SUBMISSION FROM END OF LIFE CARE EUROPE (ELCE) ON THE DYING WITH DIGNITY BILL 2020

INTRODUCTION

The aim of this submission is to enrich the debate on the Irish Bill on the basis of the experience of European and other jurisdictions where euthanasia or assisted suicide has been legalised or decriminalised. We would draw attention to the unforeseen impacts of legalising assisted suicide and euthanasia and the numerous concerns about the practise in those countries where such laws have been passed. The experiences of other jurisdictions show increasing numbers of death year on year, lax safeguards and continual expansion in all jurisdictions of the qualifying criteria for euthanasia and assisted suicide.

BELGIUM

Following the legalisation of euthanasia in Belgium in 2002 for adults experiencing *"constant and unbearable physical or mental suffering that cannot be alleviated"*[1] (subsequently interpreted as permitting physician-assisted suicide), the law was amended in 2014 to include children experiencing "*constant and unbearable suffering which cannot be eased and which will cause death in the short term*".[2] In Belgium, people have been euthanised due to depression, blindness and deafness, gender-identity crisis and anorexia. In 2013, 1.7% of all deaths were as a result of a hastened death without an explicit request from the patient.[3] *The Economist* recognised that "*Belgian doctors are unusually ready to administer life-ending drugs without explicit consent, generally to patients who have dementia or are in a coma."*[4] In a 2010 *BMJ* article reporting on the practices in Belgium, the authors concluded that only 50% of euthanasia cases are reported to the Federal Euthanasia Control and Evaluation Committee (CFCEE).[5] The CFCEE's 2016 report on the 2014-15 period revealed that in almost 25% of cases, the proper procedures or precautions were ignored in some way.[6] Three minors have been euthanised, with ages ranging from just 9-17. Of those who opted for euthanasia in Belgium in 2016 and 2017, 710 were elderly people who suffered from complaints such as blindness and incontinence. Some 77 chose to die because of unbearable psychiatric suffering. A further 19 young people aged 18-29 decided to end their lives.[7] A case from Belgium (Mortier v. Belgium) is now being considered by the European Court of Human Rights with a judgement expected imminently.[8]

THE NETHERLANDS

Passed in 2002, the Dutch law allows euthanasia for patients whose suffering is thought unbearable with no prospect of improvement. There has been a steady increase in the number of euthanasia deaths, which in 2017 accounted for more than 4% of all Dutch deaths.[9] Of the 6,585 cases reported in 2017, 169 were for people with dementia; 83 were for people with a psychiatric disorder; and 293

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1 The Belgian Act on Euthanasia of May 28 2002, *Ethical Perspectives*, 2002, pages 182-188 http://bit.ly/2Jppeo8.
2 Belgium approves assisted suicide for minors, *Deutsche Welle News*, 13 February 2014 http://bit.ly/30auIdq.
3 Chambaere, K et al, Recent trends in euthanasia and other end-of-life practices in Belgium, *NEJM*, March 2015, 372:1179-1181 http://bit.ly/2KWN0vc.
4 'The right to die', *The Economist,* 27 June 2015 https://econ.st/2NF9hzQ.
5 Smets TS et al, Reporting of euthanasia in medical practice in Flanders, Belgium: cross-sectional analysis of reported and unreported cases, BMJ 2010 ;341 :c5174.
6 Federal Euthanasia Control and Evaluation Committee Seventh Report (2014-2015), 7 October 2016, page 12 (Dutch) / page 78 (French) http://bit.ly/2XlI6JF.
7 https://www.telegraph.co.uk/news/2018/08/07/belgium-authorised-euthanasia-terminally-nine-11-year-old-youngest/.
8 http://media.aclj.org/pdf/Written-Observations,-Mortier-v.-Belgium,-9-March-2019.pdf.
9 Fifteen years of euthanasia law: key figures for 2017, Regional Euthanasia Review Committee, 3 March 2018 http://bit.ly/2J9yE8A.

were for people with an accumulation of geriatric pathologies. Studies suggest that there has been significant underreporting of cases (23% in 2010) so the true figure is likely to be far higher.[10]

In one Dutch clinic, 6.8% of those who successfully obtained euthanasia or physician-assisted suicide were categorised simply as tired of living; 3.7% reported only psychological suffering. 49.1% of those whose requests were granted characterised part of their suffering as loneliness.[11] Disabled babies are euthanized under the Groningen Protocol.[18] In June 2015, the Dutch Paediatricians' Association recommended that children under 12 should be eligible for euthanasia, a proposal now being considered by the Dutch Government.[19] A report has been submitted to the Dutch parliament suggesting that the euthanasia law should be extended to include anyone aged over 55 years of age.

