



**Submission
to
Oireachtas Committee on Justice
regarding the
Dying with Dignity Bill 2020**
Approved by Council January 2021

The College of Psychiatrists and Psychiatry

The College of Psychiatrists of Ireland (CPsychI) is the sole body in the Republic of Ireland, recognised by the Medical Council and the HSE, for the training of doctors to become specialists in psychiatry and for the continuing assurance of the career-long competence of specialists in psychiatry. As the professional body for psychiatrists, the mission of the College is to promote excellence in the practice of psychiatry and to advocate for the highest standards of care in our mental health services.

Psychiatrists have training in all aspects of mental health care, which includes expertise in mental health promotion, early intervention and management of all mental illnesses, including mild, moderate and severe mental illnesses. Psychiatrists work in a number of different places and wide-ranging services including hospitals, emergency departments, community mental health services, people's own homes, residential centres, nursing homes and prisons.

Within psychiatry there are a number of specialties. The College achieves its work through specialty Faculties (representing the specialist areas of psychiatry) Committees and Special Interest Groups. The College ensures all psychiatrists have access to training in biological, social and psychological aspects of mental illness, providing expert opinion on matters related to mental illness. The College recognises that each person with a mental illness requires a unique, personalised response which is delivered by different members of the primary care or secondary care multidisciplinary teams, and supports the delivery of mental health services through evidence based and recovery focused services.

Executive Summary

Doctors enter their profession with the expressed wish to heal, bring comfort to the suffering, and to provide compassionate care when faced with illnesses that cannot be cured, in the full knowledge that we will all face death at the end of our life's journey. With the tremendous advances in healthcare over the past century, along with an increasing focus on the rights of the individual to self-determination, there is an understandable wish to minimise suffering in all forms, and to maintain a sense of control in the face of death. In an effort to address these concerns, and the distress of those who face, or stand alongside those who face such challenges, the "Dying with Dignity" Bill seeks to legalise Physician-Assisted Suicide and Euthanasia, and to regulate it through

the involvement of doctors. However, it raises many serious concerns. We recommend addressing these essential issues through a broader piece of work, incorporating necessary improvements across a range of initiatives, including improvements in palliative care, the management of chronic pain, and enhanced supports for the ill and suffering.

The Bill states that it is an *“act to make provision for assistance in achieving a dignified and peaceful end of life to qualifying persons and related matters”* (Dying with Dignity Bill, 2020). Although these terms are not used in its wording, the Bill seeks to legislate for Physician-Assisted Suicide (PAS) and voluntary Euthanasia, which is fundamentally incompatible with the doctor’s role as healer. The Medical Council of Ireland in its *Guide to Professional Conduct and Ethics* expressly states (section 46.9) *“You must not take part in the deliberate killing of a patient”*. If enacted this Bill will result in a profound change in medical practice, affecting how doctors interact with patients who are terminally ill, but also how doctors view themselves as healers.

It is impossible not to be sympathetic to those with a terminal illness and sensitive to the worries and fears having a terminal illness creates. Whilst we all, as healthcare professionals, and as a nation, support a *“dignified and peaceful end to life”*, this is already the work of palliative care services, general practitioner, hospices, family and friends in Ireland. Contrary to popular belief, the interventions employed in physician assisted suicide and euthanasia cannot guarantee either death with dignity or avoidance of a lingering and painful death. We are deeply concerned that vulnerable people will choose euthanasia in a mistaken desire to relieve a *“burden”* on their loved ones.

The demand for Physician-Assisted Suicide and Euthanasia often rests on appeals for *“autonomy”*. Autonomy, like its opposite – dependence – is relational: human beings are inherently social, depending on others for their first moments until their last days. If assisted suicide is to be seen as a right of individuals facing intolerable suffering, there is no logic in denying this *“right”* to any individual wishing to end their life for any reason. Countries such as Belgium, the Netherlands, Luxembourg and Switzerland, for example, now permit Physician-Assisted Suicide and Euthanasia on the grounds of non-terminal illness, including mental illness. The UNESCO 2005 Universal Declaration on Bioethics and Human Rights recognizes this complexity, carefully balancing autonomy with responsibility and solidarity.

