The Right to Die:

Perspectives of

Mental Health Professionals

in Malta

by Dr. Gabriel Joshua Ellul, M.D. (Melit.), MRCPsych (U.K.)

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Faculty of Theology, University of Malta

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Abstract

Background: In their professional work, mental health professionals are continually working with individuals in distress, who at times may express a wish to end their lives.

Aims: To understand the perspectives of mental health professionals towards a person's right to die.

Methods: A mixed-method technique was employed. Stage 1 involved a validated online questionnaire that was sent to all professionals working within the Maltese public mental health service. Stage 2 involved a closed-group, multidisciplinary discussion between six professionals who were asked to manage the hypothetical case of a terminally-ill patient requesting physician-assisted suicide.

Results: An acceptability score of 1.2 was obtained for suicide in general (where 0 indicates complete disagreement and 4 complete agreement), with similar scores for suicide in the specific scenarios of bankruptcy, overwhelming despair and family dishonour. Suicide in terminal illness elicited highly polarised and divergent views (score: 2.08; standard deviation: 1.23). Advanced age and belief in the afterlife were related to a lower acceptability of suicide. Male respondents agreed more with the hiding of suicidal behaviour. Older respondents were more likely to disagree with describing suicidal people as ‘mentally ill’. The discussion revealed that in terminal illness, professionals are willing to thoroughly assess those requesting physician-assisted suicide, treating any underlying mental illness and ultimately determining mental capacity, which is deemed the necessary prerequisite to individual autonomy.

Conclusion: Mental health professionals in Malta consider autonomy as an absolute value when evaluating a person’s right to die; they adopt a relativistic and subjective paradigm when considering the value of life. After a comprehensive psychiatric assessment, they would choose not to impede the autonomous person from committing physician-assisted suicide, if legalised. However, the majority conscientiously object to actively assisting with the suicide, citing that it would go against the principle of non-maleficence and their duty as “good clinicians.”

Dedication

To my wife Anthea Maria, our infant daughter Anastasia Maria, and our recently-born son, Raffaele Pio.

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Introduction

Mental health professionals are tasked with the care and support of individuals who have been diagnosed with mental illness, and who subsequently encounter situations of heightened physical, emotional and psychological distress.

[1] This work-environment invariably leads them to encounter individuals who are in a state of great despair, with some even considering ending their suffering by taking their life through suicide.

Given their exposure to such situations on a regular professional basis, the perspectives of mental health professionals to the 'right-to-die' concept sheds light into how these professionals cope with the adversities they encounter at work. This dissertation thus seeks to clarify the position of mental health professionals in Malta on an individual's right to die, along with the factors which determine their position.

A number of questions are being explored. Do mental health professionals invariably seek to intervene to preserve an individual's life, even in situations of great despair? Are there circumstances when their position to protect the suicidal individual from harm is reversed and they would actively assist the individual in ending his life or at least refrain from intervening to stop him? Are mental health professionals able to distinguish between assisted suicide and other forms of euthanasia? Does their age, gender, professional role, or years of experience have any impact on these positions? Do their personal beliefs in the afterlife and on sin affect these positions? Do they believe that a request to die is always spurred by mental illness? And if not, how do they consider such a complex moral and ethical dilemma?

Understandably such questions require considerable exploration in order to be answered. It is for this reason that this study makes use of two stages of inquiry, an initial quantitative stage, and a final qualitative stage. While the former is intended to provide a wide overview of positions and attitudes, the latter is intended to explore in depth the ethical and moral premises which inform these professionals' perspectives.

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1. "Mental Health Professional - Wikipedia," accessed February 15, 2020, https://en.wikipedia.org/wiki/Mental_health_professional.

The questions being posed are of considerable significance. The findings will add to a wealth of literature on the matter; they will also provide insight into the inner conflicts and considerations of those whom society elects to serve as a frontline in the battle against suicide.

Mental health professionals are indeed human beings, and their choices are informed by their values and the situations they find themselves in. While adhering to an agreed code of professional conduct, they may also have personal opinions which defer from expected norms. Their understanding on the matter is also more pragmatic, since their clinical work entails an obligatory "hands-on" exposure to the repercussions of mental illness, the finality of death and the harrowing pain of suicide and suicidal attempts.

Interestingly, existing literature on the subject has seen a recent surge in interest on the topic. Multiple studies were found which explore attitudes to suicide from a number of perspectives. Some studies, including surveys, sought to obtain the perspective of the population in general. Others focused on the positions of teenagers or young adults, whereas a number of studies explored the position of clinical professionals, including psychologists, psychiatrists and oncology physicians.

This study also aims to fill-in an academic lacuna: it is to the author's knowledge that no study has yet been conducted to study the perspectives of mental health professionals as a holistic and diverse cohort, with the inclusion of a spectrum of professionals and not exclusively individual professions. No studies were found which deal with the perspectives of professionals on a national level, with most studies being limited to regions and districts. Furthermore, no recent studies were found which involved the central Mediterranean region, with most studies involving Northern European, American or Asian countries.

It is hoped that these geopolitical considerations will provide added value to the existent body of academic literature on the subject. The inclusion of a national cohort of eligible respondents, across the entire public mental health service in Malta, may hopefully also provide this study with added local significance, especially since it will be shedding insight into the perspectives of a population with its own sovereign, cultural and socio-political identity and heritage.

Chapter 1: Literature Review

This chapter provides an overview of contemporary literature on suicide and its public health repercussions. It also explores the moral, social and ethical perspectives on suicide, how they have been shaped across the millennia and the notable difference in perspectives between different cultures.

The nature of suicide

'Suicide' is defined as the direct and wilful act of ending one's own life.[2] Many have debated the exact definition, mainly in view of differences in perceptions on suicide.[3] Some argue that the definition of 'suicide' should be purely conceptual: describing the act, without bringing moral perspectives into question.[4] Others insist on a more normative definition, which evaluates suicide according to its permissibility; they argue that depriving its definition from its evaluative meaning is contrary to the very syntax of the word.[5]

Suicide can take many forms. The method varies according to gender, country of origin and accessibility to lethal means.[6] From a global perspective, the most prevalent appears to be hanging, although pesticide poisoning plays a major role in Asian countries, especially amongst women, and firearm suicide is significantly prevalent in the United States of America.[7]

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2. "Suicide," Merriam-Webster (Merriam-Webster), accessed February 15, 2020, https://www.merriam-webster.com/dictionary/suicide)
3. J. P. Moreland, "The Morality of Suicide: Issues and Options," *Bibliotheca Sacra*, 1991, https://afterall.net/papers/the-morality-of-suicide-issues-and-options/.
4. Tom L. Beauchamp; James F. Childress, *Principles of Biomedical Ethics - Paperback, New York: Oxford University Press*, vol. null, 2001, doi:Doi 10.1177/004057368003600423, quoted by Moreland, "The Morality of Suicide: Issues and Options."
5. Stanley Hauerwas, *Suffering Presence : Theological Reflections on Medicine, the Mentally Handicapped, and the Church*, ed. Notre Dame (University of Notre Dame Press, 1986), as quoted by Moreland, "The Morality of Suicide: Issues and Options."
6. Ajdacic-Gross Vladeta et al., "WHO | Methods of Suicide: International Suicide Patterns Derived from the WHO Mortality Database," *WHO*, 2011.
7. Ibid.

Interestingly, small and highly-urbanised countries, such as Malta and Luxembourg, tend to have a higher percentage of suicides involving jumping from height.[8]

Suicide: a major threat to global public health

Suicide is a pressing global issue: it is a major international public health concern, with close to 800,000 individuals dying by suicide every year across the globe.[9] This equates to an individual dying by suicide every 40 seconds. Suicide is the second leading cause of death among young adults, after death through motor vehicle accidents. It is also significantly higher in the elderly, with a global trend towards increasing suicide rates with increasing age.[10] Interestingly, males appear to have a higher preponderance to violent methods, such as firearm suicide, when compared to women who choose less violent means, including drug poisoning.[11]

The choice of suicide method is determined by one's sociocultural norms and by their overall acceptability.[12] One also has to have a reasonable opportunity to commit the act, what Cloward and Ohlin term an "opportunity structure."[13] In the face of this threat, the World Health Organisation (WHO) is encouraging health measures which seek to limit suicide.[14]

Suicide and its multifactorial causes

Reasons for suicide are diverse. A simplified model classifies it according to whether it is a reaction to acute distress or a consequence of a longstanding deterioration in one's life

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8. Ibid.
9. "WHO | Suicide Data," accessed February 15, 2020, https://www.who.int/mental_health/prevention/suicide/suicideprevent/en/.
10. "Suicide - Our World in Data," accessed February 15, 2020, https://ourworldindata.org/suicide.
11. Ajdacic-Gross Vladeta et al., "WHO | Methods of Suicide: International Suicide Patterns Derived from the WHO Mortality Database."
12. Ibid.
13. Marshall B. Clinard, Richard A. Cloward, and Lloyd E. Ohlin, "Delinquency and Opportunity: A Theory of Delinquent Gangs.," *American Sociological Review* 26, no. 3 (June 1961): 481, doi:10.2307/2090685, quoted by Ajdacic-Gross Vladeta et al., "WHO | Methods of Suicide: International Suicide Patterns Derived from the WHO Mortality Database."
14. Ajdacic-Gross Vladeta et al., "WHO | Methods of Suicide: International Suicide Patterns Derived from the WHO Mortality Database."

situation. Both these reasons may in turn be influenced by mental illness, as outlined by Wenzel and Beck, who published a cognitive model on suicidal behaviour.[15]

They propose a number of factors which may lead to suicidal behaviour, including the narrowed perception of control on one's own life, leading to a sense of decline, and ultimately suicide. They also propose predispositions which lead the individual to act in such a way, whereby subsequent stress fuels the onset of suicidal cognitions, usually also propagated by psychiatric disturbances.

Acts of despair, however, are not the only reason for suicide. Some suicides are altruistic, intended to achieve a greater purpose. Indeed, Durkheim's seminal 1897 book "Suicide: A study in sociology" gives an account of some acts of suicide as a "sacrifice… imposed for social ends".[16] Examples of this type of suicide include acts of self-immolation, such as that of Bouazizi in Tunisia in 2010, whose death is believed to have triggered the Arab Spring.[17] Acts of altruistic suicide may also include the case of the imprisoned man who chooses to end his life rather than submitting to torture and revealing crucial secrets to the enemy. This, and other examples, were detailed in David Hume's "Of Suicide", an essay which placed suicide at the centre of philosophical and ethical debate.[18]

Suicide as a consequence of mental illness

Mental illness is linked to suicide. The first such link was demonstrated by Barraclough who in 1974 published one of the first studies on the subject: he confirmed the high prevalence of mental illness in suicide victims, exceeding the rate of 90%.[19] His work was a reaction to the perceived sense of nonchalance towards suicidal patients at the time, which Barraclough

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15. Amy Wenzel and Aaron T. Beck, "A Cognitive Model of Suicidal Behavior: Theory and Treatment," *Applied and Preventive Psychology* 12, no. 4 (October 1, 2008), 178, doi:10.1016/j.appsy.2008.05.001.
16. Émile Durkheim, *Suicide: A Study in Sociology*, 2005, doi:10.4324/9780203994320.
17. "Mohamed Bouazizi | Tunisian Street Vendor and Protester | Britannica," accessed February 15, 2020, https://www.britannica.com/biography/Mohamed-Bouazizi.
18. David Hume, *Of Suicide*, (1777), 10
19. B. Barraclough et al., "A Hundred Cases of Suicide: Clinical Aspects," *British Journal of Psychiatry* 125, no. 10 (1974): 355–73, doi:10.1192/bjp.125.4.355, quoted by Kelly and Dale, "Ethical Perspectives on Suicide and Suicide Prevention", 216.

believed was due to doctors' perceptions that suicide is a reaction to moral crisis, and not a mental health issue.[20]

This link is clear, and is not restricted to any one country. In fact, in 2011, Nordentoft, Mortensen and Pederson published an immense study on the risk of suicide in individuals after their first psychiatric contact in the United States of America.[21] It involved a retrospective national cohort of more than 170,000 individuals over a span of 36 years. Amongst the mental health disorders in men, bipolar affective disorder was deemed the highest contributor to suicides related to mental illness, followed by depression and schizophrenia. In women, schizophrenia posed the highest risk, followed by bipolar disorder.[22] These findings highlight the need to ensure that suicide prevention measures effectively address mental illness.[23]

While schizophrenia and bipolar disorder ranked highest in terms of suicide risk in the United States' cohort, a similar study in the United Kingdom identified that depression was the most common diagnosis in suicide fatalities.[24] Given depression's possible effects on decisional capacity, interventions to target this disorder may prove beneficial in reducing suicide rates.[25]

However, although mental health patients are the usual victims of suicide, popular culture has frequently embraced the idea that they are to be feared. In a scathing editorial on The Lancet in 2013, reference was made to a headline which appeared in the UK's best-selling newspaper.[26] The headline presented people with mental illness as killers and failed to mention that individuals with mental illness are much more prone to die by suicide than to commit homicide.[27] The editorial proceeds to highlight the sheer difference in numbers: in England in 2011, 46 homicides were committed by people with mental illness, compared with 1333

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20. Barraclough et al., "A Hundred Cases of Suicide: Clinical Aspects."
21. Merete Nordentoft, Preben Bo Mortensen, and Carsten Bøcker Pedersen, "Absolute Risk of Suicide after First Hospital Contact in Mental Disorder.," *Archives of General Psychiatry* 68, no. 10 (October 1, 2011): 1058–64, doi:10.1001/archgenpsychiatry.2011.113.
22. Ibid.
23. Ibid.
24. Louis Appleby et al., "Safety First: Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness" (Department of Health, 2001).
25. Kelly and Dale, "Ethical Perspectives on Suicide and Suicide Prevention", 216. Theories as to how depression may lead to impairments in decisional capacity usually revolve around its effect on cognition. A model for such a concept was proposed by Wenzel and Beck, and its description may be found in page 5.
26. "Truth versus Myth on Mental Illness, Suicide, and Crime," *The Lancet* (Lancet Publishing Group, October 19, 2013), doi:10.1016/S0140-6736(13)62125-X.
27. Ibid.

fatalities by suicides in those with mental disorders.[28] This, the editorial confirms, is symptomatic of the stigmatisation of people with mental illness.[29] Furthermore, the discrimination with mental health patients also leads to a considerable number of avoidable deaths. A damning report issued in 2013 demonstrated how, on average, people with schizophrenia die 20 years younger than those without mental illness, mainly due to suboptimal care of their physical health.[30]

Ambivalence as a confounding variable in suicide risk evaluation

Ambivalence is defined as having simultaneous controversial feelings about a certain course of action.[31] It alludes to a sense of inner conflict.[32] The concept of ambivalence plays a major role in the evaluation of suicide risk, particularly in individuals who have attempted suicide but whose actions proved less than fatal. Indeed, the WHO has highlighted ambivalence as one of the factors to consider in suicide risk assessment.[33]

Indeed, it is imperative for psychiatrists to assess for ambivalence, since it provides an indication of the risk of future suicidal attempts.[34] It is of such importance that psychoanalytic theorists sought to develop their own understanding of the concept, concluding that the suicidal individual may exist with a "psychic split", internalising the "suicidal person" and the "non-

