definition, the measure will have very wide application far outside what is apparently intended.

What is a “clear and settled intention”? Patients often change their minds. Not infrequently an intention regarding death can be a symptom of a depressive state secondary to a physical illness but readily treatable.

The term is from a practical medical perspective meaningless.

**Section 9:** This section is remarkable by the absence of any form of review or independent oversight of whatever process will be prescribed by ministerial order. This is very undesirable.

The legislature in providing for the involuntary hospitalisation of persons pursuant to the Mental Health Act 2001 quite rightly prescribes a form of statutory oversight which operates quickly and effectively. A measure which would result in the deliberate ending of a human life deserves no less protection and supervision.

**Section 10:** The criteria for assessing mental capacity as set out in this section are the four well known ones, but the section fails to specify who is to carry out the assessment or prescribe the level of expertise needed. This is in stark contrast to the safeguards prescribed in the mental health legislation.

For how long is the assessment to remain valid? How long before the patient is euthanised is the assessment to be carried out? What if doctors disagree; does one just seek out more doctors in the hope that on the fourth or fifth attempt another doctor will be found to trigger the procedure? These are just some of the myriad issues that arise but are not answered in this section.

**Section 11 (2):** This sub section allows for the lethal substances to be administered in a case where the patient cannot self-administer them. A patient with capacity who self-administers the drugs may reasonably be presumed to have chosen to end their life at a particular time. But what if that is not so and a person changes their mind and is unable to communicate that only to find the lethal substance being administered to them? There is a substantial risk for abuse here.

**Section 13:** Because this Bill provides for such a change in medical ethics, no doctor should have any obligation to be involved in it unless he or she opts in. If that proposition is not acceptable and conscientious objection is to be accommodated (as it must), the current draft fails to address that matter in anything like a satisfactory way.

If subsection 1 were to stand alone, without the remaining subsections, it would likely provide adequate protection. But such purported protection is rendered nugatory by the remaining subsections.

Subsection 2 provides that subsection 1 is not to be construed as affecting any duty to participate in anything authorised by the Act. That negates the protection entirely.

It is particularly unsatisfactory when so much of the workings of the scheme are unknown and will not be known until regulations are promulgated. What duties may they create which disapply the provision?

Subsection 3 provides no protection for the conscientious objector. A doctor who regards euthanasia as unacceptable for reasons of conscience should not be compelled to bring about a euthanised death by indirect means. To so require fails to respect the legitimate objection of the doctor and the moral equivalence involved.

In a word, the so called conscientious objection provisions of the section are devoid of effect.

**Section 19:** The consequences of the Bill are both legal medical and societal. It is at variance with the core values of the medical profession particularly in the area of patient protection. It has the potential to fundamentally damage the doctor/patient relationship.

Instead of introducing euthanasia the State would be better employed in providing proper support to palliative care which has been developed largely through voluntary effort. Little financial assistance has been provided by the State and, with the exception of the Wicklow Hospice, all have been constructed through voluntary fund raising. The HSE three-year development framework has yet to be implemented<sup>11</sup>.

What effect will this measure have on the practice of palliative medicine? It is hard to imagine that it will be positive. The Netherlands provides the most frightening example of the slippery slope effect of measures such as this but is not the only example. It is not to be supposed that Ireland will be any different. That is particularly so in an aging society like ours.



10. State of Victoria. Voluntary Assisted Dying Act 2017. <https://www.legislation.vic.gov.au/in-force/acts/voluntary-assisted-dying-act-2017/004> accessed Jan 17 2021

11. HSE Palliative Care Development Framework 2017-2019  
<https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/palliative-care-services-development-framework.pdf>

**Royal College of Surgeons in Ireland**

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