The Bill refers to the applicant’s *“clear and settled intention”*. Yet this is impossible to define, as people can change their minds on an issue at any point. For example, people who are suicidal can often express a *“clear and settled”* intention regarding their death, yet this can be a symptom of a treatable psychiatric illness. The process of adjustment in the face of serious illness requires a gradual transition through a range of emotions as part of the necessary adaptation to the challenges. Such emotions may range from shock and denial to anger and despair, intermingled with hope and acceptance, courage and serenity, often changing rapidly. The desire to hasten death for patients with terminal illness is strongly influenced by psychosocial and existential issues, and more clearly linked to depression, loss of hope and the fear of being a burden, than it is to severity of physical discomfort (Thomas, 2020).

In the face of suicide, psychiatrists act in the belief that human life is always worth saving. As a society, we robustly, and rightly, fight to prevent suicide. It makes little sense to be working hard as a nation to reduce our suicide rates while legalising assisted suicide and euthanasia. Rather, we should be pursuing the adequate resourcing of neglected areas of our health service, particularly in regard to chronic pain, disability and mental health services, as well as further developments in palliative care, to ensure that any individual who is even

considering assisted suicide has access to timely, appropriate and high-quality care to address their individual healthcare needs.

How one experiences their illness, relates as much to personal factors such as one's own coping style, social circumstances, and supports, as well as to one's interaction with healthcare providers and the health-service. For example, patients with chronic pain are at least twice as likely to report suicidal ideation or to complete suicide (Racine, 2018). In the U.S.A. state of Oregon, where PAS is legal, 'Inadequate pain control, or concern about it' affected one in three people who underwent PAS in 2019 (Oregon Death with Dignity Act, 2019). In Ireland, waiting lists for outpatient pain treatment are lengthy. As at January 2020, 11,932 people are on outpatient waiting lists, 3,034 of these more than 18 months (National Treatment Purchase Fund (NTPF) waiting list, 2020). Consultant pain specialists in Ireland have decried the absence of a biopsychosocial multidisciplinary model of pain management, and complain that they are, of necessity, a "procedure-driven" service. We support the view set out by our Palliative Care colleagues, who note that while PAS was determined as a right in Canada, no similar right was determined for access to palliative care, that fewer than 30% of Canadians have access to any form of palliative care, and that fewer than 15% have access to specialized palliative care (Herx et al., 2020; Shari et al., 2018). Patients have a right to adequate pain relief and palliative care, and the challenges in providing accessible multidisciplinary care for those with terminal illness, chronic illness, or indeed chronic pain, need to be adequately addressed. It is reasonable that patients should have easy access to such services early that can help treat pain, address fears, and support the person as they manage a chronic or terminal illness.

Of note, within the Bill being terminally ill is defined 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". This definition includes a vast range of long-term conditions including many cancers, diabetes, heart failure, depression, dementia, and schizophrenia, chronic illnesses which we cannot cure but we can help people to manage with the aim of maintaining a good quality of life. As psychiatrists, we are concerned that the enactment of this Bill may eventually lead to physician assisted suicide for people with mental disorders, as has occurred in in the Netherlands and Belgium. In both countries, such a request was initially excluded by the guidelines, yet this attitude has changed over time.

The College believes that the diagnosis of a terminal illness and the effects of this illness on a person do not remove their dignity. The College believes the Health Service should continue to strive for ways to continue to improve the quality of life, including management of pain, for those with a terminal illness, and restore their own sense of dignity in ways other than assisting one to end one's life. The Bill's failure to address the issue of dignity, apart from reference to it in the title, is noteworthy. (Sections 2 and 11 refer to "assistance in dying".) We therefore join our colleagues in the Royal College of Physicians of Ireland in not supporting this Bill (cf. RCPI Position Papers 2017 and update).

