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Márta 2024

Joint Committee on Assisted Dying

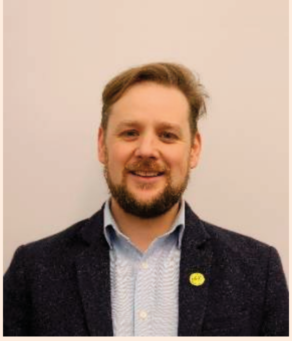
Final Report of the Joint Committee on Assisted Dying

March 2024

33/JCAD/01

MEMBERSHIP

Michael Healy Rae TD
Independent
(Cathaoirleach)



Patrick Costello TD
Green Party

David Cullinane TD
Sinn Féin

Pa Daly TD
Sinn Féin

Emer Higgins TD
Fine Gael

Alan Farrell
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Senator Fiona O'Loughlin
Fianna Fáil

Senator Lynne Ruane
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Senator Mary Seery-Kearney
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Cathaoirleach's Foreword

The remit of the Joint Committee Assisted Dying (the Committee) was to consider and make recommendations for legislative and policy change relating to a legal right to assist a person to end his or her life and a legal right to receive such assistance. The Committee also agreed that it could recommend that no legislative or policy changes be made. This report is the result of the work of the Committee over the past nine months. I was privileged to be Cathaoirleach for the Committee.

I would like to thank the Committee Members who devoted their time and attention to this very complex issue. We did not always agree with each other, but all views were listened to and respected. We worked cooperatively and collegially in order to give this important topic the attention it merits.

The Committee Secretariat was extremely diligent in its work and the Office of the Parliamentary Legal Adviser provided us with clear and detailed background information.

We are very grateful to the national and international experts who engaged with the Committee to examine end-of-life care, dying and assisted dying in detail. This included experts in law, ethics, medicine, disability, palliative care, and psychiatry.

A special thanks must go to the other witnesses who shared very moving personal stories about their experiences of end-of-life care. These heartfelt stories were difficult to tell and difficult to hear but they helped to inform the Committee Members and deepened our understanding of this sensitive topic.

This Report discusses dying including suicide. Support information can be found on the Committee's webpage.

The Joint Committee on Assisted Dying requests that the issues raised in this report be the subject of a debate in both Houses of the Oireachtas.

Michael J. Healy-Rae.

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Michael J. Healy-Rae T.D.

Cathaoirleach

Joint Committee on Assisted Dying

March 2024

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RECOMMENDATIONS

Recommendation 1

The Committee recommends that the Government introduces legislation allowing for assisted dying, in certain restricted circumstances as set out in the recommendations in this report.

Recommendation 2

The Committee recommends that any legislation for assisted dying may entail amendments to the Criminal Law Suicide Act 1993.

Recommendation 3

This Committee recommends that where any person has failed to adhere to relevant statutory requirements governing assisted dying, he or she will have committed a criminal offence.

Recommendation 4

The Committee recommends that any potential legislation on assisted dying provides that where a person has been proven guilty of coercion, they will have committed an offence under the Act.

Recommendation 5

The Committee recommends that doctors and healthcare workers involved in the provision of assisted dying be trained to the highest level possible to identify coercion when assessing or treating a patient.

Recommendation 6

The Committee recommends that if a medical professional has been proven to have acted outside of the permitted regulations or has attempted to coerce an individual, they will have committed an offence under the potential legislation and may be held liable.

Recommendation 7

The Committee recommends the inclusion in any legislation on assisted dying of mandatory reporting to An Garda Síochána of any information or evidence concerning the issue of possible coercion in relation to assisted dying.

Recommendation 8

The Committee recommends that where capacity is in doubt, a functional test for decision-making capacity should be part of the assessment for eligibility for assisted dying.

Recommendation 9

The Committee recommends that any doctor involved in determining eligibility for assisted dying must have professional training in assessing capacity and voluntariness.

Recommendation 10

The Committee recommends that following an initial successful assessment for assisted dying that finds a patient eligible, if the patient temporarily loses decision-making capacity, then that eligibility is suspended for the duration of their incapacity.

Recommendation 11

The Committee does not recommend that advanced healthcare directives allow for individuals to make requests for assisted dying. However, consideration of the issue may be included in any review of assisted dying legislation.

Recommendation 12

The Committee recommends that the updated palliative care strategy should be published by the Department of Health without delay.

Recommendation 13

The Committee recommends that palliative care and the operation of assisted dying should operate completely separately and independently of each other.

Recommendation 14

The Committee recommends that resources and funding for, and information about, palliative care services should be substantially increased, to ensure consistent and accessible services of the highest quality are provided throughout the country.

Recommendation 15

The Committee recommends that funding for assisted dying and palliative care be separate and distinct from one another, provided for in separate votes in the Department of Health budget.

Recommendation 16

The Committee recommends that a person inquiring about assisted dying, following a terminal diagnosis, should be informed of, and assisted in, accessing all end-of-life care options, including palliative care.

Recommendation 17

The Committee recommends that the right to conscientious objection of all doctors and health workers directly involved in the provision of assisted dying should be protected in law.

Notwithstanding the above, the Committee recommends that when a doctor or health care professional exercise this right, that this will not have the effect of closing off access to assisted dying to the patient. To this end, the law should place a requirement on a health care professional, who refuses to participate in the service, to refer onwards to a participating health care professionals and/or a national oversight body.

Recommendation 18

The Committee recommends that any doctor or health care workers opting into the provision of assisted dying, be provided with enhanced training and support, including funded access to international peer support networks.

Recommendation 19

This Committee recommends that any potential legislation on assisted dying uses clear and unambiguous terms and definitions, to avoid scope for uncertainty.

Recommendation 20

The Committee recommends that informal carers are robustly supported in their caring duties, with additional resources provided to include funding, counselling and respite provision.

Recommendation 21

The Committee recommends the need for much increased mental health supports to help identify and respond to mental health issues, especially age-related mental health challenges, and for mental health supports to always be made available to those receiving a terminal diagnosis.

Recommendation 22

The Committee recommends that research be carried out on the relationship between economic disadvantage and health inequalities, and the question of people feeling a burden.

Recommendation 23

The Committee recommends that the *Optional Protocol to the United Nations Convention on the Rights of Persons with Disabilities* should be ratified as a precondition of the commencement of assisted dying legislation.

Recommendation 24

The Committee recommends that if assisted dying is introduced, an assessment by a qualified psychiatrist should be required in circumstances where the patient is deemed eligible but there are concerns about whether the person is competent to make an informed decision.

Recommendation 25

The Committee recommends that eligibility for assisted dying should be limited to Irish citizens or those ordinarily resident in the State for a period of not less than twelve months.

Recommendation 26

The Committee recommends that assisted dying should be limited to people aged 18 or over.

Recommendation 27

The Committee recommends that only a person diagnosed with a disease, illness or medical condition that is:

a) both incurable and irreversible;
b) advanced, progressive and will cause death;

c) expected to cause death within six months (or, in the case of a person with a neurodegenerative disease, illness or condition, within 12 months); and

d) causing suffering to the person that cannot be relieved in a manner that the person finds tolerable,

is eligible to be assessed for assisted dying.

Recommendation 28

The Committee recommends that two formal requests for assisted dying must be made, with a set specified interval between. At least one of these requests must be recorded in writing, and before two independent witnesses.

Recommendation 29

The Committee recommends that any potential legislation for assisted dying should establish a national body with sole responsibility for assisted dying services and related supports.

Recommendation 30

The Committee recommends that the national body for assisted dying should be independent of the other state bodies.

Recommendation 31

The Committee recommends that should assisted dying be made available, a Joint Protocol be established for interagency collaboration between the potential body for assisted dying and the Health Service Executive.

Recommendation 32

The Committee recommends that all assisted dying applications and related processes should be overseen and governed by the independent national body. The responsibilities of this body will include:

a. Regularly publishing statistics on applications and procedures including statistics on the number of people who initiate the process and the number of people who complete the process and all other relevant data;
b. Ensuring that all applications and procedures are compliant with regulations;
c. Maintaining a list of medical practitioners, nurse practitioners, and psychiatrists who provide assisted dying services;
d. Maintaining a register of medications and return of medication for instances where the person has chosen to cancel their request, was no longer eligible, or has passed away prior to administration;
e. Collecting data pertaining to demographic information;
f. Providing accessible information relating to assisted dying services and supports;
g. The publication of an annual report; and
h. Carrying out preliminary investigation of any complaints or allegations of wrongdoing in relation to the process, and where appropriate make referrals to relevant bodies and to maintain any data for transfer as appropriate.

Recommendation 33

The Committee recommends the doctors have an obligation to acknowledge receipt of the request and should deliver a response within a specified timeframe.

Recommendation 34

The Committee recommends that family members, carers, guardians or holders of an enduring power of attorney cannot request assisted dying in the interest of another person.

Recommendation 35

The Committee recommends that any potential legislation for assisted dying should provide a means of access to treatment for individuals who require assistance during the administration.

Recommendation 36

The Committee recommends that if assisted dying is legislated for, a doctor or nurse practitioner must be present for the duration of the assisted dying process and must remain until after the patient’s death and must account to the responsible authority for any remaining substances.

Recommendation 37

The Committee recommends that any assisted dying legislation include a provision for a formal review after three years of the operation of the legislation.

Recommendation 38

The Committee recommends that any assisted dying legislation must include definitions for terms used, including, but not limited to, medical descriptions of the methods permitted under the Act.

Introduction

1. The Joint Committee on Assisted Dying (the Committee) was established in early 2023 to consider and make recommendations for legislative and policy change related to a statutory right to assist a person to end their life and a statutory right to receive such assistance. The Committee also agreed that it could recommend that no legislative or policy changes be made. It has looked at the topic of assisted dying in general, rather than at draft legislation.
2. The terms of reference of the Committee refer to it as the Joint Committee on Assisted Dying. The Committee Members did not agree on any one form of wording on the topic, so the terms of assisted suicide and euthanasia are also used. The Committee recognises that the use of certain terms is contested.
3. After a series of private meetings to agree a work plan, the Committee held its first public meeting on 13th June 2023 with a final public meeting on 13th February 2024. The meetings were divided into modules as agreed by the Committee in order to best cover the breadth of this challenging issue:
    a) Constitutional and legal issues in relation to the provision of assisted dying in Ireland;
    b) Ethical issues relating to the provision of assisted dying;
    c) An overview of the current international context with regards to assisted dying;
    d) An examination of safeguards in relation to the provision for assisted dying;
    e) Identification of possible unintended consequences of assisted dying; and
    f) How provision for assisted dying might operate in Ireland.
4. There was no open call for submissions from the public. Witnesses were suggested by the Committee Members or the Committee Secretariat and all were agreed by the Committee Members. The Committee had available to it the work of the previous Joint Committee on Justice together with some 1,400 public submissions that were made to it.
5. During its 24 public meetings the Committee engaged with 106 individual witnesses in person or online. These witnesses included national and

international experts in law, ethics, medicine, disability, palliative care, and psychiatry.

6. Some of the witnesses were neutral on the question of whether assisted dying should be introduced in Ireland, while others had deeply held and often contradicting views as to the relative merits and dangers of allowing for assisted dying.
7. An important group of witnesses were those who shared their personal experiences of caring for a person at the end of their life, the options that were available to them and the impact this had on the person nearing the end of their life, as well as their wider circle of family and friends.
8. The Joint Committee on Assisted Dying's work is the third examination of the complex topic of assisted dying by an Oireachtas Committee in the past six years.
9. In June 2018, the Joint Committee on Justice and Equality published its *Report on the Right to Die With Dignity*. This was an examination of the issues around assisted dying rather than a draft piece of legislation. The Committee reported that it "did not achieve a clear consensus as to whether legislative change is justified. Therefore, the Committee is not in a position to recommend legislative change at this time."
10. The Justice Committee recommended that the Houses of the Oireachtas consider referring the issue to the Citizens' Assembly for deliberation; and the issue could then be referred to a Special Oireachtas Committee for further consideration. It noted that: "given the gravity of the debate, it warrants as rigorous an examination as possible."
11. In July 2021, the Justice Committee published its *Report on Scrutiny of the Dying with Dignity Bill 2020*. This report focused on the examination of a Private Members Bill (PMB), a draft piece of legislation by Deputy Gino Kenny. The Justice Committee recommended that the Bill could not proceed any further for a number of reasons including that the Bill did not include sufficient safeguards to protect against undue pressure being put on vulnerable people to avail of assisted dying. It recommended that a Special Oireachtas Committee be established to undertake a more thorough examination of the topics raised within its report.

Note on Language Used

12. There is no clear consensus on the use of language and terminology surrounding assisted dying. Jurisdictions which have legalised assisted dying do not have any consensus on the terminology they use.
13. For the purpose of this report, **assisted dying** is used as a blanket term for all cases where medication is voluntarily administered to hasten a patient's death. **Assisted suicide** is used to denote that the medication is administered by the patient themselves. **Euthanasia** is used where a doctor or health worker administers the medication.