28. "The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Suicide and Homicide in Northern Ireland," 2011, www.manchester.ac.uk/nci, quoted in "Truth versus Myth on Mental Illness, Suicide, and Crime."
29. "Truth versus Myth on Mental Illness, Suicide, and Crime."
30. Rethink Mental Illness, "Lethal Discrimination," 2013.
31. "Ambivalence | Definition of Ambivalence by Merriam-Webster," accessed February 17, 2020, https://www.merriam-webster.com/dictionary/ambivalence.
32. Ibid.
33. Department of Mental Health WHO, "Preventing Suicide: A Resource for Primary Health Workers," n.d.
34. "Is This Patient Suicidal? Tips for Effective Assessment - Psychiatry Advisor," accessed February 17, 2020, https://www.psychiatryadvisor.com/home/topics/suicide-and-self-harm/is-this-patient-suicidal-tips-for-effective-assessment/.

suicidal person."[35] Weinberg goes as far as to say that an understanding of 'ambivalence' is essential in order to understand the suicidal mind.[36]

In clinical practice, ambivalence may be seen in drug overdose of lower severity, or when the suicidal person attracts the attention of others during the act itself, knowing that they will intervene and stop them.[37] Indeed, ambivalence is intrinsically linked with certain 'personality disorders', whereby an individual lacks the appropriate coping mechanisms to deal with stressors: treatment would thus aim at improving one's resilience.[38] Bergmans, in fact, refers directly to borderline personality disorder and its implications for treatment strategies addressing suicidality. She describes ambivalence as living in perennial "emotional flux" and that this experience is highly distressing.[39]

Borderline personality disorder is a mental condition characterised by emotional instability, impulsivity and self-harming behaviour, at times reaching a stage where one would attempt suicide.[40] A comparative study has in fact shown that in a typical lifetime, such individuals generally attempt suicide thrice.[41] Studies have indeed shown that personality disorders are exceedingly common in the psychiatric outpatient population, at a rate of 45%.[42] While not all these individuals have borderline personality disorder, an evaluation for undiagnosed

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35. Marc J. Kingsley, Tom Stockmann, and Daniel Wright, "Digital Lives in Psychotherapy: 'The Other in the Room,'" *Psychoanalytic Psychotherapy* 31, no. 2 (April 3, 2017): 160–75, doi:10.1080/02668734.2017.1303625.
36. "Is This Patient Suicidal? Tips for Effective Assessment - Psychiatry Advisor." Weinberg is a prominent publisher of psychoanalytic perspectives of suicide and his work includes the assessment of risk in individuals at a crisis.
37. Joel Paris, "Suicidality in Borderline Personality Disorder," *Medicina (Lithuania)* (MDPI AG, June 1, 2019), doi:10.3390/medicina55060223.
38. Yvonne Bergmans, Evelyn Gordon, and Rahel Eynan, "Surviving Moment to Moment: The Experience of Living in a State of Ambivalence for Those with Recurrent Suicide Attempts," *Psychology and Psychotherapy: Theory, Research and Practice* 90, no. 4 (December 1, 2017): 634 doi:10.1111/papt.12130.
39. Ibid.
40. "2020 ICD-10-CM Diagnosis Code F60.3: Borderline Personality Disorder," accessed February 17, 2020, https://www.icd10data.com/ICD10CM/Codes/F01-F99/F60-F69/F60-/F60.3.
41. Paul H. Soloff et al., "Characteristics of Suicide Attempts of Patients with Major Depressive Episode and Borderline Personality Disorder: A Comparative Study," *American Journal of Psychiatry* 157, no. 4 (April 2000): 601–8, doi:10.1176/appi.ajp.157.4.601.
42. Mark Zimmerman, Louis Rothschild, and Iwona Chelminski, "The Prevalence of DSM-IV Personality Disorders in Psychiatric Outpatients," *American Journal of Psychiatry* 162, no. 10 (October 2005): 1911–18, doi:10.1176/appi.ajp.162.10.1911.

personality disorders was strongly advised, given its significant therapeutic and prognostic value.[43]

It is also of imperative value when assessing risk, particularly after self-harming behaviour: in fact, in people with borderline personality disorder such behaviour is usually found to be innocuous.[44] Such individuals would resort to self-harm, usually through self-cutting, as a means to alleviate unbearable distress.[45] The assessing clinician would therefore need to understand that such behaviour, although undoubtedly dangerous, would not be indicative of any suicidal intent.[46]

In her phenomenological analysis of the lived experience of people with a history of recurrent suicide attempts, Bergmans advises practitioners to be considerate of the patient's "uncertainty about one's destiny…[having] not fully committed to either life or death." She adds that their act can be intended as a cry for help.[47] This has profound ethical repercussions when assessing the person's degree of autonomy.[48]

In light of these complexities, one can understand why there is still no effective algorithm which can be used by practitioners to accurately predict the risk of suicide.[49]

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43. Ibid.
44. Paris, "Suicidality in Borderline Personality Disorder."
45. Milton Z. Brown, Katherine Anne Comtois, and Marsha M. Linehan, "Reasons for Suicide Attempts and Nonsuicidal Self-Injury in Women with Borderline Personality Disorder.," *Journal of Abnormal Psychology* 111, no. 1 (2002): 198–202, doi:10.1037//0021-843x.111.1.198.
46. Ibid.
47. Margaret Pabst Battin, *The Death Debate : Ethical Issues in Suicide* (Prentice Hall, 1996).
48. Kelly and Dale, "Ethical Perspectives on Suicide and Suicide Prevention."
49. Gustavo Turecki and David A. Brent, "Suicide and Suicidal Behaviour," *The Lancet* (Lancet Publishing Group, March 19, 2016), doi:10.1016/S0140-6736(15)00234-2.

Considerations of autonomy and rationality

Upholding a person's autonomy when considering the request to end one's own life is of significant importance, particularly when determining whether it is being made rationally and with decisional capacity.[50] These considerations entail an appreciation of the person's earlier views on the subject, which is usually obtained through personal records, feedback from his loved ones or through legal instruments which allow advance care planning.[51]

Suicide as a rational and autonomous request

The concept of rational suicide dates back to Antiquity. Alvarez refers to the writings of Libianus who outlines the process adopted in ancient Greek city-states, whereby a man would request to commit suicide.[52] If the request is deemed reasonable, then the magistrate would supply the individual with hemlock; if deemed "frivolous" he would be sent back and his request would be denied.[53] Thus, even in ancient Western civilisations, a process was adopted whereby requests for suicide were screened and the state would determine whether one's request meets consensually agreed criteria.

This model is still being adopted, to a certain extent, in contemporary practice. However, Mayo argues that the notion of suicide has been medicalised.[54] He reasons that this process of 'medicalisation' of suicide started through the adoption of laws which condemned suicide,

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50. A discussion on the role of autonomy when considering suicidal pleas can be found in page 12.

51. James L. Werth and Debra C. Cobia, "Empirically Based Criteria for Rational Suicide: A Survey of Psychotherapists," *Suicide and Life-Threatening Behavior* 25, no. 2 (June 1, 1995): 231–40, doi:10.1111/j.1943-278X.1995.tb00922.x. This is discussed in further detail in page 27.

52. Margaret Pabst Battin and David J. Mayo, *Suicide, the Philosophical Issues* (New York: St. Martin's Press, 1980), quoted by David J. Mayo, "Rational Suicide?," *Journal of Personal and Interpersonal Loss* 3, no. 2 (1998): 193–203, doi:10.1080/10811449808414441.

53. Battin and Mayo, *Suicide, the Philosophical Issues*, as quoted by Mayo, "Rational Suicide?" This example was used by Mayo to demonstrate how the concept of 'rational suicide' is not new or modern, but rather dates back to the beginning of Western thought.

54. Thomas Szasz, *The Manufacture of Madness a Comparative Study of the Inquisition and the Mental Health Movement*, [1st ed.]. (New York: Harper & Row, 1970), quoted by Mayo, "Rational Suicide?" Mayo builds on the reasoning of Szasz, historically renowned for his anti-psychiatric stance. Szasz proposes that post-Industrial societies transformed moral, legal and religious condemnations into medical disorders, such as in the case of certain sexual behaviour.

which he in turn attributes to the condemnation of suicide by the Church in the 5th century A.D.[55] In their commentary on transitions in the attitudes towards suicide, Rich and Butts in fact highlight how it used to be regarded in a positive and honourable light by the Stoics, which is far different to today's general perspectives on the subject.[56]

Regardless of one's views on today's management of suicide through the medical (psychiatric) system, Mayo concedes that it is feasible to look at suicide by admitting that most attempts are committed irrationally, but that some attempts may be committed rationally. This paradigm thus proposes that society should allow some suicidal individuals to carry on with the act, provided that they meet certain criteria.[57]

Interestingly, he then proceeds to outline conditions which would allow one to deem his request for suicide as rational. Firstly, Mayo dissociates himself from discussion on the value of life, and whether this is absolute or relative.[58] Instead he proposes that one's decision to commit suicide should be assessed through the lens of "cost-benefit analysis."[59] The suicidal individual, according to Mayo, should seek to be informed of all available options, weighing them separately, without undue emotional interference, which may hinder his rational judgement.[60]

Mayo then proceeds to discuss how rational decision-making requires competence. The competent individual does not solely obtain information on relevant options, but ensures that one is in a position to comprehend the information in its deepest sense. Mayo surmises that a competent individual, therefore, has the insight to defer important decisions to a later date, to ensure that he is at his best possible mind-set to take the wisest decision possible.[61] Ultimately, Mayo is describing the process of ascertaining the presence of decisional or mental capacity

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55. Mayo, "Rational Suicide?" Mayo refers to St. Augustine's condemnation of suicide as the basis for Church doctrine on the concept. His position is discussed in page 11, where the 'sanctity of life' view is explained in more detail.
56. Karen L. Rich and Janie B. Butts, "Rational Suicide: Uncertain Moral Ground," *Journal of Advanced Nursing* 46, no. 3 (May 1, 2004): 271, doi:10.1111/j.1365-2648.2004.02987_1.x.
57. Mayo, "Rational Suicide?", 199
58. Ibid., 198
59. Ibid., 199
60. Ibid.
61. Ibid. In many ways, Mayo's description of 'competence' is similar to contemporary understand of 'mental capacity' from a psychiatric and legal point of view. Mayo then proceeds to give examples on how competence may be hindered in specific circumstances.

The concept of mental capacity

Mental capacity is one of the main legal and diagnostic tools available to assess competence to make autonomous decisions, and to protect those who lack it.[62] "One has capacity when one decides for oneself", as succinctly described by the Royal College of Psychiatrists.[63]

Mental capacity can change: the Royal College of Psychiatrists explains that since mental capacity depends on one's state of mind, which may fluctuate, then mental capacity is also variable.[64] It is assessed in stages, and is always specific, relating to a decision to a single function or task.[65]

In the United Kingdom, the Mental Capacity Act 2005 Code of Practice outlines the stages for mental capacity assessment.[66] Firstly, the individual should be able to understand all the information related to his decision. Secondly, one must be able to demonstrate retention of this information. Thirdly, the individual should be able to validate the information and process, thus arriving at a decision. Finally, one should be able to communicate the decision taken.[67]

The person is deemed to lack the mental capacity to make the decision if there is a deficiency in one of these four functions.[68] In such cases, the code stipulates that the "best-interests" decision must be made on the person's behalf, where one must seek to involve the individual, even though he is deemed to lack mental capacity.[69] This entails a consideration of the individual's views and values, and involvement of significant others, while keeping in mind

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62. "Mental Capacity Act 2005," accessed February 18, 2020, http://www.legislation.gov.uk/ukpga/2005/9/contents, as quoted by Ann Regan and Caitlin Sheehy, "Understanding Mental Capacity Law and Making Best-Interests Decisions," *Nursing Standard (Royal College of Nursing (Great Britain) : 1987)* 31, no. 14 (November 30, 2016): 54, doi:10.7748/ns.2016.e10652.

63. "Mental Capacity and the Law | Royal College of Psychiatrists," accessed February 18, 2020, https://www.rcpsych.ac.uk/mental-health/treatments-and-wellbeing/mental-capacity-and-the-law.

64. Ibid.

65. Deborah. O'Connor and Barbara. Purves, *Decision-Making, Personhood, and Dementia : Exploring the Interface* (Jessica Kingsley Publishers, 2009), as quoted by Regan and Sheehy, "Understanding Mental Capacity Law and Making Best-Interests Decisions", 59.

66. Department for Constitutional Affairs, "Code of Practice of the Mental Capacity Act 2005," 2007, www.tsoshop.co.uk.

67. Ibid., as quoted by Regan and Sheehy, "Understanding Mental Capacity Law and Making Best-Interests Decisions", 56

68. "Mental Capacity and the Law | Royal College of Psychiatrists."

69. Regan and Sheehy, "Understanding Mental Capacity Law and Making Best-Interests Decisions.", 56

their possible conflict of interests.[70] Assumptions should be avoided, and all the circumstances related to the decision in question should be considered.[71] Furthermore, if capacity may be regained in the future, the decision should be postponed, if clinically possible.[72] Ultimately, the aim should be to decide along the same lines which the individual would have decided had capacity been present.[73]

Lastly, a crucial principal in mental capacity assessment is the respect accorded to autonomous patients even in situations where their decision is deemed unwise by the caring professionals.[74] Regan and Sheehy admit that this may be the cause of considerable inner conflict for the health professional, since one would be inclined to insist that the patient adheres to the professional suggestions being given, with the aim of treating the patient.[75] However it is argued that the aim of professionals must primarily be to promote autonomy and self-determination, a view which is promoted by the Code of Conduct.[76] Consequently, an autonomous patient is entitled to make wrong decisions about his health, including refusal of treatment or early discharge from an inpatient setting, provided that his thought process is sound and rational.[77]

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70. Ibid., 57
71. Ibid.
72. Ibid.
73. Ibid.
74. Regan and Sheehy, "Understanding Mental Capacity Law and Making Best-Interests Decisions", 57
75. Ibid.
76. Department for Constitutional Affairs, "Code of Practice of the Mental Capacity Act 2005" as quoted by Regan and Sheehy, "Understanding Mental Capacity Law and Making Best-Interests Decisions", 57 Note that this position does not signify that professionals should condone anticipated criminal behaviour or acts which are prompted by mental illness, but rather that the autonomous patients are allowed to make unwise decisions in their clinical care. If there is suspicion of mental illness requiring detention, then one is obliged to apply tools provided through the Mental Health Act. Similarly, if there is suspicion that the patient may be planning a criminal act, regardless of mental capacity, one is obliged to involve the Police.
77. Regan and Sheehy, "Understanding Mental Capacity Law and Making Best-Interests Decisions." In this regard, Regan and Sheehy also comment on situations were failure to adhere to treatment may put others at risk or increase a patient's vulnerability, even though the decision is being made with full mental capacity. They suggest that such situations require more stringent application of criteria related to risk and capacity assessment. It is the author's belief that each individual has to be assessed on his own merits, on a case-by-case basis.

