Joint Committee on Assisted Dying

Minority Recommendations and Explanatory Report

March 2024

This Report arises out of the work of the Joint Oireachtas Committee on Assisted Dying.

The **Minority Recommendations** that follow have been agreed by the following Oireachtas members who formed part of that Committee:

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The **Explanatory Report** was prepared by Senator Mullen and any citation should be attributed to him.

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OUR RECOMMENDATIONS

We believe that the Government should not introduce legislation for assisted dying. The case has not been established, whereas the case against any change is overwhelming. There are no lives not worth living. **We recommend** that the existing ban on assisted dying be maintained without exceptions. **We recommend** that no change be made to the Criminal Law Suicide Act 1993.

For clarity and for any future discussion on these matters, **we recommend** that the clear definitions used in the glossary of the 2018 Right to Die with Dignity Report continue to be used. We have used these internationally established terms in this Minority Report.

Active efforts must be taken to create a society where people are able to live life on equal terms, free from discrimination. To these ends **we recommend** that the requests of various representative bodies made on behalf of vulnerable groups be prioritised as part of Government policy. **We further recommend:**

- **that** the Optional Protocol of United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) treaty be ratified. (This is included in the Committee's majority Report).

- **that** ongoing studies on ableism in Irish society are undertaken to help establish ways in which it can be mitigated.

- **that** informal carers be robustly supported in their caring duties, with additional resources provided to include funding, counselling and respite provision. Such supports should be available not only for carers of those with disabilities but also those caring for older persons.

- **that** all healthcare providers, especially those engaged in palliative care, become fully conversant with intensive caring, empowering them to be with patients who feel they no longer matter or that their lives should be ended.

- **that** sufficient funding be provided for suicide prevention programmes, including addressing the causes of suicide among older persons.

- **that** funding is provided so that long-promised high-quality palliative care services be available countrywide.

- **that,** given that many people who receive a terminal illness diagnosis can be prone to depression for a number of months following the diagnosis, much-increased mental health supports be provided to identify depression problems, especially among the elderly, and for mental health supports always to be made available to those receiving a terminal diagnosis. The public would be better served by directing funding towards mental health than towards assisted dying.

Honouring these requests will help create a more equal society, helping all citizens live and die in an environment that respects their dignity. None of these should be tied to the commencement of any legislation on assisted dying – these are needs which, as a matter of justice, require to be met in any case.

To help inform legislators, **we recommend** that further studies be carried out on matters, raised in the hearings, that contribute to people feeling they might need the option of assisted dying. These include:

- Studies on the impact of economic disadvantage on causing people to feel a burden in society and on the impact of health inequalities in contributing to people feeling a burden. Persons in their twilight years or facing serious health challenges should not need to carry the additional burden of feeling a burden. In that regard, and as a general observation, we were surprised that otherwise socially-minded members of the Committee appeared to be more wedded to neo-liberal ideas of individual autonomy than to protecting the lives of the economically vulnerable.

- Given the ingenuity of modern science, ongoing studies on pain management and pain reduction, if conducted, might change the landscape and perceived need for assisted dying.
- In the light of Article 40 of the Irish Constitution, some national research studies on coercion in Ireland would provide valuable background information. Similarly, given that the abuse of older people is largely under-diagnosed, additional training for all medical staff in assessing abuse and coercion would be helpful.

We recommend that no further discussion or consideration of legislation around assisted dying be advanced without addressing the above-mentioned safeguards, as requested by witnesses to the Committee – providing for disability and mental health supports, suicide prevention, care for older persons and palliative care.

Discussion of assisted dying is, in itself, undermining of the welfare of vulnerable persons. It engenders fear and worry. The State must at all times properly protect the right to life of all vulnerable citizens and vindicate the life and person of each and every citizen.

We are also of the view that the disasters visited upon other countries' healthcare systems by assisted dying legislation will bear out the wisdom of caution. Currently, five of the top six countries worldwide, ranked according to the quality of their palliative care systems, do not have assisted dying.

See https://globalhealth.duke.edu/news/where-best-place-die. These countries are UK, Ireland, Taiwan, Australia, Costa Rica, South Korea. Only in Australia has assisted dying been introduced, and there only in recent years, so the longer-term impact on palliative care services remains to be seen.

EXPLANATORY REPORT

Introduction

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 his or her 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.

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 assisted dying so the terms of assisted suicide and euthanasia are also used.

The Committee had available to it some 1,400 public submissions that were made to the previous Joint Committee on Justice which had scrutinised Deputy Gino Kenny's Dying with Dignity Bill 2020. There were no open calls for public submissions.

As outlined in the Report of the Committee, there were private and public meetings held from June 2023 to March 2024. The Committee engaged with 106 individual witnesses in person or online during its 24 public meetings. These witnesses included national and international experts in law, ethics, medicine, disability, palliative care, and psychiatry. Much excellent testimony was provided to the Committee during those sessions.

Following the final public Committee meeting a draft report was prepared by the Committee Secretariat together with possible recommendations. Committee members were given three working days to submit amendments. At the first private meeting to discuss this draft Report, the majority of members decided to vote on the first recommendation that *'the Government introduces legislation allowing for assisted dying, in certain circumstances as set out in the recommendations of this report.'* That vote was held and the Recommendation passed despite calls for prior consideration at Committee level of the evidence heard. One amendment to that wording was made – the addition of the word '*restrictive*.'

Thus, without any committee discussion of the over seventy hours of oral testimony or of the many private submissions, there was an early vote on the substantive issue of whether to recommend legislation for assisted dying. At that point the Committee members had not fully clarified for themselves as a Committee what was meant by assisted dying, as evidenced by one proposed amendment to the draft Report not discussed until much later.

Having regard to the committee process of the previous nine months, the hundreds of hours devoted by some parliamentarians to this task, and the valuable testimony provided by over one hundred witnesses, the Committee should first have discussed the evidence heard *in the round* and considered the summary paragraphs of the draft report, prior to the consideration of recommendations – especially the far-reaching first recommendation.

