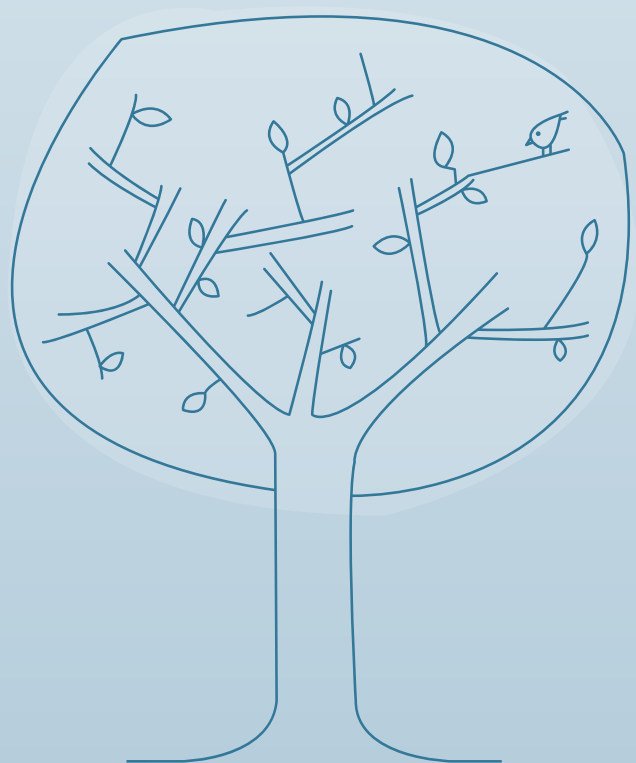


Irish Association for Palliative Care

Position Paper on Assisted Dying

Following NALA plain English guidelines

May 2023



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1. Executive Summary

We do not support any change in the law to legalise euthanasia or Physician-Assisted Suicide. We endorse the right of the competent, informed patient to refuse medical treatment, even if this leads to their death.

Palliative care focuses on quality of life, and providing multidisciplinary, holistic care to people with life-limiting conditions, and their families. Palliative care can provide care not just at the end of someone's life but at any stage of a life-limiting illness.

Palliative care should exclude any action or treatment designed to cause a patient's death.

In the Irish Association for Palliative Care (IAPC) we have put together this position paper, explaining why using euthanasia and Physician-Assisted Suicide (PAS) is incompatible with the goals of palliative care.

In this position paper, we explore patient autonomy. This includes supporting a patient's right to make choices, including the right to refuse treatment, and to make advance healthcare decisions.

We discuss management of symptoms, and appropriate care to support dying patients to die with dignity. We examine the risks of coercion, both intended and subtly implied.

We look at the experience of other jurisdictions and healthcare systems where euthanasia and PAS have been introduced.

Palliative care is vital for all who need it. We acknowledge the suffering of those with serious medical illnesses. Our focus is to help people experiencing physical and other distress, by alleviating their suffering, rather than ending their lives.

This position paper represents a general agreement among the members of the Irish Association for Palliative Care (IAPC). The views of some individuals within the organisation may vary from those in this position paper.

The IAPC Ethics Forum produced this document. This forum is a multidisciplinary committee made up of members from the IAPC.



2. Glossary

- Advance healthcare directive** A document which sets out a person's instructions for the healthcare treatments they wish to refuse or would like to request in the future, when they no longer have the capacity to do so.
- Health Service Executive, 2023
- Assisted dying** Where a person is helped to end their life by being prescribed or given certain lethal medication by a clinician.
- College of Physicians and Surgeons of British Columbia, 2022
- Euthanasia** When a doctor, at the voluntary request of the person who has decision-making capacity, intentionally causes the death of a person by giving them drugs or by carrying out an intervention.
- World Medical Association, 2019.
- IAPC** Irish Association for Palliative Care.
- MAID** Medical Assistance in Dying. (See Assisted dying).
- Palliative care** Palliative care is care that improves the quality of life of patients and their families who are facing the problems associated with life-limiting or life-threatening illness.
- Palliative care prevents and relieves suffering by identifying problems early; and by accurately assessing and treating pain and other physical, psychosocial and spiritual problems.
- World Health Organization, 2015.
- PAS** Physician-Assisted Suicide describes when a physician, at the voluntary request of a person with decision-making capacity, enables that person to end their own life. They do this by prescribing or providing medical substances with the intent of bringing about death.
- World Medical Association, 2019.



