SUBMISSION FROM THE REPUBLIC OF IRELAND PANEL OF THE PRESBYTERIAN CHURCH IN IRELAND TO THE OIREACHTAS COMMITTEE ON JUSTICE ON THE DYING WITH DIGNITY BILL 2020

JANUARY 2021

Executive Summary

1. The Presbyterian Church in Ireland (PCI) has over 535 congregations across the island of Ireland, with almost a fifth of those in the Republic of Ireland. PCI offers this submission to the Committee on Justice based on the pastoral experience of its clergy, and informed by medical and legal expertise from within the denomination. The submission does not address every question in the *Framework for Committee Scrutiny of PMBs* but focuses on questions 4 and 8 under Part A, and questions 15-17 under Part B.

2. At its General Assembly annual meeting in June 2018 a paper was received establishing PCI's policy on the matter of Euthanasia and Assisted Suicide. It highlighted that "*intentional killing (as in euthanasia, assisted suicide and abortion) is wrong because it violates a profound moral order that human life really does matter and has innate value*.[1]" This belief provides the foundation for the content of this submission.

3. In addition, PCI notes that there is no support for this Bill from the Royal College of Physicians which in 2017 stated that "*The RCPI officially opposes the introduction of any legislation supportive of assisted suicide because it is contrary to best medical practice[2]";* or from the Irish Association for Palliative Care which has recommended that there should be no change in the law in order to legalise euthanasia[3].

4. Rather than introducing this legislation more efforts should be placed on ensuring that palliative care pathways are readily available and accessible across the country, particularly in areas where service provision is inconsistent – often away from larger urban regions. It is our contention that investing in palliative pathways rather than the proposals in this Bill provide a better way of increasing dignity and peacefulness around the end of life in Ireland for qualifying patients.

[1] 2018-PCI-Annual-Reports.pdf.aspx (presbyterianireland.org) (see page 185 – 194)
[2] Royal College of Physicians of Ireland Assisted Suicide – Position Paper December 2017, adopted by the Council of the Royal College of Physicians on 8th December 2017, avail available at https://rcpi-live-cdn.s3.amazonaws.com/wp-content/uploads/2020/02/Assisted-Suicide-Position-Paper-2017.pdf
[3] Irish Association for Palliative Care Voluntary Euthanasia Discussion Paper March 2011, available at http://www.iapc.ie/iapc-publications/voluntary-euthanasia-discussion-paper/

5. The components that contribute to a peaceful and dignified death extend to other domains beyond the physical. Our experience from sitting beside countless bedsides as pastors is that social, emotional, financial and spiritual factors all contribute. How people have lived also affects how they approach and manage the final phase of their lives. By focussing so restrictedly on the physical aspects of dying, the Bill fails to take account of the other factors which contribute to a dignified and peaceful death and which mitigate or exacerbate human suffering and distress. With such a limited understanding of the human condition, and specifically on the nature of dignity and peaceful dying, how can the Bill succeed with its stated purpose?

6. The Bill, as currently drafted, has the potential to create a number of unintended consequences with significant safeguarding gaps, risks associated with extending the provision to anyone resident on the island of Ireland for at least one year, and the potential for societal alienation.

7. With regard to specific legal considerations we consider that the Bill does not sufficiently vindicate the rights of citizens and is fundamentally flawed. The decriminalisation of suicide under the 1993 Act did not give rise to a constitutional right to end one's life. The Bill does not balance sufficiently the rights of all citizens – it leaves vulnerable members of our society open to abuse, duress or the weight of a perceived expectation that they will relieve others of the burden of caring for them; and it contains no robust or sufficient safeguards.

8. Moreover, the Bill is poorly drafted with defined terms lacking precision and thus open to either misconstruction or significant ambiguity. Different terms with similar meanings are used interchangeably in the proposed legislation, in a way that would give rise to significant uncertainty and confusion.

9. Improving the care needs of those approaching the end of life in a consistent manner, to help them to live as well as possible to the end of their lives, ought to be the focus. The true measure of any society is how it treats its most vulnerable and the Bill would increase, not lessen, their vulnerability. On that ground alone, the Bill should not proceed.