Parliamentary committee scrutiny provides a mechanism for detailed examination and evaluation of issues. It allows for in-depth analysis and a deeper understanding, leading to more informed decision-making. But the process needs more than expert evidence from diverse perspectives. Informed decision-making requires that such evidence be rigorously tested in parliamentary debate and discussion among committee members. Such testing did eventually occur in subsequent committee meetings, but only after a decision had been made on the substantive issue. And even then, given the range and number of amendments, including from the Office of Parliamentary Legal Advisers, such debate on many topics was subject to unavoidable time pressure.

The substantive recommendation for assisted dying legislation, made pre-emptively, is at odds with recommendations from previous Oireachtas Committees. For comparison, the Joint Committee on Justice and Equality Report on the Right to Die with Dignity (June 2018) – hereinafter referred to as ‘the 2018 Report’ – concluded:

‘During the course of the hearings, the Committee 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.’

The Joint Committee on Justice Report on Scrutiny of the Dying with Dignity Bill 2020 (July 2021) – ('the 2021 Report') – concluded:

'Based on its consideration, as outlined above, the Select Committee has determined that the Bill has serious technical issues in several sections, that it may have unintended policy consequences (particularly regarding the lack of sufficient safeguards to protect against undue pressure being put on vulnerable people to avail of assisted dying), that the drafting of several sections of the Bill contain serious flaws that could potentially render them vulnerable to challenge before the courts, and that the gravity of such a topic as assisted dying warrants a more thorough examination which could potentially benefit from detailed consideration by a Special Oireachtas Committee.'

No new evidence adduced as a result of Committee deliberations over the past year warranted any change from these previous recommendations. Indeed the suggestion that possibly 'only one or two (persons) per year' travel to Switzerland exposes the unreality of the majority Report's proposal – that in a health system which cannot deliver basic healthcare to its young population at a critical stage in their lives, Oireachtas members are now recommending building, within medicine, a new structure around providing 'choice' for very few – a 'choice' which in the end they may not elect to take, due to the changeable nature of consent. No one on reading the recommendations of the final majority Report could honestly hold that it proposed sufficient safeguards *'to protect against undue pressure being put on vulnerable people to avail of assisted dying.'*

Based on all the evidence provided – much of which is well summarised in the narrative in the Joint Committee on Assisted Dying Report – it is clear that the case for assisted dying has not been made, nor has the need for it, and the recommendation to legislate for assisted dying goes against the balance of evidence received. Insofar as the majority Report sets out a framework for assisted dying it recommends but flimsy protection for vulnerable lives, despite a constitutional imperative to 'protect as best it may from unjust attack' the life and person of *every* citizen. Apart from two activist groups proposing change, all Irish professional bodies that gave evidence to the Committee directly or indirectly indicated their opposition to the introduction of assisted dying.

The High Court judgement in the Marie Fleming case (2012) expressed the view that *'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.'* The deliberations of the Committee over the past year have brought home that law cannot be tailor-made for the few, and that to try to do so is to open a Pandora's box for the many, many more.

The recommendations in the final draft Report failed to do justice to many concerns expressed both at public meetings and at private meetings during the drafting process. Having regard to the many warnings given by witnesses to the Committee and to help inform any future decision-making several members of the Committee declined to sign off on the final majority Report. This Explanatory Report is not an exhaustive treatment of the subject of assisted dying (nor indeed is the majority Report) but it is contended that the Recommendations above more accurately reflect the evidence considered over the past year.

Language

The Joint Committee on Assisted Dying Report March 2024 (hereinafter referred to as 'the majority Report') highlights that there was no clear consensus on the use of language and terminology surrounding assisted dying (Report Para. 12). However, in public deliberations it was generally accepted that assisted dying included both assisted suicide (where the life-ending treatment is administered by the patient) and euthanasia (where another person administered the treatment).

Revisiting the 2018 recommendations

In the light of the terms of reference of the Joint Committee on Assisted Dying it is worth adverting to the recommendations of the 2018 Report. These highlight the specific dangers involved in making any provision for assisted dying. The slow pace of progress on other recommendations in the 2018 Report also serves as a warning about too much optimism as to the speed of improvement in care provision. Any recommendations predicated on prior or parallel improvements in the funding and provision of care services should be viewed with caution.

The 2018 Committee was *'of the opinion that assisted dying should never be contemplated due to inadequate or insufficient supports or as a substitute for a holistic framework of care.'* On palliative care provision it said *'Regional discrepancies in the provision of palliative care - as identified above by MS Ireland – should be addressed as soon as possible. The Committee welcomes the fact that the Palliative Care Services Three Year Development Framework (2017 to 2019) acknowledges the regional variations and states that "new development projects rectifying the infrastructural deficits are at an advanced stage, and will be delivered during the lifetime of this Framework".'*

Notwithstanding the Palliative Care Framework objectives for the period ending in 2019, the present 2024 Committee finds itself recommending 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.'*

The 2018 Committee noted *'As part of ensuring a holistic framework of care, the Committee emphasises the importance of ensuring care and support encompasses vulnerable groups including the disabled and those suffering from mental illness or chronic physical conditions.'*

The present Committee was reminded by many witnesses of the need for such supports, regardless of any decision it might make on assisted dying.

The 2018 Committee also gave some direction which unfortunately has been largely overlooked in the majority Report. The 2018 Committee said that should consideration be given to legalising some form of assisted dying in the future, certain specific questions should be answered. Among these questions, three in particular can be highlighted:

- *Could adequate safeguards be put in place to ensure that persons requesting such assistance are not doing so out of compulsion or because their decision-making capacity is compromised by illness, anxiety or depression?*
- *Could supports for persons with disabilities be enhanced to reduce the likelihood that individuals will request assistance in dying because other supports are lacking?*
- *Could trust in the medical profession be maintained in a healthcare context in which medicine facilitates the wish of certain patients to hasten death?*

The present Committee has largely failed to provide answers to these questions in the majority Report. This is because, if the Committee had tried to answer these questions directly, the answers would have to be in the negative. In its judgement, a judgement which seems to have been informed by excessive deference to notions of individual autonomy, the Committee majority found little opportunity to give consideration to the needs of vulnerable others. The term ‘restrictive’ in the substantive recommendation was a decorative addition, there being very little in the majority Report to justify its use.