It is important also to consider the impact of the Dutch euthanasia law on medical practise overall. The use of strong doses of sedatives with the intent to end life has been increasing in recent years.[12] Continuous Sedation until Death increased from 5.6% of all deaths in 2001 to 22.6% in 2017. The most likely explanation for this increase is that a medical culture has developed which sees death as a routine solution to any form of physical or mental suffering.

There is evidence of the normalisation of suicide in the Netherlands. When the euthanasia law was introduced it was claimed that it would reduce the recourse to violent suicide. However, Prof. Theo Boer, a former member of a Dutch regional euthanasia review commission, states that: *"The assumption that euthanasia will lead to lower suicide rates is not supported by the numbers."*[13] The number of suicides has increased from 1,353 in 2007 to 1,811 in 2019 (a rise of 33.8%) whilst in neighbouring countries the suicide rates decreased.

OREGON AND WASHINGTON

In Oregon and Washington, there have been important changes in recent years. In Oregon, the law was recently changed to allow doctors to waive the 15 day waiting period, which was included in the original legislation to protect depressed and vulnerable people who might change their minds, for those said to have fewer than 15 days to live.

Trends suggest that over time increasing numbers of people are seeking assistance to commit suicide. In the first full year of the Oregon Death with Dignity Act, 27 people committed suicide using the Act. By 2019, 188 people were recorded as doing so, representing an increase of 700%.[14] Although Washington's law was only passed in 2009, similar trends to those in Oregon are emerging. In the first full year of the Washington Death with Dignity Act, 51 people committed suicide using the Act, but this has increased to 164 people by 2017, an increase of 222%.[15]

Over time, a widening range of medical conditions have fallen within the scope of the law. In 1998 and 1999 there were five terminal conditions listed as causes of death in Oregon's Annual Report; this has expanded over time. In 2014, 8.6% of deaths were recorded as "other" and included

10 Onwuteaka-Philipsen. B et al, Trends in end-of-life practices before and after the enactment of the euthanasia law in the Netherlands from 1990 to 2010: a repeated cross-sectional survey, *The Lancet*, 8 September 2012, Volume 380, No. 9845, pages 908–915 http://bit.ly/30fseKN.

11 Snijdewind M et al, A Study of the First year of the End-of-Life Clinic for Physician-Assisted Dyuing in the Netherlands, *JAMA Internal Medicine, 10 August 2015* http://archinte.jamanetwork.com/article.aspx?articleid=2426428.

12 Jotowitz A, Glick S, The Groningen Protocol: another perspective, *Journal of Medical Ethics*, Mar 2006, 32(3): 157-8 http://bit.ly/2Xqa9N5.

13 Boer, T A, 'Does Euthanasia Have a Dampening Effect on Suicide Rates? Recent Experiences from the Netherlands', *Journal of Ethics in Mental Health*, 10, Special Theme Issue II, 28 December 2017, accessible at https://jemh.ca/issues/v9/documents/JEMH%20article%20Boer%20final%20proof.pdf

14 https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/ar-index.aspx

15 Oregon Death with Dignity Act Annual Report 2017, page 3 https://bit.ly/2IaKtss

musculoskeletal and connective tissue diseases, diabetes mellitus, gastrointestinal diseases and liver disease, which are not generally considered terminal diseases. By 2018, assisted suicides prompted by 'Endocrine/metabolic disease [e.g., diabetes]' had become so normal that they warranted a specific listing hived off from 'other illnesses'. In Washington in 2017, 3% of deaths were categorised as "other illnesses" which were also described as "unknown illnesses", making it therefore impossible to establish whether the patient had a terminal illness or not.