Legal and Constitutional Issues

Introduction

14. The Joint Committee on Assisted Dying agreed that the first topic that it would examine should be the current legal situation regarding assisted dying in Ireland. This included both the current legislation covering suicide and assisting suicide, as well as the constitutional position regarding assisted dying.

Decriminalisation of Suicide

15. Suicide was decriminalised by the Criminal Law (Suicide) Act 1993.
16. While suicide was decriminalised, the offence of assisting suicide was retained and put on a statutory footing. Under section 2(2) of the 1993 Act, it is an offence for a person to aid, abet, counsel or procure the suicide or attempt at suicide of another person.
17. According to representatives of the Department of Justice, the decision to maintain this offence was driven by the possibility of abuse. The maximum penalty on conviction for the offence is 14 years imprisonment. The severity of the penalty was "to cover situations where a person deliberately procured the suicide of another for his or her own motives", and to ensure that the law recognises a scale of different offences within that offence.
18. During discussion of the hypothetical situation of an individual accompanying someone to Switzerland to access an assisted death, the Committee questioned whether that person might face prosecution. The Department of Justice representative stated that any actions that are taken in aiding, abetting, counselling or procuring the suicide of another person would be covered by the 1993 Act. She clarified that the decision to prosecute lies with the Director of Public Prosecutions, and that to the Department's knowledge, there has to date only been one prosecution and no convictions.
19. The Committee heard from Dr Andrea Mulligan that in the UK, the Director of Public Prosecutions has issued public statements that they are aware of cases where people travelled to Switzerland to avail of assisted dying, and that they did not prosecute for certain reasons.

20. The UK Director of Public Prosecutions also published guidance in 2010 clarifying their position on the factors regarded as relevant for and against prosecution of assisting suicide.
21. The UK guidelines state that a prosecution is less likely if *inter alia* the person made a voluntary, clear, settled and informed decision to end their life, and if the assister was wholly motivated by compassion. Other criteria include that if the assister tried to discourage the person from suicide, and if their actions could be seen as reluctant encouragement or assistance in the face of a determined wish of the person, prosecution is less likely.
22. Factors that would make prosecution more likely in the UK include: if the assister had a history of violence or abuse against the person they assisted; were unknown to the person; stood to gain from the person's death or were acting as a medical professional; and the person was in their care.
23. The policy aims to give a clearer understanding of how people will be treated under the law but does not in any way change the law in the UK or protect people from prosecution.
24. The Committee heard from several witnesses that decriminalising assisted dying, without introducing a legislative and regulatory framework would represent the worst of both worlds, with no ability to put in place safeguards or protections of any kind.
25. The Department of Justice recommended to the Committee that if an assisted dying framework was introduced, there would be a need to ensure that there are criminal laws about acting outside that framework in any way.

Recommendation 1

The Committee recommends that the Government introduces legislation allowing for assisted dying, in certain restricted circumstances as set out in the recommendations in this report.

Recommendation 2

The Committee recommends that any legislation for assisted dying may entail amendments to the Criminal Law Suicide Act 1993.

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This Committee recommends that where any person has failed to adhere to relevant statutory requirements governing assisted dying, he or she will have committed a criminal offence.

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The Constitution

The Constitution and the Right to Life

26. Article 40.1 of the Constitution guarantees that all citizens shall be held equal before the law. Article 40.3.2° guarantees that the State in its laws protect as best it may and vindicate the life of every citizen. The Courts have held that together Article 40.3 and Article 40.1 commit the State to valuing the life of all persons equally.

The Marie Fleming Case

27. In 2012, Marie Fleming, who was in the final stages of multiple sclerosis and physically incapable of ending her own life unaided, took legal action challenging the law criminalising assisted suicide. The case was first heard in the High Court and subsequently on appeal in the Supreme Court. Ms Fleming claimed that the blanket ban on assisted suicide breached both her constitutional rights, and her rights under the European Convention on Human Rights (ECHR). Ms Fleming also argued that that the Criminal Law (Suicide) Act 1993 was incompatible with the Constitution on the grounds of equality, as it discriminated against those who are unable to bring their own life to an end without assistance, and that s.2(2) of the 1993 Act was not incompatible with the ECHR.
28. The Supreme Court held *inter alia* that the right to life under Article 40.3.2 of the Constitution does not have a corollary right to terminate one’s life and have assistance to do so. The Court also rejected the argument that the Criminal Law (Suicide) Act 1993 was incompatible with the Constitution on the grounds of equality. Finally, the Court found that s.2(2) of the 1993 Act was not incompatible with the ECHR, holding that the European Court of Human Rights (ECtHR) has found that States are entitled to regulate activities that are detrimental to the life and safety of persons and that it is for the States to assess the risk of abuse if a blanket prohibition on assisted suicide was relaxed.

Constitutionality of Assisted Dying

29. The Committee heard contradicting views on whether assisted dying could be legislated for under the Constitution.
30. Dr Conor Casey told the Committee that in his view, Article 40.3 of the Constitution would seem to conflict sharply with the proposition that the Oireachtas could legislate to permit third parties to engage or assist in the intentional taking of human life in any circumstance.
31. Dr Tom Hickey on the other hand, cited former Chief Justice Susan Denham in the Marie Fleming ruling, stating that:

> *“It may well be, therefore, that as part of its obligation to vindicate life, the State is required to seek to discourage suicide generally and to adopt*

> *measures designed to that end. It does not, however, necessarily follow that the State has an obligation to use all of the means at its disposal to seek to prevent persons in a position such as that of [Marie Fleming] from bringing her own life to an end"*.

32. Dr Andrea Mulligan told the Committee that the Supreme Court found in the Marie Fleming case that there is not a right to die or terminate one's life. This means that the State is, for example, entitled to take steps to stop people dying by suicide, and may even be required to take steps to stop people dying by suicide. However, this did not mean that the Oireachtas is not entitled to legislate for assisted dying.
33. Paragraph 108 of the Supreme Court judgment in the Fleming case states that:

> "*Nothing in this judgment should be taken as necessarily implying that it would not be open to the State, in the event that the Oireachtas were satisfied that measures with appropriate safeguards could be introduced, to legislate to deal with a case such as that of the appellant*".

34. Both Dr Hickey and Dr Mulligan cited this paragraph as evidence that the Supreme Court views the Oireachtas as having competency to legislate for assisted dying. The competency to legislate in this area would have limits, with the Oireachtas needing to be satisfied that measures with appropriate safeguards could be introduced. This means that it would not be necessary to hold a referendum on the issue in order to amend the Constitution.
35. The Committee heard that although not binding or authoritative, commentary from the High Court judgment is not insignificant and would be relevant in trying to set neutral conditions should the Oireachtas decide to legislate for assisted dying. Dr Mulligan told the Committee that the High Court undoubtedly had sympathy for Marie Fleming, quoting a passage from the High Court judgment,

> "*If this Court could be satisfied that it would be possible to tailor-make a solution which would address the needs of Ms. Fleming alone without any possible implications for third parties or society at large, there might be a good deal to be said in favour of her case.*"

36. Speaking on the matter, Mr. Tom Curran, partner of the late Marie Fleming, told the Committee that the Court's only option was to "strike out the law."

Presumption of Constitutionality

37. Over the history of the State, the Courts have developed the doctrine of the presumption of constitutionality. This doctrine holds that legislation that has been passed by the Oireachtas should be considered to be constitutional, until it has been clearly proven not to be.
38. Dr Hickey summed up the doctrine of presumption of constitutionality with a quote from Mr. Justice Hanna's ruling in the 1939 case of *Pigs Marketing Board v Donnelly*:

> "*When the Court has to consider the constitutionality of a law it must, in the first place, be accepted as an axiom that a law passed by the Oireachtas, the elected representatives of the people, is presumed to be constitutional unless and until the contrary is clearly established ...*"

Adding a Clause to the Constitution

39. The Thirty-sixth Amendment to the Constitution replaced the text of Article 40.3.3° which had recognised the equal right to life of the pregnant woman and the unborn with a new provision, which reads:

> *"Provision may be made by law for the regulation of termination of pregnancy*."

40. The Committee deliberated on whether, other constitutional issues aside, a similar provision would need to be inserted into the Constitution in order for assisted dying to be legislated for. The Committee heard from Dr Conor Casey that the new Article 40. 3.3° was inserted due to concerns that even following the repeal of the Eighth Amendment, there may be lingering constitutional entitlements that could be pleaded. This position was backed up by Dr Tom Hickey and Dr Andrea Mulligan.
41. Dr Mulligan further stated that the new Article 40.3.3° was necessary to provide a form of "constitutional insulation" against a situation where there might yet be other unenumerated constitutional rights that would, in effect, mean that legislation for the termination of pregnancy might be unconstitutional. Dr Mulligan

stated that while such an explicit clause was probably necessary in the case of legislating for abortion, it would not be necessary in the case of assisted dying.

42. The Supreme Court in its ruling in the Fleming case stated that:

> *"Nothing in this judgment should be taken as necessarily implying that it would not be open to the State, in the event that the Oireachtas were satisfied that measures with appropriate safeguards could be introduced, to legislate to deal with a case such as that of the appellant. If such legislation was introduced, it would be for the courts to determine whether the balancing by the Oireachtas of any legitimate concerns was within the boundaries of what was constitutionally permissible. Any such consideration would, necessarily, have to pay appropriate regard to the assessment made by the Oireachtas both of any competing interests and the practicability of any measures thus introduced."*

International Models of Assisted Dying

43. Assisted dying is legal in some form in over 27 jurisdictions, including 10 US states and the District of Columbia, all Australian states and New Zealand.

44. Models of assisted dying can vary vastly between different jurisdictions. Areas of difference include:

Eligibility Criteria	Some assisted dying models specify that an individual applying for assisted dying must have a terminal prognosis, usually within a specified timeframe (for example six months). Others are based on some form of suffering, which is usually classed as irredeemable or unbearable, and which cannot be relieved.
Permitted Form	Jurisdictions vary between those which allow assisted suicide only (the individual must self-administer the medication), euthanasia only (a health worker must administer the medication) or allowing both.

Application Procedure	Processes differ in aspects such as how a request for assisted dying can be made (for example in writing or verbally), how many doctors are required to assess a patient.
Reporting and data gathering procedure	Jurisdictions differ on what data is required to be reported, how and if it is gathered.

Table 1 Areas of Difference in Assisted Dying Models

45. The Committee held a series of meetings to examine how assisted dying is operating in several different jurisdictions. The Committee sought testimony from witnesses in these jurisdictions to gather views on how their assisted dying systems were operating, and what Ireland could learn from them.

Netherlands

46. In 2002, the Netherlands introduced *The Termination of Life on Request and Assisted Suicide (Review Procedures) Act* which permits euthanasia and assisted suicide when the doctor acts in accordance with legal criteria. Eligibility is based on inter alia the physician being satisfied that the patient's suffering is unbearable, with no prospect of improvement.
47. The Netherlands is seen as having a liberal assisted dying system. For example, the Act allows for children from the age of 12, although parental consent is required until they reach the age of 16. For children between the age of 16-18 the Act requires that the parent or guardian be consulted. The Act also allows for assisted dying to be requested in an advance directive. This means that in situations where the patient (who is over 16 years of age) is no longer capable of expressing their wishes with regard to euthanasia, an advance directive may take the place of an oral request. In 2020, the Dutch Supreme Court held that a physician could lawfully end the life of a person with advanced dementia, where it had been requested in an advance directive and where the other legal criteria had been met.

48. Professor Theo Boer of the Protestant Theological University told the Committee that following a few years in the early 2000s which saw a stable number of people accessing assisted dying, the following 20 years witnessed a large increase in both the number of people requesting assisted dying, and a broadening of the reasons for which they have sought it.

Switzerland

49. The assisting of suicide that is not for selfish motives has been legal in Switzerland since 1942. However, euthanasia remains outlawed, as is inciting or assisting suicide for selfish motives. Unusually, Switzerland has not enacted centralised legislation to regulate assisted dying and it is not formally part of the health system. Instead, it is usually facilitated by non-profit organisations. Although not centrally regulated there are certain legal requirements on doctors when prescribing a lethal dose of medication to a person who wishes to end their own life, such as, for example being satisfied that the person has capacity. In addition, certain of the major non-profits have developed their own criteria for assisted dying, including that they may require that a terminal illness has been diagnosed.
50. Switzerland is also distinct in that it allows for non-residents to access assisted dying. According to Silvan Luley of Dignitas, one of the largest non-profits facilitating assisted suicide in Switzerland, Dignitas currently has close to 100 Irish members. Since 2003, 12 Irish people have accessed assisted dying in Switzerland through Dignitas, according to Mr Luley.