Understanding the missed opportunity

The first votes taken by the Committee concerned whether or not to legislate for assisted dying. This proved a fatal flaw in the Committee’s deliberations in three respects:

First, it was driven by an overriding concern for individual autonomy, i.e. the belief that, once terminally ill, a person has a right to choose the time of one’s own death and that the State should facilitate this choice. Proceeding from an ethic of autonomy made it difficult for Committee members to avoid seeing assisted dying as a ‘right’, though this word is not used, as opposed to being something to be tolerated by society and enabled though not necessarily resourced by the State, and discouraged where possible - all in an attempt to prevent contagion around its application. The Committee majority found itself unable to think in terms of attempting to minimise recourse to assisted dying within the terms in which they proposed to allow it. Thus the majority refused to accept important narrative additions by way of amendment to the Report. This mistaken mindset dogged the subsequent private meetings on amendments and recommendations. From its hastily-decided starting point, the Committee found itself off-balance. At times, it did not want to speak about a right to access assisted dying, and indeed no statutory right to assisted dying was proposed, yet it found itself wanting the medical system to provide the service in a non-judgmental manner as if assisted dying were a normal part of healthcare, and thought in terms of there being a statutory duty on the healthcare system to provide it.

Second, the Committee ignored a fundamental requirement arising from the constitutional protection for life in Article 40.3.2 that sufficient consideration be given to safeguards for those whose decision-making capacity might be compromised by coercion, anxiety, depression or by feeling a burden on others. Even what could be termed proposals for pre-legislative safeguards received insufficient consideration in finalising the majority Report (although, thankfully, some are included.)

A further consequence flowed from considering individual ‘choice’ as the driving force for legislation. Despite all the warnings given, the Committee paid too little attention to the negative impact that this newly proposed branch of healthcare might have on medicine more broadly and on palliative care in particular.

If the Committee had decided that its aim was to end unrelievable physical suffering at the very end of life, in which terms the demand by proponents of assisted dying is often made, a much more restrictive set of procedures might have been adopted.

The Committee could have adopted an alternative ethical position which proposes that every human life is of intrinsic, equal and inviolable worth (Report Para. 68), a position shared very widely within the medical profession *(‘You must not take part in the deliberate killing of a patient*’), by practically all involved in palliative care, by all religions, and by one humanist medical witness who came before the Committee.

Abandoning the principle that every life has intrinsic value, and giving power to the State to end lives, ultimately makes every life vulnerable, as we have seen time and again in countries which have adopted assisted dying. Having heard some of the horror stories from places such as The Netherlands, Belgium, Switzerland and, more recently, Canada, the Committee has chosen to hide behind an assisted dying model similar to that of New Zealand and Victoria (Australia), knowing that the new safeguards there (not very dissimilar from those elsewhere) have not yet been seriously tried and tested.

Assisted dying undermines hope, and what starts off as a limited right in time becomes a societal norm.

‘There is a saying that people can live 30 days without eating, three days without drinking, three minutes without oxygen but not three seconds without hope. Sometimes it is the total absence of hope, either in the persons themselves or in their surroundings, that contributes to their suffering. I remember one case that impressed me very much. There was a lady that was in the funnel, so to speak, in the trajectory towards receiving assisted dying at the expert centre for euthanasia that performs 1,100 euthanasia cases per year in our country. She was in that trajectory for psychiatric reasons. She had all kinds of depressions, such as bipolarity etc. She was almost at the point where she would get euthanasia and then all of a sudden, without any reason, she inherited an enormous sum of money. I think it was €500,000 from some distant family member. That gave her the possibility to buy a horse breeding company and she is still alive and she is doing that with great passion. I am not saying that she did not suffer or that she was not seriously ill. What I am saying is that suffering never comes alone. In particular, social suffering and maybe financial suffering are serious co-contributors to suffering.’ Prof Theo Boer, Protestant Theological University, The Netherlands, 26 September 2023

Medical opposition

When mainstream media covers personal stories as part of the case being made for assisted dying, the emphasis is often on the issue of physical pain – and on the claim that in certain cases such pain cannot be relieved. Ergo, assisted dying must be made available throughout the healthcare system in order to deal with this problem, it is argued.

However, the evidence presented by palliative care consultants to the Committee indicated that even difficult situations could be managed under existing pain protocols.

Numerous concerns were expressed by palliative care experts: that assisted dying would impact negatively on older people who might feel a burden, and that assisted dying might create a risk of direct or informal coercion, whether in nursing homes or in other settings. Of particular concern was that people might fear palliative care by associating it with assisted dying. There was concern that the availability of assisted dying would lead to a loss of focus on, and funding for, palliative care. Moreover, Irish palliative care professionals declined to express support for measures or safeguards to prevent the above hazards. The existence of assisted dying as an option, of itself, obstructs efforts to deliver palliative care in the best possible way. One medical professional was concerned about the impact of assisted dying on his ability to properly communicate with patients in any healthcare setting which allowed for the service:

'*Currently, I can discuss a patient's fears and options when they ask me about ending their life. In the event of legislative change, I will not be able to do so for fear of being accused of applying the worst kind of medical paternalism, namely, inappropriate influence on the vulnerable*.' (Dr Max Watson, Project ECHO, Hospice UK, 12 December 2023)

Across the world those groups most opposed to assisted dying include nurses and doctors who tend to patients in the final weeks and months of their lives. They understand death as a necessary end to the struggle of life. They wish to save lives, not take them.

By considering assisted dying as simply another form of healthcare, the Committee effectively dismissed these fears. While the Committee did agree that assisted dying should be separated from palliative care that recommendation (Recommendation 15) does not go far enough.

Given the depth and strength of professional and moral opposition to assisted dying within the medical profession, the Committee's (Recommendation 17) that *'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'* should be seen for what it is: a minimalist interpretation of the Constitutional right to conscientious objection and a complete failure to grasp that, for healthcare professionals, a refusal to participate in assisted dying is a statement that procured death is not good healthcare nor is it in the best interests of the patient. The New Zealand model – which requires an opt-in by healthcare officials – was ignored by the Committee majority which instead believes that assisted dying be mainstreamed in healthcare settings.

The State should not seek to impose a duty on either individuals or institutions with ethical or professional objections to assisted dying to have any involvement in the provision of the service.

