ROYAL
COLLEGE OF
PHYSICIANS
OF IRELAND

Assisted Suicide - Position Paper
December 2017

This is a position paper on assisted suicide that was approved by the Council of the Royal College of Physicians of Ireland on 8 December 2017.

Contents

Recommended RCPI Position **5**

1. Background **5**

2. Introduction **6**

3. Definitions **7**

Assisted suicide (AS) 7

Euthanasia 7

Palliative Sedation 7

4. Background in Ireland **2**

4.1 Legal 2

4.2 Political 3

5. Positions of relevant professional bodies in Ireland, UK and worldwide **4**

6. International legislation and recent legal cases on assisted suicide/euthanasia **9**

Recent legal cases (29) 9

7. Key elements of discourse around assisted suicide **11**

Autonomy 11

Capacity 11

Response shift and adaptation 11

Relief for unbearable suffering 12

"Pragmatic argument" 12

Creep and slippery slope 12

Evidence of harm 13

Palliative treatment/Palliative care 14

Conscientious objection 14

Concerns about dignity 15

8. Issues and concerns in countries/states where legislation on assisted suicide or euthanasia exists **16**

9. Case study- Canada **17**

Carter vs. Canada 17

Legislation 17

Eligibility 18

10. Summary of key issues 19

11. Recommended position for RCPI to consider 20

This group recommends: 20

References 21

Recommended RCPI Position

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

1. Background

Legislation to allow for assisted suicide has been in place for many years in a minority of jurisdictions, including The Netherlands, Belgium, Switzerland and in the US states of Oregon, Washington, Vermont, California, Montana, Colorado and Washington DC. Most recently, the Canadian Supreme Court directed their parliament to enact medical assistance in dying legislation in 2015 (1). Attempts to pass 'Assisted Dying' legislation in the UK and the Scottish parliaments have been defeated in recent years (2). Attempts in the courts have also been defeated in New Zealand (3). In recent years there has been both public debate and interest in the issue in Ireland.

It is appropriate that the RCPI which is placing increasing emphasis on the principles of medical ethics in medical training and is engaging with the public through the activity of its policy groups on issues such as obesity, ageing, exercise and alcohol would seek to share its considered views on this complex topic of medical, ethical and societal importance.

This position paper references the official position of various medical professional bodies in Ireland and worldwide. It also presents an overview of arguments on both sides of the debate, with reference to current literature and articulates concerns expressed by physicians around the issue, including concerns arising in jurisdictions where legislation for assisted suicide has been introduced.

Finally, this paper presents a recommendation to RCPI Council on the adoption of an RCPI position on assisted suicide in Ireland, and outlines suggested future actions for RCPI. The paper has been informed by views from representatives from a range of medical specialities within RCPI, including Geriatric Medicine, Neurology, Palliative Medicine, Respiratory Medicine, Rehabilitation Medicine, and Psychiatry. The paper was approved and adopted as a College Position Paper at the RCPI Council meeting on 8th December 2017.

2. Introduction

There have been major advances in promoting high-quality care at the end of life across the spectrum of healthcare provision in Ireland, and in particular through the provision of both palliative care services and increased training in palliative care across the professions. In addition, the professions have encouraged the development of advance care planning and provided assistance in ensuring that treatment at the end of life is proportionate to the goals of such advance healthcare plans.

One area of concern in Ireland at end of life is that of suicide: suicide kills more people each year than road crashes, and is a source of grievous hurt to family, friends and those affected by the death. Much effort has been directed towards suicide prevention, and it is encouraging that the incidence of suicide has fallen from 13.5 to 9.7 per 100,000 between 2001 and 2015, albeit with persistently high rates among certain groups (4).

Somewhat paradoxically in terms of this momentum, there has also been a movement to promote acceptance of assisted suicide which has gained legal acceptance in a very small proportion of jurisdictions around the world and which has been the subject of a private members Bill in Ireland, as well as a disputed submission to the High Court in 2014 by the then Irish Human Rights Commission (5).

That there might be two forms of suicide – one which is clearly upsetting and worthy of strenuous societal efforts to prevent, and one which might be tolerated and given the support and protection of law – is a challenging premise (6).The subject is one which accrues many misperceptions in public discourse, and it is important that the medical community provides a response to concerns and conceptions surrounding the topic of assisted suicide.

This RCPI position paper therefore seeks to provide an informed focus on the issues, professional, ethical and otherwise that relate to assisted suicide, drawing on research and scholarship from Irish and international sources in order to inform further discussion and deliberation within the College.

3. Definitions

Assisted suicide (AS)

Assisted suicide is the act of deliberately assisting or encouraging another person to kill themselves (7).

Euthanasia

Euthanasia is “the act of deliberately ending a life to relieve suffering (7).”

Palliative Sedation

This is where a person who is expected to die within a period of hours or days and is experiencing extreme physical or psychological suffering, for which there is either no effective treatment or all alternative measures have been ineffective, is sedated using sedative medications with the sole intention of relieving intractable distress.

Under the European Association for Palliative Care (EAPC) 2009 Framework on the use of sedation in palliative care (8), therapeutic (or palliative) sedation in the context of palliative medicine is “the monitored use of medications intended to induce a state of decreased or absent awareness (unconsciousness) in order to relieve the burden of otherwise intractable suffering in a manner that is ethically acceptable to the patient, family and healthcare providers.”

4. Background in Ireland

Assisted suicide and euthanasia are both currently illegal under Irish law.

4.1 Legal

The Criminal Law (Suicide) Act 1993 decriminalised suicide but assisting a suicide remains illegal. The 1996 Supreme Court decision in *Re a Ward of Court* established that the rights to privacy and personal autonomy conferred a right to refuse medical treatment, even where this would lead to death. The court also stated that 'right, as so defined, does not include the right to have life terminated or death accelerated and is confined to the natural process of dying. No person has the right to terminate or to have terminated his or her life, or to accelerate or have accelerated his or her death."

There have been three cases related to assisted dying which have come to the attention of the justice system in Ireland. The first was in 2002, involving the case of Rosemary Toole Gilhooley. She was a woman in her forties who died in Donnybrook in 2002. She had a history of depression. Her inquest in 2009 returned a verdict of suicide. However, Rev George Exxo, an American minister of his own church gave media interviews in Ireland and the US which he described providing assistance to her to commit suicide, including advising about medication, staying with her when she took the medication and placing a bag with helium over her head. Initially, he was open in media interviews about his time with her, the expenses she paid for him and his partner to travel to Ireland and assistance he gave. The Gárdaí sought his extradition from the US to Ireland, in 2007 which was refused by the US authorities on the grounds of incompatibility of legislation. Dr Brian Farrell, Dublin City Coroner invited him to attend the inquest in 2009, which he declined.