Oregon

51. Oregon was the first US State to legalise assisted dying, following the passing of the Death with Dignity Act in 1994. The Act allows for self-administered assisted dying only and does not permit euthanasia. The Act requires patients seeking assisted dying to be *inter alia* (1) 18 years of age or older, (2) acting voluntarily (3) capable of making health care decisions for themselves, and (4) diagnosed with a terminal illness that will, based on reasonable medical judgment, lead to death within six months. The patient must make two oral requests, separated by at least 15 days, and a written declaration, that must be signed by two witnesses

and provided to the attending doctor. The attending doctor cannot prescribe the medicine until 15 days has passed between the two oral declarations and at least 48 hours has passed since the patient completed the written declaration. In 2020, the Act was amended to permit a waiver of these waiting periods, in circumstances where the Doctor forms the view that the patient will die before the expiry of the timeframes.

Canada

52. In 2015, the Canadian Supreme Court struck down the blanket ban on assisted suicide ruling that it was in violation of a number of Charter rights in so far as it prohibited physician assisted death of a competent adult who clearly consents and has a grievous irremediable condition. In 2016 and in response to this ruling, legislation was enacted that permits both physician and self-administered assisted dying. The initial legislation required that a patient be suffering a from grievous and irremediable medical condition and to have their death be reasonably foreseeable. However, in 2021, following a legal challenge the requirement for death to be reasonably foreseeable was removed. It is planned to broaden access further, from those with physical conditions, to include people with mental illnesses, but this plan has been delayed until 2027, to allow for further deliberation. The Canadian government recently declared that the health system is not ready for this expansion.
53. Canada's assisted dying system has been criticised for being too expansive, allowing too wide access. Dr Heidi Janz highlighted to the Committee how the 2021 changes meant that people with disabilities are now eligible for assisted dying on the basis of those disabilities.

Australia

54. Laws regarding assisted dying in Australia are matters for the individual State and Territory governments. It is currently legal in all Australian States. It is illegal in the Northern Territory and the Australian Capital Territory, although draft legislation to legalise assisted dying was introduced in the Australian Capital Territory parliament in October 2023.

55. Victoria was the first State to introduce assisted dying under the *Voluntary Assisted Dying Act 2017 (Vic*). The other States followed suit, most recently New South Wales, where the *Voluntary Assisted Dying Act 2022 (NSW)* commenced in November 2023.
56. The assisted dying laws are similar across each State, although there are some differences. The law permits self-administered assisted dying and physician assisted dying. To be eligible, a person must be *inter alia*: aged 18 years or over; have decision-making capacity in relation to assisted dying; and be acting voluntarily and without coercion. Additionally, they must be diagnosed with a disease or condition that:
    - is advanced and will cause death. In all States except Tasmania the disease must also be progressive (i.e., the person experiences active deterioration);
    - is incurable (Victoria, South Australia and Tasmania only), and irreversible (Tasmania only);
    - is expected to cause death within six months, or 12 months for a person with a neurodegenerative disease, illness or medical condition. In Queensland, however, a person expected to die within 12 months may apply for VAD; and
    - cause suffering that cannot be relieved in a manner that the person finds tolerable. The person's suffering may be physical or non-physical e.g., psychological, existential.

New Zealand

57. Assisted Dying was legalised in New Zealand by the End-of-Life Choice Act 2019, which commenced in November 2021.As part of the Act, a referendum on the issue was held in 2020, in which 65.1% voted “Yes”.
58. The Act permits both self-administered and health practitioner administered assistance in dying. In order to be eligible for assisted dying, a person must:
    - be over 18;
    - be a New Zealand citizen or permanent resident;
    - be in an advanced state of irreversible decline in physical capability;

- suffer from a terminal illness likely to end their life within six months;
- experience unbearable suffering that cannot be relieved in a manner that the person finds tolerable; and
- be competent to make an informed decision about assisted dying.

59. Dr Kristen Good, the New Zealand Registrar (assisted dying) informed the Committee that, in developing the system, prioritising the development of safeguards was essential, describing it as “a race to be the safest and the toughest".

Ethical and Moral Considerations

60. The Joint Committee deliberated on the ethical and moral considerations relating to assisted dying.

Autonomy

61. Autonomy is one of the most common concerns cited by people arguing in favour of assisted dying. According to Dr Tom Jeanne of the Oregon Health Authority, where only self-administered assisted dying is permitted, approximately 90% of individuals seeking assisted dying in Oregon cite loss of autonomy as an end-of-life concern.
62. Dr Annie McKeown O'Donovan gave a practical definition of autonomy as being "capacity and ability to decide what to do with one's own life, as well as when and how". She told the Committee that this is always governed by one's "bio-psychosocial temporal setting"; an individual's decisions cannot be realised without the support of others.
63. Dr Thomas Finegan warned the Committee that allowing assisted dying on an autonomy rationale would mean it would be very difficult to put any limits on assisted dying. In his evidence, he told the Committee that when assisted dying is based on autonomy, there appears to be no consistent, non-arbitrary justification for limiting access, and that it would need to be available on virtually all medical grounds.
64. Dr Andrew Lyne of Irish Doctors supporting Medical Assistance in Dying told the Committee that introducing assisted dying would be offering terminally ill patients a choice at the end of their lives. He said that medical paternalism, where doctors assume what is in the best interests of their patient is no longer acceptable, and that patient's choices should be accepted and supported where reasonable.
65. In contrast, Dr Feargal Twomey, representing the Royal College of Physicians in Ireland told the Committee that while patient autonomy and choice are important, they cannot be absolute. This view was shared by Professor William Binchy of the Pro-Life Campaign who told the Committee that autonomy has limits and that the right to autonomy ends when exercising it causes harm to others.

66. Mr Lloyd Riley of Dignity in Dying told the Committee that with regard to autonomy, the question of assisted dying does not exist in a vacuum, and that people can already make autonomous decisions with regard to end-of-life care and treatment. People can already choose to refuse or end a life-extending treatment and can choose to refuse food and fluids.

The Value of Life

67. The Committee deliberated on whether there is an intrinsic value of life, and how that might impact on the morality of deliberately ending or helping to end the life of another person.
68. Dr Thomas Finegan of Mary Immaculate College told the Committee that every human life possesses profound inherent worth and questioned whether assisted dying would be contrary to that. He further argued that upholding the norm against the intentional ending of human life is essential to consistently maintain the principle that every human life is of intrinsic, equal, and inviolable worth.
69. When discussing the basis for the intrinsic value of life, Dr Finegan rejected the idea that will, autonomy or agency are the basis for that value, as this would mean that the lives of individuals who lacked these would be without value.
70. Dr Kevin Yuill, Chief Executive Officer of Humanists Against Assisted Suicide and Euthanasia, told the Committee that the principle of assuming somebody’s life is valuable and assigning value to that life means we do not take these lives.
71. Dr Yuill and Dr Finegan both put forward the position to the Committee that any form of assisted dying was incompatible with the moral conception of all lives having an inherent value. This position was opposed by Dr Annie McKeown O’Donovan. Dr McKeown O’Donovan in providing evidence to the Committee agreed that human life has moral worth and value, but also asserted that life has *prima facie* moral value that can be overridden in specific narrow contexts. She stated that life’s value can diminish in line with the perceptions of the individual whose life it is. According to Dr McKeown O’Donovan, when someone who is very close to death wants to die now, rather than postpone the inevitable, it becomes crucial to meaningfully consider whether prolonging this period of life, characterised by dying and the want to die, is morally preferable to assisting this dying person to die now.

The Meaning of a Good Death

72. The Committee deliberated on what is meant by the concept of a "good death". Professor Deirdre Madden told the Committee that when we talk about having a good death,

> "*We mean we want to not be in physical pain, to have an emotional reaction and psychological coping mechanisms to enable us to die in peace. We hope the impact of our death on our families will be eased by the gentle nature of our passing and that we will be able to work through whatever anxieties and worries we have and die on our own terms".*

73. Ms Paula O'Reilly of The Irish Hospice Foundation told the Committee that their 2016 survey on living with illness, death and bereavement "Have Your Say", found that most people want to be pain free, be treated with and die with dignity, and feel comfortable and cared for, ideally at home. In The Irish Hospice Foundation's consultation report "Dying Well at Home" focus group participants described a good death as comfortable, free from pain and suffering, honouring the end-of-life wishes of the person, and allowing people to die with dignity in the place of their choosing and with those they wanted present.
74. Ms O'Reilly stressed however that one must not get carried away by the idea of a "good death", as any death is difficulty, and people will still grieve. Instead, she said it is a question of how compassionate we can be around end-of-life and bereavement care for people.

Principle of Double Effect

75. The Committee heard from Dr Andrea Mulligan that it is lawful to provide pain relief to a dying person, even if it is understood and foreseen that this will hasten that person's death. This is based on the principle of double effect; a philosophical concept where an action has two effects, one harmful and one positive. According to the principle, the action is permissible if the intention is to bring about the positive outcome, even if it is known that the negative outcome will also occur.

76. Dr Tom Hickey told the Committee that over the last 25 years, the Irish Courts have used this principle to distinguish between letting someone die and taking an active step to bring a life to an end.
77. In his evidence, Mr Finn Keyes BL referred to the recent Supreme Court case In the Matter of JJ, wherein he explains that the Court placed emphasis on the doctrine of double effect in justifying orders that would allow doctors to withdraw respiratory support from a young boy who had suffered a catastrophic brain injury. Of particular note, he referred to the evidence provided by a consultant in paediatric palliative medicine, which was referred to by the Court in its judgment, and which outlines the nature of palliative care in this context:

> *‘The intent is never to shorten life. The goal of palliative care is to live well, but it also encompasses the potential to die well…So the intent is never to hasten death or shorten life. The intent is only to relieve suffering.*’

78. Dr Gabrielle Colleran of the Irish Hospital Consultants Association told the Committee that double effect is not something that would take place in Ireland. Similarly, when asked if double effect happens in some medical settings, Dr Feargal Twomey of the Royal College of Physicians in Ireland said that it did not.
79. There was disagreement among witnesses before the Committee as to whether the correct administration of pain relief has the effect of shortening life, and therefore whether the question of double effect would apply. Professor Deirdre Madden said that although she was not a medical doctor, she took the view that there were analgesic prescriptions that hasten death by causing respiratory depression. Professor David Albert Jones said that there were doctors who, with respect to the law, were reluctant to give pain relief because they think it will inevitably shorten life. Professor Jones said it was medically not the case that giving opiates titrated appropriately to pain relief shortens life and that this idea was a ‘kind of myth’. He said that the evidence base for the proposition that giving morphine inevitably shortens life was very weak. Sometimes pain relief lengthened one’s life, sometimes it shortened it, but there was no consistency.
80. Concerns were raised with the Committee that relying on the principle of double effect could have negative consequences. Dr Louise Campbell told the Committee that she believes that the principle of double effect is less useful in

discussions of assisted dying than a “straightforward, nuanced, very careful” examination of whether an intervention is justified.

81. Dr Brendan O’Shea of Irish Doctors Supporting Medical Assistance in Dying told the Committee that a problem with relying on double effect is that it puts receiving assistance to die at the discretion of the clinician managing the patient’s care, as opposed to being based on a set assessment and defined eligibility criteria.
82. Professor Theo Boer who opposes assisted dying, told the Committee that he believes that doctors should be allowed to end patients’ lives sometimes, and that the principle of double effect is a preferable mechanism for allowing this.
83. Similarly, Professor William Binchy of the Pro-Life Campaign told the Committee that his position is not that life should continue indefinitely regardless of pain. He cited the principle of double effect as a legitimate method to relieve that pain.

Lived Experience of End-of-Life Care

84. The Committee held a public meeting on 10 October 2023 to engage with witnesses who had lived experience relating to end-of-life care and assisted dying, either directly themselves, or through family members. Although such a small sample of individuals cannot be considered to be representative of wider society, the Committee considered it important to hear at least some such stories directly and is deeply grateful to the witnesses for sharing their deeply personal stories in such a public forum.
85. Ms Elma Walsh’s 16-year-old son Donal passed away from cancer in May 2013. Following his death, his parents established the Donal Walsh #Livelife Foundation to promote the anti-suicide message which Donal had shared in the months leading up to his death. Ms Walsh praised the palliative care team who treated Donal, both for the relief and dignity they gave to him, and for the care they gave to his family. She also told the Committee that society must promote hope, and that assisted dying is a statement of no hope.
86. Mr John Wall told the Committee of his own terminal diagnosis with cancer. He told the Committee that people with terminal illnesses do not wish to die but seek to extend their time through any avenue possible. For him, assisted dying pertains only to the very end of an individual’s life, and is about how a person says goodbye, not when. He told the Committee that in many end-of-life cases,

there is extreme pain involved, and there is nothing that can be done but wait. It is this waiting that people may want to avoid.