The criteria for rationality

The criteria which allow confirmation of a rational request for suicide have been the focus of many ethical debates. In 1986, Siegel declared that the satisfaction of three criteria would be sufficient.[78] Taken procedurally, the criteria require that the individual makes a realistic assessment of his present situation, which is subsequently followed by mental processes which are unhindered by psychological or emotional distress. Furthermore, one's motivation to commit suicide must be understandable to an observer who is otherwise uninvolved in the case.[79]

Werth and Cobia comment on Siegel's position and confer a number of interesting perspectives on the subject.[80] In their qualitative study on perspectives of psychotherapists on the subject of rational suicide, they extend upon the criteria proposed by Siegel and propose a similar cohort of three criteria, with the third one further divided into a number of considerations.[81] They remark that for suicide to be deemed rational, the suicidal individual has to have an unceasingly dismal condition, which is causing unbearable pain. Secondly, one's decision to commit suicide is a free choice, and not influence by any form of external pressure. Thirdly, they insist that the person must have arrived at his decision in a sound manner, a process which they describe by detailing a number of considerations.[82]

Werth and Cobia propose that for a decision to be deemed sound, the person must have considered all available options without undue haste, consulted with a mental health professional for assessment of "psychological competence" and consulted with an objective third-party, including one's loved ones. They proceed to remark that the suicidal individual must also take into account the impact of his act on his loved ones, while also ensuring that his

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78. K. Siegel, "Psychosocial Aspects of Rational Suicide," *American Journal of Psychotherapy* 40, no. 3 (July 1986): 405–18, doi:10.1176/appi.psychotherapy.1986.40.3.405.
79. Ibid.
80. James L. Werth and Debra C. Cobia, "Empirically Based Criteria for Rational Suicide: A Survey of Psychotherapists," *Suicide and Life-Threatening Behavior* 25, no. 2 (June 1, 1995): 237, doi:10.1111/j.1943-278X.1995.tb00922.x.
81. Ibid., 238
82. Ibid.

decision reflects his core personal values.[83] In many ways, this last condition is synonymous to Sneddon's appeal for 'deep autonomy'.[84]

Similar criteria were also proposed by Diekstra who emphasised the need to ensure that the person is making a "free-will decision", that he is suffering "unbearable physical or emotional pain" with no hope of recovery, that he is "not mentally disturbed" or that his suicide will not cause "unnecessary or preventable harm" to others.[85] Interestingly, Diekstra also emphasises that the person must have an "enduring wish to die", which is a clear appeal for consistency in one's request for suicide, over a reasonable time span.

Finally, it is understandable to find that a high proportion of inpatients in psychiatric hospitals lack mental capacity to make specific decisions: a study by Owen et al. in 2008, revealed that 60% of psychiatric inpatients were found to lack mental capacity to make decisions related to their treatment.[86] However, it is argued that the presence of mental illness does not automatically preclude one from making rational decision, even if on one's own suicide.[87] Hewitt comments on the overwhelming amount of psychiatric literature on suicide prevention and argues that some suicidal individuals may in fact be making a rational plea for suicide, even in situations of mental illness and despite the fact that 'mental illness' is one of the most crucial factors in psychiatrists' determination of suicide risk.[88]

Hewitt thus proposes a paradigm which views irrationality according to its degree of impairment: she distinguishes "constitutional irrationality", whereby one lacks any capacity for rational thought altogether, from "isolated irrationality", whereby one's decisional capacity

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83. Ibid.
84. Sneddon, "Equality, Justice, and Paternalism: Recentreing Debate about Physician-Assisted Suicide", 394. Interestingly, Werth and Cobia propose this understanding of a reflective attitude towards one's core values more than 10 years before Sneddon proposes and defines his concept of 'deep autonomy'.
85. R F Diekstra, "The Significance of Nico Speijer's Suicide: How and When Should Suicide Be Prevented?," *Suicide & Life-Threatening Behavior* 16, no. 1 (1986): 13–15, doi:10.1111/j.1943-278x.1986.tb00716.x.
86. Gareth S. Owen et al., "Mental Capacity to Make Decisions on Treatment in People Admitted to Psychiatric Hospitals: Cross Sectional Study," *BMJ (Online)* 337 (2008), doi:10.1136/bmj.39580.546597.BE.
87. Jeanette Hewitt, "Why Are People with Mental Illness Excluded from the Rational Suicide Debate?," *International Journal of Law and Psychiatry* 36, no. 5–6 (September 1, 2013): 358–65, doi:10.1016/j.ijlp.2013.06.006.
88. Ibid., 362

is impeded in exclusively specific areas of functioning.[89] Hewitt proceeds to cite Cholbi's position on mental illness, where it was argued that serious mental illness does not automatically lead to constitutional irrationality, since mental illness, even in severity, is usually confined to certain cognitive or psychological domains.[90] Cholbi then clarifies that exceptions to this argument include cases of severe dementia and traumatic brain injury, where a global deficit is usually observed.[91]

While arguing in favour of a more cautious approach in declaring psychiatric patients' plea for suicide as exclusively irrational, Hewitt also highlights the dichotomy which exists between attitudes to physical and mental suffering.[92] This inequality in contemporary attitudes tends to confer increased credibility to physical suffering while dispelling the severity of one's psychogenic suffering, which Hewitt regards as profoundly unjust.[93] This argument is based on the premise that attitudes to pain reflect underlying sociocultural and moral determinants, and as such impose upon the individual society's views of morality.[94] Hewitt thus concludes that psychiatric patients not only may have the ability to demand 'rational suicide', but that they should also be allowed to do so on grounds of psychological suffering.[95] Hewitt thus advocates for assessing suicide through the lens of objective mental capacity assessment, even in psychiatric patients, where decisions are evaluated on a case-by-case basis, with capacity being judged for specific domains.[96]

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89. Ibid.
90. Michael Cholbi, "Tonkens on the Irrationality of the Suicidally Mentally Ill," *Journal of Applied Philosophy* 26, no. 1 (February 1, 2009): 102–6, doi:10.1111/j.1468-5930.2009.00427.x, as quoted by Hewitt, "Why Are People with Mental Illness Excluded from the Rational Suicide Debate?", 362
91. Cholbi, "Tonkens on the Irrationality of the Suicidally Mentally Ill."
92. Hewitt, "Why Are People with Mental Illness Excluded from the Rational Suicide Debate?", 360
93. Ibid., 359
94. Ibid., 360
95. Ibid., 364
96. Ibid., 362

Mental capacity in Maltese law

With regards to Maltese legislation, at the time of writing, mental capacity is uniquely mentioned within the Mental Health Act of 2012.[97] In the law's preliminary section, 'mental capacity' is defined as "the patient's ability and competence to make… decisions and to be considered responsible for his actions."[98]

Part V of the Mental Health Act confirms that any person with mental illness is deemed to have full mental capacity until decided otherwise by a certified professional, who has to be a specialist in mental health.[99] Furthermore, if the person's lack of capacity is deemed to be transient in nature, and predicted to last less than fourteen days, then a note in the patient's clinical records would suffice.[100] At such a stage, a responsible carer would need to be appointed, who is tasked with making decisions on the patient's behalf.[101] If the patient himself lacks the capacity to understand his rights, the responsible carer will need to be informed of these within twenty-four hours.[102]

If it is deemed that the lack of capacity will persist for longer than fourteen days, then the specialist is instructed to make use of the eleventh and twelfth schedules.[103] The eleventh schedule is used to certify that an individual lacks mental capacity, whereas the twelfth

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97. "Mental Health Act 2012," *Laws of Malta, Cap. 525*, accessed February 18, 2020, http://www.justiceservices.gov.mt/DownloadDocument.aspx?app=lom&itemid=11962&l=1.
98. Ibid., 3
99. Ibid., 4, 15. The Maltese Mental Health Act confirms that a "specialist in mental health" is "a specialist whose name is entered in the Specialist Register for Psychiatry." The statement that all psychiatric patients must be deemed competent and if not, must be reviewed by a specialist may be found in Article 24,1-2.
100. Ibid., 15. This is clearly stated in Article 24,3
101. Ibid., 5. The responsible carer must have a close personal relationship with the patient. Article 4,3 clearly states who should be appointed as responsible carer if the patient lacks capacity to make such a decision, or if no prior preference, written by the patient when he still retained capacity, is submitted. If no significant other can be identified, then a mental health professional is to be appointed.
102. Ibid. 5. Article 3,2.
103. Ibid., 15. Article 24,4 instructs on the scope of the eleventh schedule. If the lack of capacity deemed not to require certification through the schedule, then it is standard practice that the specialist clearly documents that the patient lacks capacity in a specific area, and gives concrete reasons why. This is usually done in an inpatient setting, with documentation in the patient's medical notes.

schedule is applied to revoke the said certificate, thus confirming that the individual has recovered his mental capacity.[104]

The eleventh schedule requires that the certifying professional specify why he has arrived at such a decision.[105] One must also specify the exact domain whereby the individual is deemed to lack mental capacity, confirming that even in Maltese law, decisions on capacity are taken on a function-specific basis.[106]

Furthermore, the eleventh schedule further reinforces the specialists' consideration of the transient nature of mental capacity, when applicable. It requires that the professional provides a time window during which period the individual is deemed as lacking capacity: once this period has elapsed, the incapacitation would become invalid unless substantiated by further applications.[107] Furthermore, if there is strong reason to believe that one's capacity has recovered before this time period, then a specialist must apply the twelfth schedule, which will in turn lead to a request for a review by another independent specialist.[108]

If it is clinically deemed that the individual's capacity will not recover, such as in situations where there is severe and unremitting cognitive impairment, then the specialist may request that the individual is referred for interdiction.[109] In such a case, the interdicted person would be deemed incapable of taking care of his own affairs due to a mental condition or any other disorder; given that in such a case, the impairment in decisional capacity is deemed global in nature, once interdicted, the individual would be placed under the responsibility of a guardian, tasked with the management of all of his personal affairs.[110] In such a scenario, the impairment

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104. Ibid. 1, 48-51, 52-54
105. Ibid., 48-51
106. Ibid.
107. Ibid., 16 Reference is being made to Article 24,6.
108. Ibid., 16 Reference is being made to Article 24,7.
109. Ibid., 48-51. The eleventh schedule clearly states that if incapacitation is needed for more than 26 weeks, then the specialist must decide whether to recommend the patient for interdiction (refer to section 4 of the eleventh schedule).
110. "Civil Code," *Laws of Malta, Cap. 16*, accessed February 18, 2020, http://justiceservices.gov.mt/DownloadDocument.aspx?app=lom&itemid=8580&l=1.
Reference is made to article 188 of the Maltese Civil Code, which details the criteria for interdiction, the role of the appointed guardian and the duties which said guardian has in the promotion of the individual's wellbeing.

in mental capacity would be synonymous with the "constitutional irrationality" paradigm described by Hewitt.[111]

In order to ensure that the rights of such individuals are upheld, the Mental Health Act stipulates the appointment of a Mental Health Commissioner, who amongst other responsibilities, is tasked "to monitor any [such] person duly certified…"[112] The Commissioner's role is further clarified in Article 27, where the Commissioner is explicitly tasked with ensuring that the person is "not being neglected, abused or exploited." If the curator is found to be neglectful of his duties, the Commissioner is then tasked with filing an application to the competent court, requesting a change in curator.[113]

Interestingly, the law does not direct the specialist on how the mental capacity assessment should be conducted. It is, however, recommended practice that psychiatrists follow the guidelines set by the United Kingdom's Mental Capacity Act 2005 Code of Practice.[114] Consequently, capacity assessments follow the four stage process of ensuring that the individual understands, retains and processes information related to his decision and then communicates his decision back to the reviewing professional.

Advance healthcare directives

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111. Hewitt, "Why Are People with Mental Illness Excluded from the Rational Suicide Debate?", 362. A more thorough description of the concept can be found in page 27.

112. "Mental Health Act 2012", 7. Reference is being made to Article 6, which outlines all the functions of the Commissioner. The Commissioner's role to ensure that the incapacitated patient is respected and not restricted unnecessarily is clearly specified in function (e). There is also emphasis on his role in promoting appropriate guidelines in function (h).

113. Ibid., 17

114. Maltese Association of Psychiatry, "The Post Graduate Training Programme for Psychiatry," 2017, https://deputyprimeminister.gov.mt/en/regcounc/msac/Documents/Postgraduate Training Programme in Psychiatry_July 3rd 2017.pdf; "GMC Approved Curriculum | Royal College of Psychiatrists," accessed February 18, 2020, https://www.rcpsych.ac.uk/training/curricula-and-guidance/gmc-approved-curriculum-modules. The Psychiatry Training Curriculum clearly states that trainees must obtain Membership within the Royal College of Psychiatrists, in the United Kingdom, in order to be recognised as psychiatrists within the Maltese specialist register. The Royal College's curriculum, as referenced, requires adherence to the Code of Conduct. A sound understanding, with both theoretical and practical knowledge of capacity assessment, is required for trainees to attain membership.

Advance healthcare directives are an important legal tool which allow individuals to safeguard their autonomy in the event that they lose their decisional capacity later on. By definition, an advanced healthcare directive is in fact a legal document which allows an individual to determine how his health should be managed at a later date, in situations when he would be unable to decide for himself due physical or mental infirmity.[115] This may be of considerable relevance in degenerative brain disease, mental illness, acute confusional states, traumatic injury or in chronic medical illness, when the person would thus lose his decisional capacity.[116] Such considerations are of imperative significance in ensuring that the person dies with "dignity and grace."[117]

Indeed, literature has shown that there is a disparity between the treatment administered to the moribund person and the treatment the person wishes to receive at such a terminal stage of one's life.[118] This "disconnect" between "received care" and "desired care" can increase the individual's suffering, the suffering of one's caregivers and overall healthcare costs.[119] Through an extensive literature review on the prevalence of advance directives in the United States, Yadav et al. confirmed that approximately a third of American adults had completed a living will or a "healthcare power of attorney" directive, as a means to ensure self-determination at the end-of-life.[120] The authors proceed to define a "living will" as a written statement whereby the person determines which treatment he or she may receive or refuse in the event of incapacitation during end-of-life care; similarly, a "power of attorney" directive allows an individual to appoint a surrogate or proxy to make end-of-life decisions on his or her

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115. "Advance Healthcare Directive - Wikipedia," accessed March 4, 2020, https://en.wikipedia.org/wiki/Advance_healthcare_directive.

116. MBBS Christopher J. Ryan, "Ethics, Psychiatry, and End-of-Life Issues," *Psychiatric Times*, 2010. Ryan provides an insightful discussion on how certain diseases of the brain have a clear impact on one's decisional capacity, and then considers the role of psychiatrists in ascertaining that the person is making a competent decision if considering suicide.

117. Ibid., 26. A 'dignified death' naturally entails that it respects the dying person's values and thus logically includes a consideration of the person's earlier wishes on the treatment provided at the end-of-life.

118. Kuldeep N. Yadav et al., "Approximately One in Three Us Adults Completes Any Type of Advance Directive for End-of-Life Care," *Health Affairs* 36, no. 7 (July 1, 2017): 1244, doi:10.1377/hlthaff.2017.0175.

