About the British Humanist Association (BHA)

1. The BHA is the principal organisation representing the interests of the large and growing population of ethically concerned but non-religious people living in the UK. It exists to support and represent people who seek to live good and responsible lives without religious or superstitious beliefs. It is committed to human rights and democracy, and has a long history of active engagement in work for an open and inclusive society. The BHA's policies are informed by its members, who include eminent authorities in many fields, and by other specialists and experts who share humanist values and concerns.

Consulting our membership

2. The subjects of assisted dying / assisted suicide / voluntary euthanasia are regularly aired in BHA newsletters, web forums and local humanist group discussions, although for most humanists these are not controversial matters and members rarely express opposition. The very few reservations that have been expressed by humanists over the years have focused on the adequacy of proposed safeguards, and we do not know of any members who oppose assisted dying on ethical grounds. The Executive Committee (trustees) of the BHA are members of the Association who have been elected at an Annual General Meeting, and three of them serve, alongside two staff, on our Parliamentary Working Group. Opinion in both groups is unanimously in favour of the principle of this Bill. A BHA members’ web discussion in August 2004 received no postings arguing against the Bill. Individual members will also have participated independently in this consultation, and one member organised “Humanists for Patients’ Choice.”

Humanist principles

3. Humanists defend as important ethical principles the right of each individual to live by her / his own personal values, and the freedom to make decisions about
her / his own life so long as this does not result in harm to others. Humanists do not share some of the attitudes to death and dying held by some religious believers, in particular that the manner and time of death are for a deity to decide and / or that interference in the course of nature is unacceptable.

4. The vast majority of humanists believe that we should have the choice of deciding these matters for ourselves, as do the general public. A clear request to die with dignity is a rational choice when the postponement of an inevitable and imminent death can offer no benefit to the sufferer. This is a situation where personal autonomy is clearly important and does no harm to others – so most humanists support voluntary euthanasia and many would probably support an even more permissive Bill.

Religious opposition to assisted dying

5. The Roman Catholic Church has traditionally expressed the strongest opposition to assisted dying. It is worth noting here that only between 8.5% and 10% of the UK population are Roman Catholics, and that, according to a NOP survey in 1993 as many as 73% of Catholics oppose official Church policy on assisted dying and agree that doctors should be allowed to help an incurably ill patient to die.

6. Those with religious beliefs may sincerely hold that life is sacred and that people have no right to end it, but the law should not assume that all do, or impose the views of the religious on other people, and cannot do so on the basis of supernatural arguments.

7. It is also worth pointing out here that at least 15.5% of the population is non-religious according to the 2001 census, making this the second largest "belief" group in the UK. Other surveys on religious belief in Britain have found 30 - 40% of adults (and 61% of young people) declaring themselves atheists or agnostics.

Humanist support for this Bill

8. The BHA supports the current Bill and believes that change is well overdue.

9. We believe that regulating assisted dying is better for patients and doctors than the current system, where the needs and autonomy of patients are often disregarded and where compassionate doctors risk being charged with assisting suicide or murder. The BHA maintains that the existing situation, where helping a patient to die is covert, unreported and unregulated, involves

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1 81% in favour according to NOP, 28th October, 2002.

The Philosophers’ Magazine (Summer 2004) found that 84% of 926 visitors to its website (rising to 94% of professional philosophers) thought voluntary euthanasia acceptable.

2 For example, the Home Office Research Study 274, Religion in England and Wales: findings from the 2001 Home Office citizenship survey (http://www.homeoffice.gov.uk/rds/pdfs04/hors274.pdf), found that religion plays little part in the lives of most of people calling themselves Christians.

3 Gilmour v Coats [1949] AC 426, 444. Lord Simonds “The court can only act on proof”.

4 In a survey of 13,000 13-15 year olds, 61% declared themselves atheist or agnostic (Revd Professor Leslie Francis and Revd Dr William Kay, Trinity College Carmarthen, Teenage Religion and Values, Gracewing, 1995)
considerably greater risks to patients than does this Bill, which fully and openly involves the patient decision making. We believe that vulnerable groups will be better protected and treated as a result of this Bill.

10. The current system sometimes also results in close relatives being faced with immensely difficult choices: whether to assist a loved one who is begging for help to put an end to their suffering knowing that it is unlawful, or to deny their loved one the death they want. We do not believe that anyone should be put into the position of having to make such choices, or indeed into a position where they believe that they have no other option but personally to end the life of someone they love.

