Position Paper
on the
Public Consultation on
“Assisted Voluntary Euthanasia”

Academics
University of Malta

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Executive Summary

1. This position paper, which has been written by a multidisciplinary group of academics at the University of Malta, brings together insights from different areas of expertise as a contribution to the recent public consultation launched by the Government on "Assisted Voluntary Euthanasia", offering evidence-based reflections and recommendations.
2. Although the title of the consultation document is "Assisted Voluntary Euthanasia", the academic group notes that what is actually being proposed is both physician-assisted suicide and euthanasia, terms with distinct meanings and implications as recognised in academic literature. The document also speaks of "medical wills" which are more accurately referred to in scholarly literature as "living wills". This is a complex subject which merits a debate in its own right, certainly prior to considering the introduction of euthanasia.
3. A central concern pertains to the dissonance between the consultation document and two pivotal national health initiatives, namely, the *National Palliative Care Strategy for Malta 2025-2035* and the *National Suicide Prevention Strategy for Malta 2025-2030.* Empirical evidence demonstrates that jurisdictions which have implemented physician-assisted suicide or euthanasia have experienced a significant decline in the quality and scope of palliative care services. Palliative care services in Malta, which are already under considerable strain, will suffer similar setbacks. Studies also show a correlation between the introduction of physician-assisted suicide and increased suicide rates, a development which directly undermines national suicide prevention efforts. The academic group therefore strongly urges responsible authorities to prioritise the development of comprehensive, robust and excellent palliative care for all to ensure the availability of essential medications and to invest in proactive suicide prevention strategies. These objectives should take precedence over legislative moves towards the institutionalisation of physician-assisted suicide and euthanasia which encourage and normalise practices that are fundamentally at odds with the ethics of care and the protection of vulnerable individuals.
4. The paper also highlights several ethical concerns arising from the consultation document. Foremost among these is the recognition of the inherent, inalienable and inviolable dignity of every human being which underpins the fundamental right to life. This right is not contingent on circumstances of individual preference and must be upheld unconditionally. The state has the duty to safeguard this right through appropriate legal frameworks.
5. The legalisation of physician-assisted suicide and euthanasia significantly threatens the dignity and well-being of the most vulnerable persons in society, particularly those with limited socio-economic means. Evidence shows that the implementation of such measures correlates with decreased investment in palliative care services, disproportionately affecting those who lack access to alternative end-of-life care. Socio-economically disadvantaged individuals are also more susceptible to internalising the perception of being a burden, and this may unduly influence them towards "choosing" physician-assisted suicide or euthanasia not out of genuine volition, but due to structural constraints. Indeed, the so-called "choice to die" risks transforming into a perceived "duty to die."
6. It is also important to address one of the underlying motivations for support of physician-assisted suicide and euthanasia, namely, the fear of enduring prolonged

suffering through the obstinate provision of life-support measures which result in a drawn-out, painful death. While this concern is understandable, patients have the right to refuse or withdraw from treatment when they consider such interventions to be disproportionate either in terms of burdens or lack of therapeutic benefit. Properly applied, this right ensures that patients retain liberty, autonomy and dignity at the end-of-life without necessitating recourse to measures that end life intentionally.

7. It is imperative that clear, evidence-based clinical guidelines be established to prevent overtreatment and the practice of defensive medicine, whereby medical professionals may administer aggressive or disproportionate treatment not because of a reasonable hope of benefit but rather out of fear of litigation. Such practices unnecessarily prolong suffering and undermine patient well-being. In this context, there is a pressing need to increase awareness and education on palliative sedation, an ethically permissible and medically recognised option for end-of-life care. Despite its potential to relieve intractable suffering, palliative sedation remains underutilised due to lingering misconceptions and resistance among healthcare providers and the general public alike.

8. While proponents of physician-assisted suicide and euthanasia often invoke the principle of patient autonomy to justify such practices, it is essential to critically assess the limits of autonomy within end-of-life contexts. In reality, autonomy in such situations is frequently constrained by physical, emotional, and contextual vulnerabilities. Greater emphasis should therefore be placed on the concept of relational autonomy, which recognises the inherently social nature of human decision-making. Individuals are embedded within a web of relationships, and their choices, particularly at the end-of-life, are influenced by, and have consequences for, others within their immediate and extended circles of care. Moreover, since palliative care is still so lacking, the patient's choice can hardly be considered to be autonomous and free at all. This further points to the need to continue to invest in robust palliative care services, including respite care.

