Written evidence submitted by Humanists Against Assisted Suicide and Euthanasia (ADY0266)

Humanists Against Assisted Suicide and Euthanasia (HAASE) was formed by atheists and agnostics frustrated with the characterisation of the debate about assisted dying as compassionate, forward-thinking proponents against archaic religious prejudice. There are profound secular arguments – philosophical, historical, and moral – against changing the 1961 Suicide Act that must be considered.

Unlike those with religious values at the core of their opposition, many of us initially supported assisted suicide and/or euthanasia (hereafter ASE[1]). We realised that the issues are far more complex than the often-compelling emotive stories of dying people might suggest. We come from academia, from medicine, from the hospice movement and elsewhere. We are united by our scepticism both about religion and about the wisdom of legalising ASE in the UK.

We would like our chief executive officer to speak to the committee. Professor Kevin Yuill has written on the subject for more than 25 years, has researched the history of ASE, and has published a book entitled *Assisted Suicide: The Liberal, Humanist Case Against Legalisation* (Palgrave, 2013).

THINK AGAIN

We will concentrate on two questions asked by the committee and reflect upon three others. We will then look at both **historical** and **sociological** context for the campaign for legalised ASE.

1. **What can be learnt from the evidence in countries where assisted dying/assisted suicide is legal?**
    - Where ASE has been legalised, the numbers receiving assisted deaths have consistently increased and more categories have been made eligible. In the Netherlands, for instance, the number of cases of euthanasia has increased from 1.7% of all deaths in 2005 to 4.5% in 2015. In Canada the number has climbed to 3.3% from 1.12% in 2018.[2]
    - Once an ASE becomes **medical treatment for unbearable suffering**, more and more people who feel they are suffering unbearably demand it. Proponents, in areas where it is legal, campaign to extend its purported benefits to more and more groups.[3]
    - **Pain** is not an important reason why people opt for an assisted death. In Oregon reports – conducted since 1998 – pain has never entered the top five reasons why people opt for ASE.[4] Moreover, even in the Netherlands pain is not controlled regardless of the option of ASE; pain and restlessness care goals were not achieved, according to one study, in up to 42.8% of cases.[5]
    - Legalising ASE has minimal impact on suicide rates, belying both the claim by opponents that it encourages more suicides but also the claim by proponents that it will reduce suicides by providing a safer outlet for those forced to take their lives because of terminal illness.[6]
    - In areas that allow both euthanasia and assisted suicides, the vast majority opt for doctors to take the final action.[7]

2. **What are the professional and ethical considerations involved in allowing physicians to assist someone to end their life?**

- This is the most important question. What are the ethical implications to our society and culture of instituting death as a prescription, even if they don't have immediate tangible effects?
- The most comparable moral question is **capital punishment**. Many consider capital punishment wrong on principle regardless of the numbers involved or whether the world might be a better place without certain brutal and awful killers. Similarly, putting someone to death – or participating actively in their killing simply because they are wretched – is wrong in principle, even if sometimes right in practice.
- Another problem – again, not very tangible but still real – is the implication for our regard for the **equal value of human lives**. Society affords equal protection to all – sometimes from an individual's own actions. In relation to homicide, it is just as wicked to murder an 86yr old who does not value his life as it is to kill a 24yr old with her life ahead of her. Why would this be different than suicide? **Instituting ASE**
- **Suicide** is at the heart of the problem, despite protestations to the contrary.[8] Do we provide death on request for suicidal people? Should our support for (and assistance of) their suicide depend on how long they are expected to live, on how they assess the quality of their life, or on objective factors such as a disease or disability?

What, if any, are the physical and mental health criteria which would make an individual eligible to access assisted dying/assisted suicide services?

What information, advice and guidance would people need in order to be able to make an informed decision about whether to access assisted dying/assisted suicide services?

What capabilities would a person need to be able to consent to assisted dying /assisted suicide?

- All of these questions appear to assume that the moral question of assisting a suicide has been resolved in favour of providing it.
- There is no way to **draw a line** between those who should have access to ASE and those who should not. If **autonomy** is the major consideration, all competent adults should have the right to an assisted death, or no one should. If **suffering**, we must accept all claims of suffering. Moreover, it is important to ask whether patient or doctor determines the level of suffering.

HISTORY OF ASE

Much as it is useful to compare the experiences of other countries in relation to legalised ASE, it is also useful to understand the appearance of the demand for ASE in history throughout the world in order to understand the origins of the impetus and to understand what is unique about our perspective on the subject.