The second case is probably the best known, that of the late Marie Fleming. She petitioned the court to avail of physician assisted suicide. This case was heard in the High Court and appealed to the Supreme Court. The High Court in the Fleming case considered that the State has an interest in protecting life and considered that it was not possible to prevent abuse of the law. The court considered that the public interest is in protecting the most vulnerable, including 'the aged, the disabled, the poor, the unwanted, the rejected, the lonely, the impulsive, the financially compromised and emotionally vulnerable'. The High Court did not accept Ms Fleming's argument that as suicide is not a criminal offence, she as a disabled person was not able to end her own life without assistance and was discriminated against. Ms Fleming argued that the Director of Public Prosecutions should issue guidelines about how the DPP would exercise discretion in the prosecution of assisted suicide. The High Court ruled that the DPP has no legal duty in Ireland to issue guidelines and if it did so, it would effectively amend the law, which is the function of the Oireachtas.

The most recent case concerns Bernadette Forde, a woman with MS and her friend Gail O'Rorke. Three charges were made against Ms O'Rorke, including ordering drugs that Ms Forde would use to kill herself, planning her funeral and arranging a trip to Zurich in Switzerland. The trial judge ordered the jury to find her not guilty of ordering medication or arranging a funeral to aid and abet a suicide. The jury considered the charge of aiding and abetting a suicide by arranging travel to Zurich and found her not guilty.

The Irish Human Rights Commission made a submission to the Supreme Court in 2013, as amicus curiae in relation to the Fleming case. The IHRC did not advocate a right to die, or a right to commit suicide. The IHRC considers that the right to refuse medical treatment (as recognized in the Ward case) is 'passive euthanasia'. Most clinicians and ethicists would disagree with this. The IHRC considered that the High Court reviewed evidence in relation to euthanasia, rather than assisted suicide in making its decision and this was not appropriate. The IHRC also considered that the needs of those with disabilities were not appropriately addressed. The IHRC considers that the court should consider if the prohibition of assisted suicide is justified having regard to the interference in personal rights of an individual, and suggests that there should be some exemption from criminalisation in assisted suicide for those who assist the terminally ill (which is not defined by the IHRC) profoundly disabled mentally competent person.

4.2 Political

In November 2015, John Halligan TD proposed the private member's Dying with Dignity Bill 2015 in Dáil Éireann (9). This bill not only proposes legislation on assisted suicide, but also voluntary euthanasia. The legislation did not advance through the legislative process at that time, but Gino Kelly, TD will re-present an assisted suicide and euthanasia private member's bill on behalf of Mr Halligan, who as a minister, is currently precluded from doing so.

5. Positions of relevant professional bodies in Ireland, UK and worldwide

Jurisdiction	Body	Position
World-wide	World Medical Association	**Position (1992, reaffirmed by the 200th WMA Council Session, Oslo, Norway, April 2015.** “Physician-assisted suicide, like euthanasia, is unethical and must be condemned by the medical profession. Where the assistance of the physician is intentionally and deliberately directed at enabling an individual to end his or her own life, the physician acts unethically. However the right to decline medical treatment is a basic right of the patient and the physician does not act unethically even if respecting such a wish results in the death of the patient (10)”
UK	Royal College of Physicians (RCP)	**Position: (2014) Against assisted dying** The Royal College of Physicians (RCP) published details of their position against assisted dying in 2014 (11). This position was informed by the results of a survey of their membership’s views on the issue. A majority of members do not support change in the law to allow for assisted suicide.
UK	Royal College of General Practitioners (RCGP)	**Position (2014) - Opposed to any change in law on assisted dying.** In 2013 RCGP carried out a consultation of its members in relation to the college’s position on any change in the law relating to assisted suicide. A majority of members felt that college should maintain opposition to change in the law (12, 13).
UK	British Medical Association (BMA)	**Position (2016)**: **The BMA policy of opposition to assisted dying was upheld after a debate was held at the Annual Representative Meeting in 2016 (14).** The BMA also launched a project in 2014 to explore public and doctor’s attitudes around end of life care including the possible impact to doctor patient

		relationship if physician assisted dying were to be legalised. Under this project, the BMA commissioned a research group to conduct a series of dialogue events across UK in 2015, and a report on this dialogue was published (15). The BMA also published two other reports; one on the current legal and political context (16) and another on reflections and recommendations arising from the project (2, 17).
UK	Academy of Medical Royal Colleges (AOMRC)	Position: Annual review 2014/2015 stated that Council reaffirmed the current Academy policy of not taking a position
UK	British Geriatric Society	**2015 statement:** "… a policy which allows physicians to assist patients to die is not acceptable to us. We believe instead that the most vulnerable should be enabled to access the services and care they need to lead as independent and symptom free a life as is possible and, when the time comes, to die in the setting of their choice with dignity (18).
UK	British Society of Rehabilitation Medicine (BSRM)	To date, does not have a formal stated position on assisted suicide, but contributed to the 2008 RCP London document 'Concise Guidance on the Management of Long-term Neurological Conditions at the interface with Neurology and Palliative Care' (19).
UK and Ireland	Association for Palliative Medicine of Great Britain and Ireland (APM)	Actively campaigning against assisted suicide
Ireland	Irish Palliative Medicine Consultants' Association	Opposed to assisted suicide
Ireland	Irish Association for Palliative Care (IAPC)	Opposed to euthanasia; to date the IAPC has not developed a position on assisted suicide.
Europe	European Association for Palliative Care	2016 White paper re euthanasia and physician-assisted suicide concluded that 'it is important to contribute to informed public debates on these issues. Complete

