SUBMISSION ON THE DYING WITH DIGNITY BILL 2020

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INTRODUCTION

In this submission, I attempt to do the following:
(1) critique the principles on which the Bill is based,
(2) consider specific provisions of the Bill, and
(3) briefly propose a better way forward for the Oireachtas to proceed.

(1) THE PRINCIPLES ON WHICH THE BILL IS BASED

The Bill endorses the intentional taking of a person's life before it reaches its natural end. The Bill proposes the active involvement of doctors in the process, prescribing and, in some cases, even administering lethal substances to the person whose life it is intended to end. The Bill's provisions contradict the philosophy that I suggest should be the foundation of legislative action –one that affirms the inherent value of human existence and the inexorable moral connectedness of human beings. This philosophy rejects nihilism or value-neutrality and commits itself to the premise that the value of human existence and moral connectedness cannot be reduced to subjective perceptions. It fully respects human dignity and autonomy as part of a world that is meaningful and interconnected.[2] This philosophy is entirely consistent with that of the Universal Declaration of Human Rights.

[1] Biographical background: I am a practising barrister. I was Special Legal Adviser on family law reform to the Department of Justice (1974-1976), Research Counsellor to the Law Reform Commission (1976- 1992) and Regius Professor of Laws (1992-2012) at Trinity College Dublin, where I am Fellow Emeritus. I was a Commissioner of the Irish Human Rights Commission from 2000 to 2011. I was a Visiting Fellow at Corpus Christi College, Cambridge (Michaelmas term, 2002) and a Visiting Fellow at the Institute of European and Comparative Law, Oxford (June 2011). I represented Ireland at the Hague Conference on Private International Law in the formulation of its Conventions on marriage (1976) and intercountry adoption (1992). I participated as representative of the Irish Human Rights Commission in the formulation of the United Nations Convention on the Rights of Persons with Disabilities (2003-2006). I have been an invited expert on private international law at the European Parliament. I have lectured in Medicine and the Law at postgraduate level at Trinity and gave the Ver Hayden De Lancey Lecture on Law and Medicine at the University of Cambridge in May 2001. I was a member for a number of years of the research ethics committee of the Federated Voluntary Hospitals and St James's Hospital. I am legal adviser to the Pro Life Campaign.

[2] Cf Watt, "The Dignity of Human Life: Sketching Out an 'Equal Worth' Approach" 36 Ethics & Medicine 7 (2020); Binchy, "Dignity as a Constitutional Concept" in Eoin Carolan & Oran Doyle eds, The Irish Constitution: Governance and Values (2008), chapter 17. In Fleming v Ireland [2013] 2 IR 417, at 446-448, the Supreme Court acknowledged the values underlying the Irish constitutional order when it held that there is no constitutional right to die or a right to assisted suicide based on rights of autonomy or privacy. Denham J noted that Article 40.3.2° committed the State to protect and vindicate the life and person of every citizen. She stated:

"Can it be said that the right to life as so guaranteed, whether on its own or in conjunction with the guarantee of the protection of the person, necessarily implies as a corollary, the right of every citizen to terminate his or her life and to have assistance in so doing? At the level of abstract reasoning it is of course possible to argue that, if a citizen has a right to life, that must comprehend abandoning or terminating it. It is also possible to construct a libertarian argument that the State is not entitled to interfere with the decisions made by a person in respect of his or her own life up to and including a decision to terminate it. However, it is not possible to discern support for such a theory in the provisions of the Constitution without imposing upon it a philosophy and values not detectable from it. A right which extends to the termination of life must .... necessarily extend to a right to have life terminated by a third party in a case of total incapacity. The concept of autonomy which extends not just to an entitlement, but to a positive right to terminate life and to have assistance in so doing, would necessarily imply a very extensive area of decision in relation to activity which is put, at least prima facie, beyond regulation by the State. When it is considered that recognition of such a right implies correlative duties on the State and others to defend and vindicate that right (and which must necessarily restrict those parties' freedom of action), it is apparent that the right contended for by the appellant would sweep very far indeed. It cannot properly be said that such an extensive right or rights is fundamental to the personal standing of the individual in question in the context of the social order envisaged by the Constitution. The right to life which the State is obliged to vindicate, is a right which implies that a citizen is living as a vital human component in the social, political and moral order posited by the Constitution. While it may be said that it is of the essence of certain types of rights, such as that of the right to associate, that they logically apply as a corollary a right to dissociate, that reasoning cannot be applied to all rights guaranteed by the Constitution. In particular the protection of the right to life cannot necessarily or logically entail a right, which the State must also respect and vindicate, to terminate that life or have it terminated. In the social order contemplated by the Constitution, and the values reflected in it, that would be the antithesis of the right rather than the logical consequence of it. Thus, insofar as the Constitution, in the rights it guarantees, embodies the values of autonomy and dignity and more importantly the rights in which they find expression, it does not extend to a right of assisted suicide. Accordingly the court concludes that there is no constitutional right which the State, including the courts, must protect and vindicate, either to commit suicide, or to arrange for the termination of one's life at a time of one's choosing."