- The **first call for euthanasia** in the way we understand it came from Samuel D. Williams in his 1870 essay for the Birmingham Speculative Club. In ancient times, euthanasia meant simply good death which was defined as much by the way the person lived as how they died.[9]
- The historically-constant motivations for implementing euthanasia programs have been 1) **utility** (a resources-based argument) and 2) **compassion.** 3) **Autonomy**, though present in early discussions, only became important in the 1970s.[10]
- The **terminology** expresses the continuing need to make euthanasia more palatable. From **euthanasia** (1870-1930), which described both voluntary and involuntary euthanasia proposals, came **voluntary euthanasia** in the UK and USA (1930-2000). The term **assisted suicide** was first proposed around 1950 to distance the practice from Nazi euthanasia. In the 2000s, the term was gradually replaced with the less-exact term **assisted dying**.
- In the US in the 1890s, some ventured that suicide was not a sin, particularly when someone was dying of a terminal illness. However, no one then suggested that a **suicide should be assisted**. The 'need' for assistance in suicide emerged from later euthanasia campaigns, indicating that **autonomy was not an important factor** in campaigns for euthanasia until later.[11]
- The early campaigners for euthanasia often participated simultaneously in campaigns for **eugenics**, racial eugenics involving sterilization, and **population control.** There was a tendency for the Voluntary Euthanasia Legislation Society (later Voluntary Euthanasia Society and then Dignity in Dying) to 'disregard the distinction between involuntary and voluntary killing'.[12]

SOCIOLOGY OF ASE

- The **autonomy** argument for ASE is counterintuitive. Why campaign for assistance with something that every person can accomplish by themselves? Part of the reason, we feel, is that death has become **medicalised**. In one obvious sense it is a medical issue but, as atheists, we take no satisfaction in replacing priests as moral arbiters of the end of life with doctors.
- Reducing death to medical treatment undermines the **moral profundity of the act of taking a life**. It may be the proper course of action in very specific circumstances but should always be seen as regrettable and never taken lightly. Death should inspire awe, wonder, and perhaps even terror if we respect even the basic idea of community.
- Because of the utilitarian ethos of euthanasia, it will never be extended to those who society deems useful to society. It divides people into those who are at least potentially useful and those who are a drain on state resources. This is why **disabled people** strongly oppose the legalisation of ASE. Their lives are precarious enough already without them being given the green light for suicide whilst suicide prevention programmes are implemented for the able-bodied.
- There are **coercive implications** to legalization. We strongly support the **right of competent adults to refuse medical treatment**. The argument employed by proponents of ASE that there is little difference between 'passive euthanasia' (meaning withdrawal of treatment) and 'active euthanasia'[13] has a corollary in the prevention of competent adults from withdrawal of treatment in the name of suicide prevention. This has already occurred in the case of 'E' whereby a judge ordered the force-feeding of a woman.[14]

CONCLUSIONS

Think again! We have provided an alternative perspective on ASE from an atheistic perspective to counter that of the British Humanist Association. We oppose ASE not from a dogmatic perspective but because of our active engagement with the arguments. We are generally liberal in our other perspectives – many of us actively support **abortion rights for women**, **LGBT+** causes, and **oppose the death penalty.** But we ask the Committee – and all who have the power to do so – to reject ASE.