119. Ibid.

120. Ibid. 1245-1247. The study included a systematic meta-analysis of all studies which reported a completion proportion of advance directives among adults in the United States, conducted between 2011 and 2016.

behalf if deemed incapable of doing so.[121] While pointing towards how both these modalities fall under the legal definition of an advanced healthcare directive, Yadav et al. underline the importance of ensuring that the person making such decisions reserves the right to modify them at a later date, or even revoke them altogether.[122]

They proceed to highlight that, despite the high completion rate, advance care planning in the United States is possibly impeded by bureaucratic policies and that more effort should be made to target "vulnerable populations", such as those adults who are at a more imminent risk of death due to old age or severe illness, thus ensuring that they have a say in their care provision at the end of life.[123]

Psychiatric Advance Directives

Another relevant aspect of advance care planning is the concept of 'Psychiatric Advance Directives' (PADs). As legal instruments, PADs are similar to advance healthcare directives since they are aimed at promoting a person's autonomy and right to self-determination at a time when the patient becomes incapable of deciding for himself. However, PADs are exclusively intended for the benefit of individuals with diagnosed mental illness, allowing them to determine envisioned aspects in their future mental healthcare, such as the future provision of electroconvulsive therapy, enforced seclusion or the restriction of personal freedom in line with local mental health legislation.[124] Such a concept has received considerable attention within the Western and Anglo-American world, with legislation favouring the completion of PADs in many countries across the globe.[125] Issues however remain as to its legal enforceability and its practical implementation in clinical practice.[126]

Of notable importance is the issue of weighing patient autonomy versus the state's duty to safeguard life, prevent suicide, to ensure the safety of third parties and to uphold the integrity

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121. Ibid., 1244
122. Ibid. It is understood that such changes may be made provided that the person is found to have retained decisional capacity at that specific moment in time.
123. Ibid. 1249-1250. The authors also comment on the effectiveness of reimbursement policies targeting medical professionals in order to encourage them to discuss end-of-life planning with their patients.
124. Penny Weller, "Psychiatric Advance Directives and Human Rights," *Psychiatry, Psychology and Law* 17, no. 2 (May 2010): 218–29, doi:10.1080/13218710903496318.
125. Ibid.
126. Ibid., 225

of the clinical profession, all of which may be compromised if psychiatric treatment is not administered readily and effectively. These are in fact highlighted as the four "state interests" in a meta-analyses of case laws in United States' courts and tend to conflict with the patient's care requests, made known through his PAD.[127] This ethical conflict is pervasively highlighted in multiple literary works and stems from a concern that mental illness, unlike terminal illness, may be curable and may directly impede a person's rational decision-making ability.[128]

Understandably, for advocates of PADs, this is deemed as a potential hindrance in the effective implementation of PADs in clinical practice. Other cited factors include legal uncertainties related to their clinical application, professional's unfamiliarity to the concept, as well as the inaccessibility of PAD documents during moments of crisis, when decisions have to be taken within a short time span.[129] These are in fact deemed amongst some of the most significant clinical and organisation barriers to their effective implementation.[130]

Advance healthcare directives in Maltese law

Discussions on living wills and advance care directives sporadically surface in contemporary local debate. A recent example is the case of Joseph Magro, a sufferer of amyotrophic lateral sclerosis (ALS) who appeared before the Family Affairs Parliamentary Committee in 2016 demanding the introduction of euthanasia legislation for patients suffering from untreatable

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127. Ibid., 220. The author proceeds to compare the impact of different legislations on the completion and implementation of PADs: she comments on the "minimalist" approach adopted in New Zealand which highlights the overarching legal prerogative to ensure the patient's "best interests" despite the contents of his or her PAD. She subsequently compares this with the provisions of the law in Scotland, which provides a detailed pathway on how to consider PADs in clinical practice; Scottish law also departs from the "best interest" position as a normative tenet, instead promoting a language focused on inclusive patient participation, non-discrimination and holistic benefit.

128. Ibid.; Susan A. Salladay, "Psychiatric Advance Directive?," *Nursing* 30, no. 7 (2000): 65–66; Pablo Nicaise, Vincent Lorant, and Vincent Dubois, "Psychiatric Advance Directives as a Complex and Multistage Intervention: A Realist Systematic Review," *Health and Social Care in the Community* (John Wiley & Sons, Ltd, January 1, 2013), doi:10.1111/j.1365-2524.2012.01062.x.

129. Weller, "Psychiatric Advance Directives and Human Rights.", 224

130. Nicaise, Lorant, and Dubois, "Psychiatric Advance Directives as a Complex and Multistage Intervention: A Realist Systematic Review.", 1

illness.[131] Magro proceeded to emphasise the deterioration he expected in the coming months and years, owing to the progressive nature of his neurological disease, proceeding to claim that he would prefer ending his life by suicide rather than "getting to a point where [he could not] live life in dignity".[132] His wife also launched an online petition aimed at promoting the legalisation of euthanasia in Malta.[133]

His appeal sparked numerous reactions. Political parties mulled over whether to include it in their upcoming electoral manifesto, or else declared that it is a subject requiring greater internal debate.[134] The Church in Malta, in a letter to members of Parliament, warned that euthanasia is "never in the best interests" of the person.[135] The political party 'Alternattiva Demokratika' rejected the proposal to introduce euthanasia, but requested that terminally ill patients be allowed to complete living wills which would enable them to refuse 'extraordinary treatment'.[136]

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131. Parliament of Malta, "Family Affairs Committee Parliamentary 13th July 2016 Group Meeting," 2016, https://parlament.mt/en/12th-leg/family-affairs-committee/fac-027-13072016-0645-pm/?page=1&numItems=.

132. MaltaToday.com.mt, "[WATCH] 'I Want to Live, Not Exist', ALS Sufferer Tells MPs during Euthanasia Hearing," 2016, https://www.maltatoday.com.mt/news/national/67526/euthanasia_i_want_to_live_not_exist__als_sufferer_tells_mps#.XmjB-qhKiM_.

133. MaltaToday.com.mt, "'Let My Husband Die in Dignity': ALS Sufferer's Wife's Petitions for Euthanasia," 2016, https://www.maltatoday.com.mt/news/national/67963/let_my_husband_die_in_dignity_als_victims_wifes_petition_pleads_for_euthanasia_#.XmjL9ahKiM8.

134. MaltaToday.com.mt, "ALS Sufferer: Ministers Mulling Inclusion of Euthanasia in Electoral Programme," 2016, https://www.maltatoday.com.mt/news/national/67973/ALS_sufferer_Ministers_mulling_inclusion_euthanasia_electoral_programme#.XmjMPahKiM9.

135. The Times of Malta, "Bishops Tell MPs: 'Oppose Euthanasia,'" 2016, https://timesofmalta.com/articles/view/bishops-tell-mps-oppose-euthanasia.619940.

136. MaltaToday.com.mt, "AD Rejects Euthanasia, Proposes Living Will for Terminal Patients," 2016, https://www.maltatoday.com.mt/news/national/67658/ad_rejects_euthanasia_proposes_living_will_for_terminal_patients_#.XmjB26hKiM8. A distinction is here made between extraordinary treatment, which includes interventions which are otherwise burdensome, disproportionate and possibly futile, and ordinary treatment, which are measures which can be applied without causing undue suffering or financial burden, and which accords patients a reasonable hope of recovery. This distinction was introduced into scientific discourse by Pope Pius XII in a speech titled "Legal and moral issues of reanimation" delivered before a group of anaesthetists in 1957. This has dramatically shaped ensuing ethical views and catholic doctrine on the subject of end-of-life care.

While a Maltese law on advance healthcare directives has yet to be extensively debated, let alone introduced, such complex and sensitive issues have also been debated in previous legislatures within the purposely set-up Bioethics Consultative Committee.[137] In a committee report on living wills, Notary Joseph Sciriha highlights how, despite their relative brevity when compared to other legal documents, living wills must contain certain indispensable aspects: they must declare that the signatory, at the time of signing, was of sound mind; they must highlight the conditions which would entail its application in clinical practice, such as severe and lasting brain injury, an inability to decide on one's own behalf, and the shared clinical opinion of two independent professionals that the patient is unlikely to recover or to live a rational existence; they must subsequently propose how clinicians should care for the patient in such conditions, notably by omitting interventions which could sustain or prolong the person's life; and finally they must also exempt clinical personnel from any civil liabilities arising from "such acts or omissions".[138]

In a separate report, the Consultative Committee specifically discusses advance directives, quoting Article 5 of the Oviedo Convention which states that "an intervention… may only be carried out after the person concerned has given free and informed consent to it."[139] The report then quotes Article 9 of the Convention, which comments on how a person's expressed wishes related to medical intervention "should be taken into account" in situations when the person is unable to make his wishes known.[140] Building on the need to ensure free and informed consent, and a respect for a person's previously expressed wishes, the report proceeds to discuss the recommendations of the Council of Europe's Committee of Ministers which, in December 2009, defined the promotion of "self-determination" as the basis for the scope of advance

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137. Malta Bioethics Consultative Committee, "Committee Opinions," 2012, https://deputyprimeminister.gov.mt/en/regcounc/Bioethics-Committee/Pages/Opinions.aspx.
138. Joseph H Sciriha, "Living Wills and Maltese Law," 2010.
139. Council of Europe, "Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine," *Treaty No. 164*, 1997, https://www.coe.int/en/web/conventions/full-list/-/conventions/treaty/164; quoted in Malta Bioethics Consultative Committee, "Patients' Right to Self Determination and Advance Directives," 2012.
140. Council of Europe, "Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine"; quoted in Malta Bioethics Consultative Committee, "Patients' Right to Self Determination and Advance Directives."

directives and continuing powers of attorney.[141] The Maltese Committee proceeds to clarify that the recommendations of the Committee of Ministers allow each member state to enact changes to the circumstances which would allow the implementation of advance directives.

In fact, after discussing the local scenario, along with the benefits and limitations of advance care directives, the Consultative Committee provides a number of recommendations.[142] It proposes that the introduction of advance directives in Malta should be regulated by a sound legal framework and that they should be legally binding when planning a person's clinical care. They should not be used for economic purposes or a as a precondition to nursing homes. People should be encouraged to make use of both a living will and continuing power of attorney in order to maximise the usefulness of advance care planning. The Committee also emphasis that, under Maltese law, requests for euthanasia or assisted suicide should not form part of an advance directive, since this would be illegal and would contradict the professionals' code of ethics. The sole scope of advance directives should be to allow a person to pass in a manner consistent with his or her values, and in a spirit of "dialogue, trust and solidarity."[143]

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141. Council of Europe Committee of Ministers, "Recommendation CM/Rec(2009)11 of the Committee of Ministers to Member States on Principles Concerning Continuing Powers of Attorney and Advance Directives for Incapacity," December 9, 2009, https://search.coe.int/cm/Pages/result_details.aspx?ObjectID=09000016805c0b39; quoted in Malta Bioethics Consultative Committee, "Patients' Right to Self Determination and Advance Directives."

142. Malta Bioethics Consultative Committee, "Patients' Right to Self Determination and Advance Directives."

143. Ibid., 16-17

The concept of assisted suicide: a myriad of ethical considerations

Assisted suicide is the act of taking away one's own life, directly and intentionally, with the help of others.[144] It must be distinguished from the conventional definitions of euthanasia, and the common understanding of suicide as an individual act. The differences are apparent when one considers the details related to the act of ending one's life, to the one committing such an act, and to the role of the physician, or those present, in this entire process.

While suicide assumes an individuality in the act of killing oneself, assisted suicide entails the active and wilful support of another, without whom the act of suicide would not be possible. It also implies that the one committing the suicide requested the help of the other, without any external coercion and with full decisional capacity. Any divergence from these criteria would render assisted suicide a homicidal act, where the one who performs the suicide would in fact be performing it unwillingly, due to the actions of another, and thus against his explicit consent.

The role of the assisting other must also be considered. It involves a consideration of two main premises. The assisting other must first refrain from stopping the individual from killing himself. He or she will thus be choosing not to intervene in thwarting the suicidal act, despite being informed of its imminence. Furthermore, the same assisting other must provide the individual requesting suicide with the method and means to bring about his own death. These two considerations hold different ethical and moral valence, and will be interpreted in more detail when discussing the findings obtained from the focus group exercise.

The physician is frequently mentioned when discussing the concept of assisted suicide, most notably because the suffering patient usually resolves to ask one's physician for assistance in ending his life. The physician would thus be tasked with reversing his professional role, from the one helping the patient recover, or supporting him through the suffering, to the one actually

144. Nicola Davis, "Euthanasia and Assisted Dying Rates Are Soaring. But Where Are They Legal?," *The Guardian*, July 15, 2019, https://www.theguardian.com/news/2019/jul/15/euthanasia-and-assisted-dying-rates-are-soaring-but-where-are-they-legal.

facilitating the patient's demise through a direct act. This reversal may be seen as a threat to the physician's professional integrity.[145]

Understandably, studies have also shown that this bears significant emotional and psychological repercussions on the assisting physician.[146] In his literature review on the subject, Stevens describes that physicians are at times intimidated by the same patients who ask them to assist in their suicide, and are subsequently shocked by the sudden onset of death; powerlessness, isolation and helplessness are also well-described.[147]

It is argued that the involvement of non-governmental organisations in this process may help physicians cope with the stresses of assisting in an individual's suicide.[148] Notable examples include EXIT, Compassion and Choices and Dignitas.[149] Ziegler and Bosshard state that the involvement of these organisations helps to share the responsibilities with the physicians assisting suicide, namely by providing services such as screening, patient assessment and helping with consideration of possible alternatives to assisted suicide.

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145. K Faber-Langendoen et al., "Should Assisted Suicide Be Only Physician Assisted? University of Pennsylvania Center for Bioethics Assisted Suicide Consensus Panel.," *Annals of Internal Medicine* 132, no. 6 (2000): 482–87, doi:10.1191/0269216305PM1062OA.

146. Kenneth R. Stevens, "Emotional and Psychological Effects of Physician-Assisted Suicide and Euthanasia.," *The Linacre Quarterly* 73, no. 3 (2006): 203–16, doi:10.1080/20508549.2006.11877782.

147. Ibid.

148. Stephen J. Ziegler and Georg Bosshard, "Role of Non-Governmental Organisations in Physician Assisted Suicide," *British Medical Journal* (BMJ Publishing Group, February 10, 2007), doi:10.1136/bmj.39100.417072.be.

149. "Exit International," accessed February 15, 2020, https://exitinternational.net/; "Compassion & Choices Home | Compassion & Choices," accessed February 15, 2020, https://compassionandchoices.org/; "Dignitas," accessed February 15, 2020, http://www.dignitas.ch/?lang=en.

Euthanasia: definition and differences to suicide

Suicide must however be distinguished from euthanasia. Prior to any reasonable discussion on these important concepts, it is therefore also highlight and explore these differences.

Suicide, by definition, implies a sense of willingness to end one's life, and the direct act of killing oneself. Euthanasia has a broader meaning; it encompasses situations where one requests other's to terminate their own lives in situations of intolerable pain or suffering.[150] The suffering is usually classified as unbearable and without any practical prospect of improvement.[151]

Euthanasia also invariably implies that one dies through the act, or omission, of another. Traditional interpretations entail a sense of mercy by the one assisting the patient: a sense of compassion towards those who are vulnerable or in distress.[152] It is for this reason that an etymological understanding of the word 'euthanasia' defines it as a "gentle death."[153]

Euthanasia exists in many forms. It is classically divided into four types: 'active' and 'passive'; 'voluntary' and 'involuntary/non-voluntary'.[154] The 'active' form implies that the suffering individual's life is ended through the direct act of killing, whereas the 'passive' form leads to death indirectly, as a foreseen consequence of treatment withdrawal, or the cessation of interventions deemed unnecessary. A pertinent example would be the passing away of an individual in a persistent vegetative state, after life-support is switched off. The individual, in this case, would have died due to natural causes and not through active killing.