9. Additional concerns arise from other proposals in the consultation document. Although the right to conscientious objection is nominally acknowledged, the requirement that objectors must refer patients to colleagues who are willing to perform physician-assisted suicide or euthanasia effectively undermines the ethical integrity of such an objection. This compelled complicity places professionals in moral conflict with their deeply held convictions. Equally troubling is that there is no clear reason given behind the proposal that deaths resulting from physician-assisted suicide or euthanasia be legally recorded as natural deaths. This would constitute a factual misrepresentation on official records and raises serious concerns regarding the transparency and accountability of the entire legislative and procedural framework.

10. This position paper concludes with a series of recommendations aimed at improving end-of-life care in Malta. These include: the enhancement and universal accessibility of palliative care services through the implementation of the *National Palliative Care Strategy for Malta 2025-2035;* raising awareness amongst health care professionals as to their legal protections for honouring patients' rights to refuse treatment as well as training them as to laws related to futile, non-proportionate, obstinate or non-beneficial interventions; the cultivation of a more ethically grounded medical culture; public education initiatives to improve awareness and understanding of palliative care options; and the promotion of voluntary care programmes to foster solidarity and a renewed culture of compassion within Maltese society.

Position Paper

Introduction

1. The Government of Malta has published a consultation document setting out certain principles to serve as a foundation for a national debate on "assisted voluntary euthanasia".[1] This initiative invites all citizens to share their views on a topic that naturally evokes strong emotional responses.

2. Assisted suicide and euthanasia raise significant ethical, legal and social concerns and risks as they involve radical shifts in basic norms for society, the healthcare system, the dynamics of end-of-life care, society's outlook on old age, disability, and vulnerable groups, the process of dying, and quality of life.

3. This position paper has been written by an interdisciplinary team that includes experts in law, medicine and healthcare, psychology, disability studies, social wellbeing, spiritual accompaniment, education, sciences, public policy, philosophy, theology, and ethics, among others, in response to the Government's invitation for public engagement in an open, mature and transparent consultation process. The aim of this initiative is to ensure that such a sensitive subject is addressed within an ethical and evidence-based framework that raises the quality of the information provided to the public, as well as the ethical consciousness and conscientiousness of policymakers.

Linguistic Inaccuracies

4. The title of the consultation document "Assisted Voluntary Euthanasia" is misleading inasmuch as there is a difference between physician-assisted suicide and euthanasia. Whereas in assisted suicide the medical professional provides a patient with a means to end one's own life, and thus only 'assists' the patient in killing himself or herself, in euthanasia a doctor or another person actively carries out the act of ending a patient's life. In both cases, the act of termination of life is voluntary. In the former case, it is the patient who performs the final act, such as ingesting the lethal drug, or activating equipment that results in his or her own death. In the latter case, the doctor or another person directly administers the lethal drug (e.g. lethal injection).
5. The consultation document, under the section on procedures, proposes that "a medical professional must assist the patient in following the procedure of voluntary euthanasia. It must be the patient themselves who carries out the final procedure that leads to the end of their life. In cases of physical health limitations, the patient may delegate this task in writing through a health proxy or a trusted person."[2] This paragraph conflates assisted suicide with euthanasia, practices that are usually treated as ethically and legally distinct in academic and legal literature. In assisted suicide the person decides to end one's own life and also performs the final act. Euthanasia involves another party (usually a doctor) carrying out the final act. This distinction is crucial. Although both

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[1] Government of Malta, *Consultation Document on Assisted Voluntary Euthanasia* (Valletta: Ministry of Health and Active Ageing, 2025). Available online at https://facts.mt/proposti/.

[2] *Consultation Document on Assisted Voluntary Euthanasia*, 7.

physician-assisted suicide and euthanasia raise significant ethical concerns, euthanasia introduces additional complexities—particularly regarding informed consent, personal agency, and the moral and legal responsibilities of those who perform or authorise the act.

6. In the section addressing the "medical will", the consultation document proposes "to broaden the discussion so that Malta may introduce the possibility for individuals, through their own free choice and while still in good health, to create a medical will (living will). In this document, they may declare what level of medical care and treatment they would or would not want if they were to fall seriously ill or suffer trauma due to serious accidents."[3] This is commendable especially for persons who would not want to receive extraordinary treatment at the end of their life. However, the consultation document also seems to allow a person to request in writing that euthanasia be administered by a doctor or trusted individual when the person will be in a particular state of health as defined by the living will. This implies that the Government intends to include the explicit choice of euthanasia as an option within the living will document. Moreover, in Malta, to date, there is no law for Advance Care Directives. This is a complex subject and merits a debate in its own right, certainly prior to considering the introduction of euthanasia.