Many people across Ireland and internationally live productive, dignified lives with life-limiting conditions. The College consider it vital that the Government of Ireland, and the Department of Health, prioritise healthcare and supports for individuals living with disabilities and life-limiting or long-term conditions. Access to appropriate care, in a timely and appropriate manner, for these individuals should be the priority. The College consider that it is not appropriate to legislate for physician assisted suicide of individuals with life-limiting conditions; rather legislation should be proposed to enable people to receive appropriate health care in a timely and compassionate manner so as to promote and protect their dignity. Although described below are numerous defects in the Bill as drafted, the College does not support the Bill and believes that no changes can make it acceptable. The Health Service should continue to strive for ways to continue to improve the quality of life for

those with a terminal illness, including any associated loss of dignity, in all ways, other than by assisting one to end one's life.

Comment on Sections of the Bill

Short title and commencement – Dying with Dignity Bill 2020

The aim of medical doctors is to always enable patients to die with dignity, but also, and more importantly, to live with dignity. The aim of this proposed legislation is to enable assisted suicide and voluntary euthanasia.

Apart from the title, the issue of dignity is not addressed at all in the Bill (In Part 2, there is discussion about provision of "Assistance in Dying" and no reference to "Assistance in Dying with Dignity". Similarly, in Section 11, the procedure to be followed is titled "Assistance in Dying").

Section 7: Qualifying Persons

The Bill refers to the applicant's "clear and settled intention", yet this is impossible to define, as people can change their minds on an issue at any point. For example, people who are suicidal can often express a "clear and settled" intention regarding their death, yet this can be a symptom of a treatable psychiatric illness.

Section 8: Terminally ill

The definition of terminally ill is vague:

"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"

This might be interpreted to include a range of long-term conditions whether physical or mental, including chronic conditions like diabetes, heart failure and even schizophrenia, all of which are associated with mortality, and cannot be reversed, but are more correctly considered life-limiting conditions. This is likely to find extremely wide application.

How one experiences their illness relates as much to personal factors such as their own coping style, social circumstances, supports, as well as to their interaction with healthcare providers and the Health Service. For example, patients with chronic pain are at least twice as likely to report suicidal ideation or to complete suicide (Racine, 2018). In the USA state of Oregon, where physician-assisted suicide (PAS) is legalised, 'Inadequate pain control, or concern about it' affected one in three people who underwent PAS in 2019 (Oregon Death with Dignity Act, 2019). In Ireland, waiting lists for outpatient pain treatment are lengthy. As at January 2020, 11,932 people were on outpatient waiting lists, 3,034 of these more than 18 months (National Treatment Purchase Fund [NTPF] waiting list, 2020). Consultant pain specialists in Ireland have decried the lack of a biopsychosocial multidisciplinary model of pain management and the fact that they are, of necessity, a procedure-driven service. We support the view set out by our colleagues in Palliative Care who note that while PAS was determined as a right in Canada, no similar right was determined for access to palliative care. Less than 30% of Canadians have access to any form of palliative care and less than 15% have access to specialized palliative care (Herx et al., 2020; Shari et al., 2018). It has been questioned in Canada as to how euthanasia can truly be an informed choice

if there is no meaningful access to palliative care (Trachtenberg & Manns, 2020). The challenges in providing accessible multidisciplinary care for those with terminal illness and/or chronic illness or chronic pain needs to be highlighted. Patients should have easy and early access to services that can help treat pain, address fears and support the person as they manage a chronic or terminal illness.

As psychiatrists, we are concerned that the enactment of this Bill may eventually lead to physician-assisted suicide (PAS) for people with mental disorders. This has occurred in the Netherlands and Belgium. In all these countries, such a request was initially categorised as outside of the guidelines, yet this attitude has changed over time. In the Netherlands, the estimated total number of psychiatric patients explicitly requesting PAS in a one year period increased from 320 in 1995 to 500 in 2008 to 1,100 requests in 2016 (Denys, 2018).