PCI Response

Background

1. The Presbyterian Church in Ireland (PCI) has over 217,000 members belonging to 535 congregations across 19 Presbyteries throughout Ireland, north and south. Just under a fifth of those congregations are in the Republic of Ireland, representing around 13,000 members, many from newcomer communities and with leadership from both men and women. As one of the minority churches in Ireland, PCI appreciates the opportunity to express its views with regard to the Dying with Dignity Bill 2020.

2. PCI Ministers through service to their own congregations, and as members of their local communities, seek to provide appropriate and sensitive pastoral care at all stages of life, at those times which generate much joy and happiness as well as those times which are filled with grief and sorrow. Many PCI clergy count it a real privilege to support and journey with families who are caring for a loved one coming towards the end of their life. Indeed, the restrictions placed on all of society over the past year to combat the global pandemic have been particularly difficult in this regard for clergy of all denominations seeking to care for and support, those experiencing bereavement.

3. Many of our members work in the health and social care sectors, and more still have experience of caring for a loved one as they approach their final days. This submission on the Dignity with Dying Bill 2020, which draws on medical and legal expertise from within the denomination seeks to recognise the complexity of the issues, whilst reflecting these lived experiences.

4. The General Assembly is the supreme governing body of PCI, and represents all individual congregations and oversees the various councils and committees that deal with the day-to-day running of the various aspects of church life. The Council for Public Affairs is authorised by the General Assembly to speak on behalf of PCI on matters of public policy. The Republic of Ireland Panel considers such matters within that jurisdiction.

5. At the General Assembly annual meeting in June 2018 a paper was received establishing PCI's policy on the matter of Euthanasia and Assisted Suicide.[4] It highlighted that "*intentional killing (as in euthanasia, assisted suicide and abortion) is wrong because it violates a profound moral order that human life really does matter and has innate value"*.

6. The 2018 report concludes as follows:

   "The current laws [on the island of Ireland] on assisted suicide and the guidance that has been given for their administration continue to provide a fair, balanced and compassionate approach to a difficult and complex issue. Christians should resist the legalisation of assisted suicide and euthanasia while urging government and wider society to adopt the other options that are available for the alleviation of pain and suffering. Resources must be given generously to support palliative care research and delivery because of the need and vulnerability of those affected. Facilities like the Hospice Movement must be encouraged. Above all, the Christian community should take the lead in showing the prayerful, dignified, respectful care which assures people that they are valued and loved, even in the midst of pain and helplessness."

[4] 2018-PCI-Annual-Reports.pdf.aspx (presbyterianireland.org) (see page 185 – 194)

7. Having set out this more general perspective the rest of this submission deals more specifically with the issues arising from the *Dying with Dignity Bill 2020* during this Committee Scrutiny stage of the legislation. The submission does not deal with every question in the *Framework for Committee Scrutiny of PMBS*[5] but primarily addresses questions 4 and 8 under Part A: Policy and Legislative Analysis, along with questions 15, 16 and 17 under Part B: Legal Analysis.

Part A: Policy and Legislative Analysis

Question 4: How is the approach taken in the Bill likely to best address the policy issue?

8. The Bill makes no clear statement as to why the law is required to change. It states its purpose as:

> *"An Act to make provision for assistance in achieving a dignified and peaceful end of life to qualifying persons and related matters."*

This prompts the following three distinct questions which are addressed in the following paragraphs:

i. Is the matter addressed in the Bill of real significance?
ii. Is the current law in Ireland in need of change to achieve the stated purpose of the Bill?
iii. Will the proposed changes to legislation be likely to achieve the stated purpose?

i. Is the matter addressed in the Bill of real significance?

9. We would contend that improving the care needs of those approaching the end of life consistently across Ireland is an issue of major societal importance, - to provide the expertise and support to help people live as well as possible to the very end of life. While Ireland has led the way in palliative care services much still needs to be done to ensure that such care is readily available and accessible across our land. As many have said in different ways, the true measure of any society can be estimated in how it treats its most vulnerable, and ensuring that those made vulnerable through illness and distress are well supported is a priority for us all. This would be fundamental to our beliefs and understanding as representatives of the Presbyterian community in Ireland.