		consensus seems to be unachievable due to incompatible normative frameworks that clash (20)."
Netherlands	Royal Dutch Medical Association (KNMG)	2011 Position Statement – The role of the physician in the voluntary termination of life: "The KNMG has always taken the position that any procedure to terminate the life of a patient at his request is a last resort, to be used in cases in which the patient and physician have exhausted all options and the suffering cannot be remedied or alleviated by any means other than by ending the life of the patient at his request (21)." The KNMG has also published guidelines for the practice of Euthanasia and Assisted Suicide.
Switzerland	Swiss Academy of Medical Sciences	Stated in Ethics in End of Life Care (2012): "With patients at the end of life, the task of the physician is to alleviate symptoms and to support the patient. It is not his task to directly offer assistance in suicide; he rather is obliged to alleviate any suffering underlying the patient's wish to commit suicide (22)."
Switzerland	Swiss Medical Association (FMH)	Position Paper 2008 Assistance in suicide is not a medical activity. Every doctor can for him/herself decide, within the provisions of the legal framework how to respond to a request for assistance with suicide or death… in cases of mental illness, the Swiss Medical Association recommends that the physician refrain from providing assistance in suicide (23).
Australia	Royal Australian College of General Practitioners (RACGP)	Position (2014): "At this time, the RACGP does not have a formal position on euthanasia or assisted suicide but recognises and respects the diversity of personal, cultural and religious views on the issue. As such, we believe no law should put an obligation on doctors to recommend or participate in a procedure to which they hold a conscientious objection (24)."
Australia & New Zealand	Royal Australasian College of Physicians (RACP)	RACP Submission to Draft Voluntary Assisted Dying Bill July 2017 NSW, Australia (25).

Australia	Australian Medical Association (AMA) November 2016	The AMA believes that doctors should not be involved in interventions that have as their primary intention the ending of a person's life. This does not include the discontinuation of treatments that are of no medical benefit to a dying patient. The AMA recognises there are divergent views within the medical profession and the broader community in relation to euthanasia and physician assisted suicide. The AMA acknowledges that laws in relation to euthanasia and physician assisted suicide are ultimately a matter for society and government. If governments decide that laws should be changed to allow for the practice of euthanasia and/or physician assisted suicide, the medical profession must be involved in the development of relevant legislation, regulations and guidelines which protect: ➢ All doctors acting within the law; ➢ Vulnerable patients – such as those who may be coerced or be susceptible to undue influence, or those who may consider themselves to be a burden to their families, carers or society; ➢ Patients and doctors who do not want to participate; and ➢ The functioning of the health system as a whole. Any change to the laws in relation to euthanasia and/or physician assisted suicide must never compromise the provision and resourcing of end of life care and palliative care services. Doctors are advised to always act within the law to help their patients achieve a dignified and comfortable death. (26)
USA	American Medical Association (AMA) Policy. AMA Code of Medical Ethics - Ethical Opinions (Revised 2017)	Physician-assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide). It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal,

		painful, debilitating illness—may come to decide that death is preferable to life. However, permitting physicians to engage in assisted suicide would ultimately cause more harm than good. Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks. Instead of engaging in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Physicians: (a) Should not abandon a patient once it is determined that cure is impossible. (b) Must respect patient autonomy. (c) Must provide good communication and emotional support. (d) Must provide appropriate comfort care and adequate pain control.
USA	Ethics and the Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper (2017)	POSITION STATEMENT The ACP affirms a professional responsibility to improve the care of dying patients and their families. The ACP does not support the legalization of physician-assisted suicide, the practice of which raises ethical, clinical, and other concerns. The ACP and its members, including those who might lawfully participate in the practice, should ensure that all patients can rely on high-quality care through to the end of life, with prevention or relief of suffering insofar as possible, a commitment to human dignity and management of pain and other symptoms, and support for families. Physicians and patients must continue to search together for answers to the challenges posed by living with serious illness before death (27)
USA	American Psychiatric Association Position (2016)	The American Psychiatric Association, in concert with the American Medical Association's position on Medical Euthanasia, holds that a psychiatrist should not prescribe

or administer any intervention to a non-terminally ill person for the purpose of causing death.

6. International legislation and recent legal cases on assisted suicide/euthanasia

A 2016 study reported that euthanasia or physician-assisted suicide was legal in the Netherlands, Belgium, Luxembourg, Colombia, and Canada (Quebec since 2014, nationally as of June 2016). Physician-assisted suicide, excluding euthanasia, at the time that report was written was legal in five US states (Oregon, Washington, Montana, Vermont, and California) and Switzerland. The same report indicated that although euthanasia and assisted suicide are increasingly being legalised, the actual number of cases are rare and mainly involve patients with cancer (more than 70% of cases). Between 0.3% and 4.6% of all deaths are reported as euthanasia or physician-assisted suicide in jurisdictions where they are legal. The frequency of these deaths increased after legalisation (28).

Recent legal cases (29)

1. New Zealand (NZ) has a series of criminal law decisions on 'mercy killings' (as do most similar jurisdictions) confirming that assisted suicide in the context of terminal illness is not a proper part of care. See for example R v Faithfull (30)

   > … the starting principle must be the sanctity of human life. The suggestion that there should be some relaxation of criminal liability in the case of euthanasia or mercy killings or attempted mercy killings has not been accepted by the Court. It has been rejected on every occasion raised. The Court must carefully guard the principle of sanctity of life to ensure that the rights of the weak, the vulnerable and the handicapped are not diluted or overlooked.

2. NZ High Court decision in 2015 in Seales confirmed that 'physician assisted suicide' was criminal, and not within the scope of the 'double effect' doctrine or proper medical care (31).

3. The Supreme Court of Appeal South Africa in Stransham-Ford in December 2016 confirmed that mercy killing is murder, and on the 'other side of the coin' from proper medical care (312Prohibition on physician assisted suicide did not infringe constitutional rights (33).

4. The Scottish Court of Session in Ross in February 2016 rejected a challenge to the Prosecution Code and public guidance which did not allow an exception from

prosecution for assisted suicide in the context of 'undignified and distressing' medical conditions (34).

5. Supreme Court (on appeal) in New Mexico in Brandenburg in August 2015 confirmed that physician assisted suicide is criminal and not part of proper medical care, and that its prohibition was not unconstitutional (35).

6. The United Kingdom Supreme Court in Nicklinson in 2014 declined to declare that the prohibition against physician assisted suicide was incompatible with the ECHR (36):

7. The High Court in Ireland in Fleming in 2013 upheld the ban on assisted suicide, finding that there are "powerful countervailing considerations which fully justify" the legislation (37).

8. The Canadian Supreme Court in Carter in 2015 found that the law prohibiting assisted suicide contravened the Charter on the basis that it was too broad in application (38). The case is routinely cited as showing that assisted suicide is generally harmless. However, note that the Supreme Court in Carter declined to itself re-consider the evidence, but relied on the findings of the lower court judge on the limited evidence before her (39) (the Judge having excluded a substantial body of relevant evidence as inadmissible (40). The Canadian court also restricted itself to the very narrow question of whether legalising euthanasia/assisted suicide would result in vulnerable people being induced to commit suicide, and excluded all other risks and harms as irrelevant (41).