The application of the six-month prognosis has shifted over time. The Oregon Health Authority has confirmed that in an Oregonian context a terminal illness is considered as including conditions which, with treatment, may not be terminal. Under such circumstances, someone with diabetes could decide not to continue life-sustaining treatment for their chronic condition, as a result of which it would become terminal, qualifying them for assisted suicide.

Fear of being a burden on friends, family and care providers is a significant factor motivating people to seek death in Oregon with the percentage of those citing this as a reason for seeking an assisted suicide increasing from 25.4% in 2009 to 59% in 2019.[16] Only about 1 in 4 cited inadequate pain control or concern about it. Figures from Washington State show that of those patients who had an assisted suicide in 2017, 56% cited as a reason the fear of being a burden as a reason.

Oregon's law leaves an unresolved but key question: whether at the time the person takes the lethal drugs it is, in reality, voluntary, understood and self-administered since there is no need for witnesses or a doctor to be present. Moreover, it is notable that the suicide rate has increased. In Oregon, the suicide rate in that state was 35% higher than the US national average in 2019.[17] It increased by 33% between 2001 and 2018. In Washington State, suicides increased by 21% between 2008 and 2018.

CANADA

Canada's federal law allowing euthanasia and assisted suicide passed in 2015, and took effect in summer 2016. The 'fourth interim report' covering most of Canada states that there were 510 'medically assisted deaths' in the initial six months (June – December 2016); twice as many (1,086) in the latter half of 2017; and 2,614 in the first ten months of 2018 – more than three times the monthly average of the first recorded period.[18] The number of deaths has continued to increase and by the end of 2020, the number of MAiD deaths in Canada is likely to be around 20,000.

On 11 September 2019, a Quebec Superior Court judge ruled invalid the Criminal Code requirement that a natural death be 'reasonably foreseeable', and the Quebec law requirement that people must 'be at the end of life', before being eligible for euthanasia. The requirements were ruled discriminatory and overly restrictive; legislators were given six months to extend the laws which the Canadian parliament is now doing through the C7 Bill.[19]

COMMENTS ON THE BILL

Section 1 – Short title and commencement & Section 12 – Amendment of Criminal Law (Suicide) Act 1993

The very name of the bill – 'Dying with Dignity' – begins the work of skewing how society perceives those whose situations conform with the challenges identified in the bill, but who do

16 Oregon Health Authority Public Health Division Death with Dignity Act Data Summaries 2009-2019.
17 https://www.corvallisadvocate.com/2020/oregon-suicide-rate-above-national-average/
18 http://bit.ly/2Jss4su
19 https://globalnews.ca/news/5888949/quebec-court-medically-assisted-dying-law/

not opt for assisted suicide or euthanasia. Dignity does not depend on the degree of vulnerability of the patient, but is intrinsic to every person, regardless of his or her condition; this bill must not be allowed to masquerade as defining what it is to 'die with dignity', when its sole purpose, in practical terms, is to provide for assisted suicide and euthanasia. 'Euthanasia' does not appear in the text of the bill; nor does 'assisted suicide', despite the framers needing to amend the Criminal Law (*Suicide*) Act 1993. There are references within the bill to 'assisted dying', a common euphemism employed by activists. We would perhaps refer the Committee to a 2019 report from the American Medical Association's Council on Ethical and Judicial Affairs:

> 'The council recognizes that choosing one term of art over others can carry multiple, and not always intended messages. However, in the absence of a perfect option, CEJA believes ethical deliberation and debate is best served by using plainly descriptive language. In the council's view, despite its negative connotations, the term "physician-assisted suicide" describes the practice ["aid-in-dying", in the context of US jurisdictions which have not legalised euthanasia] with the greatest precision.'[20]

Section 2 – Interpretation

""independent medical practitioner" means a registered medical practitioner who is not a relative or partner of the attending medical practitioner, or colleague in the same practice or clinical team, and who is not the attending medical practitioner"

These requirements are insufficient to guarantee the independence of the medical practitioner responsible for evaluating the conditions provided in the law. Belgian experience shows us for example that healthcare professionals in favour of a continuous extension of the euthanasia law come together in professional networks where close relations are forged in favour of a lax interpretation of the legal requirements, even if these healthcare professionals are not "*colleagues in the same practice or clinical team".*

Section 6 – Authorisation of assisted dying

The role, mission and oath of medical practitioners and assisting healthcare professionals is incompatible with the responsibility to kill a patient at his or her request.

