Opening statement to the Oireachtas Joint Committee on Assisted Dying

Finn Keyes BL, 27 June 2023

I. Introduction

I thank the Cathaoirleach and members for the invitation to assist the Committee with its important and difficult deliberations on this sensitive issue. In my opening remarks, I propose to outline the manner in which the courts have dealt with the ethical dilemmas that arise in end of life care, and to suggest what lessons might be drawn from the court's resolution of these dilemmas.

In particular, I will discuss:

(a) consent to treatment;

(b) distinction between acts and omissions; and

(c) the doctrine of double effect.

II. Consent to treatment

It is the right of any competent adult to refuse any and all medical treatment for any reason or none, even if death may result. This flows from the constitutional guarantee of the autonomy and bodily integrity of every person.[1] A person who considers that they may at a future point lose the capacity to make such a decision may also make an Advance Healthcare Directive, now provided for under Pt. 8 of the Assisted Decision Making (Capacity) Act 2015, stipulating their will and preferences in relation to future treatment decisions, including a refusal of treatment that would prolong life. However, a person cannot consent to being seriously harmed

[1] As the High Court (Baker J.) outlined in *Governor of X Prison v PMcD* [2015] IEHC 259:

> 'Thus it seems to me that while it could not be said that a person has a right to commit suicide, it can be said that he has a right to freely elect to refuse food, provided his choice is full, free and informed and he does not require assistance to achieve that end, and it is rather the case that he has refused such assistance. The distinction is between a positive right to directly end one's life, and to make choices which have the indirect effect that death follows. The latter right is constitutionally recognised as flowing from the autonomy of the self.' (para. 109)

or killed,[2] and therefore it is no defence to a murder charge, or indeed a charge pursuant to section 2(2) of the 1993 Act, to say that the person consented to having their life taken.

The circumstances in which a court is required to make decisions about assisted dying arise in cases where the person lacks capacity to make decisions about their care at the end of life. That is, where a person lacks capacity, it may fall to the court to act as a substitute decision maker, which historically has been under the High Court's wardship jurisdiction, but going forward will be under the regime established by the Assisted Decision-Making (Capacity) Act 2015.

In cases where the courts have had to act in such a role, they have drawn on two important legal-ethical constructs to distinguish between permissible end of life care that may hasten death on the one hand, and impermissible killing on the other. These are the act-omission distinction, and the doctrine of double effect.

III. Acts v omissions

An important principle of criminal law that has particularly weighty relevance in the context of assisted dying is the distinction drawn between acts and omissions. As a general rule, subject to particular exceptions, a person can only be criminally liable in respect of positive acts, and cannot be criminally liable for their omissions. Thus, it is a crime to start a fire, but it is not a crime to refuse to put out a fire started by another, or to refuse to come to the aid of a stranger caught in one. This distinction plays a significant role in the context of assisted dying.

In light of this distinction, the courts have consistently held that a refusal on the part of medical practitioners to continue treatment where the patient cannot receive any practical benefit from it may constitute an "omission to struggle", and hence not a positive act for the purpose of the statutory prohibition on assisted dying under section 2(2) of the 1993 Act.

The phrase an "omission to struggle" entered the lexicon following a decision of the House of Lords in *Airedale NHS Trust v Bland*.[3] That case concerned a 17 year old victim of the Hillsborough disaster, Anthony Bland, who suffered a hypoxic brain injury in the crush at the

[2] *DPP v Brown* [2019] 2 IR 1; *R v Brown* [1994] 1 AC 212. See discussion in David Prendergast, 'Limiting Consent in Criminal Law: DPP v Brown [2018] IESC 67'(2020) 2 *Irish Supreme Court Review*, p. 135 – 154.
[3] [1993] AC 789.

stadium, and was left in a permanent vegetative state. After a number of years in this condition, his medical team, with the support of his parents, went to court seeking orders to allow them to discontinue life-sustaining treatment, including naso-gastric feeding. Lord Goff outlined the centrality of the act-omission distinction to the law in this area,[4] and further stated that:

> "…to act is to cross the Rubicon which runs between on the one hand the care of the living patient and on the other hand euthanasia - actively causing his death to avoid or to end his suffering. Euthanasia is not lawful at common law."

Lord Goff stated that, in his view, the act of a doctor in discontinuing life support was in law an omission, and not a positive act. In doing so, he relied on the work of Professor Glanville Williams who suggested (in his Textbook of Criminal Law, 2nd ed., p. 282) that what the doctor does when he switches off a life support machine "is in substance not an act but an omission to struggle", and that "the omission is not a breach of duty by the doctor because he is not obliged to continue in a hopeless case". Accordingly, the House of Lords declared that the withdrawal of life support would be lawful, and Anthony Bland a short time thereafter became the 96th victim of the Hillsborough disaster.