    8.1. The same evidence that was considered in Carter was reviewed by the High Court of Ireland in Fleming and by the UK Supreme Court in Nicklinson (above). Both courts concluded that the true position on the evidence was the opposite of the view reached by the Canadian court, and that there was significant risk of harm (42).

    8.2. The approach of the Canadian courts can also be contrasted to the conclusions reached by the Scottish and UK Parliaments, who conducted a far more in-depth and wide ranging analysis and rejected proposals to change the law (43-45). The United Nations Human Rights Committee and the United Nations Committee on the Rights of Persons with Disabilities have also expressed concerns about the impact on the disabled and the vulnerable in those countries where euthanasia/assisted suicide is legal (46, 47).

    8.3. The Supreme Court in South Africa said this about Carter (48):

> … it should be borne in mind that it was only on the question of overbreadth that the Supreme Court of Canada held in Carter that the criminalisation of aiding and abetting suicide unjustifiably infringed a protected right. Whether a South African court faced with the same issue would arrive at the same conclusion would need to

> be determined in the light of the very different circumstances in this country; [including] … our sense of the need to protect the poor, the weak and the vulnerable and the value attached to providing such protection.

7. Key elements of discourse around assisted suicide

Autonomy

A striking aspect of the arguments advanced by the proponents of assisted suicide is the emphasis on the autonomy of the person and their right to have control over their own body. This argues that the state should not create laws that prevent people from being able to choose when and how they die. It may be argued that we need to move away from the protection imperative which is over-broad and restrictive of the right to self-determination.

A person's autonomy cannot be absolute – while it allows a person, with the capacity to do so, to decline an intervention, that person cannot demand an intervention that is neither appropriate nor being offered to them. Attaining a balance between each of the four pillars of beneficence, non-maleficence, autonomy and justice requires careful consideration, as the application of one person's expression of autonomy must be balanced against the risk of harm to others.

At the same time, consideration of medical ethics implies that legalising assisted suicide would be in violation of the medical ethics requirement for respect for human life, and incompatible with the doctor's role as healer and to preserve human life: although generally implicit in professional ethics discourse, it is a central tenet that doctors should not kill their patients. In addition, it would be in direct contravention of the Irish Medical Council's Guide on Professional Conduct and Ethics and guidance on End of Life Care (489It would also be a paradigm shift in the role of the physician, and could lead to irreparable damage to the patient-doctor relationship.

Capacity

The assumption of mental capacity and freely given consent is based on a subjective clinical judgment, including the patient's ability to understand, believe and weigh up the implications of their decision. There are a range of emotional as well as cognitive factors which influence mental capacity. Evidence presented to the UK Commission on Assisted Dying noted that judgements about mental capacity relating to assisted suicide were inconsistent and sometimes at variance with the UK Mental Capacity Act 2005. It found that a consensus had not yet been established on what constitutes capacity for this decision (50).

Response shift and adaptation

The process of adaptation to change means that a patient's level of distress may fluctuate significantly at different points of their health journey. As a result, the anticipation of

intolerable suffering may be transformed in experience and meaning, given time and appropriate support.

Relief for unbearable suffering

Another argument for the introduction of assisted suicide is that despite the best available palliative care, a small number of terminally ill patients suffer unbearably. It has been argued that the absence of legislation supporting assisted suicide is leading to some patients having to take their own lives earlier in order to do so while they are still physically able to do so their own lives earlier in order to do so while they are still physically able to do so in anticipation of disability.

There are several challenges to this position, including a recent paper showing that in psychiatric patients, symptoms of unbearable suffering may start at an early age and may further progress because of insufficient and/or poor patient-physician communication and inefficient treatment practices (51). Financial issues are also relevant – for example, in the context of economic arguments about a health service overly concerned with "waste" of resources, disabled people may be seen as a drain, just like the elderly. We also know from the US that some people have been denied life-extending treatments because they are too costly while the cheaper assisted suicide option has been offered as an alternative (52). In addition, all major UK advocacy groups for disability have rejected assisted suicide.

"Pragmatic argument"

It is maintained by some in favour of assisted suicide that many practices used in end of life care are essentially a type of euthanasia. It may be argued that there is no coherent legal distinction between the right to decline possibly life-prolonging therapies and the taking of action to hasten the 'natural' process of dying. For example, the practice of Do Not Attempt CardioPulmonary Resuscitation (DNACPR) is considered by some as a form of so-called 'passive euthanasia'. There may also be an argument that palliative sedation is a type of active euthanasia. Thus, the so-called pragmatic argument is that assisted dying is being carried out anyway in these forms, then it is better to regulate properly for it (7).

Those who do not support assisted suicide argue that there is a fundamental difference between the appropriate withdrawal of interventions and treatments that are no longer helping at patient in order to allow a natural death to occur, and assisted suicide. RCPI does not support the use of the term 'passive euthanasia' in any context.

Creep and slippery slope

There is concern that legalising assisted suicide would lead to significant unintended consequences for healthcare system and society that societal attitudes would gradually change; that there would inevitably be a creep from restrictive to permissive eligibility and potentially to include non-voluntary and involuntary euthanasia (7). With that, there is the possibility that life would be devalued in society, particularly concerning for vulnerable people-sick, disabled and elderly. This argument includes the idea that people who are very

ill or with severe disabilities may feel pressured to request assisted suicide or euthanasia to avoid being a burden to their families.

The United Nations Human Rights Committee and the United Nations Committee on the Rights of Persons with Disabilities have expressed concerns about the impact on the disabled and the vulnerable in countries where assisted suicide is legal. The fear is that at the heart of arguments for assisted suicide is a belief that some lives- lives that are physically or intellectually compromised, are not worth living, and that the legislation undermines the rights of the disabled, both directly but also by implying lesser values of certain types of life.[i] It has been argued that it is impossible to enforce sufficient safeguards, and in particular that there are no safeguards that can truly protect the vulnerable.

In 2014 Baroness Campbell, one of Britain's most prominent disability rights campaigners, and who is seriously disabled said (53):

> " … at the moment they say they want assisted suicide for people who are terminally ill, but for how long will that last, and who decides what is terminal? If terminal illness, why not chronic and progressive conditions?.. And, if chronic and progressive conditions, why not seriously disabled people? I am already on the list. ..This sent a shiver down my spine: it is reminiscent of Belgium's slippery slope…Their euthanasia law is displaying an elasticity that no one could have imagined a few years ago."