The normative premise of the Bill appears to be that the perception of an individual person as to the meaning of life should prevail. The unstated assumption here is that society can have no value-position or understanding of the meaning of life. In fact, society, in the sense of the cumulative value-positions and cultural perspective of its members, does have such an understanding: it has a true world view, which endorses the worthwhileness of human existence, our interdependence, our place in the ecological system and our responsibilities to each other and to ourselves. Society is not some mere lifeless scaffolding that facilitates individual choices: it is a vibrant intergenerational culture, capable of affirming the worthwhileness of human existence and seeking to advance the good of its members. This is why we have laws protecting life and the environment, opposing injustice and discrimination.

Advancing the good of its members places on society the challenge of caring for their security, health and tranquillity, particularly where they are suffering or vulnerable.

The proposal that members of the medical profession should be involved in taking people's lives contradicts social solidarity. A person who intentionally takes his or her own life is not acting in isolation from others or from society.[3] Suicide can cause very significant pain and damage to others.[4] The Bill, if enacted, might place pressures on vulnerable, ill and older people to regard themselves as a burden on others.[5] On 25 January 2021, Gerard Quinn, U.N. Special Rapporteur on the rights of persons with disabilities, Olivier De Schutter, U.N. Special Rapporteur on extreme poverty and human rights; and Claudia Mahler, U.N. Independent Expert on the enjoyment of all human rights by older persons, issued a Joint Statement, in which they warned that, even when access to medical assistance in dying is restricted to those at the end of life or with a terminal illness, people with disabilities, older persons, and especially older persons with disabilities, may feel subtly pressured to end their lives prematurely due to attitudinal barriers as well as the lack of appropriate services and support:

"The proportion of people with disabilities living in poverty is significantly higher, and in some countries double, than that of people without disabilities. People with disabilities condemned to live in poverty due to the lack of adequate social protection can decide to end their lives as a gesture of despair. Set against the legacy of accumulated disadvantages their 'architecture of choice' could hardly be said to be unproblematic."[6]

Further, the Bill would destroy the honourable Hippocratic tradition of the medical profession and breach the trust between patients and doctors.

A society undergoes a profound cultural transformation if it authorises assisted suicide and the direct administration of lethal substances. Where it is permissible to take the lives of people with a terminal illness, there is no obvious, principled, objection to extending permission to other cases. Why should "tiredness of life" not be a reason?[7] Why should mature minors under the age of 18 be excluded? And what about people who are denied the opportunity to make a choice by reason of mental incapacity? Why not people with dementia? If doctors (as section 11(2)(c) of the Bill proposes) can in some circumstances directly take life, why not in other circumstances?[8]

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[3] Cf Dugdale, Lerner & Callahan "Perspectives Pros and Cons of Physician Aid in Dying" 92 Yale Journal of Biology & Medicine 747, at 749 (2019); Johnson, Altemus, Thibeau, Hunt & Wolff, "*13 Reasons Why:* Perceptions and Correlates of Media Influence in Psychiatrically Hospitalized Adolescents" (2020) Archives of Suicide Research, DOI: 10.1080/13811118.2020.1779155.

