MAPHM
MALTA ASSOCIATION OF PUBLIC HEALTH MEDICINE

26th June 2025

The Malta Association of Public Health Medicine (MAPHM) has reviewed the Public Consultation document on Assisted Voluntary Euthanasia (AVE) and the accompanying Principles and Safeguards document. In addition, we have considered the position statement issued by the Medical Association of Malta in response to these consultation documents and have concluded that we are in full agreement with the points raised by MAM.

Furthermore, we would like to highlight and expand on a number of additional considerations which are outlined in the points below

1. **Terminology** – MAPHM finds that the terminology used is incorrect- what is being proposed primarily is Physician Assisted Suicide where the final administration of the toxin is either by the patient, or through a proxy person. This terminology is in line with the international definitions mentioned by the World Medical Association (WMA) and the European Association of Palliative Care (EAPC). It is concerning and also important to note that this proposal is in direct conflict with the principles outlined in the **National Suicide Prevention Strategy, 2025-2030** [1] which was recently launched for public consultation in March 2025.
2. **There is a total lack of information both in terms of research, both local or international, upon which the need for this proposal is based**. Furthermore, there is no information about which stakeholders or stakeholder groups were consulted prior to the drafting of this document. Given the complexity and sensitivity of the subject and its ramifications at individual, familial, community, professional and societal level, the drafting of any related

---

[1] https://health.gov.mt/wp-content/uploads/2025/03/National_Suicide-Prevention_Strategy_for_Malta_2025-2030.pdf

proposal for public consideration warrants in-depth consultation with the most experienced and accredited professionals - medical, legal, human rights, ethics, leaders of faith-based institutions as well as involved NGOs, patient representatives and other expert professionals in all the policy and decision making processes and stages.

3. **The proposal conflicts with core medical ethics** - Both the European Association for Palliative Care and World Medical Association advanced strong opposition to VAE. MAPHM agrees with these positions and also believes that if VAE were to be introduced, this risks eroding the community's trust in medical professionals and the clinical advice that they provide.
4. **Strengthening palliative care** should be a stand-alone and core objective, distinct from such a proposal. Government has in fact recently launched a National **Palliative Care Strategy 2025-2035**[2] which is currently in the early stages of being implemented. While increased community services, training and resources are being planned for funding, it is important to acknowledge that capacity building takes time to materialise. Although progress has been made toward meeting international standards this has not yet be fully achieved at the national level. Therefore, proposals on VAE should not be considered, at least until the palliative care measures included in the above strategy are fully implemented. The final parting statement in the MAM position sums this up perfectly in the statement "**Let us first ensure no one chooses to die because we failed to help them live with dignity**
5. **Living Will/ Advance Care Directive**- While advance care planning is an integral part of palliative care, there are currently no legal provisions for Advance Care Directives that would have legal standing. The EAPC has suggested that such directives could serve as valuable tools for a dignified end of life care. It is regrettable that this important matter was only presented as a minor proposal in this white paper. This subject deserves a thorough debate and consideration as a stand-alone policy proposal.

---

[2] https://health.gov.mt/wp-content/uploads/2025/04/Palliative-Care-Strategy-March-2025.pdf

6. **Safeguards and 'Slippery Slope' risks-** We believe that despite the inclusion of safeguards, the risk of coercion remains, in particular the more subtle *implicit coercion*, stemming from a vulnerable patient's perception of the emotional and psychological impact on those closest to the patient experience during terminal illness. Moreover, the EAPC warns that even in instances where there are initial rigorous safeguards, experience has shown a gradual erosion of these protections, with eligibility criteria being expanded over time, for instance to include conditions such as psychiatric illness, disability or dementia, and others. Furthermore, in view of being a small close-knit community and the right to conscientious objection due to personal beliefs, one must also consider that there is the possibility that public providers may be unwilling to be involved in this process leading to the involvement of private entities with their own inevitable commercial interests. This important aspect has not been addressed in the public consultation document and warrants careful consideration.
7. **The mode of death-** Although the intention is for persons to be unconscious from the time of ingestion of the lethal medicine until death, this varies between persons. Data from Oregon in the USA shows that the range of time from drug ingestions to death can take from a few minutes to 108 hours. The prevalence of complications and failures in assisted dying suggests that applicants are at risk of distressing deaths. It is reportedly not uncommon for persons to regain consciousness and experience a state of agitation during these moments due to a death from asphyxiation. The public consultation document also mentions that the death certificate would consider this a natural death- this is a position which the Malta Association of Public Health Medicine strongly disagrees with, since mortality statistics should always reflect the real circumstances of the death [4 6 7].
8. In terms of **conscientious objection,** the proposal document indicates that this is not absolute in that doctors must be obliged to refer patients to another practitioner. MAPHM upholds that in accordance with the EAPC, **conscientious objection must be absolute,** and, therefore, no health care professional should be obliged to refer or participate in any part of the process - and this

should be extended to any other professional whose work may somehow facilitate this process if they morally object to it. In addition, medical students and doctors-in-training at all levels should be given a guarantee of full conscientious objection to participation in any formal training in relation to the provision of assisted dying.