87. Mr Tom Curran, who was Marie Fleming's partner, spoke about how she did not want her condition to have control of her ability to die, and did not want a prolonged and possibly painful end to her life. He said that Marie had investigated travelling to Switzerland to access assisted dying. However, the physical difficulties involved in making the trip, and in having to drink the medication herself, the only method used at the time, would have meant having to access assisted dying earlier than she wanted to.

88. Mr Garret Ahern told the Committee how his wife Vicky Janssens, a Belgian citizen, travelled to Belgium to access assisted dying, when the pain caused by her cancer became unmanageable and intolerable. He told the Committee that his wife did not want to die, but only to end her pain. He also told the Committee of the emotional pain Vicky faced, leaving her friends and family in Ireland, and his own feeling of isolation and lack of support accompanying her to Belgium. Mr. Ahern stressed the importance of hearing both sides of the debate; not only about what does not work but what is working in other jurisdictions.

89. The Committee also heard video evidence from the late Mr Brendan Clarke regarding his experience. Mr Clarke suffered from motor neurone disease and campaigned for assisted dying to be introduced. He had been invited to attend a Committee hearing following the summer recess 2023, but passed away before he could attend. In his video testimony, Mr Clarke expressed his hope that legislation would be introduced to allow people in similar situations to him to end their life at a time of their choosing.

Faith Views

90. The Committee invited representatives from major religions and philosophical organisations in Ireland to a public meeting to hear their views on assisted dying. Those who responded / attended included representatives from the Irish Catholic Bishops' Conference, the Presbyterian Church in Ireland, the Church of Ireland, Irish Muslim Peace and Integration Council, the Methodist Church in Ireland and the Humanist Association of Ireland.

91. Other than the Humanist Association of Ireland, all of these groups opposed the introduction of assisted dying. Their opposition was partly based on religious grounds. Beyond religious grounds, they also reiterated many of the objections to assisted dying raised by witnesses at other meetings, such as the danger of incrementalism, concerns around conscientious objection, and the fear that people may be coerced into accessing assisted dying undermining the relationship of trust on which good healthcare is founded.

92. Reverend Dr Rory Corbett, representing the Church of Ireland, suggested that if assisted dying were introduced, a second assessor could be a priest, who may have had more contact with the patient in the later stages of their illness, and so have more knowledge of any potential coercion. This would be instead of having two doctors assess a patient's eligibility, as happens in many jurisdictions. Alternatively, he suggested that assessments could not involve doctors at all, but be carried out by a societal team, or judicial review. Dr David Bruce of the Presbyterian Church in Ireland similarly suggested that any assisted dying system should be administered by the courts, or by a dedicated commission accountable to the courts. Doctors in this system would be purely professional advisers on strictly medical aspects of the application.

93. The Humanist Association of Ireland were the only group at the meeting who were in favour of legalising assisted dying. They back the introduction of assisted dying for people who are suffering from a terminal, incurable or progressive condition and feel that their quality of life is so unbearable that they want a painless death at a time of their choosing.

Safeguards and Consequences

Informed Consent

Coercion

94. Witnesses repeatedly raised with the Committee the challenge of ensuring that the decision to seek assisted dying is made of a patient's own volition and that they are not being coerced in any way. Dr Andrea Mulligan told the Committee that ensuring that the decision is uncoerced and free from external pressures is one of the most difficult things to achieve in practice.
95. Dr Deirdre Collins of the Irish College of General Practitioners warned that the first key safeguard to any assisted dying legislation would be safeguarding vulnerable people. Dr Collins highlighted particular concerns regarding patient abuse or coercion of elderly people in nursing homes and those with dementia. Dr Hannah Linane of the Irish Association for Palliative Care cited World Health Organisation estimates that one in six people over the age of 60 suffer from abuse.
96. Dr Sinead Donnelly, a palliative care doctor working in New Zealand, warned that coercion is subtle and happening regularly, and is not tied to class. She cited examples of well-off individuals who want to die in their own home, but whose partner does not want a nurse in their home as a result the patient will choose assisted dying.
97. The Committee also heard from several witnesses that attempts at coercion can be detected and screened for if the application process for assisted dying is properly set up. Dr Kristin Good, the New Zealand Registrar (assisted Dying) told the Committee that suspected coercion is investigated and documented at each stage of the application process, and that this is reviewed by her.
98. Dr Greg Mewett, an Australian assisted dying provider and palliative care doctor, told the Committee that coercion and other potentially adverse factors in informed decision making are thoroughly screened for during initial and later interviews with patients. Dr Mewett also told the Committee that in his practice, they mainly see people being coerced away from assisted dying, rather than coerced into it.

99. When discussing the experience of assisted dying practitioners in Australia, Dr Cameron McLaren told the Committee that coercion is not something they have problems with. Rather than seeing people being coerced into assisted dying, they instead see patients' family members advocating for them to be able to act on their own decisions.

Recommendation 5

The Committee recommends that doctors and healthcare workers involved in the provision of assisted dying be trained to the highest level possible to identify coercion when assessing or treating a patient.

Recommendation 6

The Committee recommends that if a medical professional has been proven to have acted outside of the permitted regulations or has attempted to coerce an individual, they will have committed an offence under the potential legislation and may be held liable.

Recommendation 7

The Committee recommends the inclusion in any legislation on assisted dying of mandatory reporting to An Garda Síochána of any information or evidence concerning the issue of possible coercion in relation to assisted dying.

Societal Coercion

100. The Committee was advised by Dr Sinead Donnelly that beyond the risk of coercion posed by individuals, be it from family members or loved ones, external societal pressures can also play a role in coercing people into assisted dying. For example, if an individual approaching the end of their life cannot access supports necessary to remain in their own home, they may instead feel pressured to access assisted dying.

101. Sinéad Gibney of the Irish Human Rights and Equality Commission (IHREC) told the Committee that the most important protection against people feeling coerced into seeking assisted dying is to ensure social conditions, support, care and services are in place so that people with disabilities or serious or terminal illnesses do not feel that they are a burden to their loved ones or to society. She went on to state that this goes beyond adequate funding and access to health and social services and must include active efforts to create a society where people are able to live life on equal terms, free from discrimination.

102. Dr Louise Campbell warned that requests for assistance in dying may mask the existence of unmet needs. The Committee heard that nobody should feel forced into seeking assisted dying because they do not have the supports needed to allow them to live a full life in the manner of their choosing.

Capacity

103. Along with ensuring that any decision to request assisted dying is voluntary and not coerced, another important aspect is the need to ensure that the person making the decision has the capacity to do so. Dr Louise Campbell told the Committee that informed consent is:

> "*the voluntary, uncoerced authorisation of a medical intervention by a person who has capacity to make a decision on the proposed intervention and has received adequate information to enable her to make the decision.*"

104. Borderline capacity, where capacity is in doubt, should be an exclusion criterion according to Dr Campbell. If an individual cannot definitely be said to have the capacity to make a decision regarding assisted dying, then they should not be eligible for assisted dying.

105. In order to ensure that capacity is properly assessed, Dr Campbell recommended that any model of assisted dying must include provision for tailored, expert-driven training for doctors and other health professionals in assessing capacity, determining eligibility and identifying compromised voluntariness or undue influence. She told the Committee that health professionals assessing capacity and voluntariness can be trained specifically within specific parameters to watch out for red flags under voluntariness criterion and capacity criterion.

Assisted Decision-Making (Capacity) Act 2015

106. *The Assisted Decision-Making (Capacity) Act 2015* (the 2015 Act) established a legal framework to provide support for people where decision making is not so straightforward. According to Dr Louise Campbell, it is a move to replace substitute decision making, where someone else makes a decision on an individual based on their perceived best interests, with supported decision making, where an individual's own desires are prioritised and acted on as much as possible.

107. Mr Finn Keyes BL described the 2015 Act as a move from a paternalistic best interest test to trying to discern as far as possible an individual's past and present wishes.

108. Dr Caroline Dalton of UCC told the Committee that the 2015 Act affirms a functional approach to capacity. This recognises that the capacity of individuals to make a decision may vary depending on the decision to be made and the context in which that decision is made, as in that capacity may fluctuate.

109. Dr Dalton also warned that while someone's capacity to make a decision to request assisted dying must be confirmed, there is also a need to ensure that people's autonomy is protected, and they are not inadvertently excluded from a range of decision-making opportunities relating to their end-of-life care.

110. Dr Dalton told the Committee that there is a need to ensure that individuals have the supports and resources they need to understand information before them and make a decision on it.

Recommendation 8

The Committee recommends that where capacity is in doubt, a functional test for decision-making capacity should be part of the assessment for eligibility for assisted dying.

Recommendation 9

The Committee recommends that any doctor involved in determining eligibility for assisted dying must have professional training in assessing capacity and voluntariness.

Loss of Capacity

111. The Committee deliberated on the issue of the possibility of an individual requesting assisted dying at a time when they had full capacity to do so but losing that capacity prior to their assisted death.

112. Many jurisdictions require an individual to make multiple formal requests for assisted dying, usually with a set period of time before them. The Committee heard that there was a possibility that decision making capacity can deteriorate very rapidly, and that there would be a possibility of an individual losing that capacity after making an initial request for assisted dying, but before any mandated subsequent request, or between a final request and the actual procedure.

113. The overwhelming view among witnesses was that given the seriousness of the act of ending a person’s life, they should have to retain their decision-making capacity up to the very point of the procedure. Several jurisdictions require that individuals accessing assisted dying must make a final and clear request or accession to the procedure directly before the medication is administered. Such a requirement may have a bearing on whether a proposed assisted dying model

allows for euthanasia or assisted suicide. It might also require that if assisted suicide is allowed, a doctor or health worker is present at the time of ingestion, to confirm that capacity has been retained.

114. Professor Mary Donnelly also suggested to the Committee that in certain circumstances, if it was envisaged that a patient might shortly lose their decision-making capacity, any prescribed period between formal requests, or waiting period after requests, might be waived.

Recommendation 10

The Committee recommends that following an initial successful assessment for assisted dying that finds a patient eligible, if the patient temporarily loses decision-making capacity, then that eligibility is suspended for the duration of their incapacity.

Advanced Healthcare Directives

115. The *Assisted Decision Making (Capacity) Act 2015* established a legal framework for advanced healthcare directives. These documents allow individuals to set out instructions in relation to healthcare treatments they wish to refuse when they no longer have the ability to do so.

116. An advanced healthcare directive comes into effect when the person lacks the decision-making capacity to make healthcare treatment decisions for themselves.

117. The Committee deliberated on the issue of whether advanced healthcare directives could have a role in any potential assisted dying system. In certain scenarios, an individual might envisage requiring assisted dying if their condition deteriorated to a certain point. Allowing people to request assisted dying in an advanced healthcare directive would permit them to plan for a situation where they would want assisted dying but were unable to request it.

The Committee heard that advanced healthcare directives only apply for as long as the individual lacks decision-making capacity, should they regain this capacity, the directive is essentially rendered moot. Mr Finn Keyes BL noted that the High

Court retains jurisdiction relating to end-of-life matters under the *Assisted Decision-Making (Capacity) Act,* and that they "give high deference to the advanced healthcare directive because consent given with capacity is the high-water mark."

118. However, most witnesses, including those in favour of legalising assisted dying, felt that it should not be allowed for under advanced healthcare directives, given the already complicated clinical and ethical issues surrounding capacity.

Recommendation 11

The Committee does not recommend that advanced healthcare directives allow for individuals to make requests for assisted dying. However, consideration of the issue may be included in any review of assisted dying legislation.

Palliative Care

119. Witnesses felt there needed to be a clear distinction between assisted dying and palliative care. This was a particular concern of numerous palliative care doctors whom the Committee heard from. This concern is grounded in two fears; the first is that if palliative care and assisted dying are confused or conflated in the minds of the public, then they will be put off seeking palliative care. The second is that funding and resources will be taken from palliative care system for assisted dying.

Conflation with Assisted Dying

120. Dr Regina McQuillan of the Irish Palliative Medicine Consultants' Association (IPMCA), for example, told the Committee that people are already fearful about seeking palliative care due to its association with the end-of-life care and life-limiting illnesses. If palliative care doctors were also involved in providing assisted dying it would make developing and maintaining trust extremely difficult.

121. In general, palliative care organisations in Ireland were strongly opposed to the introduction of assisted dying to Ireland, and in particular felt that it should in no way be seen as being a part of the palliative care system.

Protecting Funding and Resources

122. There was also concern among witnesses that introducing assisted dying would lead to funding for palliative care being affected. Access to palliative care in Ireland is affected by geographic factors; some areas have high quality palliative care services, while services in some other areas have poorer access. Any new model of assisted dying should not draw any of its funding or resources from the palliative care system.

123. Representatives from the Department of Health told the Committee that an updated palliative care strategy is due to be published in the first half of 2024.

Recommendation 12

The Committee recommends that the updated palliative care strategy should be published by the Department of Health without delay.

