MEDICAL ASSISTANCE IN DYING (MAID)

Discussion Paper

Submission to:

The Oireachtas Justice Committee in consideration of the Dying with Dignity Bill

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1. Summary and Recommendations

Irish Doctors supporting Medical Assistance in Dying (IDsMAiD) is a group of medical doctors, with a strong belief in individual patient autonomy, who support choices for people at the end of their lives. We believe that a person approaching the end of their life, should be provided with accessible, high-quality and evidence-based care to minimise suffering and support their wishes. Every citizen should be able to access their choice of medical care, including palliative care and Medical Assistance in Dying (MAiD). Their individual choices should be discussed, encouraged and promoted. Any genuine choice by a patient, including MAiD, should be respected and supported.

There is increasing support both in Ireland and internationally for MAiD. MAiD has been introduced in Canada, New Zealand and several states in the USA and Australia, amongst many other countries (1-4). Public support for MAiD has increased to 80% in Canada since it was introduced in 2016 (5).

While the medical profession has been traditionally opposed to MAiD, there is a growing acceptance within the medical community that MAiD is an ethical issue for society to determine (6). This is an issue of individual conscience and as such professional medical organisations and colleges should adopt a neutral stance, respecting the differing opinions (7). Doctors who have a conscientious commitment to MAiD should be protected, if citizens have a legal right to access this medical service (8). Doctors who have conscientious objection to MAiD, should equally be respected and there should be no compulsion to participate in the provision of MAiD (9).

The most common reasons for a person to request MAiD include the loss of ability in daily activities, inadequate control of pain or symptoms and a patient's loss of dignity (10). Palliative care can control and alleviate the symptoms of many patients, but it cannot eliminate all pain and suffering for all patients. Medical care is often unable to restore ability and function in those with terminal illness and the resulting loss of dignity. Some patients will prefer to avoid suffering at the end of their illness and they should have the choice to access MAiD.

IDsMAiD broadly support the Dying with Dignity Bill that is progressing to the committee stage in the Oireachtas.

The Dying with dignity Bill appropriately restricts the provision of MAiD in that:

- It only applies to competent adults.
- The person must be a resident of Ireland.
- The person must have a terminal illness that is '*progressive and incurable'*.

There are a number of safeguards to prevent the potential for misuse of the Act and to protect vulnerable people including:

- The person will require the assessment of two independent medical doctors on wither they qualify for MAiD. The doctors must be independent of both the patient and each other.
- The person must have capacity to consent to MAiD.
- The person must have a clear and settled intention, which has been reached voluntarily without coercion or duress.
- The person can revoke their decision at any time.
- The person should be fully informed of all care options including palliative care.
- There is a waiting period of 14-days, prior to administration of MAiD, to allow a person time to contemplate on this decision.
- As the provision of MAiD requires legislation, any future changes in criteria or safeguards will also require further legislation.

IDsMAiD would make the following recommendations to enhance the Bill, as it moves to enacted legislation:

- **Comprehensive data collection, audit and monitoring** are essential to ensure standards are being maintained. This obligation should be provided in legislation and will provide qualitative and quantitative data to guide us in relation to future changes, ensuring that vulnerable are protected, whilst maintaining access to MAiD.
- MAiD can be through intravenous medication or oral medication, by a registered medical practitioner. The patient should have the **choice** in what form MAiD is administered, be that intravenous or oral; and if Oral-MAiD be it self- or doctor-administered.
- In terms of **medical certification of death**, the underlying terminal condition should be certified as the cause of death.
- Any doctor participating in MAiD needs to be on the **specialist register** of the Irish Medical Council and main place of practice needs to be on the island of Ireland.
- **Fundamental values and principles** should be underpinned in the final piece legislation. These values and principles should be upheld by any person exercising a power or performing a function or duty under the enacted Bill and may include principles such as the following:
    - Every human life has equal value.
    - A person's autonomy should be respected.
    - A person has the right to be supported in making informed decisions about the person's medical treatment, and should be given, in a manner the person understands, information about medical treatment options including comfort and palliative care.

- Every person approaching the end of life should be provided with quality care to minimise the person's suffering and maximise the person's quality of life.
- A therapeutic relationship between a person and the person's health practitioner should, wherever possible, be supported and maintained.
- Individuals should be encouraged to openly discuss death and dying and an individual's preferences and values should be encouraged and promoted.
- Individuals should be supported in conversations with the individual's health practitioners, family and carers and community about treatment and care preferences.
- Individuals are entitled to genuine choices regarding their treatment and care.
- There is a need to protect individuals who may be subject to abuse.
- All persons, including health practitioners, have the right to be shown respect for their culture, beliefs, values and personal characteristics.

We believe that MAiD can be introduced in a safe and fair manner by the proposed Dying with Dignity Bill. Although it can be divisive issue, both in the general public and in the medical community, we believe that society has a responsibility to offer the choice of MAiD to those suffering with a terminal, incurable illness.

2. Autonomy and ethical principles underpinning MAiD

Individual autonomy, the '*ability to make one's own decisions about what to do*' is a core value of modern liberal democracies (11). Ireland has increasingly become a progressive society, respecting individual freedom and individuals' beliefs.

2.1. The primacy of autonomy

In Medicine, respecting a patient's autonomy is the primary ethical principle which supports professional decision making, but it is not absolute and is balanced against other principles including beneficence, non-maleficence and justice (12). The paternalism of Medicine's past, with doctors assuming what is in the patient's best interests, has evolved to the patient being central to shared decision making (13). The clinical practice of medicine has changed with greater respect for the patient's right to choose what medical treatments, if any, are most appropriate for them. As Gillon noted, '*if one wants to do good for a patient, one generally needs to find out what the patient wants one to do*' (13).

There needs to be a balance of respecting the autonomy of the individual, with competing ethical principles and the need to protect society. While the rights of the individual can't be absolute, any country that fails to treat individuals with compassion and respect ceases to be a caring society.

With regards to MAiD, is it humane to deny a person, with intolerable suffering with a terminal illness, access to MAiD if they wish? Suffering is an individual experience. Only the patient can define their pain and what constitutes their suffering as intolerable. We all have different views and values on what makes life worth living and supporting autonomy means we all have the right to determine when life becomes intolerable for ourselves.

Arguably it would be detrimental to society if there was unrestricted access to MAiD. However, it is also unreasonable for society to absolutely prohibit MAiD, regardless of the suffering of the person and the specific circumstances of their situation. The hypothetical fears of harm to greater society are insufficient reason to condemn real people to unnecessary suffering, in the context of our understanding of safe, regulated MAiD provision internationally (see Section 3 below).

Like many rights that we exercise as individuals, it is appropriate and right that society restricts the right to MAiD and regulates the services appropriately. The proposed Dying with Dignity Bill has many safeguards which protect society from unintended use of MAiD including:

- MAiD only applies to adults who have the necessary mental capacity to consider Assisted Dying.
- The person must have a terminal illness that is incurable and progressive.

- The person is clear of their wish, has been informed of all possible care and is free of coercion.
- It requires two independent doctors to agree that the person qualifies.
- Neither doctor can be a relative of the patient.

2.2. The boundary between passive and active euthanasia

The idea that doctors should only do good and never do harm is deceptively simplistic (12). Most medical treatments have the potential to both benefit and harm the patient. For example, chemotherapy may improve the survival from a specific form of cancer, but it could also cause renal or cardiac side effects harming the patient. Doctors strive so that good outweighs harm in any therapeutic option, causing no 'net' harm, while also being mindful of the patient's wishes (12).

When it comes to end of life care the burden of any treatment needs to be balanced with the benefit of that treatment. In some instances, the benefit of treatment is less than the possible burden and treatment is either withheld or withdrawn. Examples of this include, stopping antibiotics or stopping intravenous fluids in frail elderly patients who are unlikely to live and who are suffering. This hastening of death by withholding treatment and allowing the illness to take its course is a form of passive euthanasia (see *Section 10.1. Definitions*).

