



## Submission on the “Dying with Dignity Bill 2020”

### Executive summary:

- Euthanasia and assisted suicide should never be an option.
- The introduction of the direct or indirect killing of a patient transforms and betrays profoundly the purpose of the health system and the role of doctors and nurses.
- Lifting the absolute prohibition of killing is not a small step, it is a fundamental cultural shift.
- The legalisation of killing in a medical context has a detrimental impact on society in general and on medicine in particular.
- It is an illusion to think that assisted killing can be allowed only in limited circumstances.
- Once introduced, with time, laws permitting assisted killing become less restrictive and the number of people who die as a result grows, together with the number of abuses of the legislation.

*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?*

According to its proponent, Deputy Gino Kenny, the Bill will “help to terminally ill people to control their own death when they decide their suffering is no longer bearable”<sup>1</sup>, even if there is no mention of suffering or control in the text.

The Bill aims at allowing patients who are in distressful circumstances due to illness, to kill themselves or to be killed by a medical practitioner.

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<sup>1</sup> <https://www.oireachtas.ie/en/debates/debate/dail/2020-10-01/speech/302/> .

It will affect directly anyone who has been diagnosed “an incurable and progressive illness which cannot be reversed by treatment”, even when death is not foreseeable, as the Bill has no time limit set. A person suffering of an incurable disease and who could live for 20 years would qualify.

The Bill will also affect indirectly the family members, friends and society. As we often hear, suicide does not end the pain but it just passes it on someone else.

The Bill is not based on evidence but on ideology. Evidence does not tell us if or when the State should facilitate suicide. Instead, the Bill is based on an erroneous understanding of dignity and autonomy.

*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?*

Killing a patient on request or facilitating suicide are criminal offences.

There are no other Bills or general schemes addressing the same issue.

All previous attempts to legalise assisted killing in Ireland have failed. In 2015, Deputy John Halligan presented exactly the same text of the Dying with Dignity Bill 2020 but the proposal stalled after the government collapsed the following year.

In 2018, the Oireachtas Joint Committee on Justice and Equality published a Report on the “Right to Die with Dignity” based on a series of hearings of experts in the field. The Report did not recommend legislative change.

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

Killing a patient on request or facilitating suicide are criminal offences in the large majority of the countries in Europe and also in the rest of the world. Legislation similar to the one that Deputy Kenny is trying to introduce is extremely rare. There are 44 countries in Europe and euthanasia is legal in only three of them (Netherlands, Belgium and Luxemburg) while assisted suicide is legal in two European countries (Switzerland and Germany).

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

The approach taken in the Bill is the worst possible to address the policy issue as it betrays the basic principles of medicine (to prevent, to cure and to take care). A doctor never kills. Patients deserve instead the best care and, when death approaches, the best palliative medicine.

*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?*

The Bill doesn't allow for any psychiatric evaluation of the person requesting assistance in suicide. Evidence shows that illness can lead to depression and suicidality, which are treatable with medication and psychological intervention. Unfortunately, the Bill does not require any intervention of a psychiatric expert and it does not offer alternatives to suicide, or to the administration of lethal drugs by a medical professional when the patients are not able to kill themselves.

*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?*

There are no other Bills or General Schemes addressing the same issue.

*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?*

Once we agree with the false notion that killing ourselves, with the help of others if needed, is a more dignified death than other alternatives, it becomes harder to restrict it. It would become more difficult, for instance, to refuse a 'dignified' death to a young person who felt that clinical depression was making their life 'unbearable'.

Involuntary euthanasia also becomes harder to resist. If we decide deliberate killing is compatible with this false understanding of 'dignity', then the way is paved to authorising the death of people suffering from severe dementia, and who are seriously ill in other ways, and cannot make a decision for themselves. There is an almost natural step from "this is *a* good option" to "this is *the* good option".

For vulnerable people – because this is precisely what we are discussing here – once assisted suicide becomes socially acceptable it also becomes the expected "choice". The experience of the few countries that have introduced assisted suicide – which is still banned almost everywhere – tells us that with time those laws become less restrictive and the number of people who kill themselves grows, together with the number of abuses of the legislation.

It is not surprising that soon or later the initial restrictions are lifted because if "dying with dignity" is preferable to alternatives, there is no compelling reason why it should be restricted at all. Also, it is not surprising that what is initially presented as a "choice" becomes a social norm. Legalisation means normalisation.

We are not saying that the proposal to allow a limited form of assisted suicide is bad because it could escalate. No, it is always wrong and it would be impossible to make a distinction between bad and good suicides.<sup>2</sup> It is wrong in itself and it is much easier to see why when we consider all the necessary and logical consequences of accepting a principle that initially is limited to restricted circumstances. Let's be clear, there is no dignity in suicide and those who perpetuate this notion are spreading a very dangerous idea. Practically, it is not feasible to craft legal criteria such as

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<sup>2</sup> Des O'Neill, "Matters arising from The BMJ's stance on assisted dying". *BJM* 2015; 351: h4883.