Recommendation 13

The Committee recommends that palliative care and the operation of assisted dying should operate completely separately and independently of each other.

Recommendation 14

The Committee recommends that resources and funding for, and information about, palliative care services should be substantially increased, to ensure consistent and accessible services of the highest quality are provided throughout the State.

Recommendation 15

The Committee recommends that funding for assisted dying and palliative care be separate and distinct from one another, provided for in separate votes in the Department of Health budget.

Palliative Care and Assisted Dying in other Jurisdictions.

124. The Committee heard that when assisted dying was introduced in other jurisdictions, palliative care doctors were similarly opposed to it, but that this position has shifted among some palliative care doctors, with a growing acceptance that assisted dying is not a threat to palliative care. Silvan Luley of Dignitas told the Committee that in Switzerland there had been “competitive thinking” early on between palliative care physicians and assisted dying providers. It was stated that over the years however, there has been increasing cooperation between palliative care doctors and organisations like Dignitas for the benefit of the patient.

125. Representatives of Voluntary Assisted Dying Australia and New Zealand (VADANZ) told the Committee that the recent experience in New Zealand and Australia is similar. Dr Cameron McLaren said that in their view assisted dying is not seen and should not be seen as an alternative to palliative care, but as an option at the end of a palliative care journey. Dr Peter Allcroft, a palliative care doctor and assisted dying provider described palliative care and assisted dying

as operating on "parallel tracks" which sometimes intersect and may then separate again.

126. Dr Laura Chapman told the Committee that New Zealand started with palliative care being very against assisted dying, but that over the past two years, they are learning to work together.

> "*Palliative care is learning that assisted dying has no interest in doing anything other than support patients to receive great palliative care and assisted dying is just the very end point where some patients may choose to make different decisions.*"

Ensuring Access to All End-of-Life Care Options

127. The Committee was told by Dr Max Watson of Project ECHO and Hospice UK that assisted dying should never become the default option for people at the end of their lives. He warned that doing so could severely limit patient choice.

128. Silvan Luley of Dignitas expressed a view to the Committee that a healthcare system should offer patients a choice of many options for end-of-life care, and should also educate people about them, without prejudging which is better or worse. He said that options for assisted dying and palliative care should be available along with good care in age, and hospice care.

Recommendation 16

The Committee recommends that a person inquiring about assisted dying, following a terminal diagnosis, should be informed of, and assisted in, accessing all end-of-life care options, including palliative care.

Protecting Health Professionals

Conscientious Objection

129. The Committee heard numerous strong concerns that if assisted dying were legalised in any form, the framework for it must take into account the depth and strength of opposition to it, both moral and professional, held by many health

workers. A professional should not be expected to have a role in the assisted dying process because to do so would violate their moral and professional integrity.

130. Freedom of conscience is a constitutionally protected right and the right to conscientious objection is a long-held principle withing medical and health care. In a health care setting conscientious objection would arise where a professional who might otherwise have a role in the assisted dying process could opt out of participating because to do so would violate their moral and professional integrity.

131. Roles health professionals might be expected to undertake in an assisted dying framework might include:

- giving patients information;
- discussing treatment options and advising patients about those options;
- referring a patient to another health care professional;
- assessing patients' eligibility for assisted dying;
- assessing their capacity to make requests for assisted dying;
- prescribing and/or supplying medication for use in ending life;
- providing other forms of care to patients who are progressing through the stages of an assisted dying process; and
- completing paperwork during and after the process.

132. The Committee heard that the right to conscientious objection must not be limited to senior doctors or consultants, but to all heath workers who might be expected to be involved, including junior doctors, nurses, who are often the first point of conversation for patients on health care issues, and pharmacists, who would likely be expected to prescribe the medication used in assisted dying.

133. While a health professionals' right to freedom of conscience must be protected, it can be subject to legitimate and proportionate interference. Accordingly, it does not follow that the exercise of this right should necessarily close off an individual's ability to access treatment.

134. When considering conscientious objection from a medical ethics perspective, Professor Richard Huxtable of the University of Bristol used the term "conventional compromise" to describe how lawmakers might approach this balancing exercise. He opined:

> "*This is where lawmakers attempt on the one hand, to provide for, if it is to be a legal right, the rights of the patient to be honoured while at the same time trying to ensure the consciences of the relevant professionals are protected. The compromise consists in the fact that there will nonetheless be a bottom line, such as a duty to refer on the part of the objecting clinicians to a colleague who will be to vindicate the patient's legal rights*".

135. In some jurisdictions where assisted dying is legislated for, for example New Zealand, an objecting clinician is not expected to refer on to a colleague directly. In New Zealand, where a health professional does not want to participate in assisted dying, they must inform the patient of their objection, and tell them that they have the right to contact the Support and Consultation for End of Life in New Zealand (SCENZ) Group, a statutory body which maintains a list of medical practitioners involved in providing assisted dying services. The SCENZ Group will then give the patient the contact details of an appropriate health professional.

136. The need for sanctions for health workers who have a conscientious objection but do not follow the set process was a consideration raised to the Committee, to ensure that patients were not blocked or delayed in accessing what would be a legal medical option.

137. Dr Laura Chapman informed the Committee that conscientious objection to assisted dying in practice in New Zealand is not a binary position of health professionals being either opposed or participating. It is, rather, a spectrum with a range of views on levels of participation.

Recommendation 17

The Committee recommends that the right to conscientious objection of all doctors and health workers directly involved in the provision of assisted dying should be protected in law.

Notwithstanding the above, the Committee recommends that when a doctor or health care professional exercise this right, that this will not have the effect of closing off access to assisted dying to the patient. To this end, the law should place a requirement on a health care professional, who refuses to participate in the service, to refer onwards to a participating health care professional and/or a national oversight body.

Protecting the Doctor Patient Relationship

138. Repeated concerns were raised by witnesses to the Committee that the introduction of assisted dying to Ireland would have a damaging impact on the relationship between doctors and their patients. Dr Una Molloy of the Irish Association for Palliative Care (IAPC) told the Committee that assisted dying could change the relationship between doctors and their patients, changing the journey they travel with them.

139. Similarly, Dr Regina McQuillan of the Irish Palliative Medicine Consultants' Association (IPMCA) told the Committee that the IPMCA believe that introducing assisted dying would "significantly and negatively" impact the trusted relationship that exists between doctors and their patients, particularly in the area of palliative care. This belief is due to patients' fear of being referred to palliative care, given their role in end-of-life care.

140. Dr Brendan O'Shea of Irish Doctors supporting Medical Assistance in Dying told the Committee that the doctor-patient relationship is constantly changing. He told the Committee that over the last ten years, general practitioners have been striving to have earlier conversations with patients about their end-of-life wishes. Dr O'Shea told the Committee that if assisted dying were introduced based on the international practice of family medicine being at its heart, he was confident that it could be handled in a way that is positive and enabling, rather than prejudicial to the doctor-patient relationship.

Effect of Participating on Health Workers and Professionals

141. The Committee heard concerns that providing assisted dying could have negative effects on participating doctors. Professor Harvey Chochinov of the University of Manitoba warned that a patient's wish to die, apart from the effect on themselves, can elicit feelings of impotence and helplessness in healthcare

workers. He told the Committee that this can lead to " therapeutic nihilism and an impulse to abandon".

142. Dr Laura Chapman of Voluntary Assisted Dying Australia and New Zealand (VADANZ) told the Committee that she did not plan on becoming an assisted dying provider, and feared that she would feel like a bad doctor for participating:

> "*To my surprise, I felt like a good doctor, as I had worked with my patient to achieve the death he desired, peaceful and at home, surrounded by his family. I know I have helped some people to avoid deaths no doctor would want for anyone.*"

143. Dr Chapman told the Committee that providing clinical care for seriously unwell and dying people can create a burden on all doctors, but that the two-year experience of herself and assisted dying providers in New Zealand is that assisted dying is not different from their normal clinical duties.

Recommendation 18

The Committee recommends that any doctor or health care workers opting into the provision of assisted dying, be provided with enhanced training and support, including funded access to international peer support networks.

Incrementalism

144. The Committee heard concerns from multiple witnesses around how the legalisation of assisted dying in even limited circumstances has led to an increasing number of people accessing an assisted death. This fear was termed by some as a "slippery slope", where legalising assisted dying in even the most limited fashion inevitably leads to an expansion in the numbers of people seeking assisted dying. The two main rationales behind this concern are firstly that any eligibility criteria set by legislation will be broadened, increasing access, and secondly, societal norms regarding death will be changed.

Broadening of Legislation

145. Concerns were raised to the Committee that, when legislation was introduced in other jurisdictions with strict eligibility criteria, the legislation was amended to broaden these criteria. Canada was held up as an example of this in practice. Assisted dying legislation was introduced in Canada in 2016 for those whose death was reasonably foreseeable and did not allow access on the grounds of mental illness, long-term disability, or any curable condition. Several witnesses expressed their concern to the Committee that Canada is evidence that the broadening of assisted dying legislation beyond its original intended limits is inevitable.

146. In contrast, other witnesses told the Committee that the reason for the expansion of eligibility for assisted dying in Canada is that the initial legislation introduced was far narrower than the Supreme Court ruling which precipitated it.

147. Assisted Dying was introduced in Canada following the Supreme Court ruling in the case of *Carter v. Canada (Attorney General)* in 2015. In the Carter decision, the Court found that the Criminal Code provisions that make it a crime to help a person end their life infringed upon the rights set out by the Canadian Charter of Rights and Freedoms to life, liberty and security of the person for individuals who want access to an assisted death.

148. In April 2016, the Government of Canada tabled *Bill C-14, an Act to Amend the Criminal Code* and to make related amendments to other Acts to allow for assisted dying. Eligibility criteria included in the Act included a requirement that “natural death has become reasonably foreseeable.” The law was challenged almost immediately as being too restrictive, based on the Carter ruling. In September 2019, the Superior Court of Quebec struck down the part of the law that said that a person’s death had to be “reasonably foreseeable”.

149. The US State of Oregon was held up by several witnesses as a jurisdiction where the eligibility criteria for accessing assisted dying have not significantly expanded or changed. It was introduced in the State in 1997 by the *Death with Dignity Act*. Under this Act, to be eligible for assisted dying an individual must (among other criteria) be diagnosed with a terminal illness that will lead to death within six months. To date, the only expansion of eligibility criteria for assisted

dying in Oregon is the removal of a requirement that patients must be residents in the State, in 2022.

150. The Committee heard that one way to safeguard against later broadening of eligibility is to ensure that any terminology used in legislation is clearly defined from the outset. This would cut down on possible ambiguity, which would leave space for legal challenges.

151. Dr Simon Mills SC stated that:

> *"It is no sort of answer for a parliamentary democracy to say that it cannot introduce a law because the law might change in the future. With the greatest respect to this Committee, that would be an absolute abdication of responsibility on the part of the Oireachtas."*

Recommendation 19

This Committee recommends that any potential legislation on assisted dying uses clear and unambiguous terms and definitions, to avoid scope for uncertainty.

Normalisation and Social Mores

152. A related concern which several witnesses expressed to the Committee was that legalising assisted dying inevitably leads to a change of societal attitudes and mores towards it, and a process of "normalisation".

153. Professor Theo Boer told the Committee that the number of people accessing assisted dying the Netherlands had, after an initial period of stability, constantly increased over the last twenty years, and is accelerating. Professor Boer contributed this rise in part to what he called societal pressure. He compared it to flying, saying

> *"Everyone is flying. Even if you do not fly, you know you can fly and take an aeroplane. In the same sense, there is this general societal pressure."*

154. In contrast, Dr Simon Mills SC told the Committee that normalisation is inevitable if anything is legislated for, but that this should not presuppose that this is something morally wrong becoming acceptable. He stated that once something

is made available and legal, it is for everyone in society to decide themselves if they should consider it as long as they are engaging with it rationally and free of undue influence or duress.

Protecting Vulnerable Individuals and Groups

Reasons for Seeking Assisted Dying

155. The Committee discussed the reasons why individuals seek assisted dying. One useful insight into this question, albeit only with regard to Oregon, is the annual Oregon Death with Dignity Act Data Summary. The Oregon *Death with Dignity Act* requires the Oregon Health Authority to collect information about the patients and physicians who participate in assisted dying and publish an annual statistical report. Included in this report are end-of-life concerns reported by patients when applying for assisted dying. These concerns are not mutually exclusive, as more than one may be reported. Also, representatives from the Oregon Health Authority told the Committee that these concerns are not linked to a patient's eligibility for assisted dying and are not a reason for granting or denying a patient's request.