7. The consultation document recommends that "a law recognising a patient's right to assisted voluntary euthanasia would mean that such an act would no longer be considered a criminal act, provided it is carried out in full compliance with the established procedures and relevant legal safeguards."[4] By emphasising words such as "voluntary" and "assistance," the consultation document conceals the profound ethical import of such choices. In practice, legalised "assisted voluntary euthanasia" as proposed in the consultation document is either a suicide or a killing from an ethical perspective. These acts being considered are even graver because of the extreme vulnerability of the persons in question, since they are in the final stage of their life. It seems contradictory that physicians would be expected to act as agents of death or that psychiatrists stop treating a "desire to die" precisely with a most vulnerable segment of the population, where death is already looming on the horizon. Since the word "suicide" does not feature in the Government's document the gravity and ethical complexity of what is being proposed is obscured.

Prioritisation of High-Quality Palliative Care

8. The first ever *National Palliative Care Strategy for Malta 2025-2035* launched in April 2025 by the Ministry of Health and Active Aging is highly commendable, addressing the provision of palliative care in both secondary, primary and geriatric sectors. Its main "target is to address palliative needs and integrate palliative care as early as possible in one's chronic illness journey … By addressing all aspects of care and support including social, psychological and physical symptoms, care and human dignity is ensured at all stages of the illness regardless of the person's age and

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[3] *Consultation Document on Assisted Voluntary Euthanasia*, 10.

[4] *Consultation Document on Assisted Voluntary Euthanasia*, 8.

diagnosis."[5] Moreover, it pledges "to increase and develop the healthcare workforce in the field of palliative care, by providing more opportunities of specialization in this field and by creating multidisciplinary palliative care teams."[6] It is worth noting that the concept of dignity in the consultation document contradicts the same notion in the above-mentioned *National Palliative Care Strategy for Malta 2025-2035*.

9. Quoting from the "Resolution on Palliative Care"[7] of the Committee on Social Affairs, Health and Sustainable Development of the Parliamentary Assembly of the Council of Europe, the *National Palliative Care Strategy for Malta 2025-2035* affirms that "palliative care is thus fundamental to human dignity and is an expression of the fact that dignity should be respected throughout a person's life until his or her natural death. Ultimately, the main aim is for patients to live as well as possible, for as long as possible."[8] It is particularly striking to observe that the consultation document on assisted voluntary euthanasia contradicts the National Palliative Care Strategy which were both published by the Government within a span of a few weeks.

10. The National Palliative Care Strategy for Malta admits that palliative care services in Malta "are far from enough to meet the needs of all patients who require palliative care. Insufficient human resources is one of the main shortfalls."[9] This strategy further emphasizes that "good governance, leadership and adequate funding are key to the successful implementation of any health care reform. This palliative care strategy, the first for Malta, represents the overarching framework which will guide the development of palliative care services and investment in the palliative care sector within the next decade. There is dire need for a unifying body that brings together all stakeholders and takes an overall approach to the development of palliative care services in Malta at the national level."[10]

11. These critical gaps in palliative care services in Malta have been confirmed by the MAM[11] and the Hospice Malta[12] in their respective official responses to the consultation document. A recent report places the availability of innovative medicines used in oncology in Malta among the worst in Europe. According to the report, Maltese patients have access to only 10 per cent of innovative medicines approved for use in the EU. Furthermore, "an additional 35 medicines, roughly 20 per cent of the total, were only available through the private sector, meaning patients had to pay out-of-pocket, rely on private insurance or appeal to the Malta Community Chest Fund... A staggering 121 of the 173 new pharmaceutical products (70 per cent) were

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[5] Ministry of Health and Active Aging, *National Palliative Care Strategy for Malta 2025-2035* (Valletta: Ministry of Health and Active Ageing, 2025), iii. Available online at https://health.gov.mt/wp-content/uploads/2025/04/Palliative-Care-Strategy-March-2025.pdf.

[6] Ministry of Health and Active Aging, *National Palliative Care Strategy for Malta 2025-2035*, iii.

[7] "The Resolution on Palliative Care" Resolution 2249 (2018). Available online at https://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-en.asp?fileid=25214&lang=en.

[8] *National Palliative Care Strategy for Malta 2025-2035*, 4.

[9] *National Palliative Care Strategy for Malta 2025-2035*, para. 2.3.

[10] *National Palliative Care Strategy for Malta 2025-2035*, para. 3.6.1(emphases added).

[11] MAM, *Position Paper on the Consultation Document, 2025*. Available online at https://mam.org.mt/mam-position-on-governments-draft-on-assisted-voluntary-euthanasia/.