10. In this regard our own statements in relation to this matter, for example as stated in paragraph 6 above, would concur with the Joint Committee on Justice and Equality – Report on the Right to Die with Dignity 2018:

> *"The Committee is of the opinion that assisted dying should never be contemplated due to inadequate or insufficient supports or as a substitute for a holistic framework of care. The Committee supports the recommendations contained in the Palliative Care Services Three*

[5] The Committee on Justice invites submissions on the Dying with Dignity Bill 2020. – Committee on Justice – 33rd Dáil, 26th Seanad – Houses of the Oireachtas

Year Development Framework (2017 to 2019) and urges the Minister for Health to ensure the recommendations are implemented in full. [6]"

11. A holistic framework of care is the means we support to achieve a 'dignified and peaceful death' for more people in Ireland in contrast to changing the law in relation to Physician Assisted Suicide/Physician Assisted Euthanasia (PAS/PAE). To achieve the stated aim, we would support the expansion of holistic palliative care services as a priority.

12. We note those most involved in the care of the dying in Ireland, members of the Royal College of Physicians, are not supporting a change in the law or advocating that such a change would achieve the stated aims of the Bill.

> *"That RCPI officially opposes the introduction of any legislation supportive of assisted suicide because it is contrary to best medical practice. That RCPI promotes a considered and compassionate approach to caring for, and proactively meeting the needs and concerns of patients who may be approaching the end of their life. That RCPI would as a body promote adherence to the Medical Council's current Guide on Professional Medical Conduct and Ethics for Registered Medical Practitioners guidance on End of Life Care.*[7]"

The Irish Association for Palliative Care (IAPC) is an all-island body with the purpose of promoting palliative care nationally and internationally. The IAPC has recommended that there should be no change in the law in order to legalise euthanasia[8].

ii. *Is the current law in Ireland in need of change to achieve the stated purpose of the Bill?*

13. The Bill has as its objective the provision for terminally ill people to end their lives with legally-supplied medication or, in some cases, to have such drugs injected into them by doctors, based on the supposition that such a change in the law will achieve the goal of increasing dignity and peacefulness around the end of life in Ireland for qualifying patients. We contend that changing the law in this way will not achieve this aim.

Physician Assisted Suicide

14. Under the Criminal Law (Suicide) Act 1993 suicide ceased to be unlawful in Ireland.[1.] However, it remains unlawful to aid, abet, counsel or procure the suicide of another person. A person convicted of such an offence is liable to a sentence of imprisonment of up to fourteen years. The Act states, however, that "*no proceedings shall be instituted for an offence under this section except by or with the consent of the Director of Public Prosecutions"*[9].

Physician Assisted Euthanasia

15. Currently there is no law specifically relating to PAE in Ireland. Deliberately ending the life of another person, with or without the victim's consent, constitutes murder and is contrary to the Criminal Justice Act 1964 and to common law.

---

[6] https://data.oireachtas.ie/ie/oireachtas/committee/dail/32/joint_committee_on_justice_and_equality/reports/2018/2018-06-25_report-on-the-right-to-die-with-dignity_en.pdf

[7] Royal College of Physicians of Ireland Assisted Suicide – Position Paper December 2017, adopted by the Council of the Royal College of Physicians on 8th December 2017, avail available at https://rcpi-live-cdn.s3.amazonaws.com/wp-content/uploads/2020/02/Assisted-Suicide-Position-Paper-2017.pdf

[8] Irish Association for Palliative Care Voluntary Euthanasia Discussion Paper March 2011, available at http://www.iapc.ie/iapc-publications/voluntary-euthanasia-discussion-paper/

[9] Criminal Law (Suicide) Act 1993, Section (4)

16. Most modern societies regard with compassion people who take or attempt to take their own lives. They do not, however, regard suicide as something that is to be assisted, aided or abetted. Indeed, the high rates of suicide across Ireland are a matter of grave concern and reduction of suicide is a priority[10]. The existing law in Ireland reflects these values. It forbids assistance with suicide while its requirement that no proceedings may be undertaken without the consent of the Director of Public Prosecutions recognises that such offences are sensitive and that there could be exceptional circumstances in which a breach of the law does not call for prosecution in the public interest. This combination of deterrence with discretion ensures that the offence of assisting suicide is rare, while the serious penalties that the law holds in reserve to deal with malicious or manipulative assistance ensure that the small number of cases that do occur tend to be those where there has been much soul-searching, reluctance and genuine compassion on the part of the assister.