9. **Public knowledge** and **perceptions** on assisted dying, with the following suggested text: A UK Survey amongst British adults carried out in 2021 explored what people understood by the term "assisted dying". Whilst 43% correctly knew it meant "Providing people who have less than six months to live with lethal drugs to end their life", 42% thought it meant "Giving people who are dying the right to stop life-prolonging treatment", 10% answered "Providing hospice-type care to people who are dying", and 5% answered "don't know". This means that over half of the respondents confused the concept of "assisted dying" with palliative care. This highlights the importance of providing the public with complete and clear information on what assisted dying entails. These results also call for caution in interpreting the results of local opinion polls to gauge the public's support or otherwise of VAE [8].

In any meaningful discussion about AVE, it is essential to consider society's broader discomfort with the topic of death. Advances in public health, medicine, and living standards have significantly increased life expectancy and reduced everyday exposure to death. As a result, death has potentially become more medicalised and distant, often occurring in hospitals or institutions rather than at home, as is the case locally. This detachment can make it harder for individuals and communities to engage openly with the reality of dying, hindering transparent conversations about end-of-life choices - a challenge specifically addressed in the Palliative Care Strategy, which underscores the value of fostering open, informed discussions about death and dying. Encouraging more public dialogue around death can foster greater understanding, reduce fear, and support more compassionate, informed decisions, especially on ethically complex issues like euthanasia.

In conclusion, the Malta Association of Public Health Medicine (MAPHM) also believes that, in line with the Medical Association of Malta (MAM)'s position in this regard, the debate on Assisted Voluntary Euthanasia (AVE) is at best premature. MAPHM supports the full implementation of Malta's Palliative Care Strategy and agrees that priority should be given to further investment in the strengthening of effective palliative care services, as well as to the consideration of the introduction of a (legal) framework to support Advance Directives. Importantly, the public health medicine community emphasizes that any such proposals must respect international and local ethical medical standards and, above all, protect vulnerable individuals. All proposals should be evidence- based, transparent, and include input from highly qualified, accredited experts and stakeholders. Professional autonomy should be fully respected including the right to full conscientious objection. The integration of robust, transparent oversight into any proposed framework is paramount.

References:

1. World Medical Association (2019). *WMA declaration on euthanasia and physician-assisted suicide*. 70th WMA General Assembly, Tbilisi, Georgia https://www.wma.net/policies-post/declaration-on-euthanasia-and-physician-assisted-suicide/
2. Radbruch, L., Leget, C., Bahr, P., Müller-Busch, C., Ellershaw, J., de Conno, F., Vanden Berghe, P., & Board Members of EAPC (2016). Euthanasia and physician-assisted suicide: A white paper from the European Association for Palliative Care. *Palliative medicine*, *30*(2), 104–116. https://doi.org/10.1177/0269216315616524
3. Medical Association of Malta (2025) MAM's position on government's draft document on voluntary assisted euthanasia https://mam.org.mt/mam-position-on-governments-draft-on-assisted-voluntary-euthanasia/
4. The Office of the Chief State Medical Examiner. Medical Aid in Dying for the Terminally Ill Act 2020 Data Summary. 2021. https://www.nj.gov/health/advancedirective/documents/maid/2020_MAID_DataSummary.pdf. [Google Scholar]
5. Bakewekk F, Naik VN. Complications with Medical Assistance in Dying (MAID) in the Community in Canada. 2019. https://camapcanada.ca/wp-content/uploads/2019/05/Failed-MAID-in-Community-FINAL-CAMAP-Revised.pdf.
6. Ana Worthington, Llora Finlay, Claud Regnard. Efficacy and safety of drugs used for 'assisted dying'; British Medical Bulletin, Efficacy and safety of drugs used for 'assisted dying' - PMC
7. Harty C, Chaput AJ, Buna Det al. The oral MAiD option in Canada part 1: medication protocols review and recommendations. Canadian Association of MAiD Assessors and Providers 2018. https://camapcanada.ca/wp-content/uploads/2019/01/OralMAiD-Med.pdf. [Google Scholar]
8. Survation. Survation APPG for Dying Well Survey July 2021. 2021 [cited 2025 Jun 16]. Accessed from: https://www.survation.com/archive/2021-2/

Dr. Alexia Bezzina	Dr. Amanda Bugeja
President MAPHM	Honorary Secretary

MAPHM Executive Committee:

Alexia Bezzina, Tanya Melillo, Amanda Bugeja, Mariella Borg Buontempo, Sandra Buttigieg, Beatrice Farrugia, Sascha Reiff, Charmaine Cordina, John Paul Cauchi, Karen Borg and Gordon Muscat