[12] Hospice Malta, *Position Paper on the Draft Document on Assisted Voluntary Euthanasia*. Available online at https://hospicemalta.org/wp-content/uploads/2025/05/Hospice-Malta-Position-on-the-Draft-Document-on-Assisted-Voluntary-Euthanasia.pdf.

not available in Malta at all, either publicly or privately."[13]

12. Paragraph 654 of the Labour Party's electoral pledge to "guarantee that everyone will receive the best possible care until the final moments of life"[14] still needs a considerable amount of financial and human resources to be adequately and effectively implemented. Given the current severe inadequacies in palliative care provision, the national discussion on the introduction of assisted suicide and euthanasia is premature to say the least. One cannot start discussing assisted suicide and euthanasia without first ensuring that these deficiencies in palliative care have been adequately addressed and one cannot expect that these deficiencies are addressed two months after the launch of a 10-year strategy! Regretfully, optimal care is still not yet given due to lack of formal training and absence of protocols that enable all wards to initiate palliative care until it is taken over by consultants in the field.[15]

13. The recommendations of the national strategy for high quality palliative care services have first to be prioritised and implemented and all possibilities for a comprehensive and holistic care to all range of conditions, such as cancer, cardiovascular diseases, chronic obstructive pulmonary disease, kidney failure, chronic liver disease, rheumatoid arthritis, neurological disease, Alzheimer's disease and other dementias, congenital anomalies and other illnesses, have been exhausted. If these current deficiencies in palliative care are adequately addressed and implemented, the introduction of "assisted voluntary euthanasia" would not be needed.[16] Without first addressing these critical deficiencies, the introduction of "assisted voluntary euthanasia" undermines the role and value of palliative care, while potentially depriving patients of the comfort and dignity the effective palliative care services are designed to provide. The literature suggests that in most countries where physician assisted suicide or euthanasia was introduced as part of mainstream healthcare, palliative care rankings fell.[17]

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[13] Max Newton et al, "EFPIA Patients W.A.I.T. Indicator 2024 Survey," *IQVIA, May 2025.* Accessible at https://efpia.eu/media/oeganukm/efpia-patients-wait-indicator-2024-final-110425.pdf . See also "Malta among worst in Europe for access to innovative medicines, new data shows," *Times of Malta*, 26 May 2025. Available online at https://timesofmalta.com/article/malta-among-worst-europe-access-innovative-medicines-new-data-shows.1110200.

[14] *Consultation Document on Assisted Voluntary Euthanasia*, 3.

[15] See Pierre Mallia, "Euthanasia or Proper Implementation of Timely Palliative Care," *The Malta Independent on Sunday*, 1 June 2025, 18. Available online at https://www.independent.com.mt/articles/2025-06-01/newspaper-opinions/Euthanasia-or-proper-implementation-of-timely-palliative-care-6736270470.

[16] Renald Blundell, Martina Cini and Kiberly Blundell, "Palliative Care With Adequate Pain Relief Challenges the Need for Euthanasia Legislation," *History and Philosophy of Medicine*, 6, no. 2 (2014): 1-7.

[17] Conall Preston, "Assisted Dying: The Evidence from Abroad", in *The Reality of Assisted Dying: Understanding the Issues*, eds. Julian C. Hughes and Ilora G. Finlay, (Maidenhead, UK: McGraw Hill, 2024), 34.

Strategic Inconsistencies

14. In a matter of a few months the Government has published three documents which are in disharmony with the Government's own broader policy for social wellbeing. The inconsistency between the *Public Consultation Document on Assisted Voluntary Euthanasia* and *National Palliative Care Strategy for Malta 2025-2035* has already been highlighted above. The recent launch of the *National Suicide Prevention Strategy for Malta 2025-2030*[18] is praiseworthy and represents an important step towards safeguarding mental health and preventing self-harm. Although the strategy preventing suicide and the public consultation related to assisted suicide are separate in principle, they are ultimately related inasmuch as they both address a situation where persons are ending their own lives. As such, any strategy targeting the prevention of suicide should be fully implemented before one can productively and meaningfully engage with discourse about lawful assisted suicide and/or whether that practice should be permitted in the first place.

15. Professionals are ethically obliged to intervene, report and seek assistance whenever clients exhibit signs of suicidal ideation, in order to address the underlying causes and guide individuals towards recovery. They must not, in other words, assist clients in terminating their life. Evidence shows that the introduction of physician assisted suicide seemingly triggers mechanisms that "increase the level of individual approval of suicide and hence reinforce the high rate of suicide within the culture."[19] The researchers insist that "this is analogous to the effect of reporting that 'normalises' suicide [and] legalising physician assisted suicide also provides positive role models that help normalize suicide more generally."[20]