Creating a more equal society

It emerged strongly from the Committee hearings that certain groups within Irish society experienced a high degree of inequality. Speaking as a member of the Irish Human Rights and Equality Commission, Ms Sinead Gibney 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*.' (Ms Sinead Gibney, IHREC, 30 June 2023).

This warning echoed the voices of those witnesses to Committee who highlighted the need for what could be termed pre-legislative safeguards. As Mr Peter Kearns of Independent Living Movement of Ireland (IMLI) said, *‘it would sadden disabled people if the right to die was granted over the right to live a life course of dignity.*’(Mr Peter Kearns, IMLI, 16 January 2024)

What are these pre-legislative safeguards? Irrespective of any decision on assisted dying, it behoves politicians to help create a more equal society, thus reducing levels of vulnerability experienced by different individuals and groups. The degree to which the majority Report did not make the fulfilment of these requests preconditions for any consideration of assisted dying reflects the lack of proper consideration given to key elements of evidence presented to it.

Disability

One immediate potentially vulnerable group is that of persons with disabilities, especially given the problem of ableism in our society.

In this regard, Mr Kearns provided a more comprehensive understanding of human choice than that which drove the Committee majority’s recommendations.

‘Choice is central to the philosophy of independent living. It should be about disabled people having control over all aspects of our lives and appropriate supports and resources in order to achieve our life goals. Choice should not just happen at moments of crisis or imminent death. It is the lack of choice, control and agency throughout our life course that is the underlying reason society is so inaccessible to disabled people and excludes and isolates us systematically.’ (Mr Peter Kearns, 16 January 2024)

The immediate priority for disabled people is the supports they need in order to live independent lives.

Mr Kearns said, *‘Many disabled people are hugely concerned that discussions about assisted dying will inevitably lead to discussions about assisted suicide. In other jurisdictions where assisted suicide has been legislated for, disabled people frequently speak about feeling hopeless, having nothing to live for or feeling they* *would be better off dead, and take the State's only clear support option to cross the Rubicon to clinically assisted suicide.'*

He summed up the current needs of disabled people: *'Disabled people feel the priority right now needs to be ensuring the supports needed for the right to live independent lives are legislated for first, over a priority option of assisted suicide, as part of a constructed health policy informed by perceived narratives of life course-limiting impairment labels or conditions.'*

Without a much more focused consideration by the Government on disability rights and the implementation of same, a society with assisted dying will undermine the rights of persons with disabilities.

Sick persons and older persons

Another vulnerable group in society are those who are sick, including those who need to access palliative care.

The World Health Organisation estimates that one in six people over 60 experiences abuse and the Committee heard a similar statistic cited relating to the occurrence of abuse in community settings in Ireland during the past year. (Abuse of Older People, 2022).

These statistics underline concerns that the introduction of assisted dying would put sick or older persons at risk of being made to feel a burden or of being coerced by others to consider assisted dying. Patchy palliative care services add to the potential for societal coercion in cases of people suffering pain. The vulnerability of older people in nursing homes is accentuated during national health emergencies. Any normalisation of assisted dying within society will add to the pressures faced by older people.

Mr Brendan O'Shea, speaking on behalf of Irish Doctors supporting Medical Assistance in Dying, qualified his call for assisted dying by saying *'At the moment, however, we are not recommending that dementia be considered a primary qualifying condition on its own.*' (17 October 2023)

The only interpretation one can put on this statement is that the expansion of eligibility for assisted dying to include persons suffering from dementia should be a matter for consideration in the future. Already, in response to a report about the Committee majority’s conclusions, campaigners for assisted dying are suggesting that the proposed grounds be expanded.

Clearly, vulnerable elderly people need protection from coercion, direct and societal, from any normalisation of assisted dying, and indeed from the agenda of supporters of assisted dying who see the service as a form of healthcare on par with palliative care – as a choice of treatment for a patient to make. In that regard, it is worth noting that one overseas addressing complained that he mainly saw people being coerced away from assisted dying, rather than coerced into it. (Dr Greg Mewett, 28 November 2023)

The Committee responded to all these challenges by making a number of recommendations, i.e. that coercion be a criminal offence and that there be high levels of training for medical staff to identify instances of coercion. The Committee also recommended that decision-making capacity be a part of assessment for eligibility, that a patient who loses decision making capacity be ineligible for assisted dying, that advanced health care directives not be allowed to include requests for assisted dying, and that palliative care be separate from assisted dying. While these recommendations are commendable as far as they go, they amount in their totality to a weak response when one considers the difficulties posed by the risk of societal coercion. It is noteworthy that the Committee made no recommendation in this regard. The Committee majority further failed to accept a recommendation that borderline capacity, i.e., where capacity is in doubt, should be sufficient and necessary reason to refuse eligibility for assisted dying. The Committee majority also failed to categorically exclude assisted dying from advanced healthcare directives. It also refused to take on board a recommendation that discouragement by a medical practitioner of any patient from involvement in assisted dying should be considered as good medical practice.

Even more shockingly, the Committee majority voted down a recommendation to make it a criminal offence for any health professional to advertise assisted dying or to initiate the question of assisted dying with any patient. Any advertising or initiation of conversations around assisted dying could endanger vulnerable and suggestible persons coping with terminal illness. It would also leave them more exposed to the risk of coercion. The failure by the Committee majority to adopt this particular recommendation can only be described as reckless.

The following important considerations were presented to the Committee by Dr Harvey Chochinov from the University of Manitoba (28 November 2023), though were overlooked in the majority Report.

‘*A wish to die is an expression of human suffering. Clinicians must learn to sit down and lean into discussions exploring the nature of patients’ anguish, discerning their sources of distress, identifying potential solutions or mitigation strategies, recognising that even the very acknowledgement of suffering, like feeling a burden to others, or no longer feeling like the person they once were, is a form of affirmation that can sustain patients’ sense of worth and safeguard integrity of personhood.’*

Rather than interpreting a wish to die as an opening to evaluate eligibility for assisted dying, Dr Chochinov proposed the alternative of ‘intensive caring’, a model he has pioneered to address end-of-life suffering. Intensive caring *‘describes ways for healthcare providers to address suffering, which includes: not abandoning patients; investing in who they are as people; offering kindness, respect and hope; as well as affirming the ongoing worth of patients as human beings, while maintaining professional therapeutic humility.’*

Value-judgements can adversely affect healthcare decision-making. During the pandemic the experience internationally was that older people – especially those with medical complications, people with dementia and people with learning disabilities – were treated very differently than others as regards the application of ‘do not resuscitate’ decisions. We have yet to have our own pandemic review but there is no reason to believe that things were different here than in other countries.