“unbearable suffering” or “terminal illness” with sufficient precision. Even more difficult it would be to police those criteria by the health professionals.

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

Yes. The introduction of assisted suicide will institutionalise discrimination towards patients and people with disability. Dr Lucy Thomas wrote recently on the *British Medical Journal*: “Medically assisted dying creates a differential healthcare response to patients who express a desire to end their lives, depending on the presence or absence of an eligible medical condition. In the absence of such a condition, doctors are expected to address issues amenable to intervention; to support patients in their struggle to rediscover meaning, value, and purpose; and to do everything possible to prevent suicide. By contrast, for eligible patients with a chronic or terminal illness or disability doctors are expected to assist them in ending their lives, thus formally validating the patients’ assessment that their lives are no longer worth living. Advocates for disability rights have highlighted how this distinction institutionalises deeply discriminatory attitudes about the relative value of different lives—in a context that equates dependence with burden and indignity and too often disempowers rather than enables people living with severe illness and disability.”<sup>3</sup>

This week the UN Special Rapporteur on the rights of the persons with disabilities, together with two other UN human rights experts, has denounced legislations enabling access to medically assisted dying based on disabling conditions, including old age. The UN experts said 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.”<sup>4</sup>

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

N/A

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

This is not clear as Deputy Kenny has not presented any implementation plan.

**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?***

N/A.

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<sup>3</sup> Thomas H Lucy, “Demedicalisation: radically reframing the assisted dying debate”. *BMJ* 2020; 371 :m2919.

<sup>4</sup> <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=26687&LangID=E>.

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

See answer to question n. 13 below.

*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?*

With more patients dying, the costs for the national health system will likely decrease but the legislator should resist the cynical temptation of introducing euthanasia for financial reasons and reject this Bill.

The Irish Association for Palliative Care has stated: “The acceptance of euthanasia could ultimately be used to contain healthcare costs and, as such, could be considered an option for people with serious illnesses, disabilities or those judged to have a poor quality of life. This could result in, not only a reduction in the resources available to treat and research these conditions, but, more importantly, a failure to protect some of the most vulnerable members of our society.”<sup>5</sup>

*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, the proponent of the Bill has not provided a cost-benefit analysis. The Bill will impact on the most vulnerable particularly those in palliative care, as with less demand, also less resources will be allocated in this area.

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

There is no “right to die” in the Constitution. When, in 2013, Marie Fleming challenged the ban on assisted suicide contained in the *Criminal Law (Suicide) Act 1993*, she lost her case. The Supreme Court said that the right to life does not import a right to die and there is no express right in the Constitution to commit suicide or to arrange for the termination of one’s life.

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

The ECHR has refused to overrule practices in Member States related to the end of life, leaving those matters to the national legislatures. Nonetheless, in the *Petty vs United Kingdom* case the ECHR held that the UK government was within its authority to ban assisted suicide based on its interest in protecting the most vulnerable.<sup>6</sup>

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<sup>5</sup> Irish Association for Palliative Care *Voluntary Euthanasia Discussion Paper* (2017).

<sup>6</sup> *Petty v. United Kingdom*, No. 2346/02 §§ 7, 32, Eur. Ct. H.R., Apr. 29, 2000.

*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?*

Yes. It is an illusion to think that assisted killing can be allowed only in limited circumstances.

From a theoretical point of view, if there is a “right to die”, then why should it be limited by the State? If it depends on the level of suffering, there will always be someone who suffers a bit less than what the law provides for and who still wants to avail of the same law. If there is a “right to die”, why should it be limited to those who suffer physically? All sorts of suffering should count. Moreover, why it should depend on personal autonomy? A doctor’s duty of beneficence is contingent to the patient’s autonomy and so, if medical assisted killing is beneficial, then it should be extended to incompetent patients such as infants.

From a practical point of view, every country that has initially accepted assisted killing in limited circumstances has later expanded the limits of the law, once enough time has passed. This liberalisation happens not only through legislation but also with the permissive interpretation of the law by courts, review committees and professional bodies.

In the Netherlands, euthanasia was initially introduced for terminally ill adults who were mentally competent. Then, step by step, it was extended to those with chronic condition, with disabilities, mental health problems and even to non-mentally competent children. This happened not through a modification of the legislation but with changing the interpretation of the law in courts or by medical professionals.

In April 2020, the Dutch Supreme Court cleared a doctor who administered euthanasia to a woman in the advanced stages of dementia who resisted death when the time came to give her a legal substance. Her family helped to hold her down. She had previously said she wished to be killed when she was no longer mentally competent. The Dutch parliament currently has before it a private members bill that proposes to offer euthanasia to anyone over 75, even healthy people. If this passes, the next step will be to lower the age limit or to remove it completely.