Ethical Concerns

The Right to Life

16. The dignity of human life and the inherent, inalienable and inviolable right to life that every citizen enjoys must be respected throughout all the stages of life, from conception to natural death. This principle stands as the foundation of every civilization committed to safeguarding and protecting the rights of every human being, with the right to life being the most fundamental. It is a democratic state's principal duty to safeguard this and other fundamental rights, which are essential to the adequate functioning of every society. Consequently, the purpose of law, and of the services regulated by the law, is to provide efficient mechanisms that will protect every human life, especially when this is disadvantaged and vulnerable; it is certainly not the objective of law to facilitate and promote its deliberate termination. Every society that weakens the legal prohibition of the intentional killing of a human being would be

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[18] Government of Malta, *National Suicide Prevention Strategy for Malta 2025 - 2030*. Available online at https://health.gov.mt/wp-content/uploads/2025/03/National_Suicide-Prevention_Strategy_for_Malta_2025-2030.pdf.

[19] David Albert Jones and David Paton, "How does legalization of physician assisted suicide affect rates of suicide?" *Southern Medical Journal* 108, no. 10 (2015): 599-694. See also Lydia S. Dugdale and Daniel Callahan, "Assisted Death and the Public Good," *Southern Medical Journal* 110, no. 9 (2017): 559-561.

[20] Jones and Paton, 694.

eroding its moral and social fibre.

17. There is no globally recognised human right to assisted suicide or euthanasia under international law. The European Court of Human Rights (ECHR) has affirmed that the *European Convention on Human Rights* does not guarantee a right to euthanasia, although it allows countries to legislate on the matter. The right to life is not contingent on circumstances of individual preference and must be upheld unconditionally. The state has the duty to safeguard this right through appropriate legal frameworks. It is for this reason that the World Medical Association maintains a firm opposition to both euthanasia and assisted suicide.[21]

Entitlement to Palliative Care

18. When individuals become dependent, ill or vulnerable due to illness or severe suffering, societies at all stages of development overwhelmingly respond with robust and responsive services that provide solace and encouragement so that no one is marginalised, falls behind or is perceived as a burden on others, is socially isolated, or suffers a perceived loss of worth. A society shows its merciful countenance when vulnerable people are not abandoned at the moment of their greatest need, or, and when it does not introduce legal protection for medical assistance with the aim of wilfully precipitating the process of death. On the contrary, the medical service of palliative care ought to be consolidated and the network of social solidarity broadened through valuable free-of-charge services that Hospice Malta is already providing in the community to so many patients suffering from terminal illness as well as to their relatives or other persons chosen by the patients themselves. Palliative care is more than medical care because it encompasses emotional, psychological and spiritual support to accompany the patient and their relatives in coming to terms with their existential suffering. High quality and efficient services in this area of medical expertise offer not only comfort and great support to the patients and their relatives; they also instil peace of mind in society.

Protecting the Vulnerable

19. What begins as a so-called “choice to die” for some eventually evolves for many into a perceived duty to die! The introduction of “assisted voluntary euthanasia” risks placing pressure, implicitly or explicitly, on vulnerable individuals, such as the elderly, the seriously ill, or the disabled, leading them to come to feel that ending their lives is the only way to avoid becoming a burden on their families or society. Every person, without exception, has the right to compassionate and dignified care and it is the moral duty of society to protect this right through comprehensive, holistic care that affirms the value of human life, particularly when it is in its most fragile state.

20. The experience of countries where assisted suicide and euthanasia have been legalized demonstrates a clear slippery slope: initial safeguards and strict limitations tend to

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[21] World Medical Association, *WMA Declaration on Euthanasia and Physician-Assisted Suicide*, Adopted by the 70th WMA General Assembly, Tbilisi, Georgia, October 2019. Available online at https://www.wma.net/policies-post/declaration-on-euthanasia-and-physician-assisted-suicide/.

erode over time. One can mention the case of Canada, where in 2027 MAiD (medical assistance in dying) will be open to people suffering solely from mental illness. What begins as an option strictly available only for the terminally ill is soon extended to those with chronic illnesses, mental health conditions, or even existential distress such as loneliness or despair.[22] Once society accepts the idea that some lives are not worth living, or that death can be legitimately offered as a form of medical treatment, the door is opened to abuses, pressure and tragic misjudgement. The legalisation of euthanasia creates subtle pressure on vulnerable individuals to choose death – not because they truly wish to die, but because they feel they are a burden to others. This pressure might not be explicit, but it can be deeply internalised due to societal attitudes that equate human worth with productivity, independence, and self-sufficiency.