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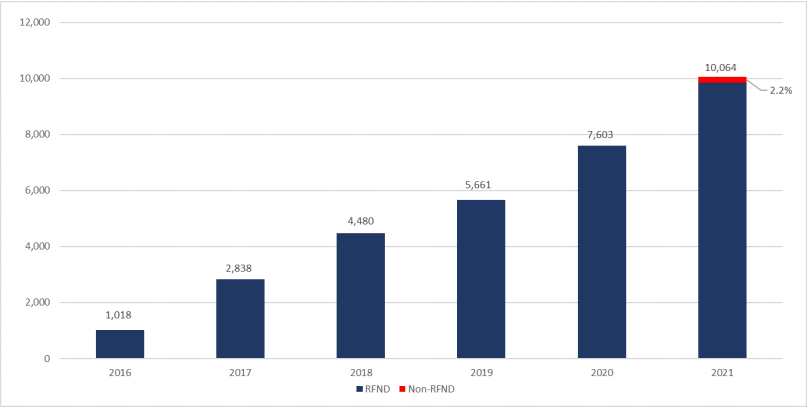
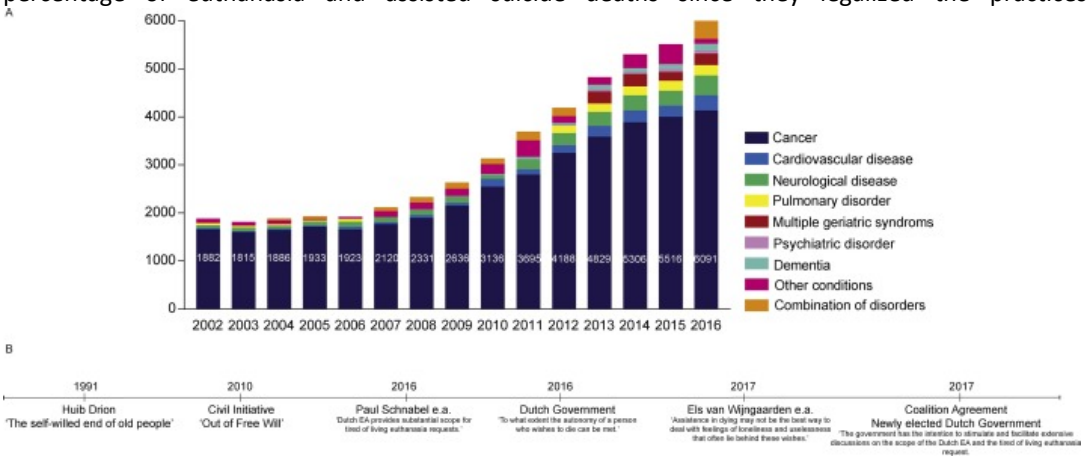
[1] Euthanasia only is legal in Belgium, whereas euthanasia and assisted suicide are legal in the Netherlands, Canada, Columbia, Spain, and Italy. Assisting a suicide is legal in Switzerland and, restricted to those with six months or less to live in 10 jurisdictions of the United States (In Montana, it has not been determined whether it allowed by their constitution). 'Assisted dying' is often used as to cover both practices.

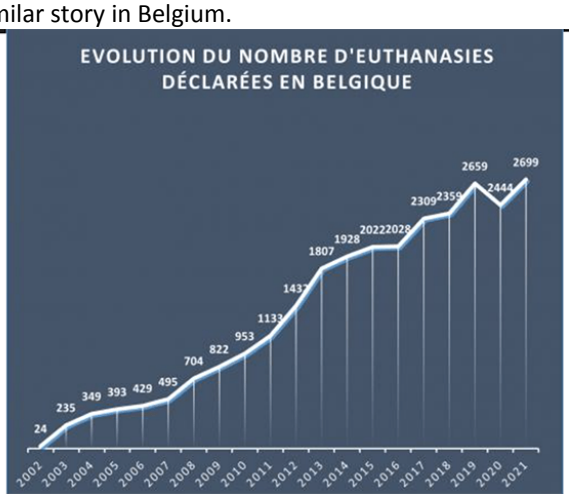
[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6394318/ In Canada, cases have risen year or year. Moreover, they now constitute 3.3% of all deaths. Source: https://www.canada.ca/en/health-canada/services/medical-assistance-dying/annual-report-2021.html#a3.1. My Death My Decision inaccurately reports this figure as 1.12%. See https://www.mydeath-mydecision.org.uk/international-examples/#1611930881959-53bc09ac-f388



In the Netherlands, the story is similar. This chart also shows how cancer patients have become a decreasing percentage of euthanasia and assisted suicide deaths since they legalized the practices in 2002.



There is a similar story in Belgium.



[3] For example, the Right to Die Society in the Netherlands (NVVE) campaigns to extend euthanasia to all those over the age of 74. In Canada, Dying with Dignity campaigns for mature minors to have access to euthanasia. In Belgium, the Association for the Right to Die with Dignity (ADMD) campaigned successfully for euthanasia to be extended to children.