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150. "Euthanasia | Definition of Euthanasia by Merriam-Webster," accessed February 15, 2020, https://www.merriam-webster.com/dictionary/euthanasia.
151. Regional Euthanasia Review Committees, "Euthanasia Code 2018," 2018, https://english.euthanasiecommissie.nl/the-committees/code-of-practice.
152. "Mercy | Definition of Mercy by Merriam-Webster," accessed February 15, 2020, https://www.merriam-webster.com/dictionary/mercy.
153. "Euthanasia | Origin and Meaning of Euthanasia by Online Etymology Dictionary," accessed February 15, 2020, https://www.etymonline.com/word/euthanasia.
154. "The Four Types Of Euthanasia Philosophy Essay," accessed February 15, 2020, https://www.ukessays.com/essays/philosophy/the-four-types-of-euthanasia-philosophy-essay.php.

When classifying euthanasia, the question of voluntariness is frequently discussed. It is a source of considerable ethical importance and stems from arguments relating to one's capability to decide on his own behalf.[155]

Voluntary euthanasia occurs when the suffering individual intentionally and deliberately asks others to end his life. Conversely, if an individual is deemed incapable of giving autonomous consent, then a best-interest decision is made on his behalf by his loved ones or by the medical team. In this case, euthanasia would be non-voluntary, due to the patient's inability to decide. A classic example for this type of euthanasia involves the comatose patient.

However, a distinction must here be made between non-voluntary and involuntary euthanasia. The latter is the ending of one's life in situations when the individual opposes the decision or was not asked about it in the first place. Involuntary euthanasia thus requires that the individual has the capacity to make decisions related to his care and was either not consulted, or was killed against one's will.[156] This is tantamount to homicide. A notable example is the eugenics "Aktion T4" programme commissioned by the Third Reich during World War II.[157] This infamous effort had led to the extermination of 300,000 individuals who had been deemed as a burden to the state or as racially inferior. Supporters of this programme had argued that the killings were a form of euthanasia, since they were allaying the sufferings of those who are impaired by physical or mental illness or who have genetic or racial "defects". It shows that the concept of 'suffering' is also open to subjective interpretation, and may be abused for socio-political purposes.

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155. Ibid.
156. Jennifer Jackson, *Ethics in Medicine* (Polity, 2006), 137
157. "Aktion T4 - Wikipedia," accessed February 15, 2020, https://en.wikipedia.org/wiki/Aktion_T4.

Ethical views on suicide

Given its complexity and sensitivity, suicide has prompted diverse positions, each based on the consideration of important values, such as the value of life, autonomy and duty towards the community.[158]

The 'respect for life' view

The conservative view holds that life is sacred and inherently good. It is deserving of respect.[159] It follows that the act of taking one's life therefore deprives one of life and destroys a fundamental good. Traditionally, theistic believers support this perspective, arguing that life is a blessing from the Creator, and that one is not allowed to remove a life which was created by God.[160] This position is promoted in Chapter 20 of St. Augustine's "City of God", where he states that "he who kills himself still kills nothing else than man."[161]

Indeed, this 'sanctity of life' argument is held by many world's religions.[162] This is notably seen with Abrahamic religions, Judaism, Islam and Christianity, which regard life as an exclusive gift from God. A different perspective is usually associated with the Eastern faiths, such as Buddhism, Brahmanism and Shinto, which at various stages of their history had permitted, if not institutionalised, the act of suicide.[163] Nevertheless, regardless of the theological position of the major religion, there is a clear trend between religiosity and suicide rates, with increased religiosity consistently associated with decreased suicidal rates in a population.[164] While the factors conferring this protective value to religion are a contentious issue between researchers, a number of theories propose that religion confers a sense of

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158. Kelly and Dale, "Ethical Perspectives on Suicide and Suicide Prevention."
159. Tom L. Beauchamp and Tom. Regan, *Matters of Life and Death : New Introductory Essays in Moral Philosophy* (McGraw-Hill, 1993), 85
160. Augustine of Hippo, *City of God (Penguin Classics)* (Penguin Classics, 2004), 35, https://www.xarg.org/ref/a/0140448942/.
161. Ibid.
162. Erminia Colucci and Graham Martin, "Religion and Spirituality Along the Suicidal Path," *Suicide and Life-Threatening Behavior* 38, no. 2 (April 2008): 229–44, doi:10.1521/suli.2008.38.2.229.
163. Ibid, 230
164. Robin E. Gearing and Dana Lizardi, "Religion and Suicide," *Journal of Religion and Health* 48, no. 3 (2009): 332–41, doi:10.1007/s10943-008-9181-2.

integration within one's community, which is in turn protective.[165] Other exponents propose that one's commitment to core religious beliefs, even if only a few, is profoundly significant in preventing suicidal behaviour, particularly due to religion's cosmological perspectives on the afterlife and on the significance of suffering.[166]The issue is complicated by the fact that despite its invariable protective effect, religion tends to exert varying degrees of protection, depending on a myriad of social and cultural factors.[167]

Regardless of the factors associated with religion's protective effects on suicidal behaviour, the 'sanctity of life' argument is still highly relevant: the act of suicide is seen as inherently bad and should be discouraged.

The role of 'autonomy' in suicide

Autonomy is defined as self-directing freedom.[168] It is a much-quoted principle in contemporary debates on social values, although its meaning may be misconstrued depending on its interpretation.[169] Beauchamp and Childress, in their landmark work on the topic, defined autonomy as "a professional obligation", and not "a mere ideal in healthcare".[170] They refer to it in terms of "decisional capacity": their definition of one's capacity to make autonomous decisions is in many ways similar to the common legal understanding of 'mental capacity'.[171] The latter is defined by Beauchamp as "the ability to grasp, appreciate the significance of, form relevant intentions and not be controlled by internal and external forces that the person cannot

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165. Jonathan H. Turner, "Emile Durkheim's Theory of Integration in Differentiated Social Systems," *Sociological Perspectives* 24, no. 4 (October 1981): 379–91, doi:10.2307/1388774.
166. Rodney Stark and William Sims Bainbridge, "Towards a Theory of Religion: Religious Commitment," *Journal for the Scientific Study of Religion* 19, no. 2 (June 1980): 114, doi:10.2307/1386246.
167. Andrew Wu, Jing Yu Wang, and Cun Xian Jia, "Religion and Completed Suicide: A Meta-Analysis," *PLoS ONE* 10, no. 6 (June 25, 2015): e0131715, doi:10.1371/journal.pone.0131715.
168. "Autonomy | Definition of Autonomy by Merriam-Webster," accessed February 16, 2020, https://www.merriam-webster.com/dictionary/autonomy.
169. "Autonomy | Internet Encyclopedia of Philosophy," accessed February 16, 2020, https://www.iep.utm.edu/autonomy/.
170. Tom L. Beauchamp; James F. Childress, *Principles of Biomedical Ethics - Paperback, New York: Oxford University Press*, vol. null, 2001, 63, Doi 10.1177/004057368003600423.
171. Kelly and Dale, "Ethical Perspectives on Suicide and Suicide Prevention", 215

resist" when making decisions.[172] If not synonymous, 'mental capacity' and 'autonomy' should be considered as intricately related.

This consideration is of great significance in contemporary ethical debate on the permissibility of suicide.[173] Hume's essay 'Of Suicide' articulated his defence of suicide on the basis of autonomy.[174] He concludes that there are circumstances when suicide may prove beneficial to the individual, one's family and society as a whole.[175] He therefore justifies suicide, and deems morally impermissible any act which seeks to prevent a person from committing suicide.

In light of this emphasis on suicide as autonomous act, a consideration must be given to the suicidal person's autonomy, and its relatedness to mental capacity. This allows professionals to act on the patient's behalf in cases of mental illness, when this is thought to be impeding the suicidal individual's decisional capacity.[176] This approach not only provides moral justification but also a moral obligation to act paternalistically for the individual's best interests.[177]

A distinction was also created between varying degrees of autonomy. Sneddon identifies "shallow autonomy" and "deep autonomy".[178] He proposes that a shallow understanding of autonomy can be seen when an individual decides on something on the basis of his ability to exert his own sense of self-determination. He describes this sense of autonomy as "superficial" and "barely scratching the surface of the depths of human psychology."[179]

Conversely, Sneddon describes 'deep autonomy' as closer to the identity of the individual, and carrying with it a consideration of one's life plan. It entails a reflection on one's values and posits that, to be truly autonomous, this individual must reflect on whether he has chosen to

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172. Beauchamp and Regan, *Matters of Life and Death : New Introductory Essays in Moral Philosophy*: 83-104
173. Kelly and Dale, "Ethical Perspectives on Suicide and Suicide Prevention."
174. Hume, *Of Suicide.*
175. Ibid. Refer to Hume's argument on altruistic suicide (page 5Acts of despair, however, are not the only reason for suicide. Some suicides are altruistic, intended to achieve a greater purpose. Indeed, Durkheim's seminal 1897 book "Suicide: A study in sociology" gives an account of some acts of suicide as a "sacrifice… imposed for social ends".).
176. Moreland, "The Morality of Suicide: Issues and Options."
177. Ibid, 220
178. Sneddon, "Equality, Justice, and Paternalism: Recentreing Debate about Physician-Assisted Suicide."
179. Ibid, 394

adopt these values and why.[180] Sneddon's perspectives on the nature of autonomy prove useful when discussing the moral permissibility of paternalistic interventions.

Suicide and one's duty towards others

Another argument against suicide was presented by Battin in 1996.[181] She argues that, provided there is no impairment in one's autonomy, then one is morally forbidden to intervene and to attempt to prevent the suicide.[182] However, if a situation exists where the individual's suicide would cause harm to others, then intervention would be permissible.[183] Kelly and Dale exemplify this concept by discussing the case of a man whose terminal illness is causing him unbearable suffering and who thus wishes to commit suicide.[184] They argue, however, that his wife has strong religious beliefs, and that in view of her distress if her husband were to commit suicide, then a brief paternalistic intervention would be morally justified.[185]

Suicide from a utilitarian perspective

Utilitarianism seeks to maximise utility, deeming good any action which maximises pleasure over pain.[186] From a utilitarian perspective, as championed by one of its main philosophers, John Stuart Mill, suicide prevention is never permissible, unless briefly, to ascertain that the individual is acting autonomously.[187] It is the utilitarian position that individual freedom and independence are amongst the greatest source of good, and therefore should be maximised, hence the absolute respect for autonomy.[188]

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180. Ibid.
181. Battin, *The Death Debate : Ethical Issues in Suicide*.
182. Margaret Pabst Battin, *The Death Debate : Ethical Issues in Suicide* (Prentice Hall, 1996), quoted in Kelly and Dale, "Ethical Perspectives on Suicide and Suicide Prevention."
183. Ibid.
184. Kelly and Dale, "Ethical Perspectives on Suicide and Suicide Prevention."
185. Ibid.
186. "Utilitarianism | Definition of Utilitarianism by Merriam-Webster," accessed February 16, 2020, https://www.merriam-webster.com/dictionary/utilitarianism.
187. John Stuart Mill, *On Liberty*, 2nd Edition (London: John W. Parker and Son, 1859), doi:10.1017/CBO9781139149785.
188. Ibid.

Mill, however, allows for a brief period of assessment, whereby one assures that the suicidal individual is acting without any internal or external influence. Once this is ascertained, it would be morally impermissible to stop one's suicide.[189] However, when discussing a period of prior assessment, Mill did not specify to what lengths one may go to ascertain that the suicidal individual is acting autonomously and what intervention may be performed if the suicidal individual is found not to be acting autonomously.[190]

A pertinent critique to Mill's view is that made by Appleby et al., who highlighted the fact that, in Mill's time, treatment for mental illness was not as effective as today.[191] One, therefore, cannot know whether, in cases of mental illness, Mill would have justified today's widespread practice of brief involuntary detention and treatment.[192]

Another interesting critique to the utilitarian perspective on suicide was that made by Feldman who argued that a utilitarian seeks to promote the 'good' of the individual, but also of others.[193] From this perspective, Feldman presented evidence that suicide is found to harm society on many fronts, including emotionally and economically.[194] He mentions how suicide leads to exorbitant costs, with hospitals having to care for individuals whose attempted suicide failed, apart from the lost productivity of the deceased individual. Furthermore, he argues that suicide is socially erosive, citing a number of 'copycat' suicides whereby individuals commit suicides in clusters. One therefore concludes that suicide, in itself, cannot be 'good' since a proper consideration of the act should also take into account its broader consequences.[195] He argues that, save for some circumstances, it would "most likely" be 'good' that suicide is not completed.[196]

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189. Ibid., quoted by Kelly and Dale, "Ethical Perspectives on Suicide and Suicide Prevention.", 216
190. Kelly and Dale, "Ethical Perspectives on Suicide and Suicide Prevention.", 216
191. Louis Appleby et al., "Safety First: Report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness" (Department of Health, 2001), quoted by Kelly and Dale, "Ethical Perspectives on Suicide and Suicide Prevention.", 216
192. Kelly and Dale, "Ethical Perspectives on Suicide and Suicide Prevention.", 216
193. David Feldman, "Can Suicide Be Ethical? A Utilitarian Perspective on the Appropriateness of Choosing to Die," *Death Studies*, June 1, 2006, doi:10.1080/07481180600742517.
194. Ibid., 531-532
195. Ibid., 535
196. Ibid., 534

Suicide prevention: paternalism or duty?

The positions summarised previously seem to either justify suicide prevention in all circumstances, as with the 'sanctity of life' argument, or to justify it in certain circumstances, ensuring that the suicidal individual is acting autonomously.

A contentious conflict of values arises when one intervenes to stop the actions of another, such as in the case of suicide.[197] Opponents of such interventions label them as 'paternalistic'. Indeed, paternalism may be defined as "the refusal to accept and go along with a person's wishes…for that person's own benefit."[198] This very definition highlights the dichotomy which exists in the ethical perspectives towards paternalism. On the one hand, there are those who condemn paternalism's refusal to accept a person's wishes, claiming that it goes against the principle of autonomy, which is absolute. Conversely, those who adhere to the beneficence model claim that society has a duty to protect and prevent people from harm, including suicide, even if this impinges on the person's autonomy.[199]

Types of paternalism

However, in light of this 'beneficence model' a distinction must be made between two degrees of paternalism: so-called 'strong paternalism' and 'weak paternalism'. The former advocates for the encroachment of a person's right to act, even if the person is rational and competent to make the said action. The latter basis itself on the premise that the person whose freedom is being restricted lacks the necessary competence or rationality to make the decision. Strong paternalism, therefore, incurs harsh criticism, whereas weak paternalism is supported by the majority of contemporary ethicists, since it dispels the conflict between beneficence and autonomy. The person being restricted lacks the necessary capacity to act autonomously and

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197. As an example, one may consider the scenario whereby one observes a bystander intervening to prevent an individual from falling from a height to his intended death. When questioned, the bystander would justify his actions by stating that he was acting in the individual's 'best interests'. In so doing, he would be placing emphasis on life, and acting beneficently, even if this led to him to obstructing the suicidal person's autonomy.
198. Moreland, "The Morality of Suicide: Issues and Options.", refer to the section on 'Paternalism and Suicide Intervention'.
199. Ibid.