Belgian and Dutch euthanasia experiences show us how confused such a responsibility can be, as the person responsible for curing and, if not possible, relieving the patient is at the same time responsible for ending his or her life.

The possibility of conscientious objection (Section 13) does not eliminate such an issue, as pressure from the patient or from other healthcare professionals is likely to lead several physicians to practise euthanasia while they do not actually wish to do so.

Section 7 – Qualifying persons

We question the decision to make residence *anywhere* on the island of Ireland – including Northern Ireland – a criterion for eligibility. Aside from the propriety of seeking to grant citizens of a neighbouring country access to practices repeatedly rejected there by parliamentarians and courts, we also express the concern that having established cross-border access as a founding principle of the legislation, the law will become open to 'suicide tourism'

20 https://www.medpagetoday.com/meetingcoverage/ama/80384

or ‘euthanasia tourism’ via abuse of the residency requirement or weakening of the 12-month requirement.

Section 8 – Terminally ill

No timeframe is provided with respect to the definition of a ‘terminal illness’, rendering the term essentially meaningless with a wide range of chronic illnesses and disabilities ushered into eligibility.

Disability rights advocate Baroness Campbell of Surbiton (living with the degenerative condition spinal muscular atrophy) has written:

> ‘the distinction between disability and terminal illness is a false one: for many disabled people a chest infection is a terminal illness unless treated. The disabled person dependant on a ventilator is terminally ill if the ventilator is switched off. I am many years over my prognosis end date, along with countless others who have a progressive condition.’[21]

Belgian and Dutch experiences show us the gradual enlargement of situations where the patient is considered as ‘terminally ill’, in particular with respect to ‘polypathologies’ (see Conclusion).

The Belgian experience shows us that depression has for example quickly become eligible to the definition of ‘terminal illness’ (while authors of the bill excluded this perspective). Nothing in the Irish bill excludes such an interpretation.

Including psychiatric illnesses in the possible definition of terminal illnesses would be in clear contradiction with the duty of the State and of healthcare professionals to protect socially and/or mentally vulnerable people, especially with suicide prevention policies.

Section 9 – Declaration

The ‘clear and settled intention’ of someone to die is by definition very hard to assess. This criterion is essentially subjective.

The state and society more broadly must be understood to have a responsibility to ensure all citizens have equitable access to health care and social support; without these, a will to live can become a desire to escape or even an offer to end life.

2018 saw reports that 'since Quebec's medical aid in dying law came into effect in 2016, doctors and workers say that access to palliative care has gone down, while patient requests for medical aid to end their lives have increased steadily.' Palliative Care Director Teresa Dellar was quoted as saying ‘the issue of medical aid in dying is available to 100 per cent of the population and palliative care the resources are only available to 30 per cent of the population’[22] with family physician Dr Paul Saba arguing that ‘people are feeling a burden, financial stress, psychological stress and lack of autonomy… So what we want is to give people is…care and support.’[23]

21 https://blogs.bmj.com/bmj/2019/02/06/disabled-people-like-me-fear-legal-assisted-suicide-it-suggests-that-some-lives-are-less-worth-living/
22 Figures echoed in a 2019 statement issued by the Canadian Hospice Palliative Care Association (CHPCA) and the Canadian Society of Palliative Care Physicians (CSPCP) https://www.chpca.net/chpcacspcp
23 https://montreal.ctvnews.ca/doctors-fear-quebecers-forced-to-choose-between-assisted-death-or-palliative-care-1.3971163

Canadians like Roger Foley, Oregonians like Barbara Wagner and Randy Stroup, and Californians like Stephanie Packer have all experienced life-saving, life-sustaining or life-affirming care and treatment being denied, but assisted suicide or euthanasia being offered.[24]

The Committee should also consider Subsection 3c –

> 'The attending medical practitioner and the independent medical practitioner, having separately examined the person and the person's medical records and each acting independently of the other, must be satisfied that the person… has a clear and settled intention to end his or her own life which has been reached voluntarily, on an informed basis and without coercion or duress'

– in the light of Subsection 2:

> 'the attending medical practitioner (but not the independent medical practitioner) may, but need not be, the registered medical practitioner who diagnosed that person as terminally ill or who first informed the person of that diagnosis.'