156. In the 2022 report, the three most frequently reported end-of-life concerns were decreasing ability to participate in activities that made life enjoyable (89%), loss of autonomy (86%), and loss of dignity (62%). The table of reported end-of-life concerns from the 2022 data summary is below:

End-of-life concerns	2022 (N=278) N (%)	2021 (N=255) N (%)	1998-2020 (N=1,921) N (%)
Less able to engage in activities making life enjoyable	247 (88.8)	233 (91.4)	1,728 (90.0)
Losing autonomy	240 (86.3)	236 (92.5)	1,740 (90.6)
Loss of dignity	172 (61.9)	174 (68.2)	1,320 (73.7)
Burden on family, friends / caregivers	129 (46.4)	136 (53.3)	914 (47.6)
Losing control of bodily functions	124 (44.6)	122 (47.8)	831 (43.3)
Inadequate pain control, or concern about it	87 (31.3)	69 (27.1)	530 (27.6)
Financial implications of treatment	17 (6.1)	20 (7.8)	88 (4.6)

Table 2 End of Life Concerns Citied in Oregon Death with Dignity Act Data Summary 2022[1]

Burden

157. The Committee deliberated on the issue of people who may seek to access assisted dying due to feeling they are a burden on their family and loved ones, or on society. Multiple witnesses warned the Committee that vulnerable individuals

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[1] Oregon Death with Dignity Act 2022 Data Summary

must be safeguarded against feeling they have no option other than seeking assisted dying. The Irish Hospice Foundation 2016 survey on living with illness, death and bereavement *Have Your Say* found that people had worries about being a burden on their families as they approached the end of life.

158. Sinéad Gibney of Irish Human Rights and Equality Commission told the Committee that this goes beyond funding and access to health and social services and must include active efforts to create a society where people are able to live life on equal terms, free from discrimination.

159. In a written submission the Alzheimer Society of Ireland warned that caring in Ireland has long been associated with poor health outcomes for carers such as stress, burnout, and illness. They cited research they carried out in 2023 which highlighted that 31% of informal carers rated their mental health as poor, 38% said they were struggling to cope with their caring responsibilities and almost one third spend over 80% of their time supporting a person with dementia. They stated that there are not enough supports and services required to meet the needs of people with dementia, and family carers are left to make up the shortfall. Given this, it must be acknowledged that the person with dementia is not the cause of carer burden. Whether someone with dementia should consider assisted dying should not be presented in the context of the impact of their condition on family members.

160. When discussing the issue of burden, Dr Cameron McLaren of Voluntary Assisted Dying Australia and New Zealand (VADANZ) differentiated between a patient feeling they are a burden on their spouse or loved one, and someone who is not comfortable having their personal care needs met by another individual. Somebody feeling they are burden on a loved one or feeling that their loved one views them as a burden requires, in Dr McLaren’s view, a focus on carer support.

Recommendation 20

The Committee recommends that informal carers are robustly supported in their caring duties, with additional resources provided to include funding, counselling and respite provision.

Recommendation 21

The Committee recommends the need for much increased mental health supports to help identify and respond to mental health issues, especially age-related mental health challenges, and for mental health supports to always be made available to those receiving a terminal diagnosis.

Recommendation 22

The Committee recommends that research be carried out on the relationship between economic disadvantage and health inequalities, and the question of people feeling a burden.

Unmet Needs of People with Disabilities

161. The Committee was keen to engage with people with disabilities in Ireland, given the concerns raised by disability groups in Canada about feeling pressured towards assisted dying. Opinions among people with disabilities on the issue of assisted dying vary, as they do among any group of people. Indeed, Peter Kearns, Development Officer of Independent Living Movement Ireland (ILMI) warned of the danger of treating disabled people as an homogeneous group.

162. Both the Disability Federation of Ireland (DFI) and ILMI told the Committee that in their view, assisted dying should not be prioritised ahead of ensuring that the resources and supports necessary to allow disabled people to live independent and full lives of their choosing. Peter Kearns told the Committee that:

> "*Disabled people are lobbying politicians to bring about a right to a personal assistance service and it would sadden disabled people if the right to die was granted over the right to live a life course of dignity*".

163. Peter Kearns expressed concern that if assisted dying were based on quality of life rather than on a terminal prognosis, there would be fear around who would decide on what a person's quality of life is. He highlighted that disability in Ireland had traditionally been looked at through a medical model, where such decisions around quality of life were made by doctors about individuals. Mr Kearns stressed the importance of viewing disability through a social model, where the importance is in examining what barriers exist in society in terms of attitudes, policy development, and access to or lack of supports that prevent people from participating in society as equals, with choice and control over their own lives.

164. John Dolan, CEO of the DFI told the Committee that many disabled people in Ireland are

> *"caught up in a daily cycle of worry about how to survive on an income that the State has recognised for decades as wholly inadequate because it does not factor in the varied and necessary additional costs of living with a disability."*

165. Additionally, disabled people are subject to intersecting layers of social and economic disadvantage and other barriers that drive health inequality, and frequently experience worse health than people without disabilities.

166. Mr Dolan told the Committee that the most important safeguard would be

> *"people being able to see in their day-to-day living that the State is actively making it possible for them to be out and about and participating and doing things*".

167. Mr Kearns told the Committee that if assisted dying were legislated for, he would like to see a strong emphasis on suicide prevention, an approach which would be run and resourced in conjunction with disabled people and organisations.

168. Multiple witnesses highlighted to the Committee that Ireland has not ratified the *Optional Protocol to the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)*. They stressed to the Committee that ratifying the Optional Protocol would be important progress in realising the rights of people

with disabilities to lead full lives. Mr. Kearns told the Committee that both “the social model of disability and the practical aspirations of the UNCRPD need to inform any discussions about how disabled people are included in Irish society.”

Recommendation 23

The Committee recommends that the Optional Protocol to the United Nations Convention on the Rights of Persons with Disabilities should be ratified as a precondition of the commencement of assisted dying legislation.

Suicide Prevention and Mental Illness

169. The Committee heard conflicting evidence on whether there is a distinction between suicidal ideation and desiring assisted dying. The possibility of differentiating between people with suicidal ideation and people who seek assisted dying is contested.

170. Dr Siobhán McHale of the College of Psychiatrists of Ireland told the Committee that she does not believe it is possible to clearly differentiate between suicidal patients, and those who request assisted dying. Professor William Binchy of the Pro Life Campaign stated that legalising assisted dying would lead to suicidal people availing of it.

171. Other witnesses told the Committee that there are clear differences in the profiles of people with suicidal ideation and people seeking assisted dying.

172. Dr Annie McKeown O’Donovan told the Committee that in testimony, individuals such as Marie Fleming or Debbie Purdy characterised their desire to end their life not as a desire to die, but a desire to end their suffering. Both women did not wish to die. Dr Eve Griffin of the National Suicide Research Foundation said that based on a review of international literature, that the profile of people who sought assisted dying did appear to be distinct from those who die by suicide; for example, people seeking assisted suicide tended to be older, and were more likely to be women. Dr Griffin identified some risk factors shared by

both groups, including living alone, having no children, and not identifying as being religious.

173. The Committee heard from Dr Stephen Duckworth an academic and social entrepreneur, among others, that in jurisdictions where eligibility for assisted dying is based on a terminal prognosis, people who seek assisted dying are not choosing between living and dying, but between two different ways of dying.

174. Dr Caroline Dalton of UCC told the Committee that, regarding whether legalising assisted dying had an effect on the suicide rate, in countries where any form of assisted dying was introduced, there was no overall reduction in self-initiated deaths and that overall suicide rates did not significantly change.

Requiring a Psychiatric Assessment Before Accessing Assisted Dying

175. The Committee engaged with witnesses on whether a psychiatric assessment is mandatory in any jurisdiction which allows assisted dying, and whether such an assessment should be required.

176. The Committee heard that the first six months after a patient receives a terminal diagnosis, they are at higher risk of psychiatric conditions such as depression or anxiety. Following this initial six-month period, the risk of these conditions then lessens.

177. Dr Anne Doherty is a consultant liaison psychiatrist, working in the psycho-oncology service. This service provides mental healthcare to people with cancer. Dr Doherty told the Committee that physical illness and mental illness are complex interrelated problems, and it is hard to separate them out.

178. Mr Finn Keyes BL cited a European Court of Human Rights case *Haas v. Switzerland*. Mr Haas, who suffered from a mental illness, sought to challenge the Swiss law as it required that he be assessed by a psychiatrist before he could be prescribed medication to end his life. The Court dismissed his application, ruling that it was a proportionate interference with Mr Haas' right to privacy, as it was a necessary state objective to provide safeguards.

179. In most jurisdictions, for example in New Zealand and Australia, if the doctor has concerns about the patient's competence or capacity, they are required to refer the patient for a psychiatric assessment before determining that they are eligible to access assisted dying. In Oregon, if the doctor determines that the

patient may be suffering from either a psychiatric or psychological condition, including depression or anything that might impair his judgement, the doctor must refer the patient for counselling. Under the Act, counselling means one or more consultations with either a psychiatrist or psychologist for the purpose of determining that the person is capable and not suffering from a condition causing impaired judgment.

180. Dr Laura Chapman does not believe such an assessment needs to be mandatory. She stated that it is within the skillset of a senior, experienced doctor to counsel patients on difficult decisions, with personal, family, clinical, physical, mental, spiritual interactions.

181. The Committee was also warned about the danger of assuming that any individual with a mental illness lacked the capacity to make decisions. Dr Simon Mills SC stated that the fact alone that a person has a mental disorder does not mean that person lacks capacity. The Committee was warned about medicalising people making a legitimate choice. A mental illness does not necessarily mean that an individual loses decision making capacity, and it should not be assumed that every individual with a mental illness cannot also legitimately choose assisted dying.

Recommendation 24

The Committee recommends that if assisted dying is introduced, an assessment by a qualified psychiatrist should be required in circumstances where the patient is deemed eligible but there are concerns about whether the person is competent to make an informed decision.

Developing an Assisted Dying Model

182. The Committee deliberated on what a model for assisted dying might look like if Ireland did in the future decide to legislate for it. It sought to examine what aspects of assisted dying systems in other countries might work best in an Irish context, and which aspects might lead to undesirable consequences.

Eligibility Criteria

Residency

183. The Committee examined the eligibility criteria applied by various existing assisted dying systems. With the notable exception of Switzerland, most jurisdictions limit access to assisted dying to either citizens or permanent residents. This is done to prevent so-called health tourism.

Recommendation 25

The Committee recommends that eligibility for assisted dying should be limited to Irish citizens or those ordinarily resident in the State for a period of not less than twelve months.

Age

184. Many jurisdictions, for example New Zealand and the Australian States, limit assisted dying to individuals aged 18 or over. Others, such as the Netherlands and Belgium, allow it for minors, although parental consent may be required depending on the patient's age. The Committee heard that given the seriousness of the decision and the complicated issues around capacity, it would be safer to allow assisted dying to those over 18 only.

Recommendation 26

The Committee recommends that assisted dying should be limited to people aged 18 or over.

Prognosis

185. Eligibility for assisted dying in most models requires an individual to have a particular medical profile. This normally takes one of two forms; either some formulation of suffering which cannot be relieved, or a terminal illness, with a prognosis of not more than a specified time period, often six or 12 months.

186. Suffering-based models, such as in the Netherlands, are usually seen as being more liberal, and allow for more people to access assisted dying. Limiting access to those with a terminal prognosis means that many people who may seek an assisted death will not be eligible.

187. However, the Committee heard from several witnesses that having eligibility criteria for assisted dying be as clearly and unambiguously defined as possible. Doing so leaves less room for any potential future challenges to broaden access. Requiring a terminal prognosis is less uncertain than a subjective measure of suffering, and so would be more likely to be resistant to future calls to widen access.

188. The Committee heard from Dr Hannah Linane of the Irish Association for Palliative Care (IAPC) that prognostication is not precisely predictable and remains an imprecise subjective judgment. This view was echoed by Dr Miriam Colleran, a palliative care doctor and representative of Hope Ireland.

189. Dr Laura Chapman of Voluntary Assisted Dying Australia and New Zealand (VADANZ) told the Committee that in the New Zealand system “likely to die within six months” is defined as 51%; it is not a certainty, but a likeliness. Dr Cameron McLaren also representing VADANZ told the Committee that he had seen difficult cases which were difficult to prognosticate on and where a six-month prognosis could not be given, and so those cases could not be progressed.

190. When asked why six months was chosen as a timeframe in New Zealand, Dr Chapman told the Committee that when the legislation was being designed, the outline was that the process would take six to eight weeks, so a shorter time frame such as three months would leave very little time. A six-month window meant that no part of the process would have to be rushed.

191. Dr Peter Allcroft also of VADANZ told the Committee that when a patient is refused assisted dying due to not having a six-month terminal prognosis, they are not abandoned, but are often referred back to their GP or to a palliative care team for active ongoing engagement.

Recommendation 27

The Committee recommends that only a person diagnosed with a disease, illness or medical condition that is:

a) both incurable and irreversible;
b) advanced, progressive and will cause death;
c) expected to cause death within six months (or, in the case of a person with a neurodegenerative disease, illness or condition, within 12 months); and
d) causing suffering to the person that cannot be relieved in a manner that the person finds tolerable,

is eligible to be assessed for assisted dying.

