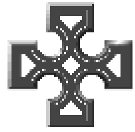

CHURCH OF IRELAND

Church and Society Commission

Church of Ireland House, Church Avenue, Rathmines, Dublin 6 D06 CF67

Tel: (+3531) 4978422
Fax: (+3531) 4978821
Email: office@rcbdub.org

28/01/2021

Committee on Justice
Leinster House
Kildare Street
Dublin
D02 XR20

Dear members of the committee,

The Church and Society Commission (CASC) of the Church of Ireland has prepared the following response to and comment on the proposed Dying with Dignity Bill 2020.

CASC is an advisory group, serving the Standing Committee of the General Synod, and engages with legislatures and governments on a variety of issues, including legislation. The mission of CASC is to provide oversight and direction for the Church of Ireland's work, in respect to social theology in action. CASC's views only become representative of the Church of Ireland after being approved by its General Synod.

Yours Sincerely,

Rev Dr Rory Corbett
Rt Rev Dr Kenneth Kearon (Chair)

Church and Society Commission
Church of Ireland

The Church of Ireland's fundamental position on assisted suicide and related end-of-life issues has been previously articulated in a CASC discussion paper, adopted by the General Synod of the Church of Ireland in 2018[1].

With particular reference to the present Bill being considered at Committee stage, we would wish to discuss the Ethical issues that are raised and secondly comment on deficiencies that we perceive in it.

Dying with dignity or assisted dying, despite being an euphemistic term, is still suicide, and this Bill not only changes the law to allow assistance to someone wishing to commit suicide, but also introduces the legalising of euthanasia, that is the killing of another human being.

We would wish to argue against the advancement of this Bill on an ethical basis and also on the basis of significant deficiencies in the wording of the Bill in its failure to adequately protect the patient requesting and also the medical practitioner, who might actually administer the fatal drugs.

We would base the ethical argument on four principles, which for us, as a Church, are based in scripture, but would be consistent with arguments from non-faith as well as other faith groups. The four principles are an affirmation of life, care of the vulnerable, a caring and cohesive society, and respect of the individual (autonomy). We do not propose to address directly the Beauchamp and Childress principles of beneficence, non-maleficence, equity (justice) and autonomy[2], but they will be included indirectly.

1. **Affirming life**. This acknowledges that both the right to life and subsequent legal protection of life, form the foundations not only of human rights law but also much of the criminal code. It is assumed that this would be the case where a person collapses, e.g. from a heart attack, that all efforts are made to resuscitate them unless there is known information to the contrary. The assisted dying scenario is the antithesis of this whereby medical professionals are being asked either to assist or to actively terminate life.

   Beyond the legal underpinning affirming life is an acceptance that each individual life has purpose, value and meaning, even if some individuals doubt that for themselves. It also encourages striving to attain the highest quality of life possible for every person. It is part of the Christian tradition to assert that every person's life is of intrinsic value, but we can get to the same position of intrinsic value from a secular position in that our healthcare is predicated on this in the time, money and energy expended on prevention of suicide programmes, premature baby care, or care for those living with dementia.

   Individuals' views of their own lives do matter, but we do not need to agree if they were to suggest that their lives were worthless. Individual autonomy is not the same as untrammelled autonomy, which can lead to negation not to affirmation. Similarly, quality of life can also be misused to suggest that the value of a person's life can be decided by others. It can lead to an assessment of what a person can do, and not who they are, and worse, what they can contribute to society. To bring someone's life to an end is not life-affirming. To kill in self-defence may be necessary but is still not life-affirming.

---

[1] Church and Society Commission. 2018. *Discussion Paper on Euthanasia and Assisted Suicide*. https://www.ireland.anglican.org/resources/508/euthanasia-and-assisted-suicide-discussion

[2] Beauchamp, Tom L., and James F. Childress. 1979. *Principles of biomedical ethics*. New York: Oxford University Press.

2. **Caring for the vulnerable**. A civilised society does care for its vulnerable members but, unfortunately, this too often, this principle has not been supported by history or even present events. Society may try to set out to protect its vulnerable but is blighted by child abuse, domestic abuse, and elder abuse. We only have to look at the effects that COVID-19 is having on these abuses to worry at any loosening of the law and its protection.

   If anything, the law should go beyond protection and make a commitment to make sure that the vulnerable are supported, cared for and enabled to live fulfilled lives, in the same way as for any other member of society.