The introduction and normalisation of assisted dying will exacerbate already existing challenges around attitudes to older and vulnerable persons.

Mental illness and suicide

Another group within society that requires extra support is that of persons suffering mental illness, including persons who are suicidal.

There was resistance among some Committee members to the use of the term ‘assisted suicide’ as it appeared to conflate voluntary unassisted suicide with assisted dying. Yet the term is widely used and understood. For those who believe assisted dying should be available to all who have the capacity to consent the linkage should be obvious.

Evidence was also presented that in certain countries unassisted suicide rates increase where assisted suicide is permitted, but the Committee majority rejected a proposal to include testimony heard on the connection between assisted dying and suicide rates.

Prof Boer quoted two studies. One study compared The Netherlands (which allows euthanasia for the category of patients who are in danger of committing suicide for reasons of psychiatry, dementia and long-term chronic illnesses) with other countries which do not have euthanasia. Since allowing euthanasia for this specific group in The Netherlands, the number of violent suicides has risen by about 35% whereas in neighbouring Germany, which does not yet have euthanasia, the number of suicides in the same period went down by 10%.

The second study compared the high-incidence regions of euthanasia within the Netherlands with the high-incidence regions of suicide. *‘We saw a co-variation which means that in places where there is more euthanasia, there is also a slightly higher suicide rate.’* (Prof Theo Boer, 26 September 2023**)**

Prof David Albert Jones quoted a European Economic Review paper by Prof Sourafel Girma and Prof David Paton. *‘Girma and Paton have gone back to the data now that more states have done this. They have used two different methods and they have found statistically significant rates of increase. There was a 6% increase in relation to suicide in general and a 14% increase in relation to suicide of women. Association is not the same as causality but there is an association, which is shown by a peer-*

reviewed paper.' (David Albert Jones, Anscombe Bioethics Centre, Oxford, 16 July 2023)

These statistics reflect the wisdom shared by Ms Elma Walsh, whose son Donal campaigned against suicide in Kerry while he himself was fighting terminal cancer.

'Society must promote hope. Assisted suicide is a statement of no hope,' she said. *'We can all help to fight against suicide by turning our back on assisted suicide.'* (Mrs Elma Walsh, 10 October 2023)

Thus a country with high suicide rates must consider the possibility of any contagion effect resulting from the introduction of assisted dying. Committee members did not discuss this beyond what took place at the public hearings. The Committee majority's report, while acknowledging the evidence that the introduction of assisted dying does not *decrease* the suicide rates, failed first to interrogate and then to acknowledge the existence of data, as cited above, that may suggest an increase in suicide rates in certain circumstances. The issue of whether the introduction of assisted dying could weaken society's ability to combat suicide effectively is a vital one. It received, unfortunately, but cursory consideration during the Committee's private deliberations.

To those supporting the introduction of assisted dying, the above issues should have led to far stronger proposals around pre-legislative change. But here again, the failure is noteworthy. The Committee recommended mental health supports (Recommendation 21) but failed to address the issue of suicide prevention.

While more research is needed, it remains a possibility that if assisted dying is introduced, some people, who might otherwise have lived, may die in Ireland by unassisted suicide.

A lack of seriousness concerning safeguards

The mistakes made by other countries, particularly Canada where the autonomy model for assisted dying is running riot, are clear to all. A Canadian doctor, Heidi Janz, made an appeal to the Committee which deserves a wide audience:

‘I sit before the committee today to implore it: for the sake of preserving true dignity and true choice for disabled, ill, old and other structurally vulnerable people in Ireland, do not be Canada. Tread carefully and prioritise ensuring that all disabled, ill and structurally vulnerable people in Ireland have adequate assistance to live over ensuring the legalisation of assistance to die.’

Given what can happen once assisted dying is legislated for, one would have expected the Committee majority to be much more determined on the issue of safeguards.

This applies all the more given the Irish Constitutional context where there remains a clear obligation to vindicate the life of every citizen.

Article 40 must provide the basic legal context against which any legislation on assisted dying would have to be judged. The relevant parts of Article 40 state:

40.1 All citizens shall, as human persons, be held equal before the law.

40.3 1° The State guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate the personal rights of the citizen.

40.3 2° The State shall, in particular, by its laws protect as best it may from unjust attack and, in the case of injustice done, vindicate the life, person, good name, and property rights of every citizen.

If permitting assisted dying for a person exercising choice results in the diminution of choice for other vulnerable people can we say that citizens are being held equal before the law? If assisted dying legislation is a threat to the life or person of vulnerable others can we say that the State is protecting the life of each and every citizen as best it can from unjust attack by passing such a law?

The majority of the legal experts expressed a view that it would be possible for the Oireachtas to pass a law permitting assisted dying that could come within the terms of the Constitution. Nonetheless it is clear that there remains a Constitutional obligation on the State to vindicate the life of citizens and one would therefore expect that any proposal for such legislation would err on the side of protecting human life.

This consideration did not weigh sufficiently heavily on the minds of Committee majority, having regard to the minimal safeguards for assisted dying legislation proposed in the Report.

Evidence was presented to show that the inclusion of euthanasia in assisted dying legislation would result in much greater numbers availing of it. The Committee, without much discussion, nonetheless went ahead and included euthanasia, to all intents and purposes, under the broad-ranging terms of Recommendation 35. If that recommendation were to be followed, and law enacted on this basis, the deterrent of being required to take one’s own life would not be in place, and the number of people availing of assisted dying would be higher than would otherwise be the case. The capacity for medical wrongdoing would also be greater.

Time and again the Committee majority had the opportunity to err on the side of protecting life in its recommendations. It did so when it recommended the *prior implementation* of the UNCRPD treaty on disabilities but it failed to include additional care for older persons or supports for palliative care in the same recommendation.