Assessment and Application

192. The Committee heard evidence on how applications for assisted dying are made and assessed in different jurisdictions. Most jurisdictions require patients to make a formal request for assisted dying. In the Netherlands, a patient can make an oral request, and there is no requirement to make a written request, and no ‘cooling off’ period is required. In Oregon, a patient must make two oral requests separated by at least 15 days; and a written declaration. There is a ‘cooling off’

period between all requests, which can be waived in limited circumstances. Canada requires patients to make a request in writing. No 'cooling off' period is required where the death is 'reasonably foreseeable'. However, a 'cooling off' applies where the death is 'not reasonably foreseeable'. This 'cooling off' period can be reduced in limited circumstances.

193. Many jurisdictions, such as New Zealand also require that the patient raises the issue of assisted dying themselves. Health professionals cannot suggest it as an option. This is seen as offering some protection against patients being coerced into assisted dying.

194. Most jurisdictions require that an application be assessed by more than one doctor, usually two. A request will usually be assessed by the initial doctor to whom it is made. If they find that the patient is eligible, the request will then be referred to a second doctor who will also assess it. In New Zealand, the second assessing doctor is assigned randomly by the Health Ministry from a register of assisted dying providers.

195. As part of the assessment process, in most jurisdictions, where the assessing doctor is of the opinion that the patient's competence is impaired, the patient must be assessed by a psychiatrist.

Recommendation 28

The Committee recommends that two formal requests for assisted dying must be made, with a set specified interval between. At least one of these requests must be recorded in writing, and before two independent witnesses.

Recommendation 29

The Committee recommends that any potential legislation for assisted dying should establish a national body with sole responsibility for assisted dying services and related supports.

Recommendation 30

The Committee recommends that the national body for assisted dying should be independent of the other State bodies.

Recommendation 31

The Committee recommends that should assisted dying be made available, a Joint Protocol be established for interagency collaboration between the potential body for assisted dying and the Health Service Executive.

Recommendation 32

The Committee recommends that all assisted dying applications and related processes should be overseen and governed by the independent national body. The responsibilities of this body will include:

a. Regularly publishing statistics on applications and procedures including statistics on the number of people who initiate the process and the number of people who complete the process and all other relevant data;
b. Ensuring that all applications and procedures are compliant with regulations;
c. Maintaining a list of medical practitioners, nurse practitioners, and psychiatrists who provide assisted dying services;
d. Maintaining a register of medications and return of medication for instances where the person has chosen to cancel their request, was no longer eligible, or has passed away prior to administration;

e. Collecting data pertaining to demographic information;
f. Providing accessible information relating to assisted dying services and supports;
g. The publication of an annual report; and
h. Carrying out preliminary investigation of any complaints or allegations of wrongdoing in relation to the process, and where appropriate make referrals to relevant bodies and to maintain any data for transfer as appropriate.

Recommendation 33

The Committee recommends the doctors have an obligation to acknowledge receipt of the request and should deliver a response within a specified timeframe.

Recommendation 34

The Committee recommends that family members, carers, guardians or holders of an enduring power of attorney cannot request assisted dying in the interest of another person.

Method Allowed

196. The two methods for administering assistance in dying are euthanasia, where a doctor or health worker administers the medication, and assisted suicide, where the patient self-administers the medication. Some jurisdictions allow one or the other, while others allow both.

197. The Committee heard that there is some evidence that restricting assisted dying to assisted suicide only contributes to keeping the numbers accessing it lower. Professor Theo Boer told the Committee that once a doctor took

responsibility for the act, it becomes easier for the individual, and so numbers go up.

198. The Committee also heard that limiting assisted dying to assisted suicide only may lead to some individuals seeking it earlier than they would if euthanasia were available. They may fear that their physical condition will deteriorate to a point where they will be unable to self-administer the medication, and so seek assisted dying before they reach that point.

199. The Committee heard that in New Zealand, both assisted suicide and euthanasia are allowed. Where assisted suicide is opted for, a doctor must still be present. This provides a further degree of safety and oversight. It also means that if the patient is unable to self-administer the medication, the doctor can do so for them.

Recommendation 35

The Committee recommends that any potential legislation for assisted dying should provide a means of access to treatment for individuals who require assistance during the administration.

Recommendation 36

The Committee recommends that if assisted dying is legislated for, a doctor or nurse practitioner must be present for the duration of the assisted dying process and must remain until after the patient’s death and must account to the responsible authority for any remaining substances.

Oversight and Review

200. Most jurisdictions allowing assisted dying have some form of oversight of the process. These vary between reviewing post death or having a role during the

application process. In the Netherlands there are five regional euthanasia review committees who assess post-fact whether a doctor has complied with the due care criteria required. Reporting and oversight may also take place during the process, rather than after it.

201. Many jurisdictions, for example Oregon and New Zealand, gather data on all assisted deaths that take place, and publish annual reports. There was some debate between witnesses on whether enough data or the right data is being gathered in different jurisdictions, but there was agreement that the more data gathered and reported the better, in order to better assess how the system is operating, and whether any changes are needed.

202. The legislation in New Zealand included a requirement for it to be reviewed after three years in operation. This was supported by several witnesses, including Dr Brendan O'Shea of Irish Doctors Supporting Medical assistance in Dying, who recommended that any Irish legislation introduced should include a provision for it to be formally reviewed after two years.

Recommendation 37

The Committee recommends that any assisted dying legislation include a provision for a formal review after three years of the operation of the legislation.

Recommendation 38

The Committee recommends that any assisted dying legislation must include definitions for terms used, including, but not limited to, medical descriptions of the methods permitted under the Act.

APPENDIX 1 - MEMBERSHIP OF THE COMMITTEE

1. Deputies nominated by the 21st Report of the Dáil Committee of Selection and appointed by Order of the Dáil on the 6th of March 2023.
2. Senators nominated by the 15th Report of the Seanad Committee of Selection and appointed by Order of the Seanad on 28th of March 2023.
3. On 24th January 2023 the Dáil approved a motion that the member of Dáil Éireann nominated by the Rural Independent Group to serve on the Joint Committee shall be Chairperson.
4. Deputy Michael Healy Rae was appointed as Cathaoirleach by the 21st Report of Dáil Committee of Selection on the 2nd of March 2023.
5. Deputy Gino Kenny was elected as Leas-Chathaoirleach on the 20th of June 2023.
6. Deputy Sorca Clarke discharged, and Deputy David Cullinane nominated to serve in her stead by the Committee Selection Report on the 26 October 2023.

APPENDIX 2 – TERMS OF REFERENCE

That, notwithstanding anything in Standing Orders—

1. a Special Committee consisting of nine members of Dáil Éireann be appointed, to be joined with a Special Committee to be appointed by Seanad Éireann, to form the Joint Committee on Assisted Dying;
2. the Joint Committee shall consider and make recommendations for legislative and/or policy change in relation to a statutory right to assist a person to end their life (assisted dying), and a statutory right to receive such assistance.

   Such consideration may include but is not limited to:

   (a) an exploration of how provision for assisted dying might operate in Ireland;

   (b) an examination of safeguards in relation to the provision for assisted dying;

   (c) an examination of the Constitutional, legal, and ethical issues in relation to such a provision; and

   (d) identification of possible unintended consequences of such a provision;

3. in its deliberations, the Joint Committee shall have regard to the report dated July 2021 published by the Joint Committee on Justice on Scrutiny of the Dying with Dignity Bill 2020 [Private Member's Bill], and shall be provided with all submissions made to that Committee for the purposes of that scrutiny;
4. the Joint Committee shall report to both Houses of the Oireachtas on the matters contained in paragraph (2) not later than 27 March 2024;
5. the quorum of the Joint Committee shall be four, at least one of whom shall be a member of Dáil Éireann, and one a member of Seanad Éireann;
6. members of either House, not being members of the Joint Committee, may attend and take part in proceedings of the Joint Committee, or any sub-Committee thereof, but without having a right to vote or to move motions or

amendments, save where they attend, pursuant to Standing Orders, as a substitute for an absent member (or for a substitute not in attendance);

7. the member of Dáil Éireann nominated by the Rural Independent Group to serve on the Joint Committee shall be Cathaoirleach; and
8. the Joint Committee shall have the powers defined in paragraphs (1), (2), (3), (4), (5), (9) and (10) of Standing Order 96.

APPENDIX 3 – PUBLIC MEETINGS

Date	Witnesses	Link to Transcript
13 June 2023	Officials from the Department of Justice: Mr Dan Kelleher Ms Rachel Woods Mr Michael O'Neill, Irish Human Rights and Equality Commission (IHREC) Ms Sinéad Gibney, IHREC Ms Clare McQuillan, IHREC	Assisted Dying, Legal and Constitutional Context
20 June 2023	Dr Conor Casey, University of Surrey Dr Tom Hickey Dublin City University Dr Andrea Mulligan, Trinity College Dublin	Assisted Dying and the Constitution
27 June 2023	Dr Louise Campbell, University of Galway Mr Finn Keyes BL, Barrister	Consent and Capacity
4 July 2023	Professor Richard Huxtable, University of Bristol Mr Kevin Kelly, Barrister-at-Law Degree Candidate, The Honourable Society of King's Inns Dr Simon Mills, Senior Counsel, Law Library	Legal Protections and Sanctions

11 July 2023	Professor David Albert Jones, Anscombe Bioethics Centre, Oxford Professor Mary Donnelly, UCC Professor Deirdre Madden, UCC	Developing a Legal Framework for Assisted Dying
26 September 2023	Mr Silvan Luley, "DIGNITAS – To live with dignity -To die with dignity" Mr Ludwig A. Minelli, "DIGNITAS – To live with dignity -To die with dignity" Professor Theo Boer, Protestant Theological University, The Netherlands	Assisted Dying in Europe
3 October 2023	Dr Annie McKeown O'Donovan, Doctor of Philosophy Dr Thomas Finegan, Mary Immaculate College Dr Kevin Yuill, Humanists Against Assisted Suicide and Euthanasia	Ethics of End-of-Life Care
3 October 2023	Professor Margaret Battin, University of Utah Dr Tom Jeanne, Oregon Health Authority Mr Craig New, Oregon Health Authority Dr Mark Komrad, Johns Hopkins Hospital, Baltimore	Assisted Dying in the United States
10 October 2023	Mr Tom Curran, Witness on the topic of end-of-life care Ms Elma Walsh, Witness on the topic of end-of-life care Mr Garret Ahern, Witness on the topic of end-of-life care	Ethics of End-of-Life Care

	Mr John Wall, Witness on the topic of end-of-life care	
17 October 2023	Dr Gabrielle Colleran, Irish Hospital Consultants Association Mr Martin Varley, Irish Hospital Consultants Association Professor Robert Landers, Irish Hospital Consultants Association Dr Feargal Twomey, Royal College of Physicians of Ireland Dr Andrew Lyne, Irish Doctors Supporting Medical Assistance in Dying Mr Brendan O'Shea, Irish Doctors Supporting Medical Assistance in Dying	Healthcare Provision and Healthcare Professionals
17 October 2023	Professor Trudo Lemmens, University of Toronto Dr Heidi Janz, John Dossetor Health Ethics Centre, University of Alberta Professor Jocelyn Downie, Dalhousie University Dr Leonie Herx, Queen's University Canada Dr Konia Trouton, Canadian Association of MAID Assessors and Providers	Assisted Dying in Canada
24 October 2023	Professor William Binchy, Pro Life Campaign Mr Lloyd Riley, Dignity in Dying Mr Andrew Copson, Humanists UK	Assisted Dying and the Ethics of Autonomy

7 November, 2023	Dr Anne Doherty, UCD Dr Stephen Duckworth Dr Caroline Dalton, UCC Ms Janie Lazar, End of life Ireland Mr Justin McKenna, End of life Ireland	Protecting Autonomy and Assessing Decision-making Capacity
14 November, 2023	Dr Eve Griffin, National Suicide Research Foundation Professor Ella Arensman, National Suicide Research Foundation Dr Léopold Vanbellingen, European Institute of Bioethics Dr Ania Ambikapathy, College of Psychiatrists of Ireland Dr Eric Kelleher, College of Psychiatrists of Ireland Professor Siobhán McHale, College of Psychiatrists of Ireland	Protecting Vulnerable Individuals from Coercion
21 November, 2023	Dr Miriam Colleran, Hope Ireland Ms Emer Maguire, Hope Ireland Ms Paula O'Reilly, Irish Hospice Foundation Professor Susan O'Reilly, Irish Hospice Foundation Dr Una Molloy, Irish Association for Palliative Care Dr Hannah Linane, Irish Association for Palliative Care	Access to Palliative Care and Social Supports:
28 November, 2023	Dr Deirdre Collins, Irish College of General Practitioners	Safeguarding Medical Professionals