Many people across Ireland, and internationally, live productive, dignified lives with life-limiting conditions. The College consider it vital that the Government of Ireland, and the Department of Health, prioritise healthcare and supports for individuals living with disabilities, chronic pain, and life-limiting or long-term conditions. Access to consultant led care in a timely and appropriate manner for these individuals should be the priority. It is not appropriate to legislate for physician assisted suicide of individuals with life limiting conditions while at the same time legislation does not exist to protect the health care access rights of these individuals, which would promote and protect their dignity.

Section 9: Declaration

Psychiatrists work within a legal framework - the Mental Health Act 2001. The legal process of a Mental Health Tribunal to review the detention of a person under the Mental Health Act 2001 is rigorous, and while it might be considered intrusive (into the doctor-patient relationship) it is justified, because involuntary admission limits human liberty.

This Bill does not propose any judicial or legal review of the declaration paperwork, or oversight, given that the issue relates to limiting human life. This Bill runs the risk of allowing doctors to unwittingly participate in assisting death for a person where there are procedural problems, and without any provision for adequate legal review prior to carrying out the act of assisted dying. A medical procedure is between the patient and their doctor and those involving legal procedures can add layers of complexity. Given the seriousness of the act of assisting death - potentially at an early stage of a patient's progressive condition - legal safeguards would be required.

Under the Mental Health Act 2001, when a treating consultant psychiatrist wishes to prescribe an antipsychotic medication to a patient with an acute psychosis who lacks capacity to consent to their treatment, an independent second opinion consultant is engaged to review the need for this treatment, in a process overseen by the Mental Health Commission. We compare these checks and balances for an antipsychotic treatment, the aim of which is to restore health and restore autonomy as well as promote dignity for the patient, with the very limited checks and balances in place in this draft piece of legislation with a sole purpose to end the life of the patient.

Section 10: Assessment of Capacity

The Bill sets out how to assess Mental Capacity using the four core tests as set out in the section. It does not, however, specify who shall assess capacity or what expertise they will have in doing so. In a general hospital

setting, the assessment of capacity is usually performed by the patient's primary physician and a second opinion sought, usually, by a consultant geriatrician or a consultant psychiatrist.

One of the important factors in assessing mental capacity is whether or not there is a contributing mental disorder which is affecting the making of the decision, but this is not included in the Bill. Another factor in addition to understanding the information given, is they must also believe it.

There is no provision for people to be given adequate and detailed information about the alternatives to euthanasia, and no provision whatsoever to ensure the rights of individual patients to access consultant-led care in a timely and appropriate manner to treat their illness.

The assessment of mental capacity is a decision-based assessment. It is based on the decision at hand. For example, someone might have capacity to decide where they live, but not to refuse treatment for a severe infection as they are confused and don't believe they are sick. For the principles of Autonomy and Non-maleficence to be given due regard it must be ensured that the assessments are carefully conducted, and that there is due regard for ensuring that the patient knows all the facts regarding all the options.

There is no pathway in this Bill for people about whom there is disagreement regarding mental capacity, i.e., if one doctor thinks the person has capacity, and another does not. It is not clear if a third doctor is required, or even a fourth? Nor is it clear who has the ultimate authority to make this decision. As the Bill stands, a person could attend doctor after doctor until they eventually find one willing to endorse their application.

The Bill does not specify which medical specialties the doctors assessing mental capacity and countersigning the declaration should be from, nor what degree of seniority is required. It does not state how far in advance the assessment of capacity can take place, nor how long it remains valid for. Again, this is in contrast to the Mental Health Act 2001, where the roles of assessing capacity and acting as the responsible treating consultant, or consultant psychiatrists offering opinions on mental health tribunal panels, are strictly limited to consultants on the relevant specialist register of the Medical Council of Ireland.

This Bill does not state if a co-decision maker or decision-making proxy can apply on behalf of a person for an assisted death, or on the role of Advance Care Directives. This Bill does not make reference to the current Assisted Decision-Making (Capacity) Act 2015, an Act that has yet to be fully implemented (commenced) and is lacking in resources for same.