In Colombia, the Constitutional Court decriminalised euthanasia in 1997. In 2014, it established the “right to die with dignity” as a fundamental right and therefore subject to special legal protection. In 2017, this ‘right’ was extended to minors, who can avail of euthanasia even without consent from their parents, while parents can request euthanasia for their children if they are not able to express themselves.

In Canada, assisted suicide was introduced in 2016 for those who are in pain and for whom death is “reasonably foreseeable”, even if the condition is not terminal. But in 2019 the Supreme Court in Quebec deemed this requirement unconstitutional and ruled in favour of two people for whom death was not foreseeable but, nonetheless, they desired to die. The court decided it was discrimination not to extend the same right to the chronically ill who might be suffering.

In Oregon, in the US, the limits were expanded without even changing the law. With time, the Oregon Health Authority took an expansive interpretation of what constitutes a terminal illness, including conditions that if treated would be not terminal. Moreover, in 2019 they removed the 15-day waiting period.

In Belgium, euthanasia was legalized in 2002 for those with incurable conditions (not necessarily terminal) and in 2014 they allowed minors to access it. Other examples of this “slippery slope” could be mentioned.

There is a logic in all those developments. If choosing when and how to die is a right, why should it be limited and restricted? If killing is a solution to ‘unbearable suffering’, there is no compelling reason to limit its availability to one category of patients. Why only those with terminal illness? Why only to those experiencing physical pain? Why only adults? Why only mentally competent?

Medicine is based on the principle of doing no harm. The introduction of the direct or indirect killing of a patient transforms and betrays profoundly the purpose of the health system and the role of doctors. Lifting the absolute prohibition of killing is not a small step, it is a fundamental cultural shift. Everything else follows from such move and this is why it has to be **rejected without compromise**. Once the threshold is passed, it is only a matter of time before the next restriction is removed and it becomes hard, if not impossible, to go back.

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

Not that we have identified.

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

Once assisted suicide and euthanasia are introduced, the meaning of medicine will change and the deliberate killing of an innocent human being will be permitted on request. Suicide will be not only tolerated but offered by the State.

Currently, no one can be forced to avail of a medical treatment. Personal autonomy is fairly balanced with the State’s duty to preserve the lives of its citizens. The State does not impose treatments but, at the same time, it does not offer death.

If assisted suicide and euthanasia will be introduced by this Bill, health professionals will be asked to procure death rather than serve health and life. This is the reasons why doctors and disability groups are the most vocal opponents of assisted killing, in the world and in Ireland.

For instance, the World Medical Association has recently reaffirmed its long-standing policy of opposition to euthanasia and physician-assisted suicide. “The WMA reiterates its strong commitment to the principles of medical ethics and that utmost respect has to be maintained for human life. Therefore, the WMA is firmly opposed to euthanasia and physician-assisted suicide”, they stated at their 2019 annual conference, “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>7</sup>

The Royal College of Physicians in Ireland “officially opposes the introduction of any legislation supportive of assisted suicide because it is contrary to best medical practice.”<sup>8</sup>

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<sup>7</sup> World Medical Association declaration on Euthanasia and Physician-assisted suicide (13 November 2019).

<sup>8</sup> Royal College of Surgeons Ireland Assisted Suicide – Position Paper (2017).

The Irish Association for Palliative Care have stated in their *Discussion Paper* on euthanasia: “Trust is a key element of any patient-doctor relationship. The legalisation of euthanasia could lead to the erosion of trust between patient and doctor. ... The legalisation of euthanasia could put severe pressures on vulnerable groups such as the elderly and those with disabilities. Euthanasia, if seen as an acceptable normal response to old age or serious illness, could lead to denying the old, the ill, or those with disabilities their right to be treated as valued members of society. A cultural acceptance of euthanasia could lead to a dilution of the value of human life, resulting in people requesting euthanasia through being socialised into feeling that they are a burden on their families and on society. Euthanasia is illegal in Ireland and healthcare professionals must not participate in the deliberate killing of a patient. The Irish Association for Palliative Care recommends that there should be no change in the law in order to legalize euthanasia.”<sup>9</sup>

*20. Are appropriate administrative and legal arrangements necessary for compliance and enforcement of the provisions of the Bill included? (e.g. if draft Bill contains a prohibition, whether the necessary criminal sanctions - including the class of fine - are included).*

The “Dying with Dignity Bill 2020” has to be rejected entirely.

### **Conclusion**

We urge our representatives to reject this Bill entirely and affirm a culture of life that safeguard the most vulnerable.

We ask our representatives to hear the pleas of the health professionals, particularly of those working in palliative care, and offer everything that make our final days more dignified.

Suicide and the killing of a patient offend human dignity. When offered by the State they become normalized and even an expectation from those who feel that they are a burden to others.

For all those reasons, the Bill has to be rejected.

On behalf of *Family Solidarity*

Dr Angelo Bottone

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<sup>9</sup> Irish Association for Palliative Care *Voluntary Euthanasia Discussion Paper* (2017).