17. The Bill sends the social message to people who are seriously ill that taking their own lives can be an appropriate course of action and it removes the deterrent against malicious assistance. Where assistance with suicide has been legalised, the death rate from this source has been seen to rise steadily. In the US State of Oregon, for example, the number of legally assisted suicides has risen twelvefold since the law was changed. Oregon's 2019 official death rate from this source is the equivalent of over 300 cases of assisted suicides annually in the Republic of Ireland if the law were to be changed along the lines of Oregon's law.

18. Where PAE has been legalised, the death rate from this source is even higher than for PAS. In the Netherlands in 2019 one death in every twenty-five from all causes throughout the country resulted from legalised PAE.

    The existing laws in this area in Ireland are not in need of change to achieve the intended aim. They combine deterrence of malicious or manipulative acts with discretion to deal appropriately with genuinely compassionate acts.

iii. Will the proposed changes to legislation be likely to achieve the stated purpose?

19. The components that contribute to a peaceful and dignified death extend to other domains beyond the physical. Our experience from sitting beside countless bedsides as pastors is that social, emotional, financial and spiritual factors all contribute. How people have lived also affects how they approach and manage the final phase of their lives. By focussing so restrictedly on the physical aspects of dying, the Bill fails to take account of the other factors which contribute to a dignified and peaceful death and which mitigate or exacerbate human suffering and distress. With such a limited understanding of the human condition, and specifically on the nature of dignity and peaceful dying, how can the Bill succeed with its stated purpose?

    Lack of evidence to support a law change

20. There is no clear evidence this Bill will achieve the "dignified and peaceful end of life" as is its stated aim. There is, however, evidence that while palliative care improves quality of life, palliative care provision across Ireland is inadequate[11]. The impact of this is evidenced in our lived experience, particularly amongst our rural and border congregations where the experience mirrors that of the National Clinical Programme for Palliative Care review which found that:

[10] gov.ie - Minister for Health and Minister for Mental Health extend National Suicide Reduction Strategy to 2024 (www.gov.ie)

[11] Adult Palliative Care Services Model of Care for Ireland: The National Clinical Programme for Palliative Care, Royal Physicians of Ireland. Published April 2019 PowerPoint Presentation (hse.ie)

"Access to palliative care and supporting services varies according to age, socioeconomic considerations, geographic location and diagnosis. Inequities in service provision includes access to GPs and other healthcare professionals providing palliative care approach services.[12]"

Evidence of unintended consequences undermining the stated purpose

21. There is evidence from legislatures that have passed such laws that restrictions on the qualifying persons are often reduced following on from initial legislation. For example, children are now eligible to request euthanasia in both Belgium and Holland (over the age of 12) and just three years after Canada changed its law a drive for extending the criteria for "physician assisted dying" to include minors and those with mental illness has begun.

22. The use of such legislation in other counties in relation to mental illness causes us particular concern. How can programmes seeking to reduce the high rates of suicide in Ireland not be undermined by such a change in the law?

Safeguards

23. The lack of adequate safeguards for vulnerable people within the legislation is a major impediment to the Bill achieving its stated aim.

- Suggested safeguards cannot be clearly defined in law, or at least have not been in other jurisdictions
- Without such safeguards there is real risk of abuse and coercion
- The monitoring of safeguards in jurisdictions with such legislation as the Bill proposes is weak and the Bill deals with the issue of safeguards without any detail
- Doctors are given responsibility within the Bill to ensure safeguards are adhered to yet they are not equipped to carry out such work.

