VOLUNTARY ASSISTED DYING (VAD)

Joint Oireachtas Committee on Assisted Dying
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Irish Doctors supporting Medical Assistance in Dying

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Executive Summary: Presentation to the Joint Oireachtas Committee on Assisted Dying

1. Why should Voluntary Assisted Dying be introduced in Ireland?

Thank you for the opportunity to make this submission on behalf of Irish Doctors supporting Medical Assistance in Dying. We represent over one hundred registered medical doctors in Ireland.

We believe that Voluntary Assisted Dying (VAD) is about offering terminally ill patients, a choice at the end of life.

Autonomy

Medical paternalism, where doctors assume what is in the patient's best interest, is no longer acceptable. Patients' choices should be respected and supported where reasonable, with decision-making shared between doctor and patient.

As a society we have empowered individuals through referenda to take control and reasonability of their personal lives. Ireland is now a progressive, caring and compassionate society which respects individual's rights. Repeated opinion polls in Ireland show that society understands that Assisted Dying may be a reasonable choice for those with terminal illness. Assisted Dying continues to have widespread support among the public in the various jurisdictions where it has been introduced. Public support for Assisted Dying in Australia is at 78% and at 83% in Victoria where it has been available for over 6 years.

Increasingly various medical bodies have recognised that there are diverse opinions among doctors on Assisted Dying and that it is a societal issue rather than a medical one. In the UK, following consultation with its members, the Royal College of Physicians, the Royal College of Surgeons and the British Medical Association have all adopted a *neutral stance* on Assisted Dying. In Ireland, the ICGP have also adopted a neutral stance.

Concern for vulnerable groups is shared by all doctors in this debate. Studies on assisted dying have repeated showed that vulnerable groups are not over-represented in those who choose Assisted Dying. In fact, people who choose Assisted Dying tend to have higher incomes, are younger, are more likely to be married and to be living at home.

Compassion in Dying

Palliative care can control and alleviate the symptoms of many patients, but it cannot eliminate all pain and suffering, for all patients. Other symptoms including shortness of breath, nausea, vomiting, or unremitting itch can be difficult to control. When the symptoms are overwhelming then terminal sedation, where the patient is rendered unconscious, may be used. Terminal sedation is very important to avoid patient distress and suffering but we should also recognise that it strips the patient of all autonomy. They are unconscious and unable to contribute to any decisions in their care.

When we look at the international experience, pain is not the most common motivation for people to request Voluntary Assisted Dying. Loss of being able to live in a meaningful way and loss of ability to perform activities of daily living, such as being able to go to the toilet independently, underlie over 80% of requests. It is understandable that an individual may choose to end their suffering, when they lose their ability to function, there is no prospect of improvement and death is foreseeable.

Many patients with distressing symptoms and incapacity at the end of a terminal illness may never wish for VAD and it is right that they have the choice of palliative care. Other patients will not want to endure the suffering that can occur with a terminal illness and would choose VAD. Their choice should also be respected and supported.

International models of VAD

VAD is currently available in multiple countries in Europe, Australasia and North America. Assisted Dying has been available in the US State of Oregon since 1997. As of October 2023, VAD is lawful and accessible in over eleven countries (1-4). Several countries are in various stages of implementing VAD, including Germany (legislation under review), the UK (Bill under review), France (legislation under review) and Portugal.

We have outlined a variety of similarities and differences in the how these countries have addressed Assisted Dying in *Table 1* below, but include:

- All the models support the provision of Assisted Dying for advanced terminal incurable illness.
- In only three countries can advanced care directives be permitted, so capacity/ the ability to consent at the time of VAD is necessary in most countries, including New Zealand and Australia.
- Where legislation was used to underpin VAD, no substantial changes to the provision of VAD occurred subsequently (e.g. Oregon since 1997, Victoria Australia since 2017). When exclusion criteria are inserted In legislation, the experience is that these exclusions are retained.