11. We note that the Joint Committee on Human Rights, having examined the issues in considerable detail, concluded that "the intentional taking of life at the request of someone who wants to die" was not incompatible with the right not to be intentionally deprived of life under Article 2 of the European Convention on Human Rights, and that the safeguards in the Bill were likely to be adequate to ensure compliance with the Convention. This was also the view of the Dutch Government when considering similar legislation.

12. We believe that the Bill provides sufficient safeguards for patients and their doctors, with a regulatory system, provision for witnesses to requests, legal oversight and monitoring.

13. We also welcome the requirement to offer alternatives such as palliative care – no-one should request assistance to die simply because appropriate palliative care or medication is not available.

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5 Belgium is one of three countries to have commissioned extensive research into what happens to people at the end of life. The Belgian research found doctors were ending patients' lives without the patient's consent or request. Compared to statistics from the Netherlands, where assisted dying was regulated by legal safeguards, the Belgians found they had four times more cases of 'non-voluntary euthanasia'. The Belgian Government was concerned that vulnerable people were at risk and so passed assisted dying laws in 2002.

"The main aim of the [Dutch voluntary euthanasia] policy is to bring matters into the open, to apply uniform criteria in assessing every case in which a doctor terminates life, and hence to ensure that maximum care is exercised in such cases" (Dutch Ministry of Foreign Affairs website: http://www.minbuza.nl/default.asp?CMS_ITEM=MBZ257609).


8 The Dutch health care system is accessible to all and guarantees full insurance cover for terminal and palliative care. However, even where patients are receiving care of the highest quality, some still regard their suffering as unbearable and plead with their doctors to terminate their lives (Dutch Ministry of Foreign Affairs website: http://www.minbuza.nl/default.asp?CMS_ITEM=MBZ257609). In Oregon where “death with dignity” is permitted, the recent annual report of the Department of Human Services (http://www.ohd.hr.state.or.us/chs/pas/ar-index.cfm) found that a very small number (42) availed themselves of the law in 2003, that they were all covered by health insurance and most were being cared for in hospices. More than 90% were able to die at home. This indicates that an assisted death is a genuine choice for some, and that a law permitting it need not lead to abuse or overuse.
14. We welcome the open definition of “unbearable suffering” (1, 2). This will include more than just physical pain.\(^9\) Quality of life is important, and the person best able to judge this and what constitutes “unbearable suffering” or is unacceptable must be the patient.

15. We agree with the provision for opt-out on grounds of conscience for medical staff. The Bill should not interfere with the right of the religious to obey their own conscience. We support the requirement (7.2) that, in cases of conscientious objection, physicians must refer the patient without delay to another physician who does not have such objections. However, we point out that in some cases, e.g. hospices run by religious organisations, the entire staff may have conscientious objections to meeting a patient’s request, and so referral to doctors from another institution would be required and must be enabled.

Some reservations about the current Bill

16. We are concerned that the requirement to have a solicitor witness the declaration (4, 2) may deter some patients – those who have no experience or relationship with a solicitor and / or those worried about the cost. We would suggest that solicitors have no particular expertise in assessing the mental health or identity of the patient and that other disinterested witnesses would serve equally well.

17. We are concerned that the minimum 14 day “waiting period” (1, 2) after requesting assistance may cause unbearable delay and suffering to some patients.

18. We would prefer that such declarations could be made well in advance of terminal illness, not just during such an illness, and that they remained in force until revoked – not just the six months proposed (in 4, 8). This would permit someone with all their faculties intact to make advance decisions about their treatment in case of sudden accident or complete incapacity, physical or mental. It would also cater for those with degenerative illnesses who should be allowed to declare in advance the circumstances in which they would want assistance to die. The facility to revoke the declaration at any time (6, 1) allows for changes of mind.

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\(^9\) The most common concerns expressed by those in Oregon requesting “death with dignity” were loss of autonomy, decreasing ability to engage in enjoyable activities and loss of dignity (http://www.ohd.hr.state.or.us/chs/pas/ar-index.cfm).

Pain, degradation and the longing to die with dignity are the main reasons why patients request euthanasia (Dutch Ministry of Foreign Affairs website: http://www.minbuza.nl/default.asp?CMS.ITEM=MBZ257609).