The key role of doctors within the Bill

24. The Bill relies on the medical profession to both adjudicate and to facilitate PAE and PAS in Ireland. Yet the evidence is that the majority of doctors in Ireland do not want to participate in such work. With a majority of doctors refusing to engage, requests for PAS/PAE would have to be considered by a minority of referral doctors with no first-hand knowledge of applicants as patients. This is likely to add additional distress and concern to patients and families at a particularly sensitive time in their lives, the exact opposite of the peaceful and dignified end of life that the Bill seeks to support.

25. While the Bill makes some provision for conscientious objection we would express concern that doing so would not lead to any detriment professionally, for example in access to promotion opportunities. On the other hand, there do not appear to be any safeguards in place to protect the mental health and wellbeing of those doctors and medical professionals who will be involved at any stage of the process.

[12] PowerPoint Presentation (hse.ie) (page 25)

Question 8: Could the Bill, as drafted, have unintended policy consequences, if enacted?

26. One of our significant concerns with the proposed Bill is the potential for unintended consequences. The legislation represents such a break from the medical and legal norms of centuries that it is impossible to identify all the potential impacts that could result from such a radical change in practice and understanding as to the nature and value of human life and death. We focus on three areas, summarised under the following headings:

    a. Safeguarding
    b. Joint Jurisdiction risks
    c. Societal inclusivity and alienation

a. Safeguarding gaps in the legislation including;

27. No requirement for prognosis is specified, opening the Bill up to be used indiscriminately in a wide variety of chronic long-term conditions such as Parkinson's disease, Schizophrenia, Multiple Sclerosis or Diabetes. The Bill defines 'terminal illness' *as "an incurable and progressive illness which cannot be reversed by treatment"* and from which the person *"is likely to die as a result of that illness or complications relating thereto".* This lack of requirement for an estimation of life expectancy is different, for example, from Oregon's PAS law, which requires not only a diagnosis of terminal illness but also a prognosis of six months or less.

28. The only stipulation regarding the doctors involved in the process is that they have to be registered. No additional training is required. The attending medical practitioner can be the doctor who makes the terminal diagnosis whilst also the proponent of instigating PAS /PAE. This is a major conflict of interest and poses real concerns. One can speculate that if Dr Harold Shipman, from Manchester, had been able to operate under the terms of this Bill his activities may have gone on unchecked for much longer.

29. While the legislation requires patients to be informed of alternatives it fails to detail how this should be done. This omission could lead to people choosing to end their lives without awareness of all the options that exist to mitigate suffering. The Bill does not make clear what informing a patient about alternatives actually means nor who is responsible for the informing. The information conveyed by a palliative care professional may be very different from that provided by an ardent advocate of PAS/E.

30. The Bill requires the person to have *"a clear and settled intention to end his or her own life"* and that a doctor considering such a request needs to be "satisfied" that this is the case. The Bill is unclear as to what it means by this term and how the degree of settled intent will be adjudged. We anticipate that most of these assessments will be carried out by Doctors unknown to the patient undervaluing further the worth of this assessment of intent as an adequate safeguard measure.

31. The Bill does not require any form of mental health assessment. The 2018 Joint Committee Report (from the Justice Committee) raises the importance of ensuring: "*that persons requesting such assistance are not doing so out of compulsion or because their decision-making capacity is compromised by illness, anxiety or depression?"*[1] The Bill ignores this point.

32. The Bill does not require the explicit exploration of issues relating to possible coercion, which poses the question as to how effectively an unknown Doctor could be at assessing whether coercion is taking place or not. The potential for the Bill to be used inappropriately in a society

where elder abuse is a sad reality, where coercion is hard to identify, and where seeking an early death could be understood to be a kind act for one's relatives cannot be ignored. The 2019 official report of the Oregon Health Authority stated that six out of ten of those who took their own lives with legally-supplied lethal drugs had stated that one of their concerns was being a "burden on family, friends/caregivers"[13].

b. Joint jurisdiction risks

33. The Bill states, as one of its qualifying conditions for PAS/PAE, that an applicant must have been "*resident on the island of Ireland*" for at least a year. This would include the people from Northern Ireland where legally and professionally involvement in PAS and PAE could lead to imprisonment or being struck off the register to practice. This is likely to cause considerable confusion, legal uncertainty, stress and distress for both patients and professionals.