(weak) paternalistic approaches are aimed at eventually restoring his individual autonomy and subsequent liberty.[200]

The question of autonomy is of paramount significance. With reference to Sneddon's differentiation between "shallow" and "deep" autonomy, priority is given to the latter.[201] In fact, he argues that a conflict between the two may arise, and importance should be given to the deeper form of autonomy: "autonomy of persons should be chosen over autonomy of choices".[202]

In practical terms, when a person's competence and autonomy is put into question, Sneddon advocates for interventions to ensure that the person comes to understand the values underpinning one's decision. Shallow autonomy may thus be sacrificed through paternalistic approaches, provided that it allows the person to reflect more deeply and attain deep autonomy.[203] All this is made possible through the introduction of this differentiation when considering autonomy.

Criticisms to long-term interventions

The principle of proportionality still holds, however, even when a paternalistic approach is justified. While many exponents justify short-term interventions, the same cannot be said to measures which extend beyond a reasonable duration. Nys argued in favour of public health measures which prevent a person from committing suicide until it is ascertained that one has reflected on his actions and confirmed that they are with his value-system.[204] This "soft paternalism" approach is intended to promote (deep) autonomy, rather than impinge on it.

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200. James F. Childress and Eric Mount, "Who Should Decide? Paternalism in Health Care," *Theology Today* 40, no. 3 (October 25, 1983): 352–57, doi:10.1177/004057368304000314; Moreland, quoted in "The Morality of Suicide: Issues and Options." A more detailed overview on the types of paternalism may be found in Gerald Dworkin, "Paternalism," *The Stanford Encyclopedia of Philosophy*, 2019, https://plato.stanford.edu/archives/fall2019/entries/paternalism/.

201. Sneddon, "Equality, Justice, and Paternalism: Recentreing Debate about Physician-Assisted Suicide.", 395

202. Ibid.

203. Ibid. Sneddon then proceeds to discuss how this new concept may be of use when discussing the ethics of physician-assisted suicide.

204. Thomas R. V. Nys, "Paternalism in Public Health Care," *Public Health Ethics* 1, no. 1 (April 1, 2008): 64–72, doi:10.1093/phe/phn002.

The same cannot be said for long-term interventions, which lead to individuals being detained against their will solely for the purpose of preventing the person from committing suicide. In this regard, Kelly and Dale refer to the criticisms raised by Beauchamp and Battin respectively.[205] In his article on this issue, Curtice underscore the inhumanity of such measures.[206] By referring to Article 3 of the Human Rights Act of 1998, he reiterates how everyone should be protected against treatment which leads to personal degradation, torture and indignity. He describes the prolonged detention of individuals on these grounds as inhumane, and tantamount to torture.[207]

[205.] Beauchamp and Regan, *Matters of Life and Death : New Introductory Essays in Moral Philosophy*; Battin, *The Death Debate : Ethical Issues in Suicide*; both cited by Kelly and Dale, "Ethical Perspectives on Suicide and Suicide Prevention.", 218. Kelly and Dale refer to these works as a means to portray the widespread criticism of longer-term prevention measures found in the academic literature.

[206.] Martin Curtice, "Article 3 of the Human Rights Act 1998: Implications for Clinical Practice," *Advances in Psychiatric Treatment* 14, no. 5 (2008): 389–97, doi:10.1192/apt.bp.107.005132, cited by Kelly and Dale, "Ethical Perspectives on Suicide and Suicide Prevention", 218

[207.] Curtice, "Article 3 of the Human Rights Act 1998: Implications for Clinical Practice."

Social perspectives on suicide and the right to die

History itself provides an astute example of the differing attitudes towards suicide, particularly when considering ancient Greek perspectives towards one's right to die, and pre-Christian positions on the topic.[208] A brief overview of common and influential determinants of suicide attitudes will thus allow a more holistic understanding of the topic.[209]

Differences between East and West

On a global scale, one may observe a stark contrast in views on suicide between Western and Eastern cultures, with the West traditionally adopting a stronger position against suicide.[210] A notable example is that of the Japanese people, who for hundreds of years considered it a desired means of preserving one's familial honour, particularly in situations where the person would have committed a grave offense to his family's social standing and reputation.[211] 'Samurai', members of Japanese nobility, were in fact encouraged to commit 'seppuku', a practice which became ritualised and even revered, whereby they inflicted fatal injury to themselves by slitting their stomachs in the presence of witnesses.[212]

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208. Battin and Mayo, *Suicide, the Philosophical Issues*. More details are provided in page 24, with sourced quotations on the early Western perspectives on suicide. This is subsequently followed by a summary of how St. Augustine's position on suicide shaped Christian doctrine and subsequently the entire Western civilisation's position on the topic.

209. This overview is by no means exhaustive but is intended to provide a panoramic perspective of how sociocultural factors affect one's perspectives towards the right-to-die concept. In the end, however, the author recognises that despite these predisposing factors, one's position on the subject is also subject to his or her own personal experiences, memories, upbringing and overall life philosophy.

210. "Eastern vs. Western Views of Death and Suicide | Owlcation," accessed February 22, 2020, https://owlcation.com/humanities/Japanese-Suicide-Death-before-Dishonor.

211. Ibid. This is detailed particularly in the fourth paragraph, with emphasis on how the Japanese romanticised the concept of suicide.

212. "Samurai - Wikipedia," accessed February 22, 2020, https://en.wikipedia.org/wiki/Samurai; "The Honorable Death: Samurai and Suicide in Feudal Japan | Ancient Origins," accessed February 22, 2020, https://www.ancient-origins.net/history-ancient-traditions/honorable-death-samurai-and-suicide-feudal-japan-005822. Some dispute whether seppuku was in fact a form of ritualised suicide, since it also involved the participation of a second. The *kaishakunin* was a master swordsman would be chosen to deliver a swift final death blow to the neck once the act of seppuku would have been committed, intended to relieve the person from unnecessary and prolonged suffering. Regardless of the technicalities of the

A similar divergence in perspective between the West and East was also discussed earlier on, whereby a distinction was made between Abrahamic faiths and the Eastern religions, with the latter at times even institutionalising suicide as a cultural practice, whereas the former regarding suicide as a grave offense against the sanctity of life.[213] Hinduism endorses the practice of suicide through self-induced starvation, a practice known as 'Prayopavesa', in situations of terminal illness, or in episodes of severe hopelessness, when the person has no desire to live, no responsibilities and no personal life goals.[214]

In contrast, Christian faiths generally deem killing, even if inflicted on oneself, as a sin against God, the Creator of life.[215] The position is not merely one of condemnation, however, as can be evidence with the rise of the palliative care movement, which was arguably introduced into Western civilisation through an originally Christian venture, particularly with the rise of hospice care for pilgrims travelling to and from the Holy Land.[216]

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act, it cannot be argued that the deceased would have already chosen to inflict fatal injury through slitting his stomach, with the aim of bringing his own demise.

213. Colucci and Martin, "Religion and Spirituality Along the Suicidal Path", 230. This is explored in more detail in page 10.

214. "Prayopavesa - Wikipedia," accessed February 22, 2020, https://en.wikipedia.org/wiki/Prayopavesa.

215. "Catechism of the Catholic Church - IntraText," accessed February 22, 2020, http://www.vatican.va/archive/ENG0015/_P7Z.HTM. Reference is being made to Chapter 2, Article 5 of the Catechism of the Roman Catholic Church, which clearly details the duty to respect human life, proceeding then to discuss various aspects of this respect. Euthanasia is specifically mentioned and direct euthanasia is deemed morally unacceptable, with the Catholic Church instead advocating for those "whose lives are diminished or weakened" as deserving of "special respect" (Article 2276-2277). Article 2280 proceeds to describe how "everyone is responsible for his life before God who has given it to him," with Article 2281 proceeding to describe how suicide "contradicts [one's] natural inclination… to preserve and perpetuate [his/her] life.

216. Joy. Robbins and Janet. Moscrop, *Caring for the Dying Patient and the Family* (Chapman & Hall, 1995), 246. Specific mention is made of Malta as possibly the site for the first form of organised hospice care, set up in 1065 through the initiative of the Knights Hospitaliers of the Order of St John of Jerusalem, aimed at caring for infirm pilgrims venturing to and from the Holy Land.

The role of demographic trends

In determining right-to-die attitudes, demographic trends are also of particular value.[217] A national survey conducted in Austria assessed attitudes towards both euthanasia and physician-assisted suicide, showing that residents of urban centres were less likely to reject euthanasia or physician-assisted suicide.[218] This finding is consistent with the sociological observations of Fischer, who linked urbanisation with deviance from traditional values. He accrued this effect on the anomic nature of living within a large population, where people feel "rootless" and are more likely to reject inherited norms.[219]

The Austrian study also found that increased affiliation to a religious creed is linked with a greater rejection for the 'right-to-die' position.[220] This finding was irrespective of the religion confessed. However, when one compares the rejection rates between respondents who identified themselves as Catholics, Protestants and Muslims, a difference is noted between Muslims and Catholics on the one-hand, and Protestants on the other, with the latter being less inclined to reject euthanasia and physician-assisted suicide.[221]

Gender was also noted to play a role, with males more inclined to approve euthanasia and physician-assisted suicide than their female counterparts.[222]

However, the most significant variable which led to a considerable rejection rate from the majority of respondents was the age of the subject in question. If the case involved an ill elderly patient, euthanasia and physician-assisted suicide were deemed much more acceptable than in

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217. One cannot however assume that the effect of these demographic variables is generalisable on a global scale and one must expect that their effect varies according to native culture, beliefs and norms. One must also respect the fact that large communities also harbour smaller, albeit significant, minorities, which may not be adequately represented in some studies. The author also wishes to highlight the fact that no study which studied factors on a continental or global level was found in the literature review and the arguments presented are based on the findings of a number of separate regional or national studies.

218. Erwin Stolz et al., "Determinants of Public Attitudes towards Euthanasia in Adults and Physician-Assisted Death in Neonates in Austria: A National Survey," *PLoS ONE* 10, no. 4 (April 23, 2015), 7 doi:10.1371/journal.pone.0124320.

219. Claude S. Fischer, "The Effect of Urban Life on Traditional Values," *Social Forces* 53, no. 3 (March 1975): 420, doi:10.2307/2576584.

220. Stolz et al., "Determinants of Public Attitudes towards Euthanasia in Adults and Physician-Assisted Death in Neonates in Austria: A National Survey.", 6-7

221. Ibid., 6-7

222. Ibid., 6

the case of a terminally ill or disabled neonate.[223] The authors concluded that this evident contrast may be reflective of the population's appreciation that the neonate lacks control and autonomy when compared to the elderly man, thus making the 'right-to-die' position much less morally permissible for the former.[224] The authors subsequently also reflect on a possible link between the Austrian's population experience during the Nazi regime and its extermination of countless neonates as part of its eugenics programme, thus leading to an even higher rejection rate in such circumstances.[225]

Age has also been hypothesised as a possible determinant in attitudes towards the end of life, with authors such as Blackhall et al. assuming that the elderly would have more conservative views when compared with the younger generation.[226] In their study on attitudes towards life-sustaining technology, conducted on a sample population from the United States, they found that this was not the case, with no significant difference in attitudes between the two age groups.[227] The main determinant which led to variability in attitudes was found to be the respondents' ethnicity.[228]

Other studies have also determined a possible link between an individual's socioeconomic status and one's acceptability of suicide or euthanasia. Steck et al. analysed the total number of assisted suicides in Switzerland over a span of five years and found an association between assisted suicide and situations of greater vulnerability, with greater rates in people living alone or divorced, as well as in females.[229] Paradoxically, they also found that assisted suicide is more common in people with higher education and within higher socioeconomic positions. In the younger Swiss population, having children was found to be a protective factor against suicide.[230] These findings were replicated in a longitudinal study published by Steck, Egger

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223. Ibid., 6
224. Ibid., 10
225. Ibid., 10. This clearly alludes to the impact which a population's collective consciousness has on its members' ethical perspectives. Reflections on the Nazi's eugenics programme may be found in page 7.
226. Leslie J. Blackhall et al., "Ethnicity and Attitudes towards Life Sustaining Technology," *Social Science and Medicine* 48, no. 12 (June 1999): 1779–89, doi:10.1016/S0277-9536(99)00077-5.
227. Ibid.
228. Ibid.
229. Nicole Steck et al., "Suicide Assisted by Right-to-Die Associations: A Population Based Cohort Study," *International Journal of Epidemiology* 43, no. 2 (2014): 616-617, doi:10.1093/ije/dyu010.
230. Ibid., 617

and Zwahlen, published in 2016, which reanalysed the data collected in the earlier study. It reconfirmed that a higher educational level is positively related to greater recourse to assisted suicide, while the inverse was also noted to be true, with individuals with lower educational backgrounds resorting more to unassisted suicide.[231]

Contrasting views and intercultural variability

There were, however, studies which revealed different associations between sociocultural variables and attitudes towards suicide. Interestingly, a cross-sectional study of the population of Liaoning province in China, published in 2016 by Zou et al., revealed that gender, ethnicity and religious beliefs had no impact on the population's perspectives towards suicide; no differences were also noted between urban and rural residents.[232] This contrasts significantly with the studies of Western populations described earlier. Zoe et al.'s study proceeds to highlight that age, socioeconomic status and previous suicidal ideation all impact the population's attitudes towards suicide.[233]

Intercultural variability is thus of great significance when understanding attitudes towards suicide and the 'right to die' position, as evidenced through the cross-national comparison study by Eskin et al., published in 2016.[234] The study recruited respondents from universities

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231. Nicole Steck, Matthias Egger, and Marcel Zwahlen, "Assisted and Unassisted Suicide in Men and Women: Longitudinal Study of the Swiss Population," *British Journal of Psychiatry* 208, no. 5 (May 1, 2016): 484–90, doi:10.1192/bjp.bp.114.160416.

232. Yaming Zou et al., "Attitudes towards Suicide in Urban and Rural China: A Population Based, Cross-Sectional Study," *BMC Psychiatry* 16, no. 1 (May 26, 2016), 7 doi:10.1186/s12888-016-0872-z.

233. Ibid. The authors clarified that despite their best efforts, including the implementation of a multi-staged, stratified random sampling approach, the complexity and multi-ethnic nature of Chinese society may have led to the study excluding certain important subgroups of the local population. Thus, they subsequently reported that their results may not be generalisable for the entire population of Liaoning province.

234. Mehmet Eskin et al., "Cross-National Comparisons of Attitudes towards Suicide and Suicidal Persons in University Students from 12 Countries," *Scandinavian Journal of Psychology* 57, no. 6 (December 1, 2016): 554–63, doi:10.1111/sjop.12318. In this extensive cross-national study, the Eskin Attitudes Towards Suicide scale (E-ATTS) was used to assess acceptability of suicide among respondents, along with the 12-item General Health Questionnaire (GHQ-12) aimed at analysing respondents' overall state of health, including their mental health. The first section of the E-ATTS tool was subsequently chosen for this study on mental health professionals in Malta, and will be discussed in more detail in subsequent sections.

across twelve different countries and demonstrated divergent attitudes towards suicide and suicidal friends (to assess social acceptance).