Passive euthanasia as described above is normal medical practice in Ireland. It is compassionate and caring in people at the end of their life. If possible, the decision is made with the consent of the patient or with the benefit of an advanced care directive. If the patient is too ill and lacks the capacity the family should be consulted on what their wishes would likely be. Sometimes this responsibility can rest entirely with the doctor in determining what is in the best interests of the patient, whether to continue to treat, or to allow the patient to die in a more comfortable manner.

Active euthanasia contrasts with passive euthanasia in that it involves the administration of medication to the patient, but the outcome from the patient's perspective can be viewed as being similar. While every case deserves to be judged on its own merits, how can active euthanasia be universally wrong while the practice of passive euthanasia has widespread support? In contrast to passive euthanasia as practised in Ireland, MAiD as proposed in the Dying with Dignity Bill must be voluntary and cannot occur without the express wish of the patient.

2.3. Arguments countering the introduction of MAiD

Concerns voiced by opponents, suggesting that the doctor-patient relationship is impacted or that MAiD will lead to a slippery-slope, have not transpired.

Opponents of MAiD often cite insufficient ethical assumptions to support their position:

- *Capacity:* Opponents of MAiD frequently state that capacity may not be not possible for MAiD (14). However, this argument is fallacious, both as consent is possible for all healthcare actions once an individual has capacity to understand their decisions, and secondly as the opponents concurrently argue capacity is possible for other societal responsibilities and healthcare procedures, which undermines the original position.
- *The slippery-slope argument:* Arguments about '*devaluing life'* are made by MAiD opponents to support their perspective. They argue that '*legalising assisted suicide would lead to significant unintended consequences for healthcare system and society that societal attitudes would gradually change; that there would inevitably be a creep from restrictive to permissive eligibility and potentially to include non-voluntary and involuntary euthanasia' (14)*. The criteria and safeguards of the Dying with Dignity Bill will be established through legislation and any changes in the Bill will require further legislation. Change will not be possible, without careful consideration and scrutiny. With over twenty years of MAiD experience internationally, especially for jurisdictions with legislative enactment of provision, we can see that these concerns can be avoided. What is perceived as good for society, may not necessarily be good for an individual patient, therefore we must prioritise a patient's autonomy in relation their own heath, above any putative consequence on wider society, which has not materialised in other countries.
- *The non-maleficence argument:* The Hippocratic maxim of '*primum non nocere*' (first do no harm) is but one ethical principle, balanced against justice, beneficence and primarily autonomy (12). A paternalistic consideration of only one ethical principle (non-maleficence), ignoring autonomy, is an unethical perspective to take in Medicine.
- Distorting the *doctor-patient relationship* in society: Years of MAiD provision has not supported this argument.
- *Conscientious objection*: Opponents of MAiD often state that conscientious objection cannot be protected. The Dignity with Dying Bill specifically supports a healthcare providers ability to conscientiously object to care.
- *The alternative argument:* This argument states that because of advances in palliative care and mental health treatment, there is no reason any person should ever feel they are suffering intolerably, whether it is physical or mental suffering or both (15). According to the argument, if the right care and environment is provided, there is no reason a person cannot have a dignified and painless natural death. However, as outlined in this Discussion Paper, as seen in the international evidence underpinning MAiD, the concept of suffering is entirely subjective and cannot be categorically removed through medical advances for all patients. This is supported with a minority of patients who continue to make autonomous decisions to proceed with MAiD, in those countries

where it is possible. Furthermore, Irish citizens continue to travel for this service, abroad, rendering this argument false.

- *The religious argument:* The religious argument states that these practices can never be justified for religious reasons, for example many people believe that only God has the right to end a human life (15). In a modern pluralistic democracy, with patients of all creeds, and none, this is not a professional argument to impact evidence-based compassionate healthcare policies.

2.4. How society treats our vulnerable

A 2020 Canadian study compared the clinical and demographic characteristics for all MAiD decedents and those of all Ontario decedents (16). Recipients of MAiD were younger, had higher incomes, were substantially less likely to reside in an institution and were more likely to be married than decedents from the general population, suggesting that MAiD is not driven by social or economic vulnerability. The experience in Canada can give comfort to those concerned that the Dying with Dignity Bill could adversely affect vulnerable people in Ireland. The criteria and safeguards are very similar. For an individual to qualify for the purpose of the act the person must have an incurable and progressive illness and is likely to die as a result from this illness.

Analyses of MAiD in Oregon and the Netherlands have concluded that there was no increased incidence of physician assisted death in elderly people, women, people with low socioeconomic status, minors, people in racial and ethnic minorities, and people with physical disabilities or mental illness (17).

MAID accounts for about 2% of deaths in Canada and 4% in the Netherlands in the 19 years since it was legalised. MAiD has brought compassion and peace to a small minority without any harm to the rest of society. Society should be judged by how it cares for our most vulnerable.

3. Irish an international experience with MAiD

Medical Assistance in Dying is the modern medical term used to describe Assisted Dying. Synonyms of MAiD and Assisted Dying include Assisted Suicide and Voluntary Euthanasia, the definitions of which are outlined in the *Section 10.1*. For the purposes of this Discussion Paper we will use the term MAiD throughout.

MAiD is currently available in multiple countries internationally, being legally available and regulated in parts of Australia, Belgium, Canada, Colombia, Luxembourg, The Netherlands, Switzerland, and several US States (1-4). It is envisaged that MAiD will be introduced in several more States in the US and Australia in the coming years. The first country to introduce Assisted Dying was Holland in 2001, followed by Belgium in 2002 and most recently a referendum in New Zealand showed overwhelming support for MAiD.

3.1. Irish experience

The Dying with Dignity Bill brought the conversation on Assisted Dying to national attention in 2020 (18). However, MAiD is illegal in Ireland, whilst it is increasingly becoming an accepted and ethical practice internationally to support autonomous and compassionate end-of-life care.

In Ireland, under Section 2 of the Criminal Law (Suicide) Act 1993, anyone who '*aids, abets, counsels or procures the suicide of another [person]*' can be convicted and imprisoned for up to 14 years. This policy direction is counter to public attitudes on MAiD, with surveys as recently as 2019 suggesting that the vast majority of the Irish public would support MAiD; up to 55% of the population thinking that MAiD should be lawfully accessible in Ireland, whilst 22% being opposed (19). Irish citizens travel abroad, if they can, to access MAiD (20).

Several high-profile cases have highlighted the lack of access to MAiD in Ireland.

- In 2002, Rosemary Toole Gilhooley died. However, it subsequently transpired that an American Minister, Rev George Exxo admitted to assisting Rosemary in her death in Ireland. His extradition to Ireland was sought, but this was subsequently refused (21).
- Marie Fleming attempted to establish her right to die, by MAiD in Ireland, in 2013 (22). Diagnosed with multiple sclerosis for over 25 years, she gave evidence that she suffered from unbearable and severe pain. She told the Court she was no longer able to control her electric wheelchair, needed help to eat and drink, and had to be washed, dressed and repositioned in her wheelchair and was losing her ability to swallow. She lost her case and the appeal to the Supreme Court (22). She died in December 2013.

- A third high-profile case related to Gail O'Rorke who was found not guilty of attempting to assist the suicide of her friend in 2015 (23). O'Rorke was charged with making arrangements for her friend Bernadette Forde to travel to Dignitas in Zurich. The trip Ms Forde had planned was eventually cancelled after Gardaí were notified by a travel agent (23).
- A fourth individual, the CervicalCheck campaigner Vicky Phelan, brought MAiD to national attention with her comments in September 2020 (24). Suffering with terminal cervical cancer, she publicly discussed the aims of the Dying with Dignity Bill, to give those in pain at the end of their lives the choice to die '*gently*' without '*unnecessary suffering*', stating '*we don't do it to animals [and] I don't see why we should do it to ourselves'* (24).