Neither doctor is required to know the patient, or have prior knowledge of their care, support systems, or pressure points (family, finance etc); yet they are empowered to approve as settled and voluntary a request for death. The phenomenon of 'doctor-shopping' is well-established: in Oregon in 2019, 290 prescriptions for assisted suicide were made out by 112 doctors, with at least one of those making out 33 that year - that averages out to their facilitating a patient's suicide every 11 days. Once again, doctors were approving requests for lethal medication for patients they had known for as little as a week.[25]

Even when doctors act to safeguard patients where the voluntary nature of their request is in question, doctors who are pre-disposed to assent to such requests can be found. Journalist Christopher de Bellaigue has related the experience of one Belgian GP:

> 'In 2017, one of her patients, a man in late middle-age, was diagnosed with dementia and signed a directive asking for euthanasia when his condition worsened. As his mind faltered, however, so did his resolve - which did not please his wife, who became an evangelist for her husband's death. "He must have changed his mind 20 times," Marie-Louise said. "I saw the pressure she was applying." In order to illustrate one of the woman's outbursts, Marie-Louise rose from her desk, walked over to the filing cabinet and, adopting the persona of the infuriated wife, slammed down her fist, exclaiming, "If only he had the courage! Coward!"'

> 'By the time she went away on holiday last summer, she believed she had won from her patient an undertaking not to press for euthanasia. But she had not reckoned with her own colleague in the practice, a doctor who takes a favourable line towards euthanasia, and when Marie-Louise returned from holidays she found out that this colleague had euthanised her patient. When I visited Marie-Louise several months after the event, she remained bewildered by what had happened… Now she was making plans to leave the practice, but hadn't yet made an announcement for fear of unsettling her other patients. "How can I stay

24 www.thestar.com/opinion/contributors/2018/04/02/the-right-to-a-compassionately-assisted-life-not-death.html
www.telegraph.co.uk/comment/personal-view/4736927/Right-to-die-can-become-a-duty-to-die.html
www.washingtontimes.com/news/2016/oct/20/assisted-suicide-law-prompts-insurance-company-den/

25 www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf

here?" she said. "I am a doctor and yet I can't guarantee the safety of my most vulnerable patients."'[26]

Section 10 – Assessment of capacity

Of the 188 assisted suicide deaths in Oregon in 2019, only one had been referred for psychiatric evaluation.[27] Psychiatrist Professor Sheila Hollins has written that 'researchers have found that some patients who have ended their lives under the terms of Oregon's assisted suicide law had been suffering from clinical depression. Depression impairs decision-making capacity, it is common in elderly people and it is treatable.'[28] It is noteworthy that the bill before the Committee does not require psychiatric or psychological evaluation, but instead leaves assessments of capacity to non-specialist doctors and nurses.

Subsection 4 – 'the fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him or her from being regarded as having the capacity to make the decision' – is deeply concerning, open to abuse. It fails to recognise that an inability to remember making such a request also suggests an inability to remember benefits felt when engaging with loved ones or accessing health and social care, especially care provided by hospices and palliative medicine specialists. An inability to 'retain the information relevant to a decision' being acceptable also widens the opening for coercion.

Section 11 – Assistance in dying

Subsection 6 requires that 'the attending medical practitioner or assisting health care professional must remain with the person until the person has… self-administered the substance or substances or have it or them administered' or 'decided not to self-administer the substance or substances or have it or them administered,' and that 'the attending doctor or healthcare professional is to be regarded as remaining with the person if the attending doctor or assisting healthcare professional is in close proximity to, but not necessarily in the same room as, the person.' This raises (at least) two concerns. The latter clarification again creates space for coercion, with the doctor or health professional not required to witness self-administration. The original requirement, meanwhile, fails to recognise the documented history of complications in assisted suicide and euthanasia deaths.