Avoiding Overtreatment

21. Patients have both a legal and moral right to refuse treatment that does not offer any reasonable hope of benefit, that incurs exorbitant costs or excessively burdensome treatment on the patient, or results in severe pain and suffering. Choosing to withhold or withdraw medical treatment for any of these reasons, while at the same time maintaining palliative care, is very different from requesting medical assistance to accelerate the process of death. While the intention in the former case is to allow the natural process of death to unfold without any unnecessary medical interference, in a way which respects the dignity of the patient and the limits of medicine, the second case involves a deliberate intervention with the explicit intention of killing the patient. The crucial distinction between allowing death and causing death marks a clear ethical boundary between accepting the limits of treatment and actively intervening to terminate life. The lack of any local unifying system present, where documentation of such decisions is available to the various professionals involved, further detracts from the robustness of such decisions.

22. One of the underlying reasons why some individuals may be drawn to the idea of "assisted voluntary euthanasia" is the fear of being subjected to obstinate or disproportionate medical treatment in the final stage of their life, particularly when such interventions prolong suffering rather than enhance quality of life. This fear is compounded when patients believe that their informed refusal of treatment might be ignored or overridden by medical professionals. To address this concern, it is essential that legal frameworks are strengthened to give full and practical effect to the right of patients to refuse medical care that they deem burdensome, futile, or misaligned with their values. By affirming and protecting this right in law, society can help restore trust in the healthcare system and affirm the ethical principle that medical care, in the absence of consent, is, with few specific exceptions, unlawful in Malta. Such legal frameworks would give patients the confidence that they have a right to decline interventions without being forced to seek "assisted voluntary euthanasia" as the only means of control.

23. A significant contributor to the practice of obstinate treatment is the phenomenon of defensive medicine, where healthcare professionals administer aggressive or non-beneficial interventions primarily to avoid potential legal consequences rather

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[22] Preston, 31.

than to serve the patient's best interests and perform as is expected from someone who trained and presented themselves to practice a health care profession. This culture of fear and liability can distort clinical judgment and lead to care that is more harmful than helpful, especially in terminal cases. To counteract this, there should be more awareness as to the legal protections when medical practitioners and other health care professions act in accordance with evidence-based medical guidelines and ethical palliative principles. By training medical practitioners as to the laws underpinning medical practice when healthcare professionals respect informed refusal and avoid futile interventions, there can be a more compassionate, balanced medical culture that focuses on preserving comfort at the end-of-life, rather than defaulting to unnecessary procedures out of legal anxiety. This, in turn, helps ensure that assisted suicide and euthanasia do not become a perceived escape from an overly aggressive and impersonal healthcare system.

24. Palliative sedation is defined as the use of sedative medications to alter the consciousness of patients in order to control distress (physical pain, respiratory distress, restlessness). This is usually carried out at the end-of-life. This practice is morally acceptable, provided it is done with the patient's consent, that appropriate information is given to the family members or persons chosen by the patients themselves, that any intention of euthanasia is ruled out, that other forms of palliative care such as pain relief are continued, and that the patient had the opportunity to fulfil his moral, familial and religious duties. Regrettably, locally, many doctors are still too reluctant or hesitant to offer this kind of care,[23] despite its ethical legitimacy, as long as the primary aim is to control pain, and not to hasten death, even though the patient's life might be unintentionally shortened as a result. Broader educational initiatives are also needed to discourage therapeutic obstinacy, that is, the unnecessary prolongation of treatment when death is imminent, and to support and promote the value of allowing death to occur naturally, ideally within the warm and familiar environment of the patient's home, surrounded by loved ones, whenever this setting is appropriate.

The Fallacy of Unconditional or Absolute Autonomy

25. The value of personal autonomy is today widely recognized and deeply cherished. People rightfully seek to shape their lives with responsibility, making choices in accordance with their values and aspirations. This is certainly an important advancement in modern civilization. However, autonomy does not equate to an unrestricted right to end one's life in response to pain or suffering, especially when such suffering can be effectively managed through palliative care. Prohibiting assisted suicide deters life endangering acts, in conformity with human rights law. A patient's request for assistance in ending one's own life, even when death is not far away (considering the six month condition), is not simply a matter of freedom of choice, more so when there are viable alternatives on offer. While important, self-determination or autonomy is neither absolute nor unlimited; indeed, human

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[23] See Jurgen Abela, "GPs and end-of-life decisions: views and experiences," *Malta Medical Journal* 27, no. 2 (2015): 31-36. See also Renald Blundell, Martini Cini and Stefan Vella "Exploring Euthanasia in Malta: An Intersectional Analysis of Medical, Legal, and Ethical Perspectives," *History and Philosophy of Medicine*, 5, no. 3 (2023): 1-7.

freedom is always linked to ethical, legal and social responsibilities. When societal conditions, or State policy, make people feel like their lives are no longer valuable, choosing assisted suicide or euthanasia becomes less about freedom and more about desperation or resignation. Once such reasoning is enshrined in the law, then the question arises where to draw a line before legislation progressively exonerates all that is today illegal or regarded as immoral.