3. Introduction

Palliative care always respects the integrity, individuality and unique worth of each person regardless of their ability or functional status. Palliative care recognises that it may not be possible or appropriate to postpone death, but, equally, death must not be hastened.

For those in the terminal phase of their illness, palliative care is about care for people with a life limiting illness, not about ending life.

Pain is not a primary reason why people seek euthanasia or PAS.

Requests for euthanasia or assisted suicide are often motivated by fears of:

- loss of autonomy
- loss of dignity
- reduced quality of life.

Other motivations include worries of:

- uncontrolled physical or psychological suffering
- the possibility of being subjected to treatments that are,
 - inappropriate
 - burdensome
 - ultimately not beneficial.

– (Emanuel et al., 2016)

In this position paper we acknowledge that all actions must be weighed up against potential benefits, risks, alternatives and consequences. We acknowledge that people on all sides of the discussion on euthanasia and Physician-Assisted Suicide are motivated by compassion and a keenness to support people through to the end of their lives.



4. A patient's right to make treatment decisions

An integral part of the right to consent to medical care is the right to refuse treatment even if that treatment will prolong life. This right is recognised both legally and ethically.

– (Medical Council 2019)

All patients are assumed legally to be competent to make decisions. If there are any doubts about this, one or more clinicians can assess them.

We endorse the right of the competent, informed patient to refuse medical treatment, even if this leads to their death.

The situation is more complex when an individual patient is unable to make decisions about their treatment options independently. Sometimes the patient has written an advance healthcare directive, and their decision covers the situation that has arisen. In these circumstances, the advance healthcare directive should be followed.

This should be done in line with the

- Irish Medical Council guidelines (Medical Council, 2019)
- The Assisted Decision Making (Capacity) legislation (Assisted Decision-Making (Capacity) Act, 2015; and Assisted Decision-Making (Capacity) (Amendment) Bill, 2022).

An advance healthcare directive has the same ethical status as a decision made by a patient at the actual time of an illness.

This means the decision should be respected as long as:

- it was an informed choice
- it covers the situation that has arisen
- the patient has not changed their mind.

– (Medical Council, 2019)



Sometimes no advance healthcare directive exists and a person may need assistance in making decisions. In this case, decisions should be made in line with the person's will and preference alongside any decision-making supports that may be in place (Assisted Decision-Making (Capacity) Act, 2015).

Although a patient may request a certain treatment or procedure, they cannot force a physician to comply with the request. This is especially true if the treatment or procedure is unlawful or of no medical benefit.

The risks and benefits of continuing treatments should be reviewed to make sure that the most appropriate care is being provided. Doctors are not obliged to initiate or persist with treatments that are disproportionately burdensome.

– (Medical Council, 2019)

Palliative care emphasises good communication between patients and healthcare professionals and the collaborative nature of care. Establishing trust between the patient and the healthcare team is vital so that patients know that their wishes will be respected, even when they are no longer able to voice them.

Trust is a key element of any patient-doctor relationship. The legalisation of euthanasia or PAS could lead to the erosion of trust between patient and doctor.

– (Hudson et al., 2015)



5. Treatment of symptoms

Both the Irish Medical Council (Medical Council, 2019) and Nursing Midwifery Board of Ireland (NMBI) (Bord Altranais agus Cnáimhseachais na hÉireann, 2021) have issued guidelines. They say that when death is imminent, it is the professionals' responsibility to make sure that a patient dies with dignity.

Basic principles of palliative care require that doctors offer patients appropriate medication to make sure that they are comfortable and pain free. This may include analgesia and sedative medication.

There is no evidence that the judicious use of strong painkillers (opioids) shortens life.