A very similar rationale was employed by the Irish Supreme Court in *Re a Ward of Court*.[5] In *Re a Ward of Court* the Supreme Court similarly held that the withdrawal of artificial life-sustaining treatment from the ward would not amount to unlawful killing, partly on the basis that such withdrawal would not constitute a positive act but rather amounted to an omission to struggle. In circumstances where continued life could be said to be not in the best interests of the patient, such an omission to struggle was legally and constitutionally permissible.[6] This of

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[4] Per Lord Goff at p. 11 of the judgment:

> "…the law draws a crucial distinction between cases in which a doctor decides not to provide, or to continue to provide, for his patient treatment or care which could or might prolong his life, and those in which he decides, for example by administering a lethal drug, actively to bring his patient's life to an end. As I have already indicated, the former may be lawful, either because the doctor is giving effect to his patient's wishes by withholding the treatment or care, or even in certain circumstances in which (on principles which I shall describe) the patient is incapacitated from stating whether or not he gives his consent. But it is not lawful for a doctor to administer a drug to his patient to bring about his death, even though that course is prompted by a humanitarian desire to end his suffering, however great that suffering may be."

[5] [1996] 2 IR 79.

[6] Significantly, the Court considered that the right to die a natural death was implicit in the right to life protected under the Constitution. As Hamilton CJ stated: 'As the process of dying is part, and an ultimate inevitable consequence, of life, the right to life necessarily implies the right to have nature take its course and to die a natural death and, unless the individual concerned so wishes, not to have life artificially maintained by the provision of nourishment by abnormal artificial means, which have no curative effect and which are intended merely to prolong life.' See *Re Ward of Court* [1996] 2 IR 79, 124.

course places a weighty responsibility on the medical practitioner to determine at what point continued life is no longer in the interests of the patient.[7]

However, it is important to reflect on what exactly the Court was characterising as an omission in these cases, namely the action of withdrawing life-sustaining treatment, in the form of naso-gastric feeding, or turning off a life support machine.[8] The rationale of *Bland* and *Re Ward of Court* therefore allows for a somewhat dubious expansion of the criminal law concept of an omission in order to bring beyond the reach of the criminal law certain humane end-of-life practices. That is, the courts have been prepared to construe the concept of an omission broadly enough to allow, for instance, the withdrawal of ventilation and/or nasogastric feeding.[9] Characterising the act of withdrawing ongoing treatment or ongoing nourishment as an omission is certainly dubious,[10] but it appears to be tolerated as a necessary fiction.

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[7] The *Guide to Professional Conduct and Ethics for Registered Medical Practitioners in Ireland*, produced by the Medical Council, provides the following advice to medical practitioners in this context:

> "Usually you will give treatment that is intended to prolong a patient's life. However, there is no obligation on you to start or continue treatment, including resuscitation … if you judge that the treatment:
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> - Is unlikely to work; or
> - Might cause the patient more harm than benefit; or
> - Is likely to cause to the patient pain, discomfort, or distress that will outweigh the benefits it may bring.
>
> You should carefully consider when to start and when to stop attempts to prolong life. You should make sure that patients receive appropriate pain management and relief from distress, whether or not you are continuing active treatment"

The above passage was quoted by the Supreme Court in *Re JJ* [2021] IESC 1, at para. 89.

[8] See Michael S Moore, *Act and Crime: The Philosophy of Action and Its Implications for Criminal Law* (Oxford University Press 2010). Moore argues that anything that involves voluntarily caused bodily movements is a human action, and should not be capable of being characterised as an omission.

[9] See *Re Ward of Court* (n 7).

[10] Iglesias has argued more forcefully that: 'The intent in the deprivation of nourishment is to bring about death, which means to kill. I cannot interpret this but as euthanasia. The issue of whether this mode of death may be chosen by the person themselves, or by their legal representatives, does not alter the facts, nor the fundamental moral and legal question of the euthanasia intent manifested in those facts. And whether intentions to bring about the death of a patient are carried out in what is done (action), or in what is omitted (omission), does not make them less euthanasia intents.' Teresa Iglesias, 'Ethics, Brain-Death, and the Medical Concept of the Human Being' (1995) MLJI 51–57 at 57, quoted in Madden, *Medicine, Ethics and the Law* (3rd edn, Bloomsbury 2016) at [12 - 74].