2. A proposed model for the implementation of VAD in Ireland

Having considered the various models of assisted dying in various countries we wish to propose the following model which has borrowed heavily from the models of care in Australia and New Zealand.

Qualifying conditions and Safeguards

We believe that the **qualifying conditions** should be underpinned though legislation and:

- Confined to individuals over 18 years, with a progressive, incurable, terminal illness.
- Prognosis of less than 6 months or a terminal illness causing severe physical deterioration.
- The patient must have capacity to consent to assisted dying.

Safeguards

- There needs to be two independent medical assessments by two doctors, both of whom have completed appropriate training.
- Reflection period of two weeks, reduced to 5 days in individuals with a short prognosis (one month or less).
- The reflection period should start from the first assessment.
- Any doctor participating in VAD needs to be on the **specialist register** of the Irish Medical Council and main place of practice needs to be on the island of Ireland.

Exclusions:

We believe that there should be specific conditions which are excluded as a qualifying condition:

- We should exclude any mental health condition as a qualifying condition for VAD.
- Due to the complexities relating to capacity and consent we are not advocating for dementia to be included in the legislation as a qualifying condition, at this point in time.

Choice of VAD:

- VAD can be self-administered with oral medication, or through intravenous medication administered by a registered medical practitioner.
- The patient should have the **choice** in what form VAD is administered, be that intravenous or oral; and if oral-VAD, be it self- or doctor-administered.

Regulations and safeguards are important to protect society and vulnerable people. It is also important that they don't become barriers to frail ill people wishing to exercise their rights.

Training of medical professionals

As part of the implementation process we will need to develop clinical guidelines and training of medical professionals. Again we can borrow from the experience of our international colleagues who have developed suitable training modules. Once established, we would envisage **two layers to the training** of medical professionals:

- *VAD-certifier:* This registered medical professional would need to complete an educational module, with training on issues including coercion, capacity and palliative care. This module would enable this doctor to support one of the two certifications needed to access VAD.
- *VAD-provider:* This registered medical professional would need to complete, in addition to the module above, an intensive educational module, on the detailed provision of medications and holistic healthcare in the context of VAD.

The education-provider would likely be one of the postgraduate medical training bodies or the HSE.

Regulation and monitoring of VAD in Ireland

- Comprehensive regulation, monitoring and reporting of VAD is needed to provide accountability and transparency to foster trust in the public.
- **Comprehensive data collection, audit and monitoring** are essential to ensure standards are being maintained. This obligation should be provided in legislation and will provide qualitative and quantitative data to guide us in relation to future changes, ensuring that vulnerable are protected, whilst maintaining access to VAD.