3. **A caring and cohesive society**. Relationship is at the heart of what it means to be human. Again, look at the effects of COVID-19 where relationships are prevented, with significant psychological effects. For a Christian, relationship with God is an essential part of their life. It is almost impossible to act in total isolation from others; even a tiny action can have an extended effect on others. John Donne noted: "No man is an island entire of itself... any man's death diminishes me, because I am involved in mankind." John Wyatt, the ethicist, has put it that "however compassionate our motives maybe, when we assist in the killing of another human being, we damage our own humanity". An individualistic 'free-for-all' would mean that the principles of affirming life and caring for the individual are unlikely to be upheld within society. Individual autonomy can only be pursued positively and fairly within a society that places it within a communal context. We must continue to build on a cohesive and compassionate society.

4. **Autonomy**. Within the context of points 2 and 3, maximum individual freedom of choice and opportunity ought to be encouraged. Individuals are made in the image of God, not nations or organisations. Treating every person with respect and dignity is a corollary of recognising the intrinsic value of every human life and is an essential part of creating a more cohesive and compassionate society. 'Common good' and individual well-being can and must go hand-in-hand.

On these grounds, we would reject the ethos that is this Bill.

When it comes to the Bill itself, why is there a demand for assisted dying, for dying with dignity? The usual argument is that of care and compassion for those with life-limiting and terminal conditions (which may include cancers, progressive neurological conditions, and dementia) to deal with the themes of intractable pain, loss of control of bodily function, loss of meaningful activity, and that anyone who argues against is lacking in care and compassion. The demand is consistent with the principle of autonomy, but as an isolated one, trumping all other principles. However, it ignores the other principles given above or the other principles in Beauchamp and Childress. It also requires full mental capacity, and depression is a common complicating factor, often leading to those requests.

The alternatives to assisted dying exist and those involved in palliative care are almost unanimous in claiming that these problems can be controlled, and existential distress is not a good reason to hasten death. The various aspects of distress need to be recognised and managed and pain relief should be fully managed by those skilled in the use of the appropriate drugs. What this Bill is indirectly highlighting is the inadequacy of hospice, palliative and end-of-life care available to the population at large.

International experience of assisted dying has revealed problems in management and oversight. Elsewhere in Europe, there have been prosecutions for acting in breach of the guidelines, and there has been the extension of accepted reasons for the procedure even to persons wishing just to end their lives, though there is no physical illness, and more recently permitting the use in respect of minors. In a 20-year review of the situation in Oregon state, USA, there are worrying findings, although records available for review are limited and only held for one year. In each of the last two years of the review, just over 100 physicians wrote approximately 220 prescriptions to enable assisted dying; from one to 25 per prescriber. The duration of contact between the patient and physician varied from one week to over 30 years with a mean of 13 weeks. The longer contact times would appear to be those with a regular physician. It transpired that one doctor wrote one eighth of all prescriptions. The number of individuals with physician contact of less than 13 weeks would support the concept of 'doctor-shopping', and also of wholly inadequate time given to make a proper assessment of the patient's mind and to deal with problems such as a feeling of being a burden or of inadequate medical management.

Looking at the proposed Bill itself, there appear to be weaknesses that have been shown in other jurisdictions:

Section 8. There is no indication of how long before an expected death the procedure can be carried out. Six months seems to be a common figure elsewhere.

Section 9. (1)(a) How long is 'clear and settled'?

(2) The attending medical practitioner need not be the registered medical practitioner who diagnosed that person as terminally ill. This would allow for doctor-shopping, and also would mean that the medical practitioner most likely to know the patient could be bypassed.

(3)(c) Assessment of "voluntarily". What is necessary? How many consultations? Over what period? There is potential for abuse such as pressure by relatives or beneficiaries.

Section 10 There is no need to make a psychiatric assessment. Depression is a frequent finding in those requesting assisted dying and this will need time to determine.

Section 11 (2)(c) The substance may be administered by a third party.

(5)(d) The substance may be administered by the attending medical practitioner.

This section's proposed changes are extremely significant, in that there is a total reversal in medical practice and that this goes against any oath taken by a medical practitioner of not administering a poison to anybody when asked to do so and that modern medical practice should include the well-being of the patient, and the utmost respect for human life.

Section 12 (2) Amendment of Criminal Law (Suicide) Act, 1993. It does not cover Section 11 (2) c or 5 (d), where the procedure is carried out by the attending medical practitioner. This leaves them open to a charge of homicide as the death would not actually be suicide, but would be the result of the intent and action of another person.

In light of these failings, the Church and Society Commission request that this Bill be rejected and not progressed further.