	Mr Diarmuid Quinlan, Irish College of General Practitioners Mr Fintan Foy, Irish College of General Practitioners Dr Edward Mathews, Irish Nurses & Midwives Organisation Ms Caroline Gourley, Irish Nurses & Midwives Organisation Dr Harvey Chochinov, University of Manitoba Dr Mary Neal, University of Strathclyde	
28 November, 2023	Dr Kristin Good, Ministry of Health, New Zealand Dr Sinéad Donnelly, Wellington Hospital Mr David Seymour, Member of Parliament for Epson in New Zealand Dr Philip Haig Nitschke, Exit International Dr Gregg Mewett, Palliative Care Physician, Australia Mr Mike Gaffney, Independent Member for Mersey, Tasmania	Assisted Dying in New Zealand
5 December, 2023	Dr Aideen Hartney, Director of the National Disability Authority Professor Desmond O'Neill, Irish Society of Physicians in Geriatric Medicine Dr Rosaleen McDonagh, Playwright and disability advocate	Protecting Vulnerable People

5 December, 2023	Dr Margaret Naughton, Irish Catholic Bishops’ Conference Ms Petra Conroy, Irish Catholic Bishops’ Conference Dr Reverend Steven Foster, Methodist Church in Ireland Dr Rebecca Stevenson, Presbyterian Church in Ireland Reverend Dr David Bruce, Presbyterian Church in Ireland Mr Neil Ward, Humanist Association of Ireland Dr Rory Corbett, Church of Ireland Dr Shaykh Umar Al-Qadri, Irish Muslim Peace and Integration Council Dr Ibraheem Tunau, Irish Muslim Peace and Integration Council	Religious, Faith-Based and other Philosophical Perspectives on Assisted Dying
12 December, 2023	Dr Mathew Doré, Association of Palliative Medicine for Great Britain and Ireland Dr Regina McQuillan, Irish Palliative Medicine Consultants' Association Dr Faith Cranfield, Irish Palliative Medicine Consultants' Association Dr Max Watson, Project ECHO, Hospice UK	Examination of Potential Consequences - Protecting and Enhancing the Provision of Palliative Care
16 January	Mr John Dolan, Disability Federation of Ireland Mr Peter Kearns, Independent Living Movement Ireland	Engagement with People with Disabilities
23 January	Dr Suzanne Crowe, Medical Council	Healthcare Professionals and Assisted Dying

	Dr Cameron McLaren, Voluntary Assisted Dying Australia & New Zealand Dr Laura Chapman, Voluntary Assisted Dying Australia & New Zealand Dr Peter Allcroft, Voluntary Assisted Dying Australia & New Zealand	
30 January	Professor Nancy Preston, University of Lancaster Professor Ben White, Australian Centre for Health Law Research Dr Frank Beck Lassen, Danish Council of Ethics Professor Merete Nordentoft, Danish Council of Ethics Professor Roderick MacLeod, University of Auckland	Designing a System for Assisted Dying and Alternative Policies
13 February	Dr Feargal Twomey, Health Service Executive (HSE) Dr Siobhán Ní Bhriain, HSE Dr Philip Crowley, HSE Mr Paul Rowe, Department of Health Ms Siobhán McArdle, Department of Health	Designing a System for Assisted Dying and Alternative Policies

APPENDIX 4 – VOTING RECORD OF THE COMMITTEE

27th February 2024

1. Question put that the recommendations of the report not be debated today. The Committee divided **Tá 5 Níl 8**

   For: Deputies David Cullinane, Pa Daly, Michael Healy-Rae, Robert Troy.

   Senators Rónán Mullen.

   Against: Deputies Patrick Costello, Alan Farrell, Emer Higgins, Gino Kenny, John Lahart.

   Senators Annie Hoey, Lynn Ruane and Mary Seery-Kearney.

2. Question put that Recommendation 1A be replaced by the amendment by Deputy Cullinane and Deputy Daly. The Committee divided **Tá 4 Níl 10**

   For: Deputies David Cullinane, Pa Daly, Michael Healy-Rae, Robert Troy.

   Against: Deputies Patrick Costello, Alan Farrell, Emer Higgins, Gino Kenny, John Lahart

   Senators Annie Hoey, Rónán Mullen, Fiona O'Loughlin, Lynn Ruane, Mary Seery-Kearney.

3. Question put that the word "restricted" be inserted before "circumstances" in the text. The Committee divided **Tá 10 Níl 2 Staon 2.**

   For: Deputies Patrick Costello, Alan Farrell, Emer Higgins, Gino Kenny, John Lahart, Robert Troy.

   Senators Annie Hoey, Fiona O'Loughlin, Lynn Ruane, Mary Seery-Kearney.

   Against: Deputy Michael Healy-Rae.

Senator Rónán Mullen.

Staon: Deputies Pa Daly, David Cullinane.

4. Question put that Recommendation 1A as amended stand part of the Report. The Committee divided **Tá 9 Níl 3 Staon 2**

    For: Deputies Patrick Costello, Alan Farrell, Emer Higgins, Gino Kenny, John Lahart.

    Senators Annie Hoey, Fiona O'Loughlin, Lynn Ruane, Mary Seery-Kearney

    Against: Deputies Michael Healy-Rae, Robert Troy,

    Senator Rónán Mullen.

    Staon: Deputies Pa Daly and David Cullinane.

5th March 2024

5. Question put that Deputy Farrell's amendment to paragraph 96 be agreed. The Committee divided **Tá 7 Níl 5**

    For: Deputies David Cullinane, Alan Farrell, Emer Higgins, Gino Kenny.

    Senators: Annie Hoey, Lynn Ruane, Mary Seery Kearney.

    Against: Deputies Pa Daly, Michael Healy-Rae, John Lahart, Robert Troy.

    Senator Rónán Mullen.

6. Question put that Amendment 90 by Senator Mullen be agreed. The Committee divided **Tá 1 Níl 11.**

    For: Senator Rónán Mullen

Against: Deputies Patrick Costello, David Cullinane, Pa Daly, Alan Farrell Emer Higgins, Gino Kenny, John Lahart, Robert Troy.

Senators Annie Hoey, Lynn Ruane, Mary Seery-Kearney.

6th March 2024

7. Question put that amendment 111 by Senator Ruane be agreed. The Committee divided **Tá 5 Níl 7**

   For: Deputies Patrick Costello, Michael Healy-Rae, Gino Kenny

   Senators Annie Hoey and Lynn Ruane.

   Against: Deputies David Cullinane, Pa Daly, Alan Farrell, Emer Higgins, Robert Troy.

   Senators Rónán Mullen, Mary Seery-Kearney.

8. Question put that the proposed wording in Recommendation 21 be agreed. The Committee divided **Tá 8 Níl 4**

   For: Deputies Patrick Costello, David Cullinane, Alan Farrell, Emer Higgins, Gino Kenny.

   Senators Annie Hoey, Lynn Ruane and Mary Seery-Kearney.

   Against: Deputies Pa Daly, Michael Healy-Rae, Robert Troy.

   Senator Rónán Mullen.

9. Question put that amendment 128 be agreed. The Committee divided **Tá 2 Níl 9**

   For: Deputy Michael Healy-Rae

   Senator Rónán Mullen

Against: Deputies Patrick Costello, David Cullinane, Pa Daly, Emer Higgins, Gino Kenny, Robert Troy.

Senators Annie Hoey, Lynn Ruane, Mary Seery-Kearney.

10. Question put that the proposed text be inserted as a recommendation after paragraph 190. The Committee divided **Tá 10 Níl 1 Staon 1**

For: Deputies Patrick Costello, David Cullinane, Pa Daly, Alan Farrell, Michael Healy-Rae, Emer Higgins, Gino Kenny.

Senators Annie Hoey, Lynn Ruane, Mary Seery-Kearney.

Against: Senator Rónán Mullen.

Staon: Deputy Robert Troy.

11. Question put that the text proposed to be added by Senator Mullen after paragraph 190 be agreed. The Committee divided **Tá 2 Níl 11**

For: Deputy Michael Healy-Rae.

Senator Rónán Mullen

Against: Deputies Patrick Costello, David Cullinane, Pa Daly, Alan Farrell, Emer Higgins, Gino Kenny, John Lahart, Robert Troy.

Senators Annie Hoey, Lynn Ruane, Mary Seery-Kearney.

12. Question put that the paragraph proposed by Senator Mullen following paragraph 190 not be included. The Committee divided **Tá 8 Níl 3 Staon 2**

For: Deputies Patrick Costello, David Cullinane, Pa Daly, Alan Farrell, Gino Kenny, John Lahart.

Senators Annie Hoey and Lynn Ruane.

Against: Deputies Michael Healy-Rae, Robert Troy

Senator Rónán Mullen.

Staon: Deputy Emer Higgins

Senator Mary Seery-Kearney

13. Question put that amendment 139 as amended be included in the report. The Committee divided **Tá 5 Níl 6 Staon 2**

    For: Deputies Pa Daly, Michael Healy-Rae, John Lahart, Robert Troy

    Senator Rónán Mullen.

    Against: Deputies Patrick Costello, David Cullinane, Alan Farrell, Gino Kenny.

    Senators Annie Hoey and Lynn Ruane

    Staon: Deputy Emer Higgins

    Senator Mary Seery-Kearney.

14. Question put that amendment 143 as amended be part of the report. The Committee divided **Tá 6 Níl 7**

    For: Deputies Michael Healy-Rae, Emer Higgins, John Lahart, Robert Troy.

    Senators Rónán Mullen, Mary Seery-Kearney.

    Against: Deputies Patrick Costello, David Cullinane, Pa Daly, Alan Farrell, Gino Kenny

    Senators Annie Hoey, Lynn Ruane.

15. Question put that amendment 148 be agreed. The Committee divided **Tá 2 Níl 11**

    For: Deputy Michael Healy-Rae

Senator Rónán Mullen

Against: Deputies Patrick Costello, David Cullinane, Pa Daly, Alan Farrell, Emer Higgins, Gino Kenny, John Lahart, Robert Troy.

Senators Annie Hoey, Lynn Ruane, Mary Seery-Kearney

16. Question put that the report as amended be adopted. The Committee divided **Tá 9 Níl 3 Staon 1**

For: Deputies Patrick Costello, David Cullinane, Alan Farrell, Emer Higgins, Gino Kenny, John Lahart.

Senators Annie Hoey, Lynn Ruane, Mary Seery-Kearney

Against: Deputies Michael Healy-Rae, Robert Troy

Senator Rónán Mullen

Staon: Deputy Pa Daly.

APPENDIX FIVE – WRITTEN SUBMISSIONS

The Joint Committee on Assisted Dying received written submissions from:

- End of Life Ireland
- The Irish Hospice Foundation (IHF)
- Dr Annie McKeown O'Donovan
- College of Psychiatrists of Ireland
- Royal College of Physicians of Ireland
- Irish Association for Palliative Care
- Dr Kate Keenan
- Mr Kevin Kelly
- Mr Robert Pierce
- Humanist Association of Ireland
- Dr Conor Casey
- The Samaritans
- Professor David Albert Jones
- Mr Gerard Quinn
- Irish Hospital Consultants Association
- Mr Gilles Genicot
- Dr Mark Komrad
- Dr Thomas Finegan
- Professor Richard Ekins
- Oregon Health Authority
- Professor Wayne Sumner
- Mr Brendan Clarke
- Dr Heidi Janz
- Professor Trudo Lemmens
- Professor Jocelyn Downie
- Irish Doctors supporting Medical Assistance in Dying
- Humanists UK
- Dr Konia Trouton

- Dr Bernadette Flood
- Dr Stephen Duckworth
- Dr Anne Doherty
- Dr Gabrielle Colleran
- Ms Tina McCafferty
- Irish Association for Palliative Care
- Dr Max Watson
- Dr Regina McQuillan
- Hospice UK
- Irish Palliative Medicine Consultants Association
- Dying with Dignity, Victoria
- Ms Corrinna Moore
- Mr Gordon Friesen
- End of Life Ireland
- The Association of Palliative Medicine Great Britain and Ireland
- Irish Nurses and Midwives Organisation
- The Medical Council
- Professor Nancy Preston
- The Department of Health
- The Health Service Executive
- Mr Eamonn Grennan
- The Alzheimer Society
- Irish Nurses and Midwives Organisation
- Dr Sarah Brennan
- The Presbyterian Church of Ireland
- The Methodist Church in Ireland
- Irish Pharmacy Union
- Dignity in Dying UK
- National Suicide Research Foundation
- Hope Ireland
- Professor Harvey Chochinov
- Irish College of General Practitioners

- Irish Muslim Peace and Integration Council
- Professor Desmond O’Neill
- End of Life Choice Society, New Zealand
- Professor Susan Bewley
- Mr Michael Gaffney
- Exit International

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