A national conversation relating to MAiD ensued. On 7th October 2020, Teachtaí Dála (TDs) voted in favour of the Dying with Dignity Bill by 81-71.

Subsequent to this vote, the Oireachtas Justice Committee will further consider the contents of the Bill.

The Dying with Dignity Bill provides for a legislative approach (as opposed to constitutional change) to introduce a highly regulated provision of MAiD for adults, over 18 years of age, in Ireland (25). The purpose of the bill is to '*make provision for the assistance in achieving a dignified and peaceful end of life*' in those who wish to die, particularly those who are suffering from a terminal illness. The specific condition which a patient suffers from must be '*incurable and progressive'* which cannot be reversed by treatment. Significant detail in the Bill relates to the procedures and safeguards necessary to provide for high-quality, safe and compassionate MAiD care (25).

3.2. MAiD in Canada

The Canadian experience over the past four years is very similar to what is proposed in the Dying with Dignity Bill. Introduced in 2016, the organisation and delivery of MAiD varies in different Canadian Provinces (2, 16, 26-29).

Eligibility Criteria: In Canada, MAiD is entirely voluntary (by self-request only) for adults who are 18 years of age or older, and patients must have capacity to make health care decisions. Clear informed consent must be given, and the service is part of publicly funded health care. The patient must be diagnosed with a '*grievous and irremediable medical condition*'(2), where a person must meet all of the following criteria:

- Serious and incurable illness, disease or disability
- Advanced state of irreversible decline in capability
- Intolerable physical or psychological suffering
- Natural death has become reasonably foreseeable

Safeguards include two independent practitioners confirming that eligibility criteria are met, two independent witnesses signing the written request form, the doctor having to confirm the request has been made freely without undue influence, a 10-day reflection period unless death or loss of capacity is imminent and there is a final confirmation and consent at the time of administration or provision of the medication or prescription for self-administration.

Importantly Canada has collected significant amounts of data from the provision of MAiD services, which can both inform the discussion on the Dying with Dignity Bill in Ireland and point to how we can monitor and regulate MAiD in Ireland (10). MAID deaths accounted for 2.0% of all deaths in Canada in 2019. There has been a steady increase in cases of MAiD since 2016, from 1,015 cases of MAiD in 2016, to 5,631 cases in 2019. Rates vary between Canadian Provinces from 0.3% to 3.3%. Fewer than seven cases in 2019 were self-administered. The average age of those who received MAiD was 75.2 in Canada and 50.9% were male (10). The main '*grievous and irremediable medical* condition' leading to a case of MAiD are outlined in *Figure 1*, but almost 7 in 10 relate to terminal cancer.

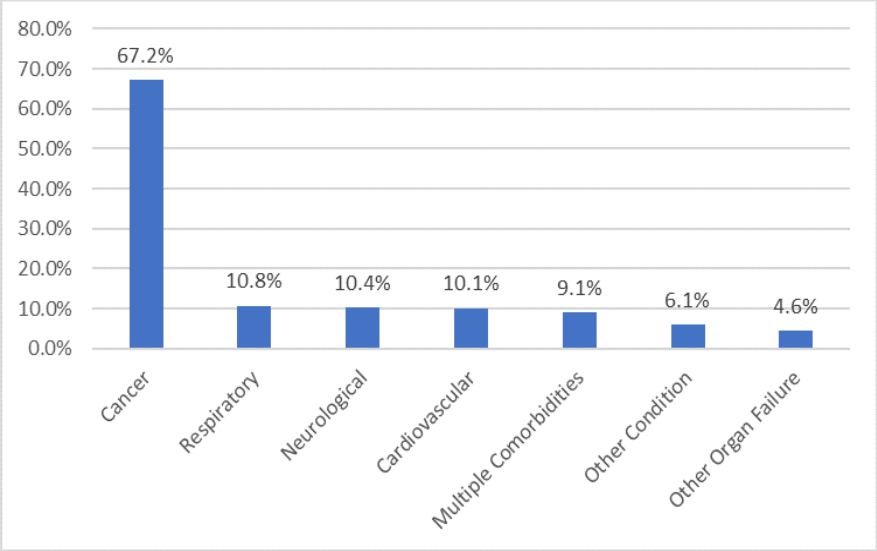

Figure 1. Medical Condition of Persons Receiving MAiD in Canada (10). *The category of "other conditions" includes a range of conditions, with 'frailty' commonly cited. Providers were able to select more than one medical condition when reporting; therefore, the total exceeds 100%.*

Of those who received MAiD, 82.1% received palliative care and 89.6% had access to palliative care. 41.2% of MAiD recipients were reported to require some disability support services (including personal care services, adaptive equipment etc.). In terms of location of death, 35% were in private residences, 36% were in hospital settings, 21% were in palliative care facilities and 7% were in residential care facilities (10).

Most doctors providing MAiD services in Canada are General Practitioners/ Family Doctors, however 35% represent other disciplines including Palliative Care specialists (see *Figure 2*).

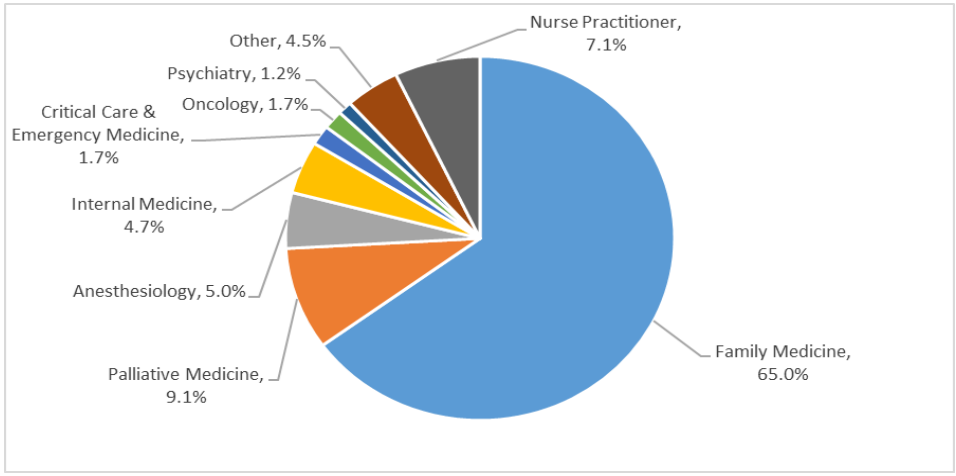

Figure 2. *Specialty of Practitioners delivering MAID in Canada (10)*

One of the eligibility requirements for MAID is that the person's illness, disease, disability or state of decline causes them enduring physical or psychological suffering that is intolerable to them. The MAID recipient's description of suffering provides insight into their reasons for requesting MAID (see *Figure 3*) (10).

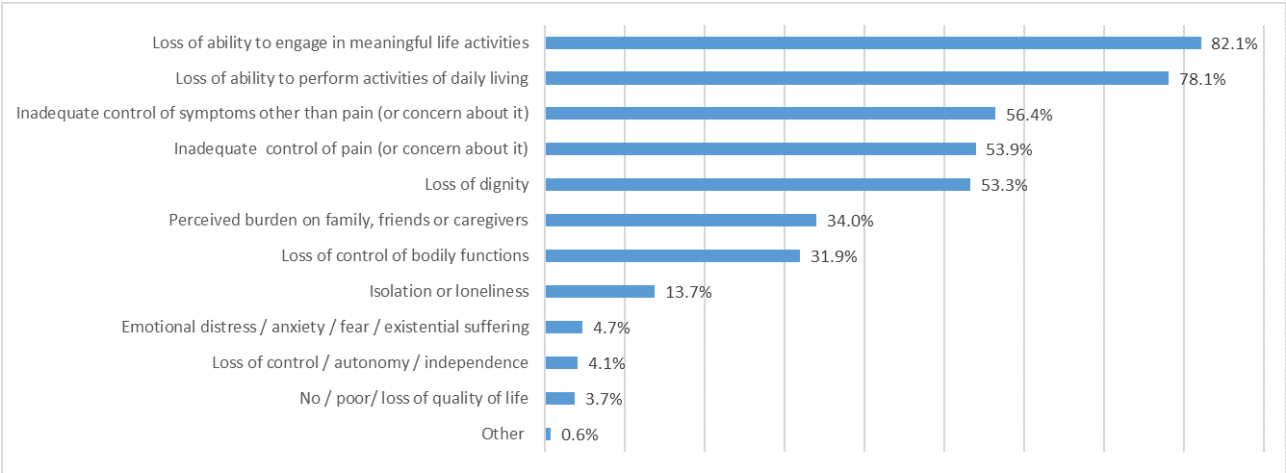

Figure 3. Description of suffering by recipients of MAiD in Canada (10)

In Canada, we have can also see how many requests for MAiD translate to the completion of MAiD. In 2019, there were 7,336 requests for MAID, yet 5389 (73.5%) resulted in MAID. Of the 1,947 (26.5%) who did not result in MAID, 15.2% died from a cause other than MAiD, 7.8% were ineligible and 3.6% withdrew the request (10).