Some people have treatable mental disorders which might be affecting their view of life, such as in the case of a depressive illness of which a central construct is "Beck's Triad" - negativity towards the self, the world and the future. Not everyone who has depression lacks mental capacity. When people are treated for depression, their suicidal wishes often resolve. This Bill fails to consider why someone might want to die, and whether they may have a mental illness which would benefit from treatment. Depression is common in people who have physical illness, and may be as common as 30% in those with a new diagnosis of cancer. We need to be mindful of not discriminating against patients with terminal conditions and co-morbid mental illnesses, and ensure they have the same rights to treatment as everyone else.

Some people with capacity may feel that the right thing to do to avoid being a burden is to request euthanasia. Vulnerable older people are at particular risk in relation to potentially feeling a burden on their children and/or

carers. This Bill risks placing those older people into a position where they feel they ought to agree to end their lives on this basis. We cannot support legislation that might place vulnerable older people into such a position.

Since the Bill regards those capable of retaining relevant information for only a short period, it would become legal for someone with early dementia, otherwise capable of many years of worthwhile life, to end their lives on receiving the diagnosis.

Section 11.2(c): Assistance in Dying

Physician-assisted suicide does not guarantee a dignified death. Interventions used in euthanasia are not always pain-free. Evidence from the Netherlands demonstrates that in one third of cases death can take up to 30 hours, and longer in a smaller number of cases.

This is a concerning clause:

“in the case that it is not possible for the self-administer then the substance or substances may be administered”.

It opens this legislation up to a huge potential for abuse. In the case where a capacitous person can physically ingest or self-administer lethal medication, one can - at least to a reasonable extent - conclude that they determined the moment of their death and chose to end their life. The risk, where this is not the case, is that a person has consented in theory to their life being ended, but at the moment of death may wish not to go through with it, while another person injects them with a lethal substance. This situation must not be allowed to occur.

This section seems designed not to exclude people whose physical incapacitation prevents them from ingesting or self-administering medication through usual means. However, in order to prevent assisted dying becoming accidental murder, the subject of the procedure must be the one to carry it out. This clause creates significant difficulties for oversight and safeguarding.

This Bill appears to serve a purpose as an extension to decriminalisation of suicide, whereby it means one has the right to end one's own life without fear of criminal sanction in the case of an able-bodied person but not in the case of a person who is physically disabled as to be unable to complete the act of suicide without assistance.

Section 11.3(c): Assistance in Dying

This states that death may be delivered after 14 days from the declaration (6 days in the case of likely death within one month – Section 11.4), but it does not state how long this remains valid for.

Section 12: Amendment of Criminal Law (Suicide) Act 1993

This section excludes any activity conducted under this Bill for the sanctions of the 1993 Act. At a time where there is public concern regarding mental health and suicide to a greater degree than ever before, it seems it undermines the valuable work done in addressing the causes of suicidality. We recognise that suicide is an act of despair or a symptom of a treatable mental illness, and we intervene, recognising that suicide is never a solution. It is unclear why this should be different in people with terminal illness. Indeed, it might be interpreted as discriminating against this group in its suggestion that we are not obliged to prevent their death by suicide by

treating any illness and alleviating their distress. Every other avenue should be explored to alleviate this despair – palliative care, pain relief and psychological help. There is some evidence internationally that suicide rates may increase following the legalising of assisted dying: the social contagion effect. It is important to avoid any suggestion that there are circumstances where society recognises or legitimises suicide as a reasonable step in the face of adversity or suffering. Over the past number of years, many agencies in Ireland have worked together to try to reduce suicides and raise awareness of this area. These include state agencies such as the HSE and Department of Health, the National Office of Suicide Prevention, the National Suicide Research Foundation, and other voluntary agencies such as Pieta House, and their ‘Darkness into Light’ movement. International evidence shows that bills that introduce physician assisted suicide normalise suicide. The College is concerned that this good work, achieved by so many groups, may be undermined by this legislation.

