



Carmichael Centre
4 Brunswick Street North
Dublin 7
D07RHA8

TEL: +353 (0)1 873 4735

EMAIL: info@iapc.ie

Registered in Dublin 475267C
CHY 14939

Opening Statement:

- The Irish Association for Palliative Care is a non-government organisation initially formed in 1993 with the purpose of promoting palliative care nationally and internationally. We use our collective expert voice to advance palliative care in Ireland. The membership, which comprises of various health professionals, reflects the entire spectrum of those who work in or have a professional interest in the provision of palliative care in Ireland. This statement is on behalf of the Association's membership.
- Palliative care is a philosophy of care that improves the quality of life of patients and their families who are facing challenges associated with life-threatening illness by preventing and relieving suffering. This is done by means of early identification, assessment and treatment of pain and other physical, psychosocial, and spiritual problems (1). **Palliative care recognises that it may not be possible or appropriate to postpone death, but, equally, death must not be hastened.** We acknowledge the suffering of those with serious medical illnesses. Our focus is to help people experiencing distress, by alleviating their suffering. This does not include ending their lives.
- Palliative care can provide care at any stage of a life-limiting illness, not just at the end of someone's life. It is important that end-of-life care and palliative care are not used interchangeably. The definition of 'end-of-life' varies in the healthcare literature, from final hours to the last year of life (2). Commonly the term end-of-life care is one that



gives a time frame to the estimated length of life. Palliative care focuses on the needs of the person with a life-limiting illness throughout the course of the illness, rather than focusing on prognosis alone (3).

- Some people fear being subjected to treatments that are inappropriate, burdensome, and ultimately not beneficial. An integral part of the right to consent to medical care is the right to decline medical treatment even if that treatment will prolong life. This right is recognised both legally and ethically (4). Declining certain medical treatments does not compromise a person's ability to access palliative care and adequate symptom control. **We endorse and support the right of the competent, informed patient to decline medical treatment, even if this leads to their death. Palliative care cares for people both on life prolonging treatment and when there is a redirection of care to focus on treatments that provide comfort and symptom control.**
- Some requests for euthanasia or assisted suicide result from worries of uncontrolled physical or psychological suffering. There is a misconception that dying is inherently painful, traumatic and undignified. Basic principles of palliative care require that doctors and healthcare professionals ensure that patients are comfortable and pain free. This may include the use of medications such as analgesia and sedative medication. **There is no evidence that careful, appropriate use of pain killers shortens life** (5–11). In a small minority, in cases of severe symptoms and patient distress, sedative medication may be used in the final stages of life to achieve an



acceptable level of patient comfort. The intention of palliative sedation is not to hasten death, nor is it common to use doses that would pose this as a risk. It is used with great care and consideration in cases of severe symptoms and patient distress which cannot be alleviated by any other intervention.

- Palliative care focuses on the delivery of care in a person-centered, compassionate way. In practice, there can be a misconception that medications, particularly opioids, are used for hastening death rather than for symptom control. This misplaced belief and fear can form a barrier to patients achieving good symptom control (12). There is a need to improve understanding and knowledge about palliative care. Introduction of assisted dying would result in an erosion of the trust between healthcare professional and patient (12).
- As a society, there needs to be more discussions about death and dying, to dispel myths and fears and to be informed about end-of-life care options. There also needs to be education and support of healthcare professionals to have these discussions, which can be challenging and emotive. It is important to understand that a person declining a burdensome treatment does not mean that all care and treatment stop, but rather that the focus is on treatments that are acceptable and deemed to be beneficial to the patient, such as by improving quality of life and symptom control.
- When euthanasia or assisted suicide is available as a choice, a key risk is that someone may not make that choice freely. For those who are dependent on others for



care, assisted suicide or euthanasia could be seen as a duty. Carers can derive positives from the caring relationship that they share with the person but unfortunately, they may also experience challenges when caregiving. There is a need to focus supports for carers in the community. There is a requirement for more care support and respite provision in the community. Resources need to be put in place to enhance psychiatric and mental health supports, care and support of our ageing population and those with increased palliative care needs along with development and research into how we optimise end of life care. The ban on healthcare professionals shortening a person's life protects patients who may be vulnerable and basing their decision to die on life situations that can be addressed with the provision of appropriate supports. An example of this may be the sense of being a burden to family, carers, or society.

- Safeguards are usually suggested with new legislation, to avoid misuse of assisted suicide and euthanasia. These safeguards may attempt to utilise prognosis to avoid misuse. Prognostication is not precisely predictable, and errors are common. Prognostication depends on one's clinical experience and knowledge and remains a subjective judgement (13). Safeguards based on specific, limited diagnoses can also be challenged.
- Suffering is a subjective experience to the individual which results not just from physical but also psychological, social, and spiritual influences. Assisted dying



legislation is a solution that fails to address the root causes or complexity of a concept and experience such as suffering. Identification and management of suffering cannot be confined to the physical domain alone. There needs to be a focus on supporting living and addressing the societal deficits that contribute to this experience. There needs to be a drive to address these issues rather than utilising physician assisted suicide and euthanasia as a permanent response to a situation that may change. Palliative Care seeks to address the complexity of suffering by responding to a person's individual physical, psychological and spiritual needs.

- We believe that dignity incorporates more than the principle of autonomy. Dignity is not dependent on a person being of use or interest to others, nor is it based on a person's merits. Dignity is a concept that requires a person to be treated with respect. It is the shared responsibility of healthcare professionals to treat patients with compassion, to manage symptoms and focus on a person's comfort and dignity at end of life (4). The perceived dignity and value of a person is influenced by societal attitudes.
- There is a concern that life would be devalued in society and there is a fear that euthanasia or physician assisted suicide could support a belief that certain types of life are not worth living and are of lesser value. A person's life has value regardless of physical wellbeing or productivity and vulnerability is a state reflective of current conditions, rather than an innate quality.



- The Irish Association for Palliative Care supports current legislation and practice and is against any change in the law to legalise euthanasia or physician assisted suicide. We acknowledge the suffering of those diagnosed with serious medical illnesses and feel that solutions lie in improving palliative care, social conditions and addressing the reasons for euthanasia or physician assisted suicide requests. The solution is not to change legal and medical practice to allow such requests. The focus should be on making sure that patients have access to resources including timely, effective, and equitable palliative care services and a greater understanding around death, dying and end of life care. The IAPC endorses the importance of access to palliative care for all who need it.



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