It is remarkable that the Committee majority failed to confine its recommendation to the provision of assisted suicide given the evidence it had heard.

The Committee majority could also have opted for assisted dying to be managed by a licensing body, outside of the mainstream healthcare sector, but chose instead to present assisted dying as a healthcare concern, conducted under a protocol with the HSE, ignoring the possibility and consequences of coercion within the healthcare system. If, as has been reported, around 1 in 6 people aged 60 years and older experienced some form of abuse in community settings in Ireland during the past year (Abuse of Older People, 2022), this must be grounds for major concern. A society with assisted dying cannot properly protect the vulnerable in society. It will be even less able to do so if assisted dying is built into its healthcare system.

As noted earlier, the Committee failed to accept a submission which would have acknowledged that dissuasion from assisted dying be deemed good medical practice.

Also as noted, it failed to include a recommendation that assisted dying would not be promoted or advertised. One significant factor affecting growth trends in assisted dying jurisdictions is whether doctors proactively offer assisted dying as an option to potentially eligible patients. Not only did the Committee decline to discourage this, by way of proposing criminal sanction or otherwise – it proposed that funding be made available for international networking among assisted dying practitioners (Recommendation 18). This proposal would be more likely to accelerate than slow down the recourse to assisted dying.

Given the possibility of abuse around Advanced Healthcare Directives the Committee majority should have recommended that assisted dying never be included in such directives. Here again, the Committee majority failed in its duty - by proposing that the issue could be examined during a review of assisted dying legislation.

It failed to recommend any pre-legislative type safeguards around suicide prevention funding. It failed to recommend necessary research on pain or the promotion of intensive caring in advance of any assisted dying legislation.

The Committee majority could have come up with much tighter eligibility criteria. It was presented with a range of more restrictive options which it chose not to adopt. It opted for an eligibility requirement of a twelve and six-month terminal prognosis, whereas three months would be equally workable and would save lives. It failed to acknowledge the unreliability of prognostication and time limits, and that this undermines reliance on these as a safeguard against the misuse of assisted dying. The Committee majority chose terminal illness as a key eligibility criterion together with unrelievable pain, but did not require that such pain be physical. Such an immeasurable subjective criterion serves as an unworkable fig leaf, suggesting restrictiveness but not meaning it.

In effect, the criteria also mean that a refusal to accept medical treatment could make a person eligible for assisted dying. The Committee failed to address why its twelve-month terminal prognosis limit for neurodegenerative conditions would not leave open the possibility of a challenge, on equality grounds, that this broader terminal time-limit prognosis should be applied to all conditions.

The Committee majority could have recommended that two formal requests be made in writing by the patient as a realistic transparency control but failed to do so. It could have required that an overseeing doctor contact the patient's GP, but did not do so. It rejected a recommendation that all persons seeking assisted dying be first examined by a qualified psychiatrist as part of the eligibility criteria. Given that around 10% of people have some form of depression this constitutes serious neglect. Despite assisted dying being irreversible for the person given the treatment, and given the potential vulnerability of people requesting assisted dying, it is remarkable that the Committee did not consider recommending that next-of-kin should be informed where a request for assisted dying be made.

The oversight criteria for assisted dying proposed by the Committee majority are extremely weak. In that regard, the majority's rejection of two proposed safeguards involving the role of legal services was significant. One proposed safeguard was that a request for assisted dying would require the involvement of a solicitor to ensure independence and voluntariness – as would arise, for example, with the making of a Will. The second rejected proposal was that applications for assisted dying would be processed by an oversight body, and that the assisted dying application could only go ahead on foot of a successful application to the High Court. The Committee majority dismissed these proposals in cursory fashion. There was little consideration before recommendations were made of how the delivery of assisted dying should be structured. But the processing of applications by an oversight body, and the requirement of a solicitor and of final sign-off by a judge within a reasonable timeframe are surely minimum necessary standards, considering the much less visible and therefore less accountable approach of having applications for assisted dying handled exclusively by medical personnel. Here again, the constitutional requirement to vindicate life does not seem to have weighed sufficiently heavily with the Committee majority. (It is worth noting, by way of comparison, that under the Assisted Decision Making Capacity Act, the High Court retains jurisdiction relating to end-of-life matters.)

These failures suggest a lack of seriousness on the part of the Committee majority about keeping the incidence of assisted dying to a minimum.

In the end, the safeguards proposed in the majority Report do not serve to safeguard against much – they are more theoretical than practical, and are in fact mere eligibility criteria with weak sanctions. They are a rehash of safeguards used elsewhere, with no basis for any confidence in their effectiveness. These are modelled largely on New Zealand/Australia (Victoria) criteria, yet New Zealand conveniently has only one full year of published statistics (and Victoria four years) against which to measure effectiveness. But, unlike the New Zealand model, under the Committee majority's proposal, Irish healthcare professionals would be permitted to raise the topic of assisted dying first with patients, and it would appear that all healthcare professionals would be presumed to participate unless they opt out of the process.

The Committee majority chose hastily from among the models on which it had been briefed by various witnesses and the legal advisor to the Committee. No thought or discussion was devoted to what particular safeguards would be appropriate to an Irish context. There was no fresh thinking.

The weak measures proposed by the Committee majority would all be easily prone to failure through inadvertence, carelessness, neglect, misadventure or through the emergence of a culture of disregard for life, and with little answerability to the State or to its citizens.

It is, again, a matter of deep regret that the Committee disregarded the call, from disability representatives in particular, to first build a society where people are able to live life on equal terms, free from discrimination. Without this, hidden coercion will be a reality for the vulnerable.

Depth of opposition to change

To judge by the limited safeguards proposed in the majority Report one might think there was substantial support among witnesses for the introduction of assisted dying.

Many of the witnesses appeared in a representative capacity, and many felt obliged to exercise a certain neutrality for various reasons, mostly because their organisation had not adopted a formal position. The Committee itself, in line with its terms of reference, was often more interested in exploring how the provision of assisted dying might operate in Ireland, rather than whether groups supported it or not.

But, that said, it would be difficult to over-emphasise the depth of opposition to assisted dying among Irish witnesses, especially among those who might be confronted with implementing the service should it be introduced. Time and again the message came across: Don't do it!