– (Sim et al., 2014)

We recognise that, for a variety of reasons, a patient in the final days and hours of life may experience restlessness and agitation. The clinician must regularly reassess the patient to identify potentially reversible causes of this.

Sometimes, it is necessary to use sedative medication in the final stages of life to achieve an acceptable level of patient comfort.

– (Cherny & Radbruch, 2009)

The dosage of medication one patient needs may vary significantly from that of another. It is the clear duty of the doctor to make sure that a patient dies with dignity and with as little suffering as possible.

The doctor should not withhold treatment to relieve distress as long as they act in accordance with responsible medical practice, and seek advice when necessary.

Doctors and healthcare professionals should treat physical and psychological symptoms, optimise social support and address the spiritual concerns for patients and their families. They must avoid injury or harm to their patients.



6. Personal autonomy

Even with excellent health services, including a palliative care service, it will not eliminate all requests for euthanasia or PAS. Requests for euthanasia or assisted suicide are often motivated by fears of loss of autonomy (Emanuel et al., 1996). Healthcare professionals have a duty to provide care that respects the values and wishes of patients. They must aim to enhance the patient's personal autonomy and sense of self-worth. Some patients may consider euthanasia or PAS as an expression of this personal autonomy. However, individual autonomy needs to be balanced against the rights of others, and the needs of society as a whole.

It is particularly important to consider the rights of those who are more vulnerable, due to:

- **health status**
- **frailty (a group of older people with reduced function and health)**
- **social status.**

Respecting a patient's right to autonomy does not mean individual health professionals must honour requests for euthanasia or PAS. The practice of euthanasia or PAS results in the death of a person. This is contrary to the principle of 'avoiding harm' which is the most fundamental principle governing the doctor-patient relationship. The health professional must consider the harm which could ensue for the patient, for society and for other healthcare professionals if they did honour such a request. Our focus should be on supporting people experiencing physical and other distress, rather than seeking to end their lives.



7. Dignity

Justice is generally interpreted as fair, equitable, and appropriate treatment of people. The dignity of each person is not only a fundamental right in itself but is the real basis of all fundamental rights. The 1948 Universal Declaration of Human Rights enshrined human dignity in its preamble

“Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world.”

– United Nations, 1948

Some people associate the loss of physical and cognitive functioning which can occur at end of life as being synonymous with a loss of dignity. They see euthanasia or PAS as a solution to this, however, human dignity cannot be lost through illness or disability. Human dignity is inherent in each person. This is affirmed in the Universal Declaration of Human Rights.

“All human beings are born free and equal in dignity and rights.”

– United Nations, 1948

Medical, nursing and other health professionals have a duty to:

- **provide dignity in care**
- **optimise the person’s comfort**
- **prevent suffering.**

This can be achieved without hastening death and shortening a person’s life.

It is important to recognise the dignity of the lives of those affected by:

- **disability**
- **long-term health conditions**
- **lower socioeconomic status.**



Euthanasia and PAS are legalised in Canada and the Benelux countries. The UN Special Rapporteur for Disabilities stated its concern about the risk to persons with disabilities from Canadian MAID practices (Devandas-Aguilar, 2019). These countries have shown the potential impact of relaxing criteria for euthanasia and PAS in practice on people living in poverty (Zhu, 2022).

In Canada, a cost analysis demonstrated the net reduction of healthcare costs that result from the introduction of MAID (Office of the Parliamentary Budget Officer, 2020). It is stressed that this report should in no way be interpreted as suggesting that MAID be used to reduce health care costs. We also stress that;

Potential financial savings should not guide decision making about assisted dying at an individual level.

– (Trachtenberg & Manns, 2017)

Quality of life is not measured simply in terms of physical wellbeing or productivity. It can be enriched at a profound level, even for those who are severely ill. We need to support and affirm the meaning in people’s lives, learn what is intolerable and respond to people’s needs.

– (American Medical Association Council on Ethical and Judicial Affairs, 2019)



8. Coercion

When someone has the option to choose euthanasia or PAS, the key risk is that they may not make that choice freely.