It is anticipated that Canadian MAiD will end up waiving the requirement for final consent in those circumstances where persons approved for MAID risk losing capacity to consent before their scheduled date for MAID, and they have an advance consent agreement with their practitioner.

3.3. Australian experience

Voluntary Assisted Dying has been approved in the State of Victoria since June 2019 (3). Western Australia and Tasmania have passed legislation to introduce MAiD but it's not expected to come into effect until 2021. It is currently not legal in other Australian States. The current government has promised to table legislation in Spring 2021 in Queensland, to introduce MAiD.

Voluntary Assisted Suicide in Victoria is broadly similar to the Dying with Dignity Bill, however it has a 'prognosis clause' which is not the Irish Bill and requires three requests. The Western Australian legislation will also require a prognosis clause (stating expected death within six months or twelve months with a neurodegenerative condition) (30). The legislation in Tasmania was passed in October 2020 and requires a prognosis clause and three requests.

3.4. New Zealand experience

New Zealand is the most recent country to introduce, passing a referendum in 2020 on Assisted Dying passed. Patients must be over 18, be a citizen or permanent resident of New Zealand, have 'significant and ongoing decline in physical capability' and 'experience unbearable suffering that cannot be eased' (4). Patients must be able to make an informed decision about assisted dying. A prognosis clause is also present, stating that patients must 'suffer from a terminal illness that's likely to end their life within 6 months' Mental health conditions, advanced age and disability are not permitted to the only reason for MAiD.

3.5. Swiss experience

Assisted suicide has been legal in Switzerland since 1937, however doctors are prohibited by the Swiss Academy of Medical Sciences from professionally participating in assisted suicide. Since being made legal in Switzerland 1937, assisted dying in Switzerland has generated international attention with organisations (Dignitas, Exit International, Dignitas and Exit/ADMD) have been formed with the purpose of helping individuals seeking assisted suicide (31). Dignitas was founded in 1998 has assisted Irish citizens to end their lives. Up to recently Assisted Dying has been different in Switzerland- and is not a form of MAiD- in that that doctors have been prohibited by the Swiss Academy of Medical Sciences from professionally participating in assisted suicide (31, 32). Patients do not need to have a terminal illness and the patient consumes oral-self-administered medications to assist in their dying. Calls to enhance the regulation of the process of Assisted Dying in Switzerland have been made (33)

4. Physician and public support for MAiD

In recent years an increasing number of countries and states throughout the world have recognised the importance of Patient Autonomy, especially in those suffering with a terminal illness. Medical Assistance in Dying is increasingly seen as a reasonable choice for patients who have intolerable suffering.

Until recently, legal MAiD was confined to the Benelux countries and self-administered euthanasia was confined to Switzerland and the state of Oregon. Over the last 10 years some form of MAiD has been introduced in Canada (2016), Colombia (2105) and the state of Victoria in Australia (2019). New Zealand has recently passed a referendum to allow for euthanasia (2020). In the USA 9 states and the district of Colombia allow for the self-administered Euthanasia.

These changes reflect a fundamental change in Western Society in recent decades recognising an individual's right for choice.

4.1. Public support for MAiD in Ireland and internationally

Up to 63% of people in Ireland are supportive of euthanasia (19). This level of support is broadly similar to the support seen in recent referendum for marriage equality 2015 (62%) and in repealing the eight amendment 2018 (66%). Ireland is now a progressive, caring and compassionate society which respects an individual's right to choose and we believe that this should include an individual's right to access MAiD.

Support for MAiD is shared in most countries, including the UK. More than 90% of the UK's population believe assisted dying should be legalised for those suffering from terminal illnesses, in a 2019 survey of 2,500 UK citizens, run by a campaign group My Death, My Decision (MDMD) (34). In 2015, a survey of over 5,000 UK residents, commissioned by Dignitas, showed that there was 82% public support for MAiD (35). Support in Australia for euthanasia has increased from 75% in 2013 to 90% in 2019 *(36)*. The End of Life Choice Act in New Zealand was passed by referendum by 65% to 37%, despite some vocal critics in their medical community (37).

Since the introduction of MAiD in Canada in 2016, the service continues to maintain strong support. An Ipsos poll in 2020 after over three years of experience of MAiD found that 86% of Canadians supported that MAID was a constitutionally protected right, given that patients satisfy a series of stringent qualifying criteria (5).

A Canadian study of new patients referred to palliative care with a life limiting illness, concluded that terminally ill patients generally agreed that physician assisted death should be available to patients with life limiting illness (38). Over 80% of participants thought that MAiD should be available to patients with an

illness that could not be cured and who cannot tolerate their suffering. This reflects the level of support for MAiD in the Canadian public.

4.2. Medical profession support for MAiD

The medical profession has traditionally opposed changing the law to permit assisted dying.

While the Irish Palliative Medicine Consultants' Association has strongly opposed legislating for MAiD there has been no published survey of the attitudes of Irish doctors in general.

However in the UK, the British Medical Association performed the first ever survey of its members' views on assisted dying, and it found that **the majority of all doctors support a change in law** to permit MAiD (35, 39). 40% of respondents said the BMA should support a law change that would permit doctors to prescribe drugs to eligible patients for self-administration to bring on death, 33% were opposed, 21% said the BMA should take a neutral stance and 6% were undecided. Half of surveyed members personally believed that there should be a change in the law to permit doctors to prescribe life-ending drugs (39). When it came to their willingness to prescribe life-ending drugs themselves, 36% of respondents were willing to do so (35). In the UK, in the last two years the Royal College of General Practitioners and Royal College of Physicians have both surveyed members on assisted dying, and the results showed that 51% and 57%, respectively, wanted their colleagues to stop opposing a change in the law on assisted death.

On account of this the **Royal College of Physicians adopted a neutral stance**, due to the diversity of opinions on MAiD (7). It is therefore very surprising that the Royal College of Physicians of Ireland has adopted a firm stance on this issue. With the legislation of MAiD in 2016 the Canadian Medical Association recognised that its policy needed to evolve and the organisation needed to support all of its members regardless of their views. No medical organisation or College in Ireland has surveyed *all* its membership to decide about their views on Medical Assistance in Dying. As this is an issue which divides, it may well be that as a matter of conscience, adopting no formal stance would be an appropriate position for most medical colleges to take. The relevant Irish colleges and associations should consider a similar change in policy recognising that in such ethical issues there is neither right or wrong and that all members are deserving of their support.

The changing opinions in the public and amongst physicians reflect changing attitudes internationally by doctors who no longer see themselves as the moral custodians of society and believe that MAiD is predominately an ethical issue for society to determine. While doctors will be needed to conduct MAiD, many people no longer seen as a medical issue, but as a human right.