34. It also has the potential of causing some political tension if the legislation is seen as interfering in the care of patients in Northern Ireland where neither patients nor professionals have had their opinion sought around the need to provide support for families and patients choosing to travel across the border for PAS or PAE.

c. Societal inclusivity and alienation.

35. Modern Ireland prides itself on its inclusivity. However, historically minorities have not always been well tolerated. The Bill is likely to alienate a large minority of Irish society, including many Presbyterians, who disagree with such legislation because of firmly held ethical, religious and moral principles. While real alternatives to achieving the aim of the Bill exist which will not cause such alienation across our communities could the Oireachtas not engage with these proven alternatives first to achieve the stated aim before proceeding with unproven changes to the current legal framework?

Part B: Legal Analysis

36. Moving to the Legal Analysis, for the reasons set out below we consider that the Bill does not sufficiently vindicate the rights of citizens and is fundamentally flawed.

37. Legislation cannot pass into law without being signed by the President. Having regard to the nature of this legislation it is very likely that the President, having consulted the Council of State, would refer the Bill to the Supreme Court for a determination as to its constitutionality. If the Supreme Court decides that any provision of the Bill is repugnant to the Constitution then the President cannot sign the Bill and the Oireachtas must go back to the drawing board.

38. Where legislation is extremely vulnerable to a finding of unconstitutionality, as here, then very considerable scrutiny is appropriate. An analysis of the law as it stands suggests that there is little prospect of the constitutionality of the Bill being upheld.

[13] https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf

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

39. Article 40.3.1 Bunreacht na hEireann provides:

    "The State guarantees in its laws to respect and, as far as practicable, by its laws to defend and vindicate the personal rights of the citizen."

    Article 40.3.2 provides:

    "The State shall, in particular, by its laws protect as best it may from unjust attack, and in the case of injustice done, vindicate the life, person, good name, and property rights of every citizen."

40. Those provisions must be read in the context of the Constitution as a whole, McGee -v- Attorney General [1973] IESC2. The Constitution guarantees rights of general application for every citizen, not a limited class of persons, Fleming -v- Ireland [2013] IESC 19.

Question 16: Is the draft PMB compatible with EU legislation and human rights legislation?

41. Suicide is no longer a crime: s2(1) of the Criminal Law (Suicide) Act 1993, which provides that it is a crime to aid, abet, counsel or procure the suicide of another and that a prosecution may not be brought in that regard other than by or with the consent of the DPP. The decriminalisation of suicide under the 1993 Act did not, however, give rise to a constitutional right to end one's life: *Fleming*. So, while there is a constitutionally protected right to life, there is no right to die, and there is a positive onus on the State to protect life. Article 2 of the ECHR has also been found not to confer any right to die: Pretty -v- UK (Application No. 2346/02).

42. The courts in considering the precise issue sought to be addressed by the Bill have expressed deep concerns as to the risks of abuse inherent in legislating for a right to die. As the Divisional Court stated in Fleming -v- Ireland [2013] IEHC 2,

    "The detailed evidence available to us demonstrates that the State has established an ample evidential basis to support the view that any relaxation of the ban would be impossible to tailor to individual cases and would be inimical to the public interest in protecting the most vulnerable members of society. The evidence from other countries shows that the risks of abuse are all too real and cannot be dismissed as speculative or distant. One real risk attending such liberalisation is that <u>even with the most rigorous system of legislative checks and safeguards, it would be impossible to ensure</u> that the aged, the disabled, the poor, the unwanted, the rejected, the lonely, the impulsive, the financially compromised and emotionally vulnerable would not avail of this option in order to avoid a sense of being a burden on their family and society. The safeguards built into any liberalised system would, furthermore, be vulnerable to laxity and complacency and might well prove difficult or even impossible to police adequately (emphasis added)."

43. The ECtHR has also emphasised that the risks inherent in a system that facilitates access to assisted suicide "should not be underestimated" and that in such systems strict regulations are "all the more necessary", Haas -v- Switzerland (Application No. 31322/07).