It might also be argued that if assisted suicide were to be allowed for physical suffering, then why not for psychological suffering also? If allowed for patients with 'terminal illness' why not anyone else, for example those with a life-long illness?

Another fear would be that there would be a move towards a utilitarian approach to death within healthcare system. For example, a recent article looked at potential cost savings associated with implementation of medical assistance in dying in Canada and found that it could reduce healthcare spending (54).

Evidence of harm

Where there is legislation for assisted suicide there is no evidence that the existence of legislation has led to significant harms, but such studies have rarely looked at perceptions of illness, nihilism or ageism, all of which can be affected and influence care policies. For example, in societies where a negative public discourse related to living with dementia is tolerated, despite evidence of maintained quality of life for those so affected, assisted suicide or VAE may undermine the collective will to improve services and supports for those living with dementia (55).

At the same time, the possibility for other forms of harm cannot be discounted. One unintended consequence for example, would be that a person may choose euthanasia based on mistaken medical diagnosis or prognosis.

Palliative treatment/Palliative care

With advances in medicine, in palliative care and in mental health treatments, effective treatments at the end of life are available to the vast majority of people – to ensure that nobody should be suffering either mentally or physically. In New Zealand, expert evidence from both sides indicates that in the worst cases, palliative sedation was available to address intractable physical pain (56). In Ireland, as in Europe (8), palliative sedation in the context of palliative medicine is used to relieve the burden of otherwise intractable suffering in a manner that is ethically acceptable to the patient, family and healthcare providers.

There is a concern that a move towards assisted suicide would result in a shift in focus away from the development and the delivery of palliative care services and cure, and that research into palliative care may be discouraged (7).

Conscientious objection

It has also been argued in the literature recently that there should be protections for patients from doctors' personal values and there should be more severe restrictions on the right to conscientious objection, particularly in relation to assisted dying. Of note is the Swedish approach where individual healthcare professionals have no recognised right of conscientious refusal – but there are legal cases challenging this in the European Court of Human Rights (57).

Healthcare professionals are thus concerned regarding their right to conscientiously object to authorise or perform certain lawful services. A recent UK case may provide some parallels. In UK- Doogan (2015) the Supreme Court determined that two senior midwives who objected to abortion were, nevertheless, obliged to provide administrative and supervisory assistance to other healthcare professionals who were providing abortions (56).

Concerns have been expressed from within the medical profession that physicians may not be allowed to conscientiously object to provide assisted suicide (58). Similarly, there is concern that the duty of a healthcare professional to refer or to provide a patient with information may undermine the professional's conscientious objection (59). It remains unclear under what circumstances there would be an ethical obligation to inform terminally ill patients about assisted dying as an end-of-life option – and whether conscientious objection would be allowed (60).

Text quoted from an advanced draft of guidance to support the implementation Draft Recommendations for the Code of Practice for Health and Social Care Professionals

On Advance Healthcare Directives is instructive in this regard:

> Failure, by a health and social care professional, to comply with a valid and applicable AHD may give rise to civil or criminal liability. A health and social care

professional may disagree in principle with a person's treatment preferences and refuse to comply with a valid and applicable AHD.

In line with the approach of the European Court of Human Rights (61) conscientious objection is a limited right and cannot lead to the restriction of the rights and freedoms of another person. Therefore, if a HSCP has a conscientious objection, he or she should take the following steps:

- He or she should make their objection clear when the matter initially arises and when he or she realises that the person's AHD conflicts with his or her own held values.
- He or she must inform the designated healthcare representative (if there is one) and also inform colleagues of the conscientious objection.
- He or she must then make arrangements to transfer the care of the person to another HSCP who does not have a conscientious objection. Arrangements to transfer a person for care or treatment should not be delayed or impeded in any way. The transfer arrangements should be noted on the person's file.
- If it is not possible to make arrangements to transfer the person, then the person must be treated in accordance with the valid and applicable AHD.

Concerns about dignity

Some of the advocates of assisted suicide and voluntary euthanasia argue that one should be entitled to a 'death with dignity'. Its proponents assert that there is a right to prevent our dignity from being undermined by disability and suffering. Because the concept of human dignity carries strong rhetorical and moral force, we are obliged to examine any claims that our society is failing to act in accordance with it. Human dignity is not a thing that can be lost through disability, disease, dependency, or suffering, although insensitive treatment or attitudes to those so affected can constitute undignified care. It is important that the healthcare professions promote a critical debate on the complexities of discourse relating to dignity, and maintain care philosophies and routines that promote dignified care.

8. Issues and concerns in countries/states where legislation on assisted suicide or euthanasia exists

Assisted Suicide or Euthanasia is currently legal in six countries (Belgium, Colombia, Canada, The Netherlands, Switzerland, and Luxembourg). It is also legal in seven US States (California, Colorado, Montana, Oregon, Vermont, Washington and Washington DC) (62, 63).

A number of concerns have been documented in relation to what is actually happening in some jurisdictions where assisted suicide or euthanasia has been legalised (56).

- In the Netherlands, a 2013 review showed that 97 people with dementia were 'euthanised' in that year, along with 42 people with mental illness, and that euthanasia without explicit request from the patient was increasing.
- Between 2011 and 2014 in Belgium the euthanasia of two deaf adults was approved on the basis that they were going blind, and another adult in his 30s was approved on the basis of autism. A clinic that 'euthanised' a woman suffering from tinnitus was reprimanded for being 'careless'.
- Belgium also now allows euthanasia of children, while the Netherlands allows euthanasia of children over the age of 12 and babies under a different protocol.
- Euthanasia in Belgium and the Netherlands and assisted suicide in Oregon in increasing significantly as the practice is normalised.
- The incidence of 'unassisted suicide' in Oregon is 41% higher than the national average and is the second leading cause of death in those aged 10-34. In the Netherlands, there has been a 30% increase in the suicide rate in the general population between 2008 and 2012.

Other evidence of issues include (in the state of Oregon):

- Out of 18 patients given clearance for physician assistance in dying, three were depressed at the time of requesting medical assistance in dying but that this was neither investigated nor treated (64).
- Contrary to suggestions, the highest resort to physician assistance in dying in Oregon is among the elderly (64).
- In 2000, those who delayed in taking the medications survived for as long as ten months to 2.7 years (6/12 survival an eligibility criterion). Reporting of this data ceased in 2005 (64).