Introduction of MAiD is likely to have very little effect on most doctor patient interactions as the numbers requesting MAiD (or consultations where it might be relevant) are likely to be very small, as shown in jurisdictions where it is already legal.

In the relevant consultations, would the knowledge that MAiD is available introduce a new openness and frankness into the consultation? It would no longer be necessary for doctors to draw the distinction between treatments given to relieve symptoms, but which might also have a side effect of being life shortening and treatments given to end life. This might lead to a more open discussion about death and the limits of currently available treatment.

As MAiD is simply offering further choice to the patient and is based on respecting the autonomy of the patient it is difficult to expect any adverse effect on the doctor patient relationship.

5. Provision of end-of-life and palliative care, currently, in Ireland

The World Health Organisation defines palliative care as '*an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual* (40).'

It is widely stated that palliative care is every health care worker's responsibility, be they GPs, hospital doctors, nurses or a member of a specialist Palliative Medicine team (41). The ethos of palliative care, to quote William Osler, is to '*cure sometimes, relieve often, comfort always'* and the aim is to assist the patient in living until they die.

There are areas in the Republic of Ireland where specialist palliative care services are under-resourced, which can lead to unequal availability of care (42). Where available, palliative care is holistic and the medicine is of high standard. It is patient-centred and aims to care for a dying person in their own home, when requested.

Palliative care teams traditionally look after patients with incurable cancer, but Irish Hospice Foundation has noted that this has expanded to include patients with non-malignant diagnoses including advanced incurable neurological disease, cardiovascular disease and respiratory failure.

Some conditions have more predictable disease trajectory than others. Certain malignancies, as one example, can have a shorter period of predicted decline. Non-malignant conditions such as congestive cardiac failure or chronic obstructive pulmonary disease can be more difficult to predict and can have variable trajectories. Generalised frailty of the body systems or dementia are examples of cases where there is a prolonged period of decline prior to death.

The idea of palliative care is that death is neither hastened nor delayed. Judicious decisions are made around introduction and withdrawal of potentially life prolonging interventions such as IV fluids and parenteral or enteral nutrition. The doctrine of double effect applies i.e. if the patient has pain and required high dose narcotics or sedatives for relief and in so treating the symptoms the sedating effects of the medications result in reduced consciousness and respiratory depression which contributes to the dying process. At times the patient can be induced into a terminal sedative state secondary to medication.

The proposed legislation would allow for terminally ill Patients over-18 who have capacity to consent, to end their lives with legal medical assistance before their body naturally dies. MAiD offers patients with

terminal illness a further choice in treatment options and palliative care should continue to be promoted and supported. Healthcare has advanced significantly in the field of oncology in particular and some patients can survive with a large burden of disease. Complexity has come with the success and chronicity of survival and advances in Medicine. Having the option of MAiD, for patients, may well help reduce anxiety relating to the end of life.

MAiD should be seen as complimenting palliative care rather than any attempt to diminish it. It offers patients with terminal illness a further choice in treatment options and does nothing to inhibit good palliative care.

6. Regulation and monitoring of MAiD in Ireland

Comprehensive regulation, monitoring and reporting of MAiD is needed to provide accountability and transparency to foster trust in the public.

The Canada health services MAiD report from 2019 is an excellent example of how a comprehensive reporting system can create trust and confidence in the public. In earlier years each province reported individually but in 2019 the results for the entire country with published in one report (10).

As discussed *in Section 2.3*, opponents of MAiD voice concerns of a 'slippery slope', that once MAiD is introduced it will become widely available and will be poorly regulated. The Canadian experience of regulated MAiD- and the data from its annual report- provides direct evidence that this is not the case (10). The proposed Dying with Dignity Bill in Ireland restricts MAiD to those who have terminal illness, are over 18 , have mental capacity and most importantly want it (25). Any change would require further legislation and scrutiny by the Dáil. There is no reason to believe that any change in the legislation would not be as carefully studied as this current Bill. It is important that the Bill as proposed is discussed rather than hypothetical fears that the bill clearly excludes.

7. The clinical and medication context underpinning Intravenous- and Oral-MAiD protocols

This Discussion Paper is not a clinical guideline, however a basic understanding of Intravenous- and Oral-MAiD options are important as background context if we consider the implementation of MAiD in the Republic of Ireland.

MAiD can be provided through oral medications (taken by mouth) and intravenous (IV) or parenteral medications, which are typically injected into a patient's vein. Each option certain advantages and disadvantages outlined below.

Whilst the autonomy of the individual to decide which type of MAiD they receive should be respected, **it is worth considering that IV-MAiD is the preferred choice for over 99% of Canadians who accessed MAiD in 2019** (10).

A considerable body of literature published over the past number of years supports the ethical imperative for the provision of MAiD services, however there is a paucity of literature addressing the medical aspects of medical provision. A scoping review in BMJ Open in 2020 concluded that there are a wide variety of methods for MAiD, there are few reports of how often protocols have been used (43). The common medications in MAID provision were outlined in the review, though more research is needed to 'identify the medications, dosages, administration techniques and procedures that produce the most predictable outcomes and mitigate distress for those involved' (43). The authors highlighted the emphasis on Canadian practice where there are a much larger number of documented protocols with a wide variety of medications used.

7.1. Intravenous options for MAiD

The main advantages of the intravenous option are the ease of administration in the presence of a well-functioning IV access and the effectiveness and the reliability in bringing about death. It facilitates patients who are incapable or intolerant of the oral route or where there is concern around safe and effective self-administration by the patient. The main disadvantage of this option is that it relies on the presence of a skilled clinician, potentially impacting patient autonomy and agency and may be perceived as providing a more clinical, than natural death. IV-MAiD is the preferred route of over 99% of patients who choose MAiD in Canada (10).

Common medications which are given in IV-MAiD protocols can include:

- Benzodiazepines/ anxiolytics (e.g. midazolam): Benzodiazepines bind to stereospecific receptors on the post synaptic GABA neuron in the Central Nervous System (CNS) and enhance the inhibitory effect of GABA, causing reduced anxiety. Typically midazolam is used in IV-MAiD.
- Local anaesthetic agents (e.g. lidocaine): Lidocaine is an amide local anaesthetic which blocks voltage gated sodium channels on neuronal membranes. It can reduce pain associated with propofol or phenobarbital. It can also be cause cardiac arrythmias. 20-100mg is given by IV push over 30 seconds as part of IV-MAiD dosing in Canada.
- Coma-inducing agents (e.g. propofol, barbiturate): Propofol is a short-acting intravenous general anaesthetic, which causes widespread CNS depression from $GABA_A$ agonism and potentially inhibition of the NMDA receptors. Propofol is recommended as the first line by the Canadian Association of MAiD Assessors and Providers (CAMAP). The dose of propofol used in IV-MAiD is 5-10 times the normal dose used for the induction of anaesthesia. Barbiturates (Phenobarbital and Thiopental) also act on $GABA_A$ receptors and cause widespread CNS depression and an anti-convulsant effect.
- Neuromuscular blocking agents (e.g. rocuronium, cisatracurium, atracurium, vecuronium): These medications are non-depolarizing muscle relaxants, inhibitors of acetylcholine receptors on the post synaptic membrane resulting in paralysis of skeletal muscle. All neuromuscular blockers used in IV-MAiD are intermediate acting.
- Adjunctive medications:
    - Opioids (e.g. morphine, fentanyl, hydromorphone) can induce pain relief, but also respiratory depression, euphoria, sedation and drowsiness.
    - Anti-emetics (e.g. metoclopramide): Metoclopramide is used in most IV-MAiD protocols as it blocks dopamine and serotonin receptors to prevent nausea/ vomiting and it increases gastric emptying and gastrointestinal (GI) motility by enhancing the response to acetylcholine in the tissue of the upper GI tract.
    - Asystole-inducing agents (e.g. bupivacaine). Bupivacaine has been added to some protocols in Canada to induce a cardiac arrest asystole. It is an amide local anaesthetic and inhibits the initiation and conduction of nerve impulses by voltage blocking voltage -gates sodium channels on neuronal membranes.