Austria, the United Kingdom, Japan and Saudi Arabia registered the highest suicide acceptance rates while respondents from Tunisia, Turkey, Iran and Palestine were noted to be the least accepting of suicide. Interestingly, these results were not exactly replicated when considering social acceptance of suicide: respondents from Tunisia, Italy, Turkey and the United States of America reported the greatest social acceptance of suicide, whereas Japanese, Jordanian, Saudi Arabian and Palestinian respondents were the least socially accepting of suicidal behaviour.[235] The authors in fact conclude that the results demonstrate that the greater one's acceptance towards suicide, the less one's disposition to provide help and emotional support to a suicidal friend.[236] Furthermore, apart from being less accepting of suicidal peers, such respondents were found to disapprove of those who disclosed suicidal thoughts.[237]

The reasons behind such transnational divergences are up for debate: Eskin et al. proceed to highlight how male respondents were more accepting of suicide than their female counterparts, whereas female respondents were more inclined to assist a friend with suicidal ideation.[238] Interestingly, respondents who were more accepting of suicide, but less predisposed to support suicidal friends, were found to have a higher degree of psychological distress and a stronger history of suicidal behaviour.[239]

Clinical and epidemiological considerations

The findings of Eskin et al. indicate that while an understanding of attitudes to suicide and one's right-to-die is of considerable academic and ethical interest, it may also hold crucial clinical and epidemiological value. Eskin et al. in fact argue how the differential-stigma hypothesis may be at play when studying suicide and attitudes towards suicidal behaviour.[240] They cite an earlier article which had proposed that cultures which are more accepting of suicidal behaviour tend to lead individuals to consider suicide more strongly when in situations

235. Ibid., 558
236. Ibid., 561
237. Ibid.
238. Ibid., 558
239. Ibid., 558-559
240. Ibid., 555

of overwhelming distress.[241] Conversely, if a population is more rejecting of suicidal behaviour, an individual who recovers from a suicidal attempt would be more prone to face stigma and discrimination.[242]

This is also cited in other works. Kleiman et al. in fact propose that increasingly positive attitudes towards suicide are linked with an increased prevalence of suicidal behaviour, thus placing populations who are more accepting of such behaviour at an increased suicidal risk.[243] Similar observations are also made by Stack and Kposowa, who described how, through social learning, individuals in populations with a higher rate of suicide may be more exposed to "suicidal role models" who provide the individual with a "positive definition" of suicide.[244]

On a similar note, studies have also shown how, when determining end-of-life decisions, the family's wishes is deemed of great importance.[245] This is particularly so in patients who are unable to communicate their desires.[246] Thus, one may postulate that if society is increasingly accepting of the right-to-die position, then this may also lead to families opting to advocate more for physician-assisted suicide or euthanasia.

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241. Mehmet Eskin, "Adolescents' Attitudes toward Suicide, and a Suicidal Peer: A Comparison between Swedish and Turkish High School Students," *Scandinavian Journal of Psychology* 36, no. 2 (June 1, 1995): 201–7, doi:10.1111/j.1467-9450.1995.tb00979.x; Eskin et al., "Cross-National Comparisons of Attitudes towards Suicide and Suicidal Persons in University Students from 12 Countries.", 555

242. Ibid.

243. Evan M. Kleiman, "Suicide Acceptability as a Mechanism of Suicide Clustering in a Nationally Representative Sample of Adolescents," *Comprehensive Psychiatry* 59 (May 1, 2015): 17–20, doi:10.1016/j.comppsych.2015.02.002. They base their conclusions on the clustering of suicidal behaviour in adolescents.

244. Steven Stack and Augustine J. Kposowa, "The Association of Suicide Rates with Individual-Level Suicide Attitudes: A Cross-National Analysis," *Social Science Quarterly* 89, no. 1 (March 2008): 39–59, doi:10.1111/j.1540-6237.2008.00520.x.

245. S J Genuis, S K Genuis, and W C Chang, "Public Attitudes toward the Right to Die.," *CMAJ : Canadian Medical Association Journal = Journal de l'Association Medicale Canadienne* 150, no. 5 (March 1, 1994): 701–8, http://www.ncbi.nlm.nih.gov/pubmed/8313289., 704

246. Ibid. The 1992 Edmonton survey study confirmed that 84% of respondents support a family's right to withdraw life support from patients in irreversible coma, while 90% declared that they would support an adult's request to end his life by having his life support withdrawn, provided that he is deemed mentally competent.

The perspectives of mental health professionals

Psychiatrists, psychologists and physicians

Studies have sought to compare the attitudes of psychiatrists to that of other physicians. Levy et al. in fact conducted an Israeli study in 2012 with the aim of understanding and comparing perspectives on euthanasia and assisted suicide.[247] Their study revealed that psychiatrists tend to be more conservative than physicians, after adjusting for religious views, and thus express more reservation in condoning assisted suicide or euthanasia.[248] The authors propose that this may be due to issues related concepts such as autonomy and voluntariness, which are put into question when an individual is diagnosed with mental illness; they also hypothesise that some psychiatrists may perceive that the adoption of a more permissive attitude on euthanasia and assisted suicide is actually a cooperation with the individual's suicidal act, which directly contradicts their professional practice.[249] Furthermore, compared with their male counterparts, female physicians had more conservative views on the matter.[250] The authors thus surmise that the differences in perspectives may be due to differences in the doctors' sub-speciality education, while concluding that psychiatrists are well-suited for their prominent role in evaluation of requests for euthanasia.[251]

An earlier comparative study by Hammond and Deluty sought to research the attitudes of a wider variety of professionals.[252] A mailed questionnaire was sent to psychologists, psychiatrists and oncologists working in the United States of America, who had been randomly selected to minimise bias.[253] Although the study dates back to 1992, it shows trends of historical interest: notably, suicide prompted by intolerable physical illness was deemed more acceptable than in situations of chronic psychiatric illness.[254] In turn, psychologists were more accepting

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247. Tal Bergman Levy et al., "Attitudes towards Euthanasia and Assisted Suicide: A Comparison between Psychiatrists and Other Physicians," *Bioethics* 27, no. 7 (September 2013): 402–8, doi:10.1111/j.1467-8519.2012.01968.x.
248. Ibid., 405
249. Ibid.
250. Ibid., 406
251. Ibid.
252. Linda K. Hammond and Robert H. Deluty, "Attitudes of Clinical Psychologists, Psychiatrists, and Oncologists toward Suicide," *Social Behavior and Personality: An International Journal* 20, no. 4 (May 18, 2006): 289–92, doi:10.2224/sbp.1992.20.4.289.
253. Ibid., 290
254. Ibid., 291

of suicide in response to chronic pain, whereas oncologists were the least accepting in this regard.[255] There were no significant difference in attitudes when comparing professionals who had personally experienced suicidal ideation and those who had not, contrasts with the findings of Eskin et al. in their study on University students' perspectives.[256] Interestingly, however, professionals who had lost a loved one through suicide earlier on were found to feel more responsible if a patient under their care passes away through a suicidal act.[257]

Another study, published in 2013, assessed attitudes towards suicidal behaviour in Oslo, Norway.[258] The study by Norheim, Grimholt and Ekeberg was conducted on mental health professionals working in outpatient clinics specialised in Child and Adolescent Psychiatry or in District Psychiatric Centres, which care for the adult, non-elderly population. Using a standardised suicide scale, disseminated through an anonymous questionnaire, they determined that the majority of respondents believe that suicide is preventable.[259] Furthermore, those who had received specialist training had more positive attitudes towards patient recovery.[260] Understandably, however, all respondents admitted that a patient's suicide is invariably a stressful event.[261] When asked on the aetiology of suicidal behaviour, psychiatric disorders were deemed to be the most common cause; psychotherapy was subsequently voted as the most

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255. Ibid. The authors propose that this finding is acceptable in view of oncologists' experience in treating chronic pain, thus deeming pain as an insufficient reason as a request to end one's life.

256. Ibid., 291; Eskin, "Adolescents' Attitudes toward Suicide, and a Suicidal Peer: A Comparison between Swedish and Turkish High School Students." One may assume that this finding is indicative of the professional role assumed by physicians, who should aspire to distance their own personal experiences from their professional judgments.

257. Hammond and Deluty, "Attitudes of Clinical Psychologists, Psychiatrists, and Oncologists toward Suicide.", 292

258. Astrid Berge Norheim, Tine Kristin Grimholt, and Øivind Ekeberg, "Attitudes towards Suicidal Behaviour in Outpatient Clinics among Mental Health Professionals in Oslo," *BMC Psychiatry* 13 (March 19, 2013): 90, doi:10.1186/1471-244X-13-90. The study included psychiatrists, nurses, psychologists, social workers and a minority of other specialised professionals working in such centres and whose role remained undisclosed. In line with earlier studies on the general population, religion was also found to play a role, with respondents who identified themselves as Christians reporting significantly less suicide acceptability.

259. Ibid., 6

260. Ibid.

261. Ibid., 7

appropriate form of treatment, arguably in view of the negative cognitions which predominate when a depressed individual considers suicide.[262]

Inter-cultural considerations

These same authors proceeded to conduct a similar study in 2016, where they compared professional attitudes to suicide between professionals working in outpatient clinics in Oslo, Norway and those in Stavropol, Russia.[263] Differences between the two countries were highlighted, including how professionals in Russia were more condemning of patients who exhibit suicidal behaviour.[264] Similarly, Stavropol professionals were more likely to avoid discussing suicide with their patients, and regarded suicide in their patients as a personal failure in their provision of care.[265] Despite this, an overall disposition to help in suicidal patients' recovery was reported, regardless of other attitudes, while psychotherapy was deemed the most significant treatment measure.[266] Mental health professionals were reportedly aware of the need for further education on how to deal with patients who exhibit suicidal behaviour.[267] The authors concluded their article by stressing the need for improved cooperation between mental health teams and other medical specialists, while also highlighting the acute need for greater support to professionals who have lost their patients to suicide.[268]

Attitudes of psychiatrists in Eastern cultures are evidently less researched, but the study of Jiao et al. on psychiatrists in Shanghai is of notable interest.[269] From an epidemiological standpoint,

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262. Ibid., 8; Amy Wenzel and Aaron T. Beck, "A Cognitive Model of Suicidal Behavior: Theory and Treatment," *Applied and Preventive Psychology* 12, no. 4 (October 1, 2008): 189–201, doi:10.1016/j.appsy.2008.05.001. This is explained in more detail in page 5.
263. Astrid Berge Norheim et al., "Attitudes toward Suicidal Behaviour among Professionals at Mental Health Outpatient Clinics in Stavropol, Russia and Oslo, Norway.," *BMC Psychiatry* 16, no. 1 (July 27, 2016): 268, doi:10.1186/s12888-016-0976-5.
264. Ibid., 9
265. Ibid., 8-9
266. Ibid., 9-10
267. Ibid., 9
268. Ibid., 10
269. Yumei Jiao et al., "Cross-Sectional Study of Attitudes about Suicide among Psychiatrists in Shanghai," *BMC Psychiatry* 14, no. 1 (March 25, 2014): 87, doi:10.1186/1471-244X-14-87. The literature search on attitudes of mental health professionals on suicide led to a disproportionately large number of studies on perspectives from Western countries. This study, by Jiao et al., is amongst one of the few large-scale validated attitudinal studies on suicide and mental health professionals in non-Western civilisations.

note was made of the different suicide prevalence rates in China, with rates higher in rural, rather than in urban areas.[270] The female-to-male ratio is quite similar and mental illness is reportedly less prevalent in persons with suicidal behaviour.[271]

In this context, according to Jiao et al., psychiatrists in Shanghai are more likely to perceive suicide as a preventable behaviour when compared to other (non-professional) members of their community.[272] Interestingly, these psychiatrists also reported that they consider suicide as a significant social problem and perceive suicidal individuals more negatively and less empathically than non-professionals.[273] They reported a belief that suicidal persons can exert a control on their impulses, implicating weakness of will as a cause of suicide.[274] They also expressed concerns that discussing suicide with their patients would increase their overall risk, a belief which is discredited by the evidence-based psychiatric research which argues that discussing suicide is, conversely, protective.[275] Interestingly, psychiatrists with a longer period of formal education reported more empathy towards suicidal individuals, while younger psychiatrists were able to better distinguish between fatal and non-fatal suicidal behaviour.[276]

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270. Ibid., 2. Comparison is made with epidemiological data from Western countries, which are discussed, with intercultural comparisons, in page 38.
271. Ibid.
272. Ibid., 4
273. Ibid.
274. Ibid.
275. Ibid., 5; T. Dazzi et al., "Does Asking about Suicide and Related Behaviours Induce Suicidal Ideation? What Is the Evidence?," *Psychological Medicine* (Cambridge University Press, December 6, 2014), doi:10.1017/S0033291714001299.
276. Jiao et al., "Cross-Sectional Study of Attitudes about Suicide among Psychiatrists in Shanghai.", 4

A focus on psychologists' perspectives

Psychologists' perspectives have also been studied, with a notable example being the study by Werth and Cobia on criteria for rational suicide.[277] Apart from researching how psychologists perceive this sensitive topic, they also found that psychologists understandably feel a sense of duty towards intervening to stop clients from attempting suicide.[278] This was in part reinforced by perceptions that failure to do so may in turn lead to harmful medico-legal repercussions.[279] In fact, in a separate article, Johnson et al. comment on the lack of academic literature on the topic, with practicing psychologists lacking evidence-based guidelines on how to assess patients with requests for physician-assisted suicide, even if their country of practice has the necessary legal frameworks.[280]

Gagnon and Hasking conducted a similar attitudinal study on psychologists in Australia, which paradoxically showed that psychologists believe they have satisfactory expertise on suicide and self-harm.[281] They concluded that psychologists felt confident in dealing with patients exhibiting such behaviours, which contrasts with the position of Johsnon et al., who advocate for more evidence-based guidelines on expected practice in such situations.[282] Gagnon and Hasking proceed to highlight how younger psychologists were found to be more confident in working with such clients and exhibited a greater tendency to accept one's right to die.[283] They concluded that there is a need for more research on the subject, with the aim of determining in more detail how psychologists' attitudes impact their behaviour towards suicidal patients.[284]

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277. Werth and Cobia, "Empirically Based Criteria for Rational Suicide: A Survey of Psychotherapists." A detailed summary on the findings of these authors may be found in page 27, which also highlights factors which psychologists deemed relevant when considering the rationality of a person's wish to die.
278. Ibid., 238
279. Ibid.
280. Shara M. Johnson et al., "The Role of and Challenges for Psychologists in Physician Assisted Suicide," *Death Studies* 38, no. 9 (2014): 585, doi:10.1080/07481187.2013.820228.
281. Jennifer Gagnon and Penelope A. Hasking, "Australian Psychologists' Attitudes towards Suicide and Self-Harm," *Australian Journal of Psychology* 64, no. 2 (June 2012): 78, doi:10.1111/j.1742-9536.2011.00030.x.
282. Ibid., 78; Johnson et al., "The Role of and Challenges for Psychologists in Physician Assisted Suicide." This observation highlights how differences between countries' culture also bear an impact on their professional practitioners.
283. Gagnon and Hasking, "Australian Psychologists' Attitudes towards Suicide and Self-Harm.", 79
284. Ibid.