[4] Berardelli, Erbuto, Rogante, Sarubbi, Lester & Pompili, "Making Sense of the Unique Pain of Survivors: A Psychoeducational Approach for Suicide Bereavement" 11 Frontiers in Psychology 1244 (2020). Azorina, Morant, Nesse, Stevenson, Osborn, King & Pitman "The Perceived Impact of Suicide Bereavement on Specific Interpersonal Relationships: A Qualitative Study of Survey Data" 16 International Journal of Environmental Research & Public Health 1801, at 1801 (2019) report that,
"[a]lthough previously the WHO had estimated that each suicide left behind approximately 10 bereaved friends and family members, empirically-derived estimates suggest figures of between 60 and 135. People bereaved by suicide are at risk of a range of adverse mental and physical health outcomes, including an increased risk of suicide, suicide attempt, depression, and psychiatric admission. Their risk of suicide and of suicide attempt applies to non-genetically related contacts (spouses and friends), as well as blood relatives, indicating that the psychological (environmental) effects are **likely to have wide reach within the social networks of the deceased**."

[5] Cf Ahlzen,"Suffering, Authenticity, and Physician Assisted Suicide" 23 Medicine, Health Care and Philosophy 353, at 355 (2020).

[6] Office of the U.N High Commissioner on Human Rights, "Disability is not a reason to sanction medically assisted dying – UN experts" 25 January 2021 *hchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=26687&LangID=E#:~:text=Disability%20is%20not%20a%20reason%20to%20sanction%20medically%20assisted%20dying%20–%20UN%20experts&text=GENEVA%20(25%20January%202021)%20–,conditions%2C%20including%20in%20old%20age.*

[7] Cf Cohen-Almagor, "Euthanizing People Who are 'Tired of Life' in Belgium" in Jones, Gastmans & MacKellar (eds.), *Euthanasia and Assisted Suicide: Lessons from Belgium* (2017), 188.

[8] For a comprehensive analysis of the subject, see Keown, *Euthanasia, Ethics and Public Policy, An Argument Against Legalisation* (2nd ed, 2018).

(2) SPECIFIC PROVISIONS OF THE BILL

The Bill is poorly drafted. The following observations are designed to establish this fact and are certainly not intended to seek to improve the Bill, which is profoundly damaging to the common good and the protection of vulnerable people.

Section 1(1)

The short title to the Bill is misleading in failing to identify its true purpose, which is to render lawful the provision of assistance to the intentional ending of a person's life, as well, in the cases covered by section 11(5)(d), actually killing another person with his or her consent and direction.

Section 6

The section uses the expressions "medical practitioner" and "doctor" in a manner that is inconsistent with the other provisions of the Bill. This is probably attributable to defects in drafting, but, if it is intentional, raises further concerns.

In most of the Bill's provisions, the expression "registered medical practitioner" is used. This term, defined in section 2 by reference to the definition in section 2 of the Medical Practitioners Act 2007, has a clear meaning and forecloses debate about whether other people with medical qualifications are lawfully entitled to engage in the process of prescribing or in certain instances actually administering lethal substances. The use in section 6 of the expressions "medical practitioner" and "doctor" can only cause confusion. (A similar confusion arises in respect of the use of the word "doctor" in section 11(6) and (8).)

Section 7

Under section 7, an adult resident in Ireland is a "qualifying person" if he or she is terminally ill, has a clear and settled intention to end his or her own life and has made a declaration to that effect in accordance with section 9. There is no requirement that the intention to end one's life has to be in any way connected with the illness. Neither is there any requirement that the person be in pain or suffering. Nor is there any requirement that the person who wishes to end his or her life actually needs the assistance of the medical practitioner. The person, who may be well capable of ending his or her own life, may simply choose instead to avail himself or herself of the involvement of a medical practitioner in the process.

Section 8

Section 8 provides that, for the purposes of this Act, a person is terminally ill if that person has been diagnosed by a registered medical practitioner as having an incurable and progressive illness which cannot be reversed by treatment, and the person is likely to die as a result of that illness or complications relating thereto ('a terminal illness')". This definition is very wide. It captures illnesses that, on the doctor's own reckoning, may not result in death at all (as likelihood is a test falling considerably short of certainty) Furthermore, it captures illnesses that may not result in death for many years, perhaps decades.[9]

The definition may be interpreted as extending beyond physical illnesses to certain psychiatric illnesses[10] as it may be said of certain mental illnesses that they are progressive, irreversible by treatment and likely to result in the death of the person. It would be quite wrong to authorise medical assistance to terminate the lives of people with mental illness.