26. The consultation document lists as one of its criteria that "the individual's free choice must be respected after they have been given all possible support and a full explanation of the available palliative care and medical treatment options to alleviate suffering."[24] Since palliative care is still inadequate, the patient's choice can hardly be considered to be autonomous and free at all, because no real alternatives are in fact given. This further points to the need to continue to invest in robust palliative care services, including respite care.

27. Autonomy is not an absolute principle and must always be understood within the context of the common good of society as a whole. There is general agreement among scholars, not least among feminist scholars, that nobody possesses complete autonomy, particularly in medical settings, where personal agency is often constrained, even if only partially, by circumstance, vulnerability or the complexity of decision making.[25] This limitation becomes even more pronounced in the final phases of one's life. Rather than viewing autonomy as purely individualistic, therefore, it is more accurate to speak of relational autonomy, that is, a form of personal liberty that is shaped by both interpersonal relationships and the demands of social justice. In other words, one's liberty is never unlimited, but is inherently demarcated by the need to respect the autonomy and liberty of others. It is therefore a balancing exercise based on proportionality. Introducing physician assisted suicide and euthanasia would harm the common good by limiting investments in palliative care,[26] by introducing a practice in local medical institutions that is contrary to the aim of the medical profession, and by normalising physician assisted suicide and euthanasia. The proposed radical shift in medical care would therefore erode the fabric of medical care, diminishing the collective commitment of society to support, protect, and accompany individuals through their most vulnerable moments.[27]

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[24] *Consultation Document on Assisted Voluntary Euthanasia*, 5.

[25] See Onora O'Neill, "Autonomy and Assisted Suicide," *Living and Dying Well*, 30 June 2010. Available online at https://livinganddyingwell.org.uk/wp-content/uploads/2020/02/LDW-Report-Autonomy-and-Assisted-Suicide.pdf. See also Onora O'Neill, "Real Life is Too Complex", *The Guardian*, 30 July 2010. Available online at https://www.theguardian.com/commentisfree/belief/2010/jul/30/assisted-suicide-legislation and, Autumn Alcott Ridenour and Lisa S. Cahill, "The Role of Community" in *Dying in the Twenty-first Century: Toward a New Ethical Framework for the Art of Dying Well* ed. Lydia S. Dugdale, (Cambridge, MA: MIT Press, 2015), 108 – 130.

[26] Preston, 34.

[27] Department of Disability Studies at the University of Malta, "Feedback by the Department of Disability Studies (DDS) at UM on the 'Assisted Voluntary Euthanasia Consultative Document'," *Facebook*, 24 May 2025. Available online at https://www.facebook.com/um.disabilitystudies/posts/pfbid0YifmHvdnRS4gNyGnadXaQUrpvUwgTpbp3GGDybsYXeEkqqy6EL7H22EzGfgFiU73l

28. The protection of human life, especially when that life is fragile, dependent or vulnerable, is an ethical and legal principle that goes beyond the principle of autonomy. Reducing medical practice to a mere "technical" function/service whereby doctors are expected to fulfil any patient request so long as some safeguards are satisfied entails a restricted contractual understanding of clinical work that seriously undermines the integrity of the medical profession. In such a case, the doctor's role would shift from healer and protector of life to one who facilitates death, contradicting the very nature of the medical profession, consistently understood from Hippocrates to the *Declaration of Geneva*[28] that physicians affirm to "maintain the utmost respect for human life." Altering the legal framework surrounding the protection of life would bring about a profound cultural and moral shift in our society. It would reshape the way the elderly and people with chronic illnesses and disabilities are viewed and valued. Rather than safeguarding, promoting and celebrating life, it would normalize the legal sanctioning of death. Moving from a society that protects and cherishes life to one that legitimizes its premature termination is not progress, but a regression. A study carried out in Malta in 2016 showed that about 90.2% of Maltese doctors were against euthanasia.[29]

Quality of Life

29. It is important to note that nowhere in the document is unbearable pain or distress mentioned. In any case, some argue that when people suffer unbearable pain or become completely dependent on others, their quality of life diminishes to the point where life itself loses its value. In such cases, they hold that the wishes of those who have become tired of life and have lost the will to fight its battles should be respected. We do acknowledge and understand the physical, social, psychological, emotional and spiritual suffering that patients and their loved ones experience in these deeply challenging circumstances. We stand in empathy and solidarity with each person experiencing the profound hardship of suffering. However, we firmly believe that the value of their life is not determined by their physical condition or degree of independence. Human dignity remains intact in both sickness and health. Assisting patients to bring about the abrupt and intentional termination of life can never be considered an act of compassion, nor can it be aligned with the best interest of society. It would also alter the relationship of trust with medical professionals[30] and erode the cultural ethos that respects and celebrates life, even in its most difficult times.