Some complications with IV-MAiD have been outlined in the literature including difficulty obtaining and maintaining IV access, the patient dying too slowly or quickly and pain on the site of injection.

7.2. Oral options for MAiD

It is worth considering that self-administered Oral-MAiD was provided in <1% of MAiD in Canada in 2019 (10). However, this choice should be made available to support patient autonomy.

Out of 163 published studies outlining MAiD clinical protocols, 50 outline oral options for MAiD (43).

The main advantage of offering patients an oral option for MAiD (compared to IV options) is the autonomy it provides for patients to take the medication themselves, and re-establish some control during a challenging time of their disease or illness. It can provide greater patient autonomy, with a perceived improved experience of controlling the timing and circumstances of the patients own death including self-administration. Oral MAiD may also increase accessibility where there are few providers or large geographical regions with limited providers. It can also provide comfort to those clinicians who perceive IV options for MAiD as having an active involvement in the patient's death (26, 27).

The disadvantages to oral options for MAiD, include: i) Failure of the medications which can relate to reduced absorption of medications, pre-existing tolerance to the medications, pre-existing nausea, vomiting or malabsorption syndromes relating to a medical condition; ii) Oral-MAiD is given in a one-time dose, which cannot be supplemented, therefore if it is ineffective there is a need to revert to an IV-MAiD option (26, 27).

Typical oral-MAiD protocols involve the following medications:

1. Pre-medication with anti-emetics (anti-nausea) and or pro-motility (pro-kinetic) agent is recommended to improve absorption of medication and decrease risk of nausea or vomiting which will increase distress but reduce the absorption of the oral Maid regimen resulting in possible failure. They are usually given one hour prior to the coma inducing agent. Examples of these medications include Metoclopramide 10 mg, Ondansetron 8 mg- 24mg, or Haloperidol 5 mg. Two anti-emetics are given in some protocols.
2. An anti-anxiety medication (anxiolytic) given 5-10 minutes before the coma inducing agent. Examples include Lorazepam 0.25-2mg, Diazepam 1g or Midazolam 10mg.
3. The coma inducing agent. The main agents outlined in protocols for Oral-MAiD are barbiturates alone (37 studies) or in conjunction with an opioid medication (seven studies) (43)

The coma inducing-agent can be given alone or in combination with other medications

- Barbiturates are a group of medications which are called $GABA_A$ receptor agonists. By directly binding to this receptor at multiple sites in the body, it leads to barbiturates acting as an anxiolytic, hypnotic and anticonvulsant, that can induce total anaesthesia, and in large doses they cause respiratory then cardiac arrest. Barbiturates are used in 94% of documented oral protocols and in 74% of cases they are used as a single agent (43).

- Other medications: Non-barbiturate medications can include opioids (e.g. morphine or fentanyl), benzodiazepines (e.g. midazolam), digoxin (which can cause cardiac arrythmias in large doses) and choral hydrate (which is less favorable with oral-MAiD as it can be toxic to oral and gastric mucosa).
- Single-regimens to induce a coma could include either Secobarbital or Phenobarbital. *Secobarbital* has a fast onset of sleep and respiratory arrest as compared with other barbiturates. *Phenobarbital* has longer time to sleep and death and is therefore not an ideal MAiD coma inducing agent.
- Combination medications: One combination used in British Columbia includes phenobarbitone, chloral hydrate and oral morphine. There have been issues with this method with the long onset of action of phenobarbital, chloral hydrate causing mucosal burning and with morphine having inconsistent effects on respiratory depression where opioids have already been used for analgesia. Another combination oral-MAID protocol in Washington State is called DDMP1 and DDMP2, developed due to the high-cost of secobarbital. The protocol uses the medications digoxin, diazepam, morphine and propranolol (DDMP2 being Digoxin 50mg, Diazepam 1g, Morphine 15g and Propranolol 2g). The average time to sleep with this protocol is 8 minutes and the average time to death is between 145 minutes and 450 minutes.

In Canada and the Netherlands, the vast majority of patients opt for the IV protocol as there is a 3-10 % failure rate with Oral-MAiD, though failure in some studies means death not occurring within 2 hours (29, 44). The patient's clinical status may also change from the point of initial assessment and oral MAID provision may no longer be advised. In countries of greater geographic area and wide population distribution such as Canada, there may be areas which will not have clinician providers. The number of providers may increase once Oral-MAiD options are introduced (26). There are also local restrictions and limitations in certain jurisdictions. In Canada for instance the prescribing physician must be present to obtain final consent ensure safe delivery and be prepared to provide IV MAiD in the event of failure. In the US IV MAiD is illegal while oral barbiturate choice is currently quite limited.

Where difficulties can arise with MAiD, it is thought these can be pre-empted with close fundamental collaborations between a) The patient and the physician; and b) The physician and the pharmacist (26). Section 3 of the 2018 CAMAP report on the processes underpinning high-quality Oral-MAiD provision, recommends ten key points which support the patient-practitioner collaboration and five points supporting the physician-pharmacist collaboration (26). The following groups of patients are contra-indicated from Oral-MAiD, which means IV-MAiD option is preferable; i) Incapable of swallowing sufficient volume of liquid which can be up to 120mls; ii) Pre-existing severe nausea, oesophagitis or gastritis; iii) Severe Dehydration; and iv) Pathology of the gastrointestinal tract likely to interfere with absorption.

Best practices for the safe dispensing, administration, and evaluation of the plausibility of an oral MAiD provision (26).

1. Clinician presence recommended to evaluate success and effectiveness and intervene with IV medications in case of delay.
2. With greater experience with oral medications there may come a time where clinician presence is not needed.
3. Clinicians should write prescriptions for both oral and IV medications for patients requesting MAiD.
4. Regular communication with the patient should be maintained to confirm the patient's preference and ongoing appropriateness for the oral route.
5. Patients should refrain from eating 6 hours prior to taking the coma inducing medications. Clear non-carbonated fluids can be continued.
6. The patient is recommended to take an anti-emetic at least 1 hour before consumption of the coma inducing agent.
7. Secure delivery of the medication is important to prevent harm to others from this medication. The medication should be dispensed directly to the providing physician.
8. In preparation for potential delay or failure of oral option ease of vascular access should be assessed. Where this is foreseen to be possibly difficult IV access may need to be established before oral ingestion
9. Clinicians should come to an agreement with patients prior to the oral MAiD procedure on an agreed upon time for IV intervention in the event of delay or failure.
10. Instructions from pharmacies should be followed explicitly with respect to reconstitution of oral MAiD supplementation.
11. Immediately before the start of the procedure clinicians should obtain a final consent for MAiD included in that a consent for IV intervention if required.
12. Clinicians should witness the ingestion of medication. Patients should assume a standard Fowler's position of 60 degrees when consuming the medication and remain sitting for at least 20 minutes even if unconscious to optimize absorption and prevent regurgitation.
13. The patient should consume all medication in 4 minutes. Clear fluids can be given between swallows as long as it does not increase the duration of consumption
14. After consuming all the medication the aftertaste can be mitigated by consumption of a strong liquor or a room temperature non-carbonated drink. Any milky or creamy liquors should be avoided.
15: Any unused medications should be returned to pharmacy for appropriate disposal.

Section 10.2 (MAiD medication options (oral and IV) and protocols in Canada outlines more information relating to the medications and protocols used in Canada (26-29). A significant amount of regulation

underpins the success of IV-MAiD. Both the Canadian and Dutch models emphasise the importance of regulation, guidelines, protocols and preparation to ensure a safe and reliable death.