Section 13: Conscientious objection

There is a moral equivalence in performing an action (be it for benefit or for harm) and having someone else perform it. Compelling a conscientious objector to facilitate, by referral to another agent, an action such as euthanasia, which one finds morally repugnant, is a sham.

There is a certain logical difficulty in a rapid transition from a course of action being illegal, and punishable, to it being a course of action from which a clinician cannot easily be excused. This becomes even more fraught with concern where there are strongly held ethical views on this point.

Palliative medicine specialists provide expert end of life care, and most feel very strongly that assisted suicide is not ethical. The need to refer their patients to other practitioners for the purposes of assisted suicide would likely be felt by someone with strong views on the ethics of this process, as collusion, and not ethically acceptable.

Summary

The College of Psychiatrists of Ireland does not support this legislation. We are of the view that it will render vulnerable patients at risk and that it does not address the issues of dying with dignity. It rather seeks to introduce physician assisted suicide and euthanasia into Irish legislation, and we do not consider this to be of benefit to patients in this country. It makes little sense to be working hard as a nation to reduce our suicide rates while legalising assisted suicide and euthanasia. The government should instead move to put more resources into our Health Service, particularly in regard to supporting palliative care and mental health services. These must surely be resourced first, to ensure that any individual who is even considering assisted suicide has had access to timely, appropriate and high-quality care to address their individual healthcare needs. Addressing issues of pain management and disability, and having sufficient consultants appointed to offer truly high-quality care to individuals with such significant illnesses must be the mainstay of treatment and the priority approach by all physicians. We therefore join our colleagues in the Royal College of Physicians Ireland and the Palliative Care Consultants groups in advising the Government that we cannot support this legislation. Instead, as outlined, we advocate for improvements to our healthcare service to improve access, service delivery, symptom management and well-being in individuals with terminal and non-terminal illness

References

NOSP Report 2020. <https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/publications/nosp-annual-report-2019.pdf>

Dying with Dignity Bill 2020. <https://www.oireachtas.ie/en/bills/bill/2020/24/>

Medical Council Guidelines 8th edition 2019. <https://www.medicalcouncil.ie/news-and-publications/reports/guide-to-professional-conduct-ethics-8th-edition.html>

Denys, D. (2018). Is Euthanasia Psychiatric Treatment? The Struggle With Death on Request in the Netherlands. *Am J Psychiatry*, 175(9), 822-823. doi: 10.1176/appi.ajp.2018.18060725

National Treatment Purchase Fund. <https://www.ntpf.ie/home/nwld.htm>** As at January 2020, almost 64,907 people were awaiting orthopaedic appointments with almost 12,648 waiting more than 18 months. Similar patterns are seen for rheumatology appointments (17,853 waiting, 4366 more than 18 months)

Ilggen MA, Kleinberg F, Ignacio RV, Bohnert ASB, Valenstein M, McCarthy JF, et al. Non cancer pain conditions and risk of suicide. *JAMA Psychiatry*. 2013;70:692–7

Oregon Death with Dignity act 2019.

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

Medical Independent 2017. <https://www.medicalindependent.ie/advancing-pain-services-at-sivuh/>

Herx L, Cottle M, Scott JF (2020) The normalization of euthanasia in Canada: the cautionary tale continues. *World Medical Journal* 66(2): 28-37.

Racine M. Chronic pain and suicide risk: A comprehensive review. *Prog Neuropsychopharmacol Biol Psychiatry*; 2018; 87(Pt B): 269–280.

Shari MJ, Gingerich M. Endgame: Philosophical, Clinical and Legal Distinctions between Palliative Care and Termination of Life. *Second Series Supreme Court Law Review* [Internet]. 2018 Jun 21 [cited 2020 Feb 29]; 85: 225-293. Available from: https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3191962

Trachtenberg AJ, Manns B. Cost analysis of medical assistance in dying in Canada. *CMAJ* 2017 Jan 23;189: E101-5.

Thomas L. 2020. Demedicalisation: radically reframing the assisted dying debate. *BMJ* 2020;371