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[28] World Medical Association, *Declaration of Geneva (1948)*, 2017. Available online at https://www.wma.net/policies-post/wma-declaration-of-geneva/.

[29] Jurgen Abela and Pierre Mallia, "Maltese Doctors: Views and Experiences on End of Life Decisions and Care," *Malta Medical Journal*, 28 no. 2 (2016): 16-26.

[30] Cees Hertogh, "Making euthanasia legal in the Netherlands: implications for the doctor–patient relationship" in *The Reality of Assisted Dying: Understanding the Issues*, eds. Julian C. Hughes and Ilora G. Finlay, (Maidenhead, UK: McGraw Hill, 2024), 41). See also Frank Brennan, Adrian Dabscheck and Leeroy William, "The Australian Perspective" in *The Reality of Assisted Dying: Understanding the Issues*, eds. Julian C. Hughes and Ilora G. Finlay, (Maidenhead, UK: McGraw Hill, 2024), 68.

Conscientious Objection

30. Health care professionals have the right to conscientious objection and this principle is recognised in the consultation document. However, in the section addressing the role of medical professionals, the document states that they are still obliged to respect the patient's wishes and, therefore must refer the patient to other professionals for this purpose. This framing undermines the full scope of conscientious objection. Conscientious objection, rightly understood, is not limited to direct participation in physician assisted suicide or euthanasia. It also encompasses the right of healthcare professionals not to cooperate at all in physician assisted suicide or euthanasia, or its facilitation. This right to conscientious objection applies also to other health care professionals, who might be asked to assist doctors or carry out procedures on their orders, as well as pharmacists who may be requested to dispense lethal drugs or equipment used for "assisted voluntary euthanasia". Upholding this right is essential to preserving the moral integrity of healthcare providers and ensuring that no professional is compelled to act against deeply held ethical or moral convictions.

Conclusion

31. It is the fundamental duty of society to protect its most vulnerable members, and the laws it enacts must reflect this commitment. The introduction of what is referred to in the public consultation document as "assisted voluntary euthanasia" would compromise this commitment, erode public trust in medical institutions, send a troubling message that some lives are more valuable than others, and that life can be treated as a disposable commodity. Such a radical shift in societal values would have far reaching and potentially irreversible repercussions. Rather than normalising the intentional killing/ending of human life, we must strive at building a more compassionate and supportive society which stands beside those who are suffering, especially in the final stage of their life. True progress lies in reaffirming the dignity of every human being, and in strengthening the systems of care that provide comfort, presence, and meaning when life becomes most fragile.
32. Our society is duty-bound to continue safeguarding the dignity of human life from its conception to natural death. Among the best achievements our country has striven for and nurtured in our Maltese culture is a deep respect for human life at every stage. This commitment reflects a core value of our national identity: a heritage built on compassion, human dignity, and the protection of the vulnerable. This legacy must not only be cherished and preserved, but also strengthened and consolidated, so that it may be passed intact and undiminished to future generations.

Recommendations

Since current palliative care in Malta, though developing, remains uneven, overly reliant on non-profit and religious institutions, and lacks adequate funding and professional training pipelines, rather than introducing assisted suicide and euthanasia, Government must instead commit to:

- implementing the recommendations of the *National Palliative Care Strategy for Malta 2025-2035*;
- supporting nationally funded hospices and home-care programmes;
- providing specialist training in palliative medicine and psychological and spiritual care;
- ensuring universal provision of culturally competent palliative services that include spiritual support as a standard component;
- formulating guidelines on patient and patient-chosen representative involvement in care decisions to avoid unnecessary overtreatment;
- establishing guidelines on the use of palliative sedation;
- strengthening legal frameworks to give full and practical effect to the right of patients to refuse medical care that they deem burdensome, futile, or misaligned with their values;
- training medical practitioners about laws and legal safeguards when informed refusal is followed and futile interventions are avoided with a view towards fostering a more compassionate, balanced medical culture that focuses on preserving dignity and comfort at the end-of-life, rather than defaulting to unnecessary procedures out of legal anxiety;
- training health care professionals as to the legal framework applicable to end-of-life care;
- launching public education campaigns to promote understanding of what palliative care can truly offer;
- investing in voluntary work training and programmes working with persons in the final stage of their life to help re-instil a sense of care of the most vulnerable persons in society.

A truly compassionate response to the end-of-life lies in the provision of high-quality palliative care services to all who need them.

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