8. Enhancing safeguards for certain clinical conditions

8.1. Mental Health and Assisted Dying

In Canada, mental illness is specifically excluded as an indication for MAiD, the Act stating '*that persons whose sole underlying medical condition is a mental illness are not eligible for medical assistance in dying'* (2). In Victoria, the Act states a *'person is not eligible for access to voluntary assisted dying only because the person is diagnosed with a mental illness'* (45). However, the Netherlands and Belgium permit Assisted Dying in cases where the primary illness is a mental illness rather than a physical illness, but is exceptionally rare (46).

Some are of the opinion that mental health conditions can result in suffering that is as painful as physical disorders and not respond to treatment, resulting in people making suicide attempts rather than ending their life in a safe way (47).

As we know, in Ireland mental illness does cause great suffering, but it is rarely incurable, and it is unlikely to be terminal. In those people with severe and intractable mental illness it would be very difficult to assess their capacity to make this decision. They are especially vulnerable to manipulation and abuse. These patients need increased preventative measures, supports, resources and treatment.

A 2019 public consultation by the Government of Canada, a majority of Canadians were not in favour of extending MAID to people who suffer from mental illness (48). Also in 2019, a majority of Dutch survey respondents expressed their supported for MAiD in those with mental illness (49, 50).

The use of the term Assisted Suicide is unfortunate as it deliberately creates confusion due to its inaccuracy. MAiD is a logical considered decision made by citizens, who are facing a terminal illness and are dying. Suicide in Irish Society is associated with an emotional, illogical decision by individuals, which if prevented, can allow those recovering from mental health distress live many healthy years ahead. Using the term Assisted Suicide is unhelpful to those people with mental illness and is also hurtful to those with terminal illness contemplating MAiD.

We believe that a person should not qualify for MAiD on the basis of a mental illness alone, in proposed Bill providing for MAiD services in Ireland. Further research and studies are required before it should be considered. We specifically recommend that Bill should adopt the opinion of Canada and Victoria (Australia) and **exclude mental illness** as qualifying as a terminal illness to eliminate any doubt or confusion on this issue. However, patients with mental illness should not be precluded from accessing MAiD, if they have a terminal illness which meets legislative criteria and they have capacity to consent to MAiD.

8.2. MAiD and Dementia

The eligibility for MAiD in patients with dementia, has differed in those jurisdictions where MAiD is legally available. The ethical discussions which have been considered relate to; i) whether dementia meets the legal definition for eligibility for MAiD; and ii) whether an advanced healthcare directive can allow an individual receive MAiD at a later point in time, when that person subsequently loses capacity. The second scenario has proved controversial.

Under current Canadian law, a person in the advanced states of dementia it technically not able to consent to MAiD. Consent to MAiD requires the person- at the time of receipt of MAiD- to be capable of retaining and understanding new information, analysing the information and making an informed decision (2). Since the effects of dementia, in an advanced state, may impair a person's capacity to make an informed decision about their end-of-life care, this precludes many with dementia from accessing MAiD.

In Canada two doctors must independently state that an applicant for MAiD has a '*grievous and irremediable'* medical condition which the law defines as '*a serious and incurable illness disease or disability*' that cause enduring physical or psychological '*suffering that is intolerable'* and ' an *advanced state of irreversible decline in capability'*. In Canada some people with dementia have been able to access MAID, if they retain capacity at the time of receiving MAiD .

Changes to Canadian legislation are planned to enable citizens with dementia access MAiD, through making an advance request.

From 2020, in Holland, patients with severe dementia who previously provided a written request, can receive MAiD. This can be done before the patient develops advanced dementia provided certain legal requirements are met even if the patient's subsequent condition means they become unable to confirm that request.

The majority of the Dutch public support persons with advanced dementia having access to MAiD through advanced care directives (51). A majority of Belgian GPs also support access to MAiD for patients with advanced dementia (52). MAiD on the basis of an advanced care directive in the context of dementia has broad support in Canada. The Alzheimer's Society of Canada advocates for the rights of persons with dementia to access MAiD, including though advance requests, should be respected (53). They have advocated that individuals with dementia should note be discriminated against on the basis of their illness.

There is clearly an ethical basis to suggest that dementia qualifies as a terminal illness and that access to MAiD should be a fundamental right for people with dementia. However access to MAiD, for patients with advanced dementia who had previously made an advanced care directive, remains an evolving issue due to the need for advanced consent.

We would recommend that the Irish Bill proceeds **without the provision for advanced requests** to access MAiD services. With more research and experience from other jurisdictions, relating to informed consent for MAiD in patients with dementia, this is something which could be dealt with on a legislative basis in the future.

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10. Appendices

10.1. Definitions

10.1.1. Medical Assistance in Dying (MAiD)

- Medical Assistance in Dying (MAiD) became legal in Canada in June 2016 and refers to either assisted suicide, voluntary euthanasia,. both (2, 27). The understanding of MAiD in Canada (regulated and operated by the provinces) includes options of intravenous administration of medications by physicians or nurse practitioners, or self-administration of oral medications.

10.1.2. Assisted Dying

- Assisted Dying can be defined as a doctor or nurse practitioner giving a person medication to relieve their suffering by bringing on death; or, the taking of medication by a person to relieve their suffering by bringing on death (4). This is the definition which was taken in New Zealand.

10.1.3. Assisted suicide (AS)

- Assisted Suicide is the intentional ending of one's own life with the assistance of someone else. In a medical context, this might take the form of a physician prescribing a lethal dose of medication for a patient to take by themselves (15).

10.1.4. Euthanasia

- Euthanasia is the "intentional termination of the life of a person, by another person, in order to relieve the first person's suffering" – for example, a physician administering an IV medication to a patient in order to cause their death (15, 54).
    - Euthanasia can be passive or active (55). All forms of euthanasia involve the intention to hasten death in the patient's interests (because of their expected negative quality of life) (55). Passive euthanasia involves intentionally letting a patient die by withholding a treatment, such as artificial life support from a ventilator or a feeding tube. Active euthanasia involves the intention to hasten the death of a patient through an active means e.g. injection of an agent.
    - Euthanasia in this document refers only to '*voluntary euthanasia'* which occurs expressively with the individual's consent.

10.1.5. Palliative Sedation

- This is where a person who is expected to die within a period of hours or days and is experiencing extreme physical or psychological suffering, for which there is either no effective treatment or all

alternative measures have been ineffective, is sedated using sedative medications with the sole intention of relieving intractable distress (15).

10.2. MAiD medication options (oral and IV) and protocols in Canada

10.2.1. Main medications, doses frequency for Oral-MAiD provision (43)

Description	Dose Range	Frequency (Oral MAiD regimes detailed in 50 of 163 reports of total MAiD Provision)
Barbiturates		
- **Not specified**	N/A	17
- **Pentobarbital**	9-15g	21
- **Phenobarbital**	20g	10
- **Secobarbital**	9-15g	20
Benzodiazepines		
- **Not specified**	N/A	6
- **Diazepam**	1g	3
- **Lorazepam**	0.25-2mg (IV MAID intervention)	3
- **Midazolam**	10mg (IV intervention)	2
Anti-emetics		
- **Not specified**	N/A	8
- **Metoclopramide**	10-20mg	8
- **Ondansetron**	8mg	5
- **Haloperidol**	5mg	2
Opioids		
- **Morphine**	15mg- 3g	13
Miscellaneous		
- **Chloral Hydrate**	20g	5
- **Digoxin**	50mg	3
- **Propranolol**	2g	3
- **Neuromuscular blocker**	2g	11