- In 2014, the median time to death was 25 mins but varied up to 104 hours; six patients woke up and none of those re-attempted assisted suicide (65).
- Between 1990 and 2010 the ratio of euthanasia to assisted suicide in the Netherlands increased from 141:18 to 475:21 (66).
- Difficulties were reported in administering the drugs in 10% of cases of physician assisted suicide and 5% of euthanasia, with vomiting in 7% and 3% of cases respectively. Deaths also took a long time of up to 7 days in 15% and 5% of cases respectively (67).

9. Case study- Canada

Carter vs. Canada

Carter vs. Canada was a landmark decision of the Canadian Supreme Court. In February 2015 the court ruled that parts of the criminal code needed to comply with the Canadian Charter of Rights and Freedoms. The parts in question, those that prohibited medical assistance in dying under certain conditions, were deemed no longer valid. The Supreme Court gave the government until June 6th 2016 to create a new law. The federal government passed legislation on June 17th 2016 that allows eligible adults to request medical assistance in dying (68).

Legislation

Under the 2016 legislation, medical assistance in dying can be legally provided by physicians and nurse practitioners (a registered nurse who, under the laws of a province, is entitled to practise as a nurse practitioner (68). The physician or nurse practitioner can directly administer a substance causing death, such as an injection of a drug, or can give or prescribe a drug that is self-administered to cause death (1).

People who can help in providing medical assistance in dying, without being charged under criminal law include pharmacists, health care providers who help both physicians and nurse practitioners and family members or other people asked to help by the person receiving the medical assistance in dying. All those involved must follow the rules set out in the criminal code and any applicable provincial and territorial health related laws, rules and policies (1).

Eligibility

For a person to be eligible for medical assistance in dying, they must meet all of the following conditions (1).

- They must be eligible for health services funded by the federal government or a province or territory. This means that generally, visitors to Canada are not eligible.

- They must be over 18 and mentally competent.

- They must have a grievous and irremediable medical condition. This condition does not need to be fatal or terminal, but it must be a serious disease, illness or disability that is in an advanced stated that cannot be reversed. The person must be suffering unbearably from the condition, and must be at a point where their natural death has become reasonably foreseeable.

- The request for medical assistance in dying must not be the result of outside pressure or influence.

- They must give informed consent to receive medical assistance in dying. Informed consent must include the person receiving information about their medical diagnosis, available forms of treatment, and available options to relieve suffering, including palliative care. At the time the service is provided, the physician or nurse practitioner will ask the person to confirm their choice before medical assistance in dying is administered. Consent may be withdrawn at any time.

10. Summary of key issues

A small number of countries have legislated for assisted suicide and euthanasia. However, such action presents many concerns for physicians and other healthcare professionals. These concerns are so great that, for example in the UK, most of the professional medical bodies have expressed their opposition to introduction of legislation on assisted suicide. In Ireland also, a number of professional healthcare/medical bodies have also expressed opposition. In most cases, the bodies in question have arrived at this position through reviews from expert groups, and through survey(s) of their membership.

In recent legal cases relating to assisted suicide, courts in Ireland, New Zealand, South Africa, Scotland, the UK, and New Mexico upheld prohibition on assisted suicide. The Canadian Supreme Court in Carter vs. Canada however found that the law prohibiting assisted suicide was too broad in application. However the Canadian Supreme Court didn't itself examine the evidence but relied on the opinion of the lower court where much relevant evidence was declared inadmissible and excluded. In relation to cases brought before the Scottish and Westminster parliaments, a far more in-depth and wide-ranging analysis was conducted leading to rejection of rejected proposals to change the law. The Irish High Court also recognised significant risk of harm.

Within the discourse around assisted suicide there are a number of arguments in support of and against assisted suicide and euthanasia. It is the position of RCPI that the potential harms of assisted suicide outweigh the arguments in favour of legislation for assisted suicide. A majority of professional healthcare and medical bodies worldwide are of the same view.

In jurisdictions where assisted suicide or euthanasia have been legalised, a number of issues raise concerns. These include euthanasia of those with dementia, mental illness, depression and non- terminal conditions; the extension of eligibility to allow euthanasia of children; and an increase in 'unassisted' suicide rates.

11. Recommended position for RCPI to consider

This group recommends:

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

In public messages and advocacy around this issue, RCPI spokespeople should focus on the following key messages/rationale underpinning its position:

1. The Irish medical profession views assisted suicide as a major concern in Ireland
2. The discontinuation of treatments and interventions that are no longer of medical benefit to a dying patient is not assisted suicide.
3. The use of the term 'passive euthanasia' in any context is not supported by RCPI.
4. Advances in palliative care and in mental health treatment in Ireland mean that there are effective treatments to provide care for patients at the end of their lives. In the rare cases where a patient's physical, spiritual and/or psychosocial suffering cannot be fully alleviated despite implementing the best physical, spiritual and psychological care available, the RCPI would still not advocate Assisted Suicide. The monitored use of palliative sedation as defined in this document (See section 3) remains an appropriate option in the most intractable of cases.
5. Public and private discussion with regard to assisted suicide should be seen to represent concerns over adequacy of treatment and support as well as existential concerns relating to the future: these need to be proactively addressed
6. A physician engaging in assisted suicide is a violation of medical ethics: doctors should not kill their patients,
7. It would be impossible to completely safeguard vulnerable people in our society from unintended direct and indirect consequences of assisted suicide. People who are very ill or with severe disabilities may feel pressured to request assisted suicide or euthanasia to avoid being a burden to their families, or to society.

References

1 Government of Canada: Medical assistance in dying. : https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html Date modified: 2017-04-26 Government of Canada: Medical assistance in dying [Internet]. Updated: 2017 April 26. Available from: https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html

2 British Medical Association. End-of-life care and physician-assisted dying – Reflections and Recommendations [Internet]. UK; Updated: 2016 March. Available from: https://www.bma.org.uk/-/media/files/pdfs/working%20for%20change/improving%20health/elcpad%20report%20vol%203%20march%202016.pdf?la=en

3 Care Alliance. Judgement of Collins J [Internet]. New Zealand; 2015 June 5. Available from: http://carealliance.org.nz/wp-content/uploads/2015/11/Judgment-final.pdf

4 National Suicide Research Foundation. Statistics, Suicide [Internet]. Ireland; 2015. Available from: http://www.nsrf.ie/statistics/suicide/

5 O'Neill DJ: A sad day for human rights in Ireland. In: The BMJ Opinion [Internet]. 2013 March 13. Available from: http://blogs.bmj.com/bmj/2013/03/13/desmond-oneill-a-sad-day-for-human-rights-in-ireland/

6 O'Neill DJ. Matters arising from The BMJ's stance on assisted dying. BMJ 2015; 351: h4883

7 NHS Choices. Euthanasia and Assisted Suicide [Internet]. UK; Updated: 2016 June 29. Available from: http://www.nhs.uk/Conditions/Euthanasiaandassistedsuicide/Pages/Introduction.aspx

8 Cherny NI, Radbruch L. The Board of EAPC: European Association for Palliative Care (EAPC) recommended framework for the use of sedation in palliative care. Palliat Med. 2009, 23: 581-593.

