MOVIMENT GRAFFITTI

Public Consultation on Assisted Voluntary Euthanasia

Moviment Graffitti's Input

Introduction

Moviment Graffitti supports the introduction of voluntary euthanasia, believing that individuals should have the autonomy to choose to end their pain and suffering when faced with a terminal or incurable illness. While respecting the diversity of worldviews and perspectives on life, suffering, and death, the state and others should not impose their beliefs on those who may wish to make this deeply personal choice in the absence of hope for recovery.

Moviment Graffitti also recognises that voluntary euthanasia is not solely a matter of individual choice, but also a complex social issue that carries potential risks – such as the possibility of coercion or the danger that individuals may opt for euthanasia due to inadequate medical and social care.

Therefore, it is essential that the introduction of voluntary euthanasia be accompanied by a robust regulatory framework and effective institutions to prevent abuse and unintended consequences. Additionally, there must be a strong emphasis on ensuring access to high-quality palliative care and comprehensive community support, so that the decision to pursue euthanasia remains truly voluntary and not driven by avoidable circumstances.

Specific Points

After rigorously assessing the publicly available details of the proposal, and collaborating with professionals across the medical, social, and philosophical fields, we would like to officially submit a proposed list of amendments and modifications.

- We propose an amendment to the current criteria defining which patients are eligible for access to this service. The criterion referring to a "6-month prognosis" should be removed, as it is both arbitrary and exclusionary, given the significant variability in how patients may present. Additionally, providing prognosis-based timeframes may have broader ramifications on a patient's psychological well-being and may lead to decision-making driven by desperation or despair rather than thoughtful planning. Instead, we recommend that assisted voluntary euthanasia be made accessible to **all individuals suffering from incurable, life-limiting physical illnesses that significantly and adversely impact quality of life.** This would ensure that the most vulnerable members of the community - those most likely to seek access to such services - are not unjustly excluded.

- The proposed exclusionary criteria of "disability" and "illnesses associated with old age" are both overly limiting and broad, allowing for an unacceptably wide spectrum of patients to be excluded from this service based on subjective interpretations of these terms. Such criteria may also create unnecessarily vague legal barriers for individuals seeking end-of-life services, as well as for healthcare professionals attempting to provide them. Thus, as long as individuals are suffering from "incurable, life-limiting physical illnesses that significantly and adversely impact their quality of life", they should be eligible to access assisted voluntary euthanasia, regardless of the causes of such illnesses.

- We suggest an alternative to the current proposed structure in the form of a senate or jury - comprising a retired judge, lawyer, doctor, and psychiatrist - that would oversee the decisions made for each patient. We propose that decisions made in the best interests of the patient continue to be carried out by the multidisciplinary team already involved in their care. This team, tailored to each patient's individual needs, should include their primary practitioners, as well as members of palliative care, social work, occupational therapy, physiotherapy, and other professionals who have consistently demonstrated their commitment to the patient's well-being. This structure would ensure that each patient is reviewed by individuals who are not only familiar with their unique circumstances but are also well-equipped to develop an informed plan grounded in both professional experience and empathy.

  Furthermore, if the government opts for a jury format, it must be ensured that all members are free from prejudicial views against assisted voluntary euthanasia that could prevent them from delivering an unbiased judgement.

- We recommend that patients who choose to access assisted voluntary euthanasia be given the option to receive support from individuals who can accompany them in their psycho-spiritual needs - whether that be someone from their chosen religion or a psychologist/therapist, according to their preference.

- The current proposed restriction on allowing assisted voluntary euthanasia only in private residences and hospitals should be removed, since it is restrictive for individuals in alternative living arrangements, such as community living centres or incarcerated persons, who may otherwise meet the inclusion criteria but are excluded simply due to the absence of a private residence.

- We support and give importance to the exclusion of private institutions from providing this service, which not only ensures continued accessibility, but also prevents euthanasia from becoming a means of monetary profiteering.

- The government needs to strengthen existing healthcare structures upon which many patients in vulnerable situations currently depend. Palliative care training should be improved, beginning at its most fundamental level - through the development of more in-depth study of palliative care at university level - and incorporated into all courses related to end-of-life care and support systems surrounding patients. This should be complemented by ongoing initiatives to educate and engage holistic medical teams in this crucial aspect of healthcare throughout their professional lives. We also underline the importance of ensuring appropriate cohesion between the proposed end-of-life strategy plan and the proposal on assisted voluntary euthanasia.

- Alongside the education of healthcare professionals, we also propose initiatives to engage the general public with clearer knowledge of what each facet of this sphere entails. This should include the provision of clear definitions for commonly used terms such as “palliative,” “hospice,” and “terminal,” to ensure that individuals have the necessary information to make constructive, autonomous, and informed decisions regarding their healthcare in all respects.

- We propose that additional resources be allocated to the development of specialised wards and centres, including community-based facilities, to ensure universal access to targeted and personalised palliative and hospice care, supplementing the services already provided at a governmental level. Public funding of such supportive centres would help ensure that the needs of these patients are met holistically, allowing those requiring access - regardless of financial or social barriers - to do so safely in environments that promote and support their full spectrum of needs.

- We would like to emphasise the importance of rigorous, adequate, and holistic treatment for all patients, as a safeguard against the risk of euthanasia becoming a solution borne out of an inefficient or under-resourced healthcare system. Euthanasia should remain a last-resort decision - considered only after all other options have been thoroughly discussed and exhausted through appropriate medical and allied healthcare interventions. For this reason, it is imperative that these options are not only readily accessible and available to all patients in need, but also openly and non-judgementally discussed with them. This ensures that any decision made by the patient is truly autonomous and based on comprehensive, well-informed understanding.

- We further emphasise the importance of removing legal and social barriers that may discourage practitioners from providing adequate care - whether related to palliative and hospice services or euthanasia. In this context, we would like to draw attention to the initiatives outlined in the national suicide prevention strategy plan put forth by the Department of Health and Active Ageing, and the protocols recommended within it. Furthermore, if a practitioner is unable or unwilling to provide euthanasia as a service, they should refer the patient to an alternative practitioner who can support the patient in making autonomous, informed decisions, as is their right.

1st July 2025