The Position of the Roman Catholic Church on Assisted Suicide, presented on behalf of the Irish Catholic Bishops' Conference by Ms. Petra Conroy and Dr. Margaret Naughton

The Catholic Church regards the service of those who are sick and dying as an integral part of its mission. A key focus of the ministry of priests and lay chaplains, both in hospitals and in parish communities, is the accompaniment of people who are dying. This pastoral care of the sick also brings us into close contact with family members and friends who, despite their own sadness, often play such an essential role in contributing to the well-being of those who are dying. Their participation contributes to a healthy grieving process following the death of their loved one.

Death is a natural part of the human condition. We do not propose the use of extraordinary or aggressive treatments to prolong life in a way which conflicts with reason or with the dignity of the person. Our focus is on how people might be helped to experience a good death. We are opposed to the deliberate ending of human life, both for reasons of faith and for reasons connected with the defence of the common good.

Our Christian faith, which is shared by a significant proportion of the Irish people, teaches us that life is a gift which we hold in trust. The life and death of each of us has its impact on others and there is no such thing as a life without meaning or value.

The common good is the good of each and of all, and it is the responsibility of the state to uphold it. It is our understanding that the primary focus of this Oireachtas Committee is on how the State can best fulfil its responsibility for the common good. People across Ireland are already helped, ethically and legally, to approach death with dignity, within the interdisciplinary framework of good palliative care. Assisted suicide is something very different and we believe that it would undermine the common good in several different ways:

1. Our experience of pastoral care (as a Church community) has shown us that, in the final weeks of terminal illness, many people can be helped to experience human and spiritual growth. Faced with the reality of their own mortality, they can and do come to understand themselves better, and engage in a new way with family members and friends. This can be a time when old hurts are healed and people find inner peace. This process is supported through palliative and pastoral care, which places the focus on the needs of the whole person. A decision to end life prematurely, by contrast, cuts off any prospect of growth or healing and represents a failure of hope.

2. What begins as a limited right tends to become a societal norm. Assisted suicide does not simply affect the person who dies in this way: it affects their family, their loved ones and all of society. It sends out a message to others who are terminally ill that they also should consider that, perhaps, their continued existence is an unbearable burden on themselves, on their families, or on the healthcare system. While the legalisation of assisted suicide is sometimes represented as compassionate care, it is actually a failure to respond to the very real challenge of caring holistically for terminally ill patients as they approach the end of their lives.

3. Doctors and nurses are given privileged access to the human body and to the use of drugs, so that they can serve life and health. Assisted suicide presumes that doctors and nurses will be directly involved in the taking of human life. We believe that this undermines the essential relationship of trust on which good healthcare is founded. We are aware that proposals to legalise assisted suicide generally claim to respect the right of healthcare professionals to conscientious objection. Invariably, however, that respect is undermined by the assumption that healthcare professionals who have a conscientious objection will be willing to refer their patients to a colleague, who will perform the procedure which they themselves believe to be unethical. The legalisation of assisted suicide would undermine the ethos of healthcare, as well as the ethical concept of non-maleficence ("*do no harm*").

4. Finally, we know from studying the experience of other countries, that assisted suicide, once it is legalised in "limited cases" very quickly expands beyond people who are terminally ill, to include others who have poor health or physical or intellectual disability. This has happened in Belgium, the Netherlands and in Oregon. Our own High Court, in its judgement in the case *Fleming v Ireland,* supports this position. It says: "*the fact that such a strikingly high level of legally assisted deaths without explicit request occurs in countries such as Belgium, The Netherlands and Switzerland without any obvious official or even popular concern speaks for itself as to the risks involved in any such liberalisation*."[1]

These, in summary, are our principal objections to the legalisation of assisted suicide. We ask the Committee not to recommend the legalisation of assisted suicide, but rather to advocate strongly for greater investment in the provision palliative care across Ireland, as well as better awareness of its scope and purpose which is often poorly understood.

[1] Fleming v. Ireland *[2013] IEHC 2 and* Fleming v. Ireland *[2013] IESC 19.*