A study published in *Anaesthesia*, journal of the Association of Anaesthetists in 2019 found that (our emphases in bold):

> 'In voluntary assisted dying (in some US states and European countries), the common method to induce unconsciousness appears to be self-administered barbiturate ingestion, with death resulting slowly from asphyxia due to cardiorespiratory depression. Physician-administered injections (a combination of general anaesthetic and neuromuscular blockade) are an option in Dutch guidelines. Hypoxic methods involving helium rebreathing have also been reported. The method of capital punishment (USA) resembles the Dutch injection technique, but specific drugs, doses and monitoring employed vary. However, for all these forms of assisted dying, there appears to be a relatively high incidence of **vomiting** (up to 10%), prolongation of death (up to 7 days), and **reawakening from coma** (up to 4%),

26 www.theguardian.com/news/2019/jan/18/death-on-demand-has-euthanasia-gone-too-far-netherlands-assisted-dying

27 www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year22.pdf

28 www.telegraph.co.uk/news/health/10875414/Assisted-dying-Bill-can-you-really-tell-if-someones-of-sound-and-settled-mind-for-suicide.html

constituting failure of unconsciousness. This raises a concern that some deaths may be **inhumane**.'

'Data from the Dutch protocols, and other similar methods used elsewhere, suggest that after oral drug sedative ingestion, patients usually lose consciousness within 5 min. However, death takes considerably longer. Although cardiopulmonary collapse occurs within 90 min in two thirds of cases, in a third of cases **death can take up to 30 h**. Other complications include **difficulty in swallowing** the prescribed dose (in up to 9%) and **vomiting** thereafter (in up to 10%), both of which prevent suitable dosing, and **re-emergence from coma** (in up to 2%). Each of these potentially constitutes a failure to achieve unconsciousness, with its own **psychological consequences**, and it would seem important explicitly to acknowledge this in suitable consent processes. Complications are still reported: **difficulties with intravenous access** which preclude proceeding (3%); **prolonged time to death (up to 7 days** from drug administration in up to 4%); and failure to induce coma (with patients re-awakening, even sitting up, in up to 1.3%), and are more common in those who are not frail.'[29]

Aside from the most basic question – do such experiences represent 'dignity'? – the Committee must also consider the bill's failure to demand medical accompaniment until death.

Section 13 – Conscientious objection

Section 13(3) forces healthcare professionals who conscientiously object to euthanasia to participate in ending their patient's life, as they are required to "*make arrangements*" in order to "*enable the qualifying person to avail of assistance in ending his or her life*". Such an obligation of referral is in clear contradiction with the fundamental right to freedom of conscience. It is worth noting that in Canada, the same obligation – to make effective referrals – had to be affirmed by the courts after the fact of legislation[30], whereas here, the framers of the bill are very clear, from the off: doctors would have the right to object in accordance with their conscience, but an obligation to act in contravention of their conscience.

Experience from Belgium and the Netherlands show us that a conscientious objection is in any case hard to guarantee as no institutional objection is provided. Therefore, as the State has the possibility to force every healthcare institution to provide for euthanasia services, no physician or healthcare assistant who conscientiously objects to euthanasia would have the possibility to work in an institution where euthanasia is not allowed. The law adopted by the Belgian Parliament in March 2020[31] confirms the intention of the legislator to criminalise healthcare institutions (hospitals, nursing homes) where euthanasia is not part of the healthcare vision.

In a similar spirit, British Columbia responded to Canada's 2016 federal euthanasia legislation by developing a policy which requires a hospice to allow patients to access MAiD ('Medical Aid in Dying' – euthanasia and assisted suicide) in their facility, if their beds are more than 50% publicly funded. In February 2020, a health authority there gave 12 months' notice that it would withdraw funding from Delta Hospice Society, which runs a 10-bed hospice, for its 'refusal to comply with the provincial medical assistance in dying (MAiD) policy.'[32] In June 2020, in anticipation of a referendum on euthanasia later that year, a New Zealand High Court judge supported the right of hospices to prohibit euthanasia, but stated in his decision that there was

29 https://associationofanaesthetists-publications.onlinelibrary.wiley.com/doi/full/10.1111/anae.14532
30 https://www.canlii.org/en/on/onca/doc/2019/2019onca393/2019onca393.html
31 www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&cn=2020031502&table_name=loi
32 https://www.catholicregister.org/item/31746-court-deals-blow-to-delta-hospice
https://news.gov.bc.ca/releases/2020HLTH0047-000328

nothing to prevent the government authority from withholding health care funding if a hospice refused to allow euthanasia.