9 Houses of the Oireachtas. Dying with Dignity Bill [Internet]. Ireland; 2015. Available from:https://www.oireachtas.ie/viewdoc.asp?fn=/documents/bills28/bills/2015/12515/document1.htm

10 World Medical Association. WMA statement on physician-assisted suicide [Internet]. 2005, April 30. Available from: https://www.wma.net/policies-post/wma-statement-on-physician-assisted-suicide/

11 Royal College of Physicians. RCP reaffirms position against assisted dying [Internet]. London UK; 2014 November 27. Available from: https://www.rcplondon.ac.uk/news/rcp-reaffirms-position-against-assisted-dying

12 Royal College of General Practitioners. RCGP remains opposed to any change in the law on assisted dying [Internet]. UK; 2014 February. Available from: http://www.rcgp.org.uk/news/2014/february/rcgp-remains-opposed-to-any-change-in-the-law-on-assisted-dying.aspx

13 Royal College of General Practitioners. Assisted Dying Consultation Analysis [Internet]. UK; 2014 January. Available from: http://www.rcgp.org.uk/-/media/Files/Policy/Assisted-Dying-Consultation/Assisted-Dying-Consultation-Analysis.ashx?la=en

14 British Medical Association. Physician Assisted Dying BMA Policy [Internet]. UK; Updated: 2017 May 9. Available from: https://www.bma.org.uk/advice/employment/ethics/ethics-a-to-z/physician-assisted-dying

15 British Medical Association. End-of-life care and physician-assisted dying – Public Dialogue Research [Internet]. UK; Updated: 2016 January. Available from: https://www.bma.org.uk//media/files/pdfs/working%20for%20change/improving%20health/elcpad%20report%20vol%202%20jan%202016.pdf?la=en

16 British Medical Association. End-of-life care and physician-assisted dying – Setting the scene [Internet]. UK; Updated: 2016 January. Available from: https://www.bma.org.uk//media/files/pdfs/working%20for%20change/improving%20health/elcpad%20report%20vol%201%20jan%202016.pdf?la=en

17 British Medical Association. End-of-life care and physician-assisted dying project - Key recommendations on end-of-life care [Internet]. UK; 2016. Available from: https://www.bma.org.uk//media/files/pdfs/working%20for%20change/improving%20health/elcpad-recommendations-2016.pdf?la=en

18 British Geriatrics Society. Physician Assisted Suicide [Internet]. UK; 2015 July 10. Available from: http://www.bgs.org.uk/ethicslaw/subjectreference/ethicslawcapacity/position-assisted-suicide

19 British Society of Rehabilitation Medicine (BSRM). Long-term neurological conditions: management at the interface between neurology, rehabilitation and palliative care – National Guidelines [Internet]. UK; 2008 March. Available from: http://www.bsrm.org.uk/downloads/long-term-neurological-conditions-concise.pdf

20 Radbruch L, Leget C, Bahr P, Müller-Busch C, Ellershaw J, de Conno F, Vanden Berghe P; Board Members of EAPC. Euthanasia and physician-assisted suicide: A white paper from the European Association for Palliative Care. Palliat Med. 2016 Feb; 30(2):104-16.

21 KNMG. The role of the physician in the voluntary termination of life [Internet]. The Netherlands; June 2011. Available from: http://www.consciencelaws.org/archive/documents/2011-08-30%20KNMG-position-paper.pdf

22 Swiss Academy of Medical Sciences. Ethics in end-of-life care guidelines [Internet]. Switzerland; 2012. Available to download from: http://www.samw.ch/en/Ethics/Ethics-in-end-of-life-care.html

23 Swiss Medical Association (FMH). Position Paper - L'assistance au suicide n'est pas l'aide au décès [Internet]. Switzerland; 2008. Available from: http://www.fmh.ch/files/pdf2/2008_01_28_meinung_sterbehilfe_f1.pdf

24 Royal Australian College of General Practitioners. Comments on the Medical Services (Dying with Dignity) Exposure Draft Bill [Internet]. Australia; 2014 August 21. Available from: http://www.racgp.org.au/download/Documents/Reports/RACGP-response-to-senate-commitee.pdf

25 Royal Australasian College of Physicians. RACP Submission: Draft Voluntary Assisted Dying Bill 2017 NSW [Internet]. Australia; 2017 July. Available from: https://www.racp.edu.au/docs/default-source/advocacy-library/pa-racp-submission-nsw-vad-bill-submission.pdf

26 Australian Medical Association. AMA Position Statement on Euthanasia and Physician Assisted Suicide [Internet]. Australia; 2016 November. Available from: https://ama.com.au/sites/default/files/documents/241116%20%20AMA%20Position%20Statement%20on%20Euthanasia%20and%20Physician%20Assisted%20Suicide%202016.pdf

27 Lois Snyder Sulmasy, JD; Paul S. Mueller, MD, MPH; for the Ethics, Professionalism and Human Rights Committee of the American College of Physicians. Ethics and the Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper. Ann Intern Med. 2017; 167 (8):576-578. DOI: 10.7326/M17-0938

28 Manuel EJ, Onwuteaka-Philipsen BD, Urwin JW, Cohen J. Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe. JAMA. 2016 Jul 5; 316; 316(1):79-90. doi: 10.1001/jama.2016.8499

29 Personal communication from Dr S Donnelly to Dr F Twomey

30 R v Faithfull HC Auckland CRI 2007-044-7451, 14 March 2008

31 Seales v Attorney-General [2015] NZHC 1239, [2015] 3 NZLR 556

32 Minister of Justice and Correctional Services v Estate of Stransham-Ford 0531/2015) 2016 ZASCA 197 (6 December 2016). E.g. at [35] – [40] on the issues of causation and culpability in providing drugs for the purpose of suicide, at [52] – [57]. Noting the Court's comments in the illegitimacy of a court overruling the established law and medical ethics in the context of a confined case (e.g. at [5] and [41]).

33 Finlay IG, George R Legal physician-assisted suicide in Oregon and The Netherlands: evidence concerning the impact on patients in vulnerable groups—another perspective on Oregon's data Journal of Medical Ethics 2011; 37:171; 37:171-174.