10.2.2. Global Practices Oral MAiD provision (43)

Country	Administration	Premedication	Coma inducing medication	Notes
Canada	Physician presence recommended	Antiemetic Metoclopramide 20mg or Ondansetron 8-24mg or Dexamethasone 8mg	1st Line Secobarbital 15g (Compounded) 2 DDMP2 or Phenobarbital 20g+Chloral hydrate +morphine 3g	Clinician required to obtain consent, to determine oral route Is desired and possible dose is delivered securely verify ingestion and death. Need to be prepared to administer IV MAiD if failure of oral method
Netherlands	Physician presence is required	Anti-emetic Metoclopramide 30mg 12 hours, 6 hours and 1 hour before coma inducing agent given	100ml of Mixtura Nontherapeutica is given containing 15g of phenobarbital compounded into a palatable drink or Secobarbital 15mg	Patient should be sitting up. If the patient vomits proceed to IV MAiD route If there is a prolonged delay in dying, IV route is given.
Belgium	Self-administered Physician assisted	Anti-emetic	Phenobarbital	1% oral route
Luxembourg	Self-administered Physician assisted	No data	No Data	In 10 years, there have been 71 patients who have received MAiD, only 3 opted for the oral route.
Switzerland	Non clinicians can assist. No data on physician assisted	No data	No data	IV MAiD is illegal
Australia – State of Victoria	Self and physician assisted		Pentobarbital 15 g in 100ml with mixing solution and sweetener	

USA – 7 states	Self-administered. Physician may attend but must not be involved in medication delivery.	Metoclopramide 20 mg and haloperidol	Secobarbital 9-10g or Pentabarbital or phenobarbital +chloral hydrate + morphine or DDMP1 or DDMP2	IV MAiD is illegal
Columbia	Oral MAiD is available	No data	No data	

10.2.3. Main medications used doses frequency for IV MAiD provision (43)

Description	**Dose Range**	**Frequency (Oral MAiD regimes detailed in 50 of 163 reports of total MAiD Provision)**
Benzodiazepines		
- **Not specified**	PRN	14
- **Diazepam**	10-120mg	3
- **Lorazepam**	2.5-5mg, PRN	2
- **Midazolam**	2-120mg, PRN	30
Coma Inducing Agents		
- **Propofol**	1000-2000mg, PRN	21
- **Thiopental**	1-2g, 20mg/kg	21
- **Pentobarbital**	1-15g	7
- **Secobarbital**	9g	5
- **Phenobarbital**	3000mg	8
Neuromuscular blockers		
- **Not specified**	PRN	26
- **Mivacurium**	Not reported	1
- **Atracurium**	50-100mg	2
- **Pancuronium**	18-20mg	9

- **Rocuronium**	50300mg, PRN	17
- **Vecuronium**	10-60mg	6
- **Cisatracurium**	20-40mg	7
Opioids		
- **Not specified**	N/A	20
- **Morphine**	16-480mg	3
- **Fentanyl**	25-1500ug	2
Bupivacaine	400mg	2
Lidocaine	40-120mg	20

10.2.4. Global Practice IV MAiD (43)

Country	Premedication	Induction of Coma	Neuromuscular blocker	Optional agents
Canada	Midazolam 2.5- 20mg slowly	Propofol 1000mg	Rocuronium 200mg or Cisatracurium 40mg	Lidocaine (propofol induced injection pain) 40g Sodium Chloride flushes Bupivacaine 500mg
Netherlands	Midazolam if required 2.5mg	Thiopental 2000 mg or Propofol 1000mg	Rocuronium 150mg Atracurium 100mg Cisatracurium 30mg	2ml % lidocaine with propofol
Belgium	Midazolam 5-15mg Midazolam	Thiopental 2000mg or Propofol 1000mg	Atracrium 100mg Cisatracurium 20mg Mivacurium 20mg Rocuronium 100mg	Not specified
Luxembourg	Not specified	Thiopental	Not specified	Not specified
Columbia	Midazolam 1mg/kg	Propofol 20mg/kg or Thiopental 30mg/kg	Vecuronium 1mg/kg	Lidocaine 2mg/kg Fentanyl 25ug/kg
Australia		Propofol	Rocuronium	

State of Victoria

10.3. Abbreviations

AS – Assisted suicide

AD – Assisted dying

CNS - Central nervous system

GABA - Gamma-aminobutyric acid

GP – General Practitioner

Kg - Kilogram

IM - Intra-muscular

IV- Intra-venous

MAiD - Medical Assistance in Dying

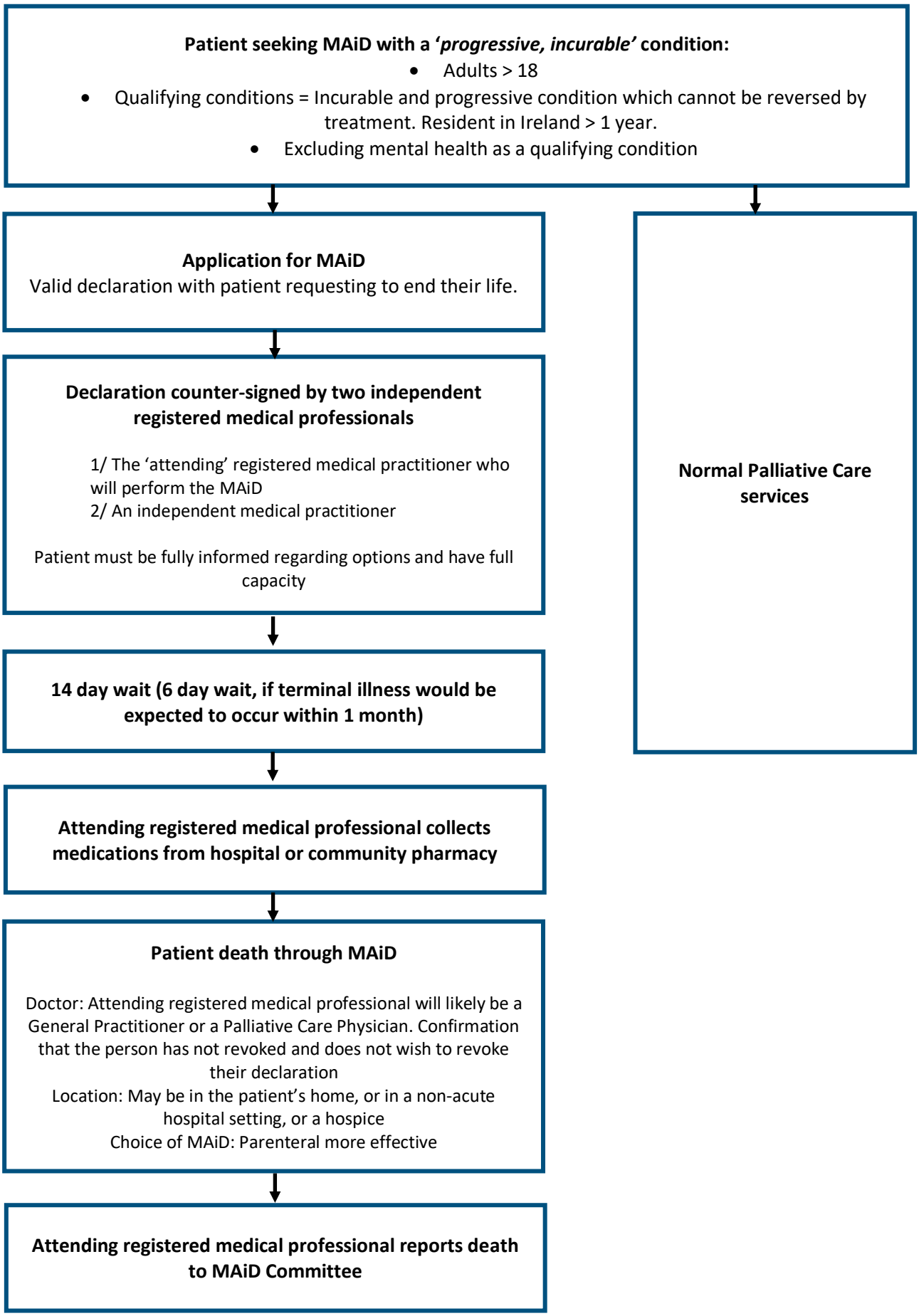
Mg - Miligram

N/A - Not applicable

PRN - Pro re nata (when necessary)

ug - Microgram

10.4. Likely model of MAiD in Ireland



10.5. Registered medical professionals in Ireland supporting MAiD

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