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[9] Moreover, there would inevitably be cases where the illness turned out not to have been terminal. In *Fleming v Ireland,* [2013] 2 ILRM 9, at 25-26, Kearns P, delivering the judgment of the Divisional High Court, noted that:

"cases of wrongful diagnosis of terminal illness are not unknown. Thus, when a Select Committee of the House of Lords set about examining the Assisted Dying for the Terminally Ill Bill, they were told by the Royal College of Pathologists in 2004 that:

'...post-mortem research and clinical audit studies performed in the UK, Europe, USA and many other countries consistently show about a 30% error rate in the medically certified cause of death [and that] significant error (i.e., misdiagnosis of the terminal illness resulting in inappropriate treatment) occurs in about 5% of cases.'

If the law were so liberalised, there would accordingly be the attendant risk that some patients who were so wrongly diagnosed might elect to opt for physician assisted suicide rather than endure the debilitating terminal illness which clinicians had, in fact, wrongly diagnosed.

Even if it is also allowed that cases of this nature would be exceptional or, at least, unusual, the fact remains that it is impossible to predict with accuracy the duration and course of a terminal illness."

[10] Cf Togliatti, "Systemic Psychology", in Carta, *Encyclopedia of Life Support Systems, Vol 1: Psychology* (UNESCO in association with EOLSS, 2009) 298, at 306.

Section 9
Section 9 requires the attending medical practitioner and the independent medical practitioner to be satisfied that the person has the capacity to make the decision to end his or her own life and has a clear and settled intention to do so which has been reached voluntarily, on an informed basis and without coercion or duress. The Bill does not provide any criterion for capacity in this context.

Section 10
Section 10 would not prevent the suicide by many people with an underlying psychiatric condition. There is no requirement for professional input by psychiatrists.

Further, the section ascribes capacity to people who choose to end their life on the basis of information given to them (possibly in "simple language") where they are unable to retain that information for more than "a short period". No indication is given as to how short this period might be. One can envisage cases where people with severe cognitive limitations are able, for only a few minutes, to understand and recall what was said to them.

Section 11
It may be noted, at the outset of consideration of this section, that it is plagued by a host of drafting defects, which render the overall meaning of this crucial provision unclear. Some of these defects are trivial, but others are so serious as to prevent the section from having any certain meaning. These defects are set out below.

The substance of the section, which reflects the policy of the Bill, is to authorise the active intentional involvement of medical practitioners in the taking of life. This is contrary to the common good and destroys the integrity of the medical vocation.

Specifically, subsection (2)(c) (with the drafting defect corrected) provides that, "in the case that it is not possible for the [qualifying person to] self-administer then the substance or substances may be administered". The doctor thus kills the qualifying person, with that person's consent. At present, conduct of this kind comes within the offence of murder. The word "murder" has a strong emotive impact in our society. This is because of the awesome implications of the act of intentionally taking another person's life. If our society sets aside its revulsion about taking the life of another person, it is rejecting the foundations of its philosophy of human life and human relationships and replacing it by a profoundly different set of values. No longer could it be argued that human lives are inviolable; it becomes a matter for debate in each new case of controversy. If euthanasia is permissible in one case, what principled basis is there for objecting to it in another case?

The drafting defects should be noted in detail:

In subsection (1), the word "a" is omitted between "prescribe" and "substance".

Similarly, in subsection (2)(a), the word "a" is omitted between "of" and "substance".

In subsection (2)(b), the word "those" is omitted between "or" and "substances".

Subsection (2)(c) is a crucial provision in the Bill, yet the provision, as it is drafted, is meaningless. It seems fairly clear that the words "qualifying person to" have been omitted between "the" and "self-administer".