***Figure 1**: Proposed model for VAD in Ireland*

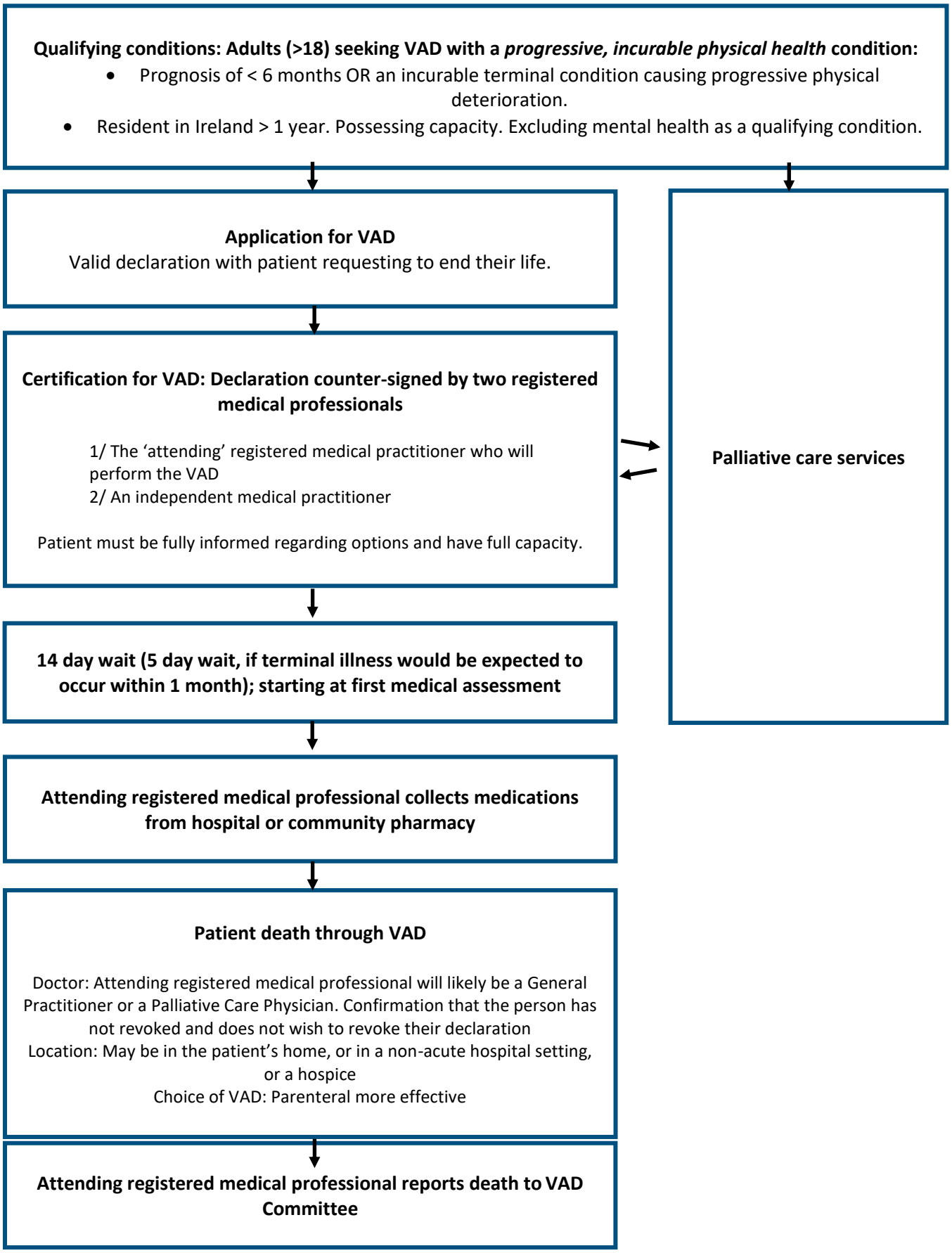

Table 1: *Summary of VAD provision internationally*

	Europe						Australasia		Americas	
Country	**Austria**	**Switzerland**	**The Netherlands**	**Belgium**	**Spain**	**Luxemburg**	**New Zealand**	**Australia (all States by 2024)**	**US states (11)**	**Canada**
Year commenced	2021	1942 (but really since 1980s)	2002	2002	2021	2006	2021	2017 (based on 'Oregon model')	Various	2016
Terminal conditions *** Various definitions** **e.g. 6 months prognostic clause** **e.g. living with chronic, debilitating, and incurable *physical* condition causing unbearable pain or making a dignified life impossible**	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
Severe chronic physical conditions	☑	☑	☑	☑	☑	☑				☑
Chronic mental health conditions		☑	☑	☑	☑	☑				☑
Advanced directives for dementia	☑		☑	☑						☑ 'Waiver of Final Consent'
Adults only	☑	☑	(12-16 with parental consent)	Parental consent	☑	☑	☑	☑	☑	☑
Number of medical assessments to decide on *eligibility*/ certification (before VAD)	Two	Two	Two	Two	Two (attendant physician and consultant physician)	One - two	Two	Two	Two	Two
Pre-approval (on top of certification process)							☑			

							(On top of certification)			
Reflection periods built in (between medical assessments or before VAD)	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
Self-administer only	☑	☑							☑	
Audit/ monitoring	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑

3. References

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