The text of the majority Report bears out this assessment:

Out of six groups, five representing five major religions, '*other than the Humanist Association of Ireland, all of these groups opposed the introduction of assisted dying.'* (p. 91 Report)

'Repeatedly witnesses raised with the Committee the challenge of ensuring the decision to seek assisted suicide is made of a patient's own volition and that they are not being coerced in any way.' (p. 94 Report)

'The Committee were warned 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.' (p. 100 Report)

'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.' (p. 113 Report)

'*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.'* (p. 118 Report)

'In general, palliative care organisations in Ireland were strongly opposed to the introduction of assisted dying to Ireland' (p. 121 Report)

'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.' (p. 129 Report)

'*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.'* (p. 138 Report)

'…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.' (p. 139 Report)

'The Committee heard concerns from multiple witnesses around how the legislation of assisted dying in even limited circumstances has led to an increasing number of people accessing assisted death.' (p. 144 Report)

'*Multiple witnesses warned the Committee that vulnerable individuals must be safeguarded against feeling they have no option other than seeking assisted dying'.* (p. 157 Report)

'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.' (p. 168 Report)

As the summary report was produced by Committee officials there was naturally some jockeying in the final private meetings around text that should have been included. Notable among proposed amendments to the text that were not supported by the Committee majority were:

- text which mentioned that evidence was provided on some of the negative impacts of assisted dying in Canada (e.g., closure of nursing homes which opposed the service and in New South Wales (funding cuts in palliative care budgets to fund voluntary assisted dying);

- text which claimed that evidence was given by doctors that the objectives of palliative care were at cross purposes with those of assisted dying;
- text which showed that where euthanasia and assisted suicide was legalised the death rates were much higher than where assisted suicide only was legalised;
- text which suggested that unassisted suicide rates were higher in countries which had legalised assisted dying.

Among witnesses giving evidence to the Committee there were also proponents for change. One group foresaw that, in the initial stages of its operation, hundreds of persons each year would be seeking assisted dying, if it were permitted on grounds of terminal illness. A spokesperson for Irish Doctors Supporting Medical Assistance in Dying said that “at the moment, however” they were “not recommending that dementia be considered a primary qualifying condition on its own” (Mr Brendan O’Shea, 17 October 2023). This implied that the doctors’ group saw no reason in principle to oppose such a ground.

Some overseas witnesses spoke highly of assisted dying as good healthcare. Among these witnesses there was criticism of paternalism in the medical profession, including of palliative care doctors who were opposed to assisted dying. One doctor appeared to complain of people being coerced *away from* assisted dying. (Dr Greg Mewett, 28 November 2023, p. 98 Report)

The argument of those who support assisted dying is that the patient must be offered all choices regarding care, including the offer of death as a treatment. This directly opposes the palliative care approach.

Issues overlooked

One of the biggest failures of the Committee deliberations was the lack of attention it gave to addressing the real fears of particular groups. The reality of legalising assisted dying is that vulnerable people will get caught up in the net, whether by way of feeling a burden or cost to family or to the State, or whether by way of unassisted suicide being an ill-chosen response to a loss of hope. The Committee did not deliberate together on any of these questions, the majority presuming – without anything like sufficient evidence – that safeguards similar to those introduced elsewhere would be good enough. But it is important to ask what might happen here in Ireland:

-Will older persons in nursing homes who might otherwise live their final days in peace become victims of the despair that assisted dying places on their shoulders?

-Will people with terminal illness be euthanised without sufficient prior knowledge by their relatives of their intention?

-Will people prone to depression find themselves on a conveyor belt to assisted dying?

-Will financial pressures or the absence of proper healthcare supports lead people to take the assisted dying option?

-Will so-called safeguards be gamed for the advantage of persons other than the patients themselves?

The answers to all these questions is yes. Notwithstanding the aspiration of Article 40.3 of the Constitution to vindicate life, the Committee's majority Report exacerbates, rather than assuages, the above fears.

For example, the Committee was told that in other jurisdictions, conversations about assisted suicide had led to societal discussions about quality of life and had enabled comments such as, "If I was you, I would kill myself". Such comments have impacted negatively on disabled persons' lives and happiness. Ableist thinking abounds, and it will not simply disappear just because the State may sign up for a UN treaty, important as that United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) is.

More consideration needs to be given to the link between depression and the wish to die, an issue highlighted by palliative care doctors. Mental health supports need to be easily available to anyone receiving a terminal ill diagnosis, as that is when persons are vulnerable to temporary depression.

The impact that assisted dying legislation might have on unassisted suicide numbers requires much more consideration than it received. The impact of assisted dying on suicide prevention programmes was not weighed. Indeed, a question similar to that posed by Dr Max Watson arises: if assisted dying becomes part of healthcare will anti-suicide measures be seen as unacceptable medical paternalism?

Witnesses encouraged the Committee to promote pain research, as one way of addressing the problem of those experiencing irremediable suffering. The Committee was also encouraged to consider the promotion of intensive caring, as discussed by Dr Harvey Chochinov, as a positive approach to end-of-life suffering. Neither suggestion received adequate consideration.

No consideration was given either to the suffering experienced by some people in the assisted dying process, due to medical complications, as not everyone opting for assisted dying slips away quietly. The matter of uncomfortable deaths by assisted suicide was not explored.

The concern was expressed that by making assisted dying part of healthcare, this would impact negatively on funding for palliative care as well as on institutions unwilling to be associated with assisted dying. In Canada and in Belgium some hospices unwilling to provide assisted dying were forced to close. The Committee did make a welcome recommendation on separating palliative care from assisted dying, but it was unwilling to consider institutional ethical concerns. To judge by the Committee majority's treatment of conscientious objection it seems that the majority believes that, once the State legislates for assisted dying, it must somehow become an obligation for a State-funded institution, or indeed any caring institution, to provide it. Yet any legislation reflecting such thinking may lead to the closure of many care homes and the withdrawal of staff from an already understaffed Irish healthcare sector.