IV. Doctrine of double effect

A further legal-ethical construct that plays a central role in cases dealing with end of life decision making is the doctrine of double effect.[11]

The doctrine of double effect can be defined as the distinction between consequences that are intended, and consequences which are foreseen but not necessarily intended.[12] Thus, according to the principle of double effect, it is permissible to do an act intending a good effect, albeit in the full knowledge that it will also result in a second, bad effect.[13] The doctrine, which originated in the work of Thomas Aquinas,[14] has many uses in moral philosophy, including in relation to ethics in war,[15] but has played a particularly important role in end of life decision making. In this context, the doctrine of double effect can justify the administering of palliative care (such as pain relief) that is likely to hasten death, if the primary motivating purpose of that treatment is to alleviate suffering and not to cause the death of the patient. By contrast, a doctor

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[11] The Law Lords in *Airedale NHS Trust v Bland* [1993] AC 789 were reasonably explicit in framing the ethical question as implicating the doctrine of double effect. As Lord Goff stated at:

> "The central issue in the case was described by the Law Lords as "whether artificial feeding and antibiotic drugs may lawfully be withheld from an insensate patient with no hope of recovery when it is known that if that is done the patient will shortly thereafter die."

[12] John Lombard, 'Sedation of the Terminally Ill Patient: The Role of the Doctrine of Double Effect' (2015) (21) 7 *Medico-Legal Journal of Ireland* 22.

[13] Its criteria have been stated as:

> (i) The act itself must be morally good or at least indifferent.
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> (ii) The agent may not positively will the bad effect but may merely permit it. If he could obtain the good effect without the bad effect, he should do so. The bad effect is sometimes said to be indirectly voluntary.
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> (iii) [T]he good effect must be produced directly by the action, not by the bad effect. Otherwise, the agent would be using a bad means to a good end, which is never allowed.
>
> (iv) The good effect must be sufficiently desirable to compensate for the allowing of the bad effect.

Connell, F.J., "Double Effect, Principle of," *New Catholic Encyclopaedia* (Volume 4), (New York: McGraw-Hill, 1967), p. 1021, quoted in Alison McIntyre, 'Doctrine of Double Effect', *Stanford Encyclopaedia of Philosophy*, 2018.

[14] Aquinas argued that 'Nothing hinders one act from having two effects, only one of which is intended, while the other is beside the intention … Accordingly, the act of self-defence may have two effects, one, the saving of one's life, the other is the slaying of the aggressor.' Thomas Aquinas, *Summa Theologica* (Fathers of the English Dominican Province tr, Benziger Brothers, 1947) (II-II, Qu. 64, Art.7).

[15] See, e.g., Michael Walzer, *Just and Unjust Wars* (Basic Books, New York, 1977) pp. 151–9.

who administered the same dose of pain relief with the intention of hastening death would act impermissibly.

In a recent major decision on end of life decision making, *In the Matter of JJ*,[16] the Supreme Court placed express emphasis on the doctrine of double effect in justifying orders that would allow doctors to withdraw respiratory support from a young boy who had suffered a devastating brain injury. The Court quoted approvingly from the evidence of a consultant in paediatric palliative medicine in the case, who outlined the nature of palliative care in this context: 'The intent is never to shorten life. The goal of palliative care is to live well, but it also encompasses the potential to die well… So, the intent is never to hasten death or shorten life. The intent is only to relieve suffering.'[17]

Interestingly, the Court appeared to implicitly accept that the doctrine of double effect is a less than fully satisfactory basis for dividing the boundary between lawful and unlawful killing. The Court stated: 'It is possible to argue that the distinction is no longer feasible, or should no longer be maintained, but so long as the law retains an absolute prohibition on euthanasia, it remains a critical and valid distinction both for medicine and the law.'[18]Thus, the Court appeared to accept that the doctrine of double effect is philosophically questionable, but is nevertheless an essential fiction as long as the prohibition on euthanasia remains a legal reality.

V. Conclusion

In my opening remarks this morning, I have sought to illustrate the very fine distinctions that have been drawn by the courts within the current legal framework in order to accommodate certain humane end of life practices and to protect medical practitioners from criminal liability. These fine distinctions are open to critique and challenge, but they are likely to remain a feature of the law for as long as the current legal framework in respect of assisted dying is maintained. Thank you for your attention and I welcome any questions.

[16] [2021] IESC 1.
[17] *Re JJ* [2021] IESC 1 at [72].
[18] ibid.