44. *Fleming* suggests that no legislative scheme providing for PAS or PAE could pass constitutional muster in Ireland for the reasons expressed by the Divisional Court. Allowing, however, that on an interpretation of the Supreme Court judgment in *Fleming* it might be possible to legislate for

PAS or PAE in a manner that sufficiently vindicated constitutional rights, is there any basis on which the Bill could conceivably meet the necessary standard of a most rigorous system of legislative checks and balances?

45. The Bill plainly does not meet this standard. It does not balance sufficiently the rights of all citizens – it leaves vulnerable members of our society open to abuse, duress or the weight of a perceived expectation that they will relieve others of the burden of caring for them; it contains no robust or sufficient safeguards. It does not meaningfully even acknowledge the inherent risks identified in *Fleming* and *Haas*, or sufficiently provide for such risks; and it cannot vindicate the right to life guaranteed under the Constitution.

46. The existing law is balanced and compassionate, providing as it does for discretion as to whether a person found to have aided, abetted, counselled or procured another's suicide should be prosecuted. By contrast the Bill is contrary to public policy as clearly reflected in the Constitution and in decisions of the Courts interpreting its provisions.

Question 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?

47. In terms of the provisions of the Bill, it is poorly drafted, with defined terms lacking precision and thus open to either misconstruction or significant ambiguity. Different terms with similar meanings are used apparently interchangeably in the proposed legislation, in a way that would give rise to significant uncertainty and confusion.

48. By way of example, the term 'healthcare professional' is so widely defined as to permit anyone styling him or herself as a healthcare professional to fall within the protections of the legislation, without any qualifications or accreditation. The term 'medical practitioner' is used, but not defined. The term 'doctor' is similarly used without any definition.

49. It is not possible to identify with any reasonable clarity what would constitute a terminal illness and the criteria applied to it are not rigorous, as already identified above. For example, in some jurisdictions where PAS and PAE have been legislated for, depression has been found to constitute a sufficient basis for assisting the ending of life. The vagueness of the terminology here is likely to give rise to considerable uncertainty as to which medical conditions fall within the provisions.

50. Other examples of concern are that a qualifying person is to be "fully informed' of the palliative care options available but there is no requirement that he or she understand those options. The term "failing to make the decision" in Section 5(2) strongly reeks of duress or at least promotes an intolerance of indecision which may render the vulnerable even more vulnerable to the processes and supposed safeguards sought to be outlined.

Conclusion

51. If the Oireachtas wishes to legislate for a regime of assisted suicide, then this Bill is not remotely an adequate means for any such fundamental legislative change. It is, in any event, impossible (as stated by the Divisional Court in *Fleming*) to protect the aged, the disabled, the poor, the unwanted, the rejected, the lonely, the impulsive, the financially compromised and emotionally vulnerable if legislating to permit assisted suicide, even with the most rigorous system of legislative checks and safeguards. The vulnerable in our society would be substantially at risk of abuse under the proposed regime.

52. As stated by the Divisional Court in *Fleming*,

    "The Court finds that the State has provided an ample evidential basis to support the view that any relaxation of the ban on assisted suicide would be impossible to tailor to individual cases and would be inimical to the public interest in protecting the most vulnerable members of society.

    A further point of some importance is that if physicians were to be permitted to hasten the end of the terminally ill at the request of the patient by taking active steps for this purpose this would be to compromise – perhaps in a fundamental and far-reaching way – that which is rightly regarded as an essential ingredient of a civilised society committed to the protection of human life and human dignity. It might well send out a subliminal message to particular vulnerable groups – such as the disabled and the elderly – that in order to avoid consuming scarce resources in an era of shrinking public funds for health care, physician assisted suicide is a "normal" option which any rational patient faced with terminal or degenerative illness should seriously consider."

53. Accordingly, as submitted above, improving the care needs of those approaching the end of life consistently, to help them to live as well as possible to the end of their lives, ought to be the focus. The true measure of any society is how it treats its most vulnerable and the Bill would increase, not lessen, their vulnerability and on that ground alone should not proceed.