Moreover, as we see it in Belgium and in the Netherlands, the potential impact of euthanasia on someone's conscience is not limited to healthcare professionals, but also to other patients, residents of nursing homes, and volunteers, who wish to have the possibility to live in an environment where euthanasia is not allowed.[33] The possibility of conscientious objection is not provided in the Bill for these categories of people.

Section 14 – Obligation to keep and provide records

The evaluation of the euthanasia procedure is carried out *a posteriori* by the Review Committee. This is problematic, as the consequence of an irregular euthanasia procedure is no less than the death of the patient, which is by definition irreversible and irreparable. Moreover, experience from the situation in Belgium (where the evaluation is also carried out a posteriori) shows us a clear lack of control by the Federal Control and Evaluation Committee. One of the main reasons for this lies in the fact that the information provided by healthcare professionals in their declarations is taken as granted by the Control and Evaluation Committee.

CONCLUSION

In *every* country where euthanasia has been decriminalized (in particular Belgium[34] and the Netherlands), we see a double evolution:

- Constant increase in the numbers of euthanasia deaths, which normalises euthanasia as a way of dying.
- Constant increase of the types of pathologies and situations eligible for euthanasia, especially 'polypathologies' (8% of all euthanasia in Belgium in 2019), i.e., a combination of non-terminal illnesses (e.g. reduced mobility or impaired vision) that is considered as leading to a loss of autonomy and social exclusion, and therefore as the cause of unbearable suffering for the patient.

This is related to the rapid evolution of the motives of euthanasia, with movement from the argument of unbearable suffering to that of 'chosen death' (or death on demand) and to the subjective will of the patient (which the healthcare professional has no legitimacy to question). Euthanasia is never necessary, as medicine already offers solutions to every single situation of pain, including with palliative sedation for terminally ill patients. Even if the decriminalisation of euthanasia were desirable in some specific cases, the protections included in the current bill are not satisfactory.

This bill will inevitably lead to incremental extension with respect to its interpretation, as it is the case in every single country that decriminalised euthanasia. One reason for this inevitable evolution is the focus on the subjective will of the patient, which is considered as the ultimate criteria for assessing their suffering and, eventually, their right to end their life with the help of healthcare professionals. Another reason is the principle of non-discrimination, which was

33 T. Devos et al. (2021), Euthanasia: Searching for the Full Story. Experiences and Insights of Belgian Doctors and Nurses, www.springer.com/gp/book/9783030567941.
34 https://www.ieb-eib.org/docs/pdf/2012-10/doc-1554801153-41.pdf
https://www.ieb-eib.org/docs/pdf/2017-01/doc-1554801216-19.pdf

rapidly invoked in Belgium and in the Netherlands to enlarge the legal requirements, in particular to allow euthanasia for minors.[35]

We urge the Committee to consider the position statement of the Association for Palliative Medicine of Great Britain and Ireland[36], and we fully endorse these findings of the Spanish Bioethics Committee (a consultative body attached to Spain's Ministry of Health, Social Services and Equality):

> 'To legalize euthanasia and/or assisted suicide implies the initiation of the devaluing of human life, the frontiers of which are difficult to predict. …In these difficult times that we are living, it is good to remember once again that the risk of utilitarianism has not disappeared from our society. … Euthanasia and assisted suicide are not signs of progress but rather a regression of civilization… In the context in which the value of human life is already often conditioned by criteria of social utility, economic interest, family responsibilities... the legalization of early death would add a new set of problems.'[37]

35 https://www.ieb-eib.org/docs/pdf/2017-01/doc-1554801216-19.pdf
36 https://apmonline.org/wp-content/uploads/2020/10/AS-position-statement-Final.pdf
37 (In Spanish)
http://assets.comitedebioetica.es/files/documentacion/Informe%20CBE%20final%20vida%20y%20la%20atencion%20en%20el%20proceso%20de%20morir.pdf
(Limited English translation) www.carenotkilling.org.uk/articles/not-signs-of-progress-but-rather-a-regression/