It is remarkable that this issue got such little attention among the Committee majority. The possibility that legislation for assisted dying might be such as to tolerate its permissibility outside of the medical arena – that it might be provided in controlled circumstances by licenced individuals or organisations, and subject to oversight but not financial support from the State or administrative support from State-funded healthcare institutions – was dismissed by the majority. But given the overwhelming opposition to assisted dying among the medical profession, it would have been prudent to have researched and discussed this option before making any recommendations.

It seems clear that any incorporation of assisted dying into the healthcare system will have the effect of promoting recourse to it. It is certainly arguable that by countenancing such incorporation, or even by providing any level of State funding for the service, even where independently provided, the State would fail in its Constitutional duty to vindicate life by not doing its utmost to dissuade people from choosing assisted dying and to protect vulnerable and/or suggestible people from feeling that they must have recourse to it.

The Committee's proposal that the ratification of the Optional Protocol to the United Nations Convention on the Rights of Persons with Disabilities be a precondition for the commencement of Assisted Dying legislation was welcome in so far as it went. But it was an arguably inappropriate linkage since the case for ratifying the Optional Protocol should and does stand on its own merits. Furthermore, as has been noted earlier, other necessary preconditions were rejected by the Committee majority.

Despite calls for the Committee to consider the health economics aspect of the question, no consideration was given to the financial issues surrounding assisted dying. Why should the service be provided by the State? How can one ensure that a Government seeking savings in the health-care system will not prefer assisted dying over end-of-life medical treatments? How can one ensure that health insurers do not promote assisted dying as a cheaper option for elderly or chronically ill patients? Given the potential, and possibly hidden, impact of potential budgetary savings on policy, the Committee should have undertaken to investigate these matters in depth.

Throughout the Committee proceedings there was little indication given by witnesses that assisted dying was something that they wished to see happen in the near future. Many groups argued against it outright. Some expressed the view that a more equal society would be needed if invisible coercion factors were not to play out, arguments mentioned earlier under 'Creating a more equal society'. The Assisted Decision-Making Capacity Act is only beginning to be implemented and needs time before its effectiveness can be considered. The jurisdictions seen as models for Irish legislation, New Zealand and the Australian state of Victoria, have but a few years of full records to draw on – certainly far from enough to evaluate effectiveness. The reckless failures of Canada's seven-year old assisted dying regime are only now gaining international publicity.

Studies on pain management and reduction, if carried out, might change the landscape and perceived need for assisted dying. In the light of Article 40, some Irish studies on coercion would provide valuable background information and could have been recommended by the Committee. The HSE has not considered if or how the Irish medical system could cater for assisted dying, given the deep opposition to it within the healthcare sector. Any or all of these factors could have given the Committee good grounds for pause. The Committee could have laid out its findings under each area of study without making any recommendation on the matter at this point in time. However, the Committee majority gave insufficient consideration to all these reasonable grounds for avoiding, or at least delaying, its substantive recommendation.

In conclusion

Recently, after exhaustive study which commenced in May 2023, the Westminster (House of Commons) Health and Social Care Committee decided not to recommend any action towards a change in the law on assisted dying. This is the correct approach. The case for assisted dying is far from self-evident. Unfortunately, the Committee on Assisted Dying, in a rush to judgement and conveying little desire for even-handedness, failed to properly consider many important human factors involved. The result is a deeply-flawed majority Report.

A reluctance to acknowledge that one cannot safeguard against human nature has led the Committee to point the Government along a well-worn path similar to that trodden by The Netherlands, Belgium, Canada, Australia and more recently New Zealand. An assisted dying system built on an ethic of autonomy is very likely to run away from legislators. There were many opportunities presented by informed witnesses that, if adopted, would help to avoid unintended consequences, but most of these were ignored. That decisions to end the lives of vulnerable citizens be left in the hands of healthcare professionals, with minimal oversight, would seem to be in blatant disregard of guaranteed constitutional protection for the life and person of every citizen. Yet this is what the Committee majority's recommendation amounts to.

This Explanatory Report concludes with a consideration of the recent report of the Danish National Council on Ethics on the issue of assisted dying.

When the Danish Council overwhelmingly advised the Danish parliament against legislating for assisted dying it stated that *'If assisted suicide or euthanasia is carried out, it is an irreversible act. We are therefore justified in making high demands that no mistakes are made and that the wish is formulated and the decision made on an informed basis.'*

The Council argued that if assisted dying is to be allowed, it requires legislation which can handle all borderline cases, while being able to protect all citizens without exception. Such a wish would be in keeping with protection of the right to life of every citizen as expressed in Article 40.3.2 in the Irish Constitution. It was the inability to protect all, without exception, that led the Danish Council to recommend against assisted dying legislation.

The Danes also noted that even people with a long-term wish to die experience moments of ambivalence. The Council did not believe that it was possible to develop legislation that would function properly. It was concerned about the ability to adequately monitor and restrict the practice and possible expansions. *'The only thing that will be able to protect the lives and respect of those who are most vulnerable in society will be a ban without exceptions.'*

The Danish Council acknowledged that assisted dying risks causing unacceptable changes to basic norms for society and healthcare. *'The very existence of an offer of assisted dying will decisively change our ideas about old age, the coming of death,* *quality of life and what it means to take others into account. If assisted dying becomes an option, there is too great a risk that it will become an expectation aimed at special groups in society. An institutionalisation of assisted dying therefore risks threatening the principle that we have the same claim to respect and dignity, regardless of how much we suffer and how high the quality of life is assessed to be. If we offer assisted dying, it says, directly or indirectly, that some lives are not worth living.'*

The philosophical depth of these analyses and conclusions on the Danish side contrasts starkly with the tone and content of the Committee majority's report. The Report confines itself to recitals on what the different witnesses said, and to a set of recommendations. But there is no evidence of respect for complexity, no narrative outside of the bare recommendations as to policy, and no speculation as to the past or to the future.

Implicit, however, in the Committee majority's report is a naive and misplaced dependence on notions of autonomy and the majority's decision, consciously or unconsciously, to elevate the autonomy of some over that of others.

In doing so, the Committee majority has fallen into the trap of which the Danish Council was so wary, the trap of saying *'directly or indirectly, that some lives are not worth living.'*

That these 'some lives' might become many lives would be the most likely foreseeable result should the Committee majority's ill-considered recommendations ever be expressed in legislation.