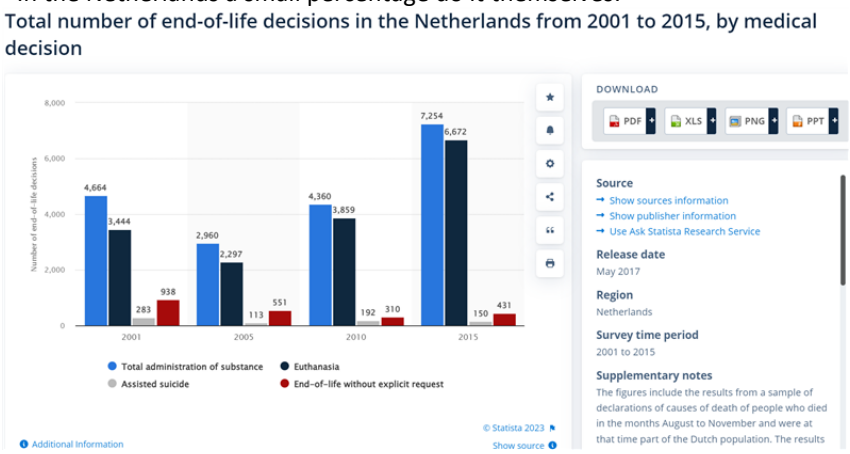
[4] The top reasons in Oregon in 2021 were: 1. losing autonomy 2. Less able to engage in activities making life enjoyable 3. Loss of dignity 4. Burden on family, friends/caregivers 5 Losing control of bodily functions 6. Inadequate pain control, or concern about it 7. Financial implications of treatment. See https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/year24.pdf. In the Netherlands, pain was not a major reason for euthanasia. See 'Pauline S. C. Kouwenhoven, Ghislaine J. M. W. van Thiel,Agnes van der Heide,Judith A. C. Rietjens &Johannes J. M. van Delden, 'Developments in euthanasia practice in the Netherlands: Balancing professional

responsibility and the patient's autonomy' *European Journal of General Practice* Volume 25, Issue 1 (2019) https://www.tandfonline.com/doi/full/10.1080/13814788.2018.1517154.

[5] Madelon T Heijltjes , Lia van Zuylen, Ghislaine JMW van Thiel, Johannes JM van Delden, Agnes van der Heide, 'Symptom evolution in the dying', *BMJ Supportive & Palliative Care* 2022; 0:1–4.

[6] Switzerland and Oregon reported elevated rates of self-initiated death among older women. If we regard assisted deaths where it is legal as suicides, it evens the ratio between men and women. Anne M Doherty, Caitlyn J Axe, David A Jones 'Investigating the relationship between euthanasia and/or assisted suicide and rates of non-assisted suicide: systematic review' *British Journal of Psychiatry* Vol 8, No. 4 (June 3, 2022). https://www.cambridge.org/core/journals/bjpsych-open/article/investigating-the-relationship-between-euthanasia-andor-assisted-suicide-and-rates-of-nonassisted-suicide-systematic-review/223FDD723EB5CAE84D2EF02C65A9F446

[7] In the Netherlands a small percentage do it themselves:



https://www.statista.com/statistics/523047/total-number-of-end-of-life-decisions-in-the-netherlands-by-medical-decision/. In Canada only a handful – less than one per cent – of all medically-assisted dying deaths are assisted suicide.

[8] There is a long history of denial that purposefully ingesting poison prescribed by a doctor is suicide. The term – which dates from 1950 as an alternative to euthanasia – has been rejected by some of its proponents in favour of 'assisted dying' or 'medical assistance in dying' in the English-speaking world. Other countries refer where it is legal refer to assisted suicide (Netherlands, Switzerland, Spain, Columbia). Moreover, the Canadian Health Minister David Lametti recently admitted in an interviewer to 'remember that suicide generally is available to people. This is a group within the population who, for physical reasons and possibly mental reasons, can't make that choice themselves to do it themselves. And ultimately, this provides a more humane way for them to make a decision they otherwise could have made if they were able in some other way.' https://www.thestar.com/politics/provincial/2022/11/29/justice-minister-david-lametti-under-fire-for-unbelievable-comparisons-between-euthanasia-and-suicide.html?rf

[9] T. A. Boer, S Groenewoud, K Yuill, 'The use and abuse of history in the debate about euthanasia and assisted suicide (forthcoming, available on request).

[10] *Ibid*.

[11] Kevin Yuill, 'Suicide versus Euthanasia in the American Press in the 1890s and 1900s: "A Man Should be Permitted to Go Out of This World Whenever He Sees Fit"' *Journal of Policy History*, Volume 34, Number 2, 2022, pp. 213-244.

[12] Ian Dowbiggin 'A Prey on Normal People': C. Killick Millard and the Euthanasia Movement in Great Britain, 1930-55 *Journal of Contemporary History* , Vol. 36, No. 1 (Jan., 2001), pp. 59-85, 61.

[13] See, for instance, https://www.bbc.co.uk/ethics/euthanasia/overview/activepassive_1.shtml

[14] See Chapter 5 'The Coercive Implications of Legalisation' in Kevin Yuill, *Assisted Suicide: The Liberal, Humanist Case Against Legalisation* (Palgrave, 2013), 129-145.

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