People respond to the wishes and feelings of others, especially when they depend on them for care. Healthcare professionals or others may not be able to identify coercion whether it is stated or implied.

Issues like depression, loss of hope and the fear of being burdensome are more clearly linked to a desire to hasten death for terminally ill patients than the severity of physical discomfort.

–

(Racine, 2018)

The ban on healthcare professionals shortening a person's life protects those who feel they ought to die. It protects vulnerable patients who may be basing their decision to die on things that can be addressed like a sense of being a burden or mental health conditions.



9. The legalisation of euthanasia

The introduction of legislation to legalise euthanasia or PAS usually includes safeguards that limit when it can be used. These are designed to avoid misuse of euthanasia or PAS.

In jurisdictions where euthanasia or PAS have been legalised (including Belgium, Netherlands and Canada), safeguards have changed over time. Eligibility for euthanasia or PAS has been expanded in Belgium to include children (Kelly, 2014), the Netherlands to include infants (Verhagen & Sauer, 2005) and Canada to include people with disabilities whose deaths are not foreseeable (Government of Canada, 2021). Palliative care physicians in Canada have published their concerns about how it is becoming normal to use euthanasia or PAS in society (Herx et al., 2020).

There is a concern that life would be devalued in society and there is a fear that euthanasia or PAS could support a belief that certain types of life are not worth living and are of lesser value.

– (Royal College of Physicians Ireland, 2021)

There has been concern expressed in international literature, by healthcare professionals and by medical professional bodies that legislation for assisted dying will shift the focus away from the development and delivery of palliative care services (Royal College of Physicians Ireland, 2020, Mathews et al., 2021 Ho et al., 2021).

The focus should be on making sure that patients have access to resources and discussions about their end of life and dying. Healthcare professionals need to be upskilled and supported so they feel able to engage in conversations about death and dying with their patients.

Too few healthcare professionals are aware of options for end-of-life care. This raises concerns that patients may ask for euthanasia or PAS because they fear physical suffering that could in fact be relieved.

– (American Medical Association Council on Ethical and Judicial Affairs, 2019)



10. Conclusion

We are against any change in the law to legalise euthanasia or PAS. We acknowledge the suffering of those diagnosed with serious medical illnesses. Solutions lie in improving palliative care and social conditions and addressing the reasons for euthanasia or PAS requests. The solution is not to change legal and medical practice to allow such requests.

We endorse the importance of access to palliative care for all who need it.

The IAPC Ethics Forum prepared this policy paper on behalf of the IAPC multi-disciplinary membership.

This position paper follows NALA plain English guidelines.



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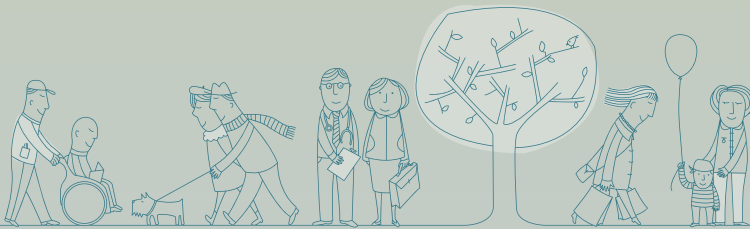


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Established in 1993 as an all-island body with the purpose of promoting palliative care nationally and internationally, the Irish Association for Palliative Care (IAPC) is a multidisciplinary membership non-government organisation. The intention of the founders was that IAPC would be identified by its inclusiveness and would encompass the whole island of Ireland.

The IAPC membership reflects the entire spectrum of all those who work in or have a professional interest in the provision of palliative care. This includes doctors, nurses, social workers, chaplains and pastoral carers, pharmacists, psychologists, physiotherapists, occupational therapists, dietitians, as well as executive staff, academics and educators. Membership also includes clinicians and allied health professionals working in related areas such as geriatrics, oncology, psycho-oncology, paediatrics, and pain management.

The IAPC is organised around a number of working groups designed to create forums aimed at promoting best practice, professional development, research and learning in palliative care. education and research.

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