34 Ross v Lord Advocate [2016] CSIH 12

35 Morris v Brandenburg 33,630 (N.M. Ct. App. 2015)

36 Nicklinson v Minister of Justice [2014] UKSC 38 at [225] – [229], see also [255] – [256].

37 Fleming v Ireland [2013] IEHC 2, upheld on appeal at IESC (Ir SC)19

38 Carter v Attorney-General [2015] SCC 5

39 Carter (Supreme Court) at [105] – [109]

40 As noted by the UK Supreme Court in Nicklinson v Minister of Justice [2014] UKSC 38 at [224]

41 Carter (Supreme Court) at [99]

42 Fleming v Ireland [2013] IESC (Ir SC)19 at [92]-[105]; Nicklinson v Minister of Justice [2014]UKSC 38 at [224] – [229]

43 Health and Sport Committee, Stage 1 Report on Assisted Suicide (Scotland) Bill, 6th Report, Session 4 (2015), Bill rejected 15 May 2015 Available from: http://www.scottish.parliament.uk/S4_BusinessTeam/pm-v5n8-s4.pdf

44 UK House of Lords debate [Internet]. Date: 2015 July 18. Available from: http://www.publications.parliament.uk/pa/ld201415/ldhansrd/index/140718.html#contents

45 UK House of Commons [Internet]. Date: 2015 September 11. Available from: http://www.publications.parliament.uk/pa/cm201516/cmhansrd/cm150911/debtext/150911-0001.htm

46 United Nations Human Rights Committee. Human Rights Committee discusses follow-up to concluding observations and to views [Internet]. Date: 2014 March 24. Available from: http://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=14430&LangID

47 United Nations Committee on the Rights of Persons. Committee on the Rights of Persons with Disabilities considers the initial report of Belgium [Internet]. Date: 2014

September 19. Available from:
http://www.ohchr.org/ru/NewsEvents/Pages/DisplayNews.aspx?NewsID=15073&LangID=E

48 Minister of Justice and Correctional Services v Estate of Stransham-Ford at [72].

49 Medical Council. Guide to Professional Conduct and Ethics for Registered Medical Practitioners [Internet]. Ireland; 2009, 7th Edition. Available from:
https://medicalcouncil.ie/News-and-Publications/Publications/Professional-Conduct-Ethics/Guide-to-Professional-Conduct-and-Behaviour-for-Registered-Medical-Practitioners-pdf.pdf

50 Price, A., McCormack, R., Wiseman, T. et al. Concepts of mental capacity for patients requesting assisted suicide: a qualitative analysis of expert evidence presented to the Commission on Assisted Dying. BMC Med Ethics (2014) 15: 32.

51 Verhofstadt M, Thienpont L, Peters GY. When unbearable suffering incites psychiatric patients to request euthanasia: qualitative study. Br J Psychiatry. 2017 Oct;211 (4):238-245.

52 The Guardian. Legalising assisted dying is dangerous for disabled people. Not compassionate [Internet]. UK; 2016 September 9. Available from:
https://www.theguardian.com/commentisfree/2016/sep/09/legalising-assisted-dying-dangerous-for-disabled-not-compassionate

53 The Telegraph. Disabled peer: Lord Falconer's assisted suicide plans 'send shiver down my spine' [Internet]. UK: 2014 March 24. Available from:
http://www.telegraph.co.uk/news/uknews/law-and-order/10717279/Disabled-peer-Lord-Falconers-assisted-suicide-plans-send-shiver-down-my-spine.html

54 Trachtenberg AJ, Manns B. Cost analysis of medical assistance in dying in Canada. CMAJ. 2017 Jan 23; 189; 189(3):E101-E105. doi: 10.1503/cmaj.160650.

55 The Telegraph. I'd hate to become a burden to my family [Internet]. UK; 2014 March 24. Available from: http://www.telegraph.co.uk/women/womens-health/11439398/Joanna-Trollope-Id-hate-to-become-a-burden-to-my-family.html

56 Casey V. 'The right to die' and 'rational suicide': respecting human rights for all or a claim for privilege by the strong? The case for the status quo [Internet]. Australia & New Zealand; 2015. Available from: https://www.victoria.ac.nz/law/centres/nzcpl/publications/human-rights-research-journal/current-issue/Victoria-Casey-HRR-2015.pdf

57 Clarke S Conscientious objection in healthcare: new directions Journal of Medical Ethics 2017; 43:191.

58 Fletcher J. Right to die in Canada: respecting the wishes of physician conscientious objectors. CMAJ. 2015 Dec 8; 187(18):1339.

59 Cowley C Conscientious objection in healthcare and the duty to refer Journal of Medical Ethics 2017; 43:207-212.

60 Buchbinder M. Aid-in-dying laws and the physician's duty to inform. J Med Ethics. 2017 Mar 21. pii: medethics-2016-103936.

61 Pichon and Sajous v. France (dec.), (EHCR) no. 49853/99, 4 October 2001

62 Emanuel EJ, Onwuteaka-Philipsen BD, Urwin JW, Cohen J. Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe. JAMA. 2016 Jul 5;316; 316(1):79-90.

63 New York Post. Colorado votes to legalize medically assisted suicide [Internet]. Colorado; 2016 November 8. Available from: http://nypost.com/2016/11/08/colorado-votes-to-legalize-medically-assisted-suicide/

64 Finlay IG, George R Legal physician-assisted suicide in Oregon and The Netherlands: evidence concerning the impact on patients in vulnerable groups—another perspective on Oregon's data Journal of Medical Ethics 2011: 37:171-174.

65 Oregon Public Health Division. Oregon Death with Dignity Act Annual Reports, 1998-2015. Available from: https://public.health.oregon.gov/ProviderPartnerResources/EvaluationResearch/DeathwithDignityAct/Pages/ar-index.aspx

66 George Rob. We must not deprive dying people of the most important protection BMJ 2014; 349 :g4311

67 Johanna H Groenewoud, Agnes van der Heide, Bregje D. Onwuteaka-Philipsen, Dick L. Willems, Paul J. van der Maas, Gerrit van der Wal. Clinical Problems with the Performance of Euthanasia and Physician-Assisted Suicide in the Netherlands N Engl J Med 2000; 342:551-556

68 Justice Laws Website. An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying [Internet]. Canada; 2016. Available from: http://lawslois.justice.gc.ca/eng/AnnualStatutes/2016_3/FullText.html