There is an inconsistency between subsection (3) and section 2 of the Bill. Subsection (3)(a) provides that any substance or substances prescribed under subsection (1) shall only be delivered to the person for whom they are prescribed "(i) by the attending medical practitioner, or (ii) another registered medical practitioner who has been authorised to do so by the attending medical practitioner", yet section 2 defines "assisting medical practitioner" as meaning "a registered medical practitioner **or registered nurse** who has been authorised by the attending medical practitioner to deliver any substance or substances prescribed under section 7 of this Act". (Emphasis added.)

In subsection (5), first line, the words "or have" are omitted between "has" and "been".

In subsection (5)(b), the word "medicine" is used, instead of "substance or substances".

In subsection 5(d), the words "but the decision to self-administer or have administered the substance or substances must be taken by the person for whom the substance or substances has been prescribed" appear at the end of the sentence. It is clear that these words cannot qualify the earlier part of the sentence (which is premised on an inability to self-administer); the intention of the drafters may have been that these words should qualify the subsection as a whole rather than subsection (5)(d).

In subsection (6)(a), the word "have" should be "had".

In subsection (6), between Subsection (6)(a) and subsection 6(b), the word "or" is omitted.

In subsection (6), there should be a full stop at the end of subsection 6(b) and a new sentence should begin (preferably in a new sub-section) with the word "For".

In subsections (6) and (8), the word "doctor" is used. This can only cause confusion, as the comments in relation to section 6 above have already indicated.

Section 13

This section is completely unclear in its intended meaning; so far as it is possible to guess tentatively at what may be intended, the section is abhorrent. It is completely violative of medical ethics to require doctors and nurses to be indirectly implicated in a process of taking the life of another person. The section specifically violates the World Medical Association Declaration on Euthanasia and Physician Assisted Suicide, adopted by the 70th WMA General Assembly in 2019, that:

"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."

The lack of clarity about the section reflects a prior lack of clarity about what is envisaged by the drafters to be the extent of a person's entitlement to insist on receiving medical assistance in the termination of his or her life. Section 6 confers legality on the assistance given by the medical professionals (subject to adherence with the requirements of section 11), but it places no obligation on any medical professional to provide that assistance when requested. Thus, it deals only with cases where the medical professionals involved in the process have chosen to do so. Nowhere in the Bill is there any conferment on a person of a right to insist that any particular medical professional, or the medical profession generally, ensure that assistance is provided. The Supreme Court in *Fleming v Ireland*[11] has made it clear that there is no constitutional right to take one's own life or to require the assistance of any medical professional. The import of section 13, however, is that there is such a right. Subsection (2) provides that "Subsection (1) shall not be construed **to affect any duty to participate** in anything authorised by this Act". (Emphasis added.) No such duty is prescribed elsewhere in the Bill. One suspects that subsection (2), in referring to "any duty to participate", is intended actually to **create** such a duty. If that is so, the drafting is completely defective.

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[11] [2013] 2 IR 417.

(3) A BETTER WAY FORWARD FOR THE OIREACHTAS TO PROCEED

The Oireachtas, together with the Government, can do a great deal to improve the position of people who are contemplating suicide. We recognise that suicide should be discouraged and minimised in our society. That is why we admire the great work that is being done by organisations in this area. They should receive greater practical and financial support from the State and the State itself should invest a far greater effort, rather than subvert the message of hope and solidarity.

There is an acknowledged urgent need to improve the psychiatric services.[12] Physician assisted suicide would contradict rather than advance the necessary reforms.[13]

Palliative care should be given a central position in health policy. It has been observed that "Ireland would appear to have the most rapidly rising need for palliative care in Europe."[14] Far more needs to be done to support and expand these services.

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[12] See Kelly, "Irish Medical Organisation Doolin Memorial Lecture 2019: Rhetoric and Reality in Mental Health—Ireland and the World" 189 Irish Journal of Medical Science 1127 (2019).

[13] Cf Kelly, "Invited Commentary on .... When Unbearable Suffering Incites Psychiatric Patients to Request Euthanasia" 211 British Journal of Psychiatry 248 (2017).

[14] Kane, Daveson, Ryan, McQuillan, Higginson & Murtagh, "The Need for Palliative Care in Ireland: A Population-Based Estimate of Palliative Care Using Routine Mortality Data, Inclusive of Nonmalignant Conditions" 49 Journal of Pain & Symptom Management 726, at 729 (2015).

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