Studies have also been performed on how perspectives on suicide vary between psychologists and other professionals. Osafo et al. compared perspectives on suicide between nurses and psychologists in Ghana.[285] They found that psychologists tend to view suicide as a mental health issue, whereas nurses tend to view suicide as a morally condemnable act, tantamount to a crime.[286] They consequently advocate for greater awareness and education, as well as inclusion of suicide management in formal training programmes in the country, claiming that this is imperative given health professionals' "responsibility…and duty to preserve life".[287]

Wider, multidisciplinary considerations: the role of nurses, occupational therapists and social workers

This responsibility extends to all members of the caring team, with studies highlighting how training on suicide management may provide significant gains for all professionals, regardless of speciality. In fact, Joung et al. described how training on suicide management for the elderly led to beneficial effects on the readiness of the caring multidisciplinary team.[288] The study evaluated attendees' case notes before and after their attendance to a suicide management workshop and included social workers, occupational therapists, physicians, psychologists and nurses.[289] The post-workshop notes revealed attendees' added awareness on prognostic categories required for a holistic suicide risk assessment, as well as a heightened sensitivity to the possibility of suicidal behaviour in the elderly.[290]

Given the importance of involving specialists across the multidisciplinary spectrum, studies have also been conducted on the role of occupational therapists in suicide intervention strategies. McDonald and Fenton highlighted the possible role of occupation therapists in bolstering the resilience of university students against the impairments caused by mental

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285. J. Osafo et al., "Attitudes of Psychologists and Nurses toward Suicide and Suicide Prevention in Ghana: A Qualitative Study," *International Journal of Nursing Studies* 49, no. 6 (June 1, 2012): 694–696, doi:10.1016/j.ijnurstu.2011.11.010.
286. Ibid., 696
287. Ibid., 698
288. Joung T. Huh et al., "Effects of a Late-Life Suicide Risk-Assessment Training on Multidisciplinary Healthcare Providers," *Journal of the American Geriatrics Society* 60, no. 4 (April 1, 2012): 775–80, doi:10.1111/j.1532-5415.2011.03843.x.
289. Ibid., 776
290. Ibid., 779-780

illness.[291] An appreciation for the role which occupational therapists may play in improving the abilities of the suicidal individual were also highlighted by Ferreira and Gonçalves in their study on occupational therapy students' perspectives on their training curriculum in Brazil.[292] A significant proportion of students had in fact argued in favour of more tuition on suicide and its management. This is also reiterated in other works: White, Hewitt and Rouleau prompted similar considerations for the inclusions of suicide management skills in formal occupational therapy training in Canada.[293]

The focus on multidisciplinary care unequivocally involves a consideration on the role of the nurse, particularly in sensitive end-of-life issues. In fact, it has been shown that in The Netherlands the nurse is the first professional with whom the individual requests assisted suicide or euthanasia.[294] In light of the significance of the nursing role, Evans conducted an extensive literature review with the aim of understanding the factors which determine a nurse's role to suicide.[295] He cites the earlier findings of a 2009 British poll conducted by the Royal College of Nursing which had shown that 49% of nurses supported assisted suicide, while a minority of 40% opposed it.[296] In his review, Evans highlighted four main factors which influence a nurse's attitude on the issue: geographical location, workplace, level of education and religion.[297] Geographical location was the factor which elicited the most varied response. Interestingly, strong nursing opposition to assisted suicide was registered in states which have a legally permissive structure, such as in the American state of Oregon and in The Netherlands;

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291. Kaye McDonald and Lara Fenton, "Identifying the Role of Occupational Therapists in Promoting Student Resilience: An Environmental Scan of Mental Health Initiatives on Canadian University Campuses," *Occupational Therapy Now* 20, no. 1 (2018).

292. Karine Guedes Ferreira and Monica Villaça Gonçalves, "The Students' Perspective on Suicide Approach during Occupational Therapy Training," *Brazilian Journal of Occupational Therapy* 26, no. 4 (2018): 883–91, doi:10.4322/2526-8910.ctoAO1610.

293. Catherine White, Kimberly Hewitt, and Marc Rouleau, "Suicide Prevention Skills: Enhancing Opportunities in Occupational Therapy Education," *Occupational Therapy Now* 21, no. 6 (2019).

294. G. G. Van Bruchem-van De Scheur et al., "The Role of Nurses in Euthanasia and Physician-Assisted Suicide in The Netherlands," *Journal of Medical Ethics* 34, no. 4 (April 1, 2008): 255, doi:10.1136/jme.2006.018507.

295. Luke Evans, "Nurses' Attitudes to Assisted Suicide: Sociodemographic Factors," *British Journal of Nursing* (MA Healthcare Ltd, 2015), doi:10.12968/bjon.2015.24.12.629.

296. Royal College of Nursing, "RCN Position Statement on Assisted Dying | Royal College of Nursing," 2009, https://www.rcn.org.uk/about-us/policy-briefings/pol-2314#tab1; qouted by Evans, "Nurses' Attitudes to Assisted Suicide: Sociodemographic Factors.", 629

297. Evans, "Nurses' Attitudes to Assisted Suicide: Sociodemographic Factors.", 630-631

Japanese nurses were the least supportive of assisted suicide, with only 23% declaring their support in a 2001 poll.[298]

Social workers' attitudes have also been studied, albeit to a lesser extent. A study on Oregon nurses and social workers revealed that a significant number of social workers are approached at least once by patients requesting to end their lives. [299] Another study revealed that, despite their pre-eminent role, social workers are unprepared to address suicide, with a lack of formal education and training on the subject.[300] They thus call for further studies on the perspectives of social workers on the subject, and better tuition.[301]

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298. A. Asai et al., "Doctors' and Nurses' Attitudes towards and Experiences of Voluntary Euthanasia: Survey of Members of the Japanese Association of Palliative Medicine," *Journal of Medical Ethics* 27, no. 5 (October 1, 2001): 324–30, doi:10.1136/jme.27.5.324; quoted by Evans, "Nurses' Attitudes to Assisted Suicide: Sociodemographic Factors.", 629

299. Lois L Miller et al., "Attitudes and Experiences of Oregon Hospice Nurses and Social Workers Regarding Assisted Suicide.," *Palliative Medicine* 18, no. 8 (December 1, 2004): 685–91, doi:10.1191/0269216304pm961oa.

300. A A Manetta and J G Wells, "Ethical Issues in the Social Worker's Role in Physician-Assisted Suicide.," *Health & Social Work* 26, no. 3 (August 2001): 163 doi:10.1093/hsw/26.3.160.

301. Ibid., 165

Chapter 2: Methodology

This chapter details how the study was divided into two stages: a quantitative and a qualitative stage. It subsequently explores how each stage was carried out. Prior to its commencement, ethical approval was sought from the Faculty Research Ethics Committee, as well as the Clinical Chairperson and the Chief Executive Officer of the public mental healthcare system.[1]

The primary quantitative stage

The first stage of the study involved the use of an online questionnaire, aimed to elicit responses on attitudes towards varying dimensions of suicide.

The choice of study instrument

The questionnaire consisted of a total of twenty-nine questions.[2] The first four questions were intended for the collection of demographic data while the final question was aimed at recruiting participants for the second stage of the study.

The bulk of the questionnaire consisted of twenty-four questions adopted from Eskin's Attitudes towards Suicide Scale.[3] The validity of this tool, adopted with direct permission from Eskin, has been investigated independently, and by separate authors, whereby its appropriateness for further research purposes on attitudes towards suicide was empirically confirmed.[4] The Attitudes towards Suicide Scale eloquently categorises attitudes towards

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1. The Faculty of Theology Research Ethics Committee conferred its approval to the study via official communication on the 4th of July 2019.
2. Appendix 1.
3. Mehmet Eskin, "The Effects of Religious versus Secular Education on Suicide Ideation and Suicidal Attitudes in Adolescents in Turkey," *Social Psychiatry and Psychiatric Epidemiology* 39, no. 7 (July 2004): 536–42, doi:10.1007/s00127-004-0769-x. Permission was sought from Eskin, who allowed its use in this study. A decision was made to make use of the first section of Eskin's tool, which consisted of a varimax rotated factor analysis of opinions about and attitudes towards suicide.
4. Ingo W. Nader et al., "Investigating Dimensionality of Eskin's Attitudes Toward Suicide Scale with Mokken Scaling and Confirmatory Factor Analysis," *Archives of Suicide Research* 16, no. 3 (July 1, 2012): 226–37, doi:10.1080/13811118.2012.695271.

suicide into separate dimensions, which allows researchers to stratify the findings more easily. It also includes a dimension on spirituality, which was deemed of particular interest in this study, given the numerous research articles citing the impact of faith on suicide perspectives.

Although the tool's external validity for the Maltese population has not yet been studied, particularly in the context of mental health professionals, most responses registered a favourable Cronbach's alpha on statistical analysis.[5] This indicates good internal consistency of results, which thus strengthens the validity of these research findings. In fact, this tool had initially been devised and used by Eskin on adolescents, but was then also used in a multinational study, aimed at investigating for diversity of opinion on the subject, and thus indicating its potential multi-ethnic applicability.[6]

Given that its practicality enabled its appropriateness for a non-professional population, it was deemed to serve as an easy-to-use tool for professionals, whatever their level of understanding on the subject may be, since it avoids the unnecessary and confusing use of jargon. Furthermore, the local healthcare professional population consists of a significant number of foreign healthcare workers and the use of such a tool was deemed as more appropriate in reaching the intended scope of this study, especially given that it has recently been employed to study opinions on suicide across a multitude of cultures.[7]

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5. This is described in more detail in page 65.

6. Eskin, "The Effects of Religious versus Secular Education on Suicide Ideation and Suicidal Attitudes in Adolescents in Turkey"; Eskin et al., "Cross-National Comparisons of Attitudes towards Suicide and Suicidal Persons in University Students from 12 Countries."

7. "Foreign Healthcare Workers Living On Work Permit In Malta Get Automatic Three Month Extension Amid COVID-19 Concerns," accessed May 17, 2020, https://lovinmalta.com/news/foreign-healthcare-workers-living-on-work-permit-in-malta-get-automatic-three-month-extension-amid-covid-19-concerns/. The Maltese healthcare system increasingly relies on foreign healthcare workers who take up residence in Malta with work permits that allow them to offer their professional services locally. Their input is significant, so much so that amid the COVID-19 pandemic, these foreign workers were immediately granted work permit extensions to ensure that they remain employed within the system. This is arguably different from the work permit conditions of other foreign workers working in different sectors.

Professional recruitment and consent form procedure

All mental health professionals working within the Maltese public mental health system were invited to participate in this study, amounting to a total of 601 potential respondents from various mental healthcare specialities.[8]

Recruitment was made exclusively via electronic mail. Departmental heads from each speciality within the mental health sector were asked to forward the questionnaire to professionals within their department, who were then asked to complete the questionnaire anonymously through an online form. This exercise was done twice, with the first call for dissemination being made in October 2019 and the second and final call being sent in January 2020.[9]

The online questionnaire was designed in such a way as to provide each respondent with a brief summary of the intended scope of the study followed by six statements on consent.[10] All participating respondents were asked to read these statements and to confirm their consent to them, prior to proceeding further with the study.[11]

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8. This data was obtained through direct correspondence with management personnel within the public mental health sector. As of the 13th of January 2020, the total number of mental health professionals in each respective speciality were as follows: nurses – 377; carers – 10; nursing aides – 71; psychiatric consultants – 17; medical staff (psychiatric trainees and resident specialists) – 30; foundation year doctors – 12; psychologists (all grades) – 45; occupational therapists – 22; physiotherapists – 6; social workers – 11.

9. This interval was meant to maximise response rate while avoiding dissemination of the questionnaire during the busy festive period. No direct contact with any respondent was made at any stage of quantitative data collection, with the departmental heads serving as intermediaries in the dissemination process.

10. Refer to Appendix 1.

11. Informed consent was ascertained after inquiring all respondents to confirm that they understand the scope of the study, that they are at liberty to withdraw their participation from the study at any point in time, that their responses will be stored confidentially, used exclusively for research purposes, and not disclosed to third parties or used to trace the identity of participants. All participants were also invited to contact the author or the study supervisors if in need of any clarification prior to filling-in the questionnaire.

Data Analysis

The responses were received electronically and anonymously through Google Forms software, in a secure, password-protected online repository. The Statistical Package for the Social Sciences (SPSS) software was then employed for data analysis.[12]

Replies to the statements adopted from Eskin's Attitudes towards Suicide Scale were subsequently grouped into 7 attitudinal dimensions.[13] Mean acceptability scores were subsequently calculated, representing the respondents' attitude towards each statement on suicide, demonstrated through the use of a Likert scale, where '0' signifies complete disagreement and '4' signifies complete agreement. A mean dimensional score was subsequently calculated for the statements included in each dimension. These were checked for internal consistency.[14]

The analysis then included a consideration of respondents' demographic data. The Kruskal Wallis test was performed to determine if there are any significant relationships between respondent demographic data and their attitude towards different statement dimensions on suicide.[15] The Spearman Rank Correlation Coefficient was employed to determine whether the respondents' attitudes towards a particular dimension being studied affected their attitudes towards the other dimensions.[16]

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12. A meeting was also held with Profs Liberato Camilleri to ensure correct statistical analysis.
13. Eskin, "The Effects of Religious versus Secular Education on Suicide Ideation and Suicidal Attitudes in Adolescents in Turkey." The concept of categorising statements into dimensions was also adopted from Eskin's work and the attitudinal dimensions employed in this study are the same as those highlighted in his work. Also refer to Appendix 1, questions 2a to 7a, found from page 4 onwards. All statements are grouped into the dimensions outlined by Eskin.
14. Internal consistency was measured through the use of Cronbach's alpha test. Statements which lacked good internal consistency were excluded from further analysis. The Shapiro-Wilk test was subsequently employed to determine the normality of the data being studied. This allowed the appropriate selection of subsequent statistical measures based on the distribution of the data being studied.
15. Respondents were stratified according to age, gender, professional role and years of professional experience,
16. The level of significance was determined at 0.05. A positive coefficient indicates a direct relationship between variables, whereas a negative coefficient indicates an inverse relationship between them.

The secondary qualitative stage of the study

The qualitative stage was intended to highlight the wider underlying interplay of ingrained values which affect perspectives on suicide. Such an interplay of values was made most evident through the diverse array of responses elicited when asked on the acceptability of suicide in the context of terminal illness.[17] It is for this reason that a case on terminal illness was chosen and presented for discussion in this second stage of the study.

Recruitment of focus group participants

The final question of the online questionnaire invited respondents to send an email to the research author if they wished to participate in a focus group discussion.[18] After receiving these expressions of interest, the names of all potential focus group participants were recorded and stored in a secure, password-protected file.

All interested professionals were then sent an email invitation with instructions on the discussion format and the consent procedure.[19] Through a separate confidential online form they were then asked to electronically suggest favourable dates for them to attend the focus group discussion.[20] The 31st of January 2020 was found to be the most convenient date for the majority of the interested participants. Participants were informed that the focus group discussion would include a hypothetical case vignette but no other details were provided.

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17. Refer to mean dimensionality score and standard deviation for statement 2d, as outlined in Figure 6 on page 73.
18. Refer to Appendix 1.
19. Refer to Appendix 2.
20. Refer to Appendix 3.

The focus group discussion

The 90-minute discussion was held in a closed room at Ċentru Tommaso Chetcuti. With their written consent, the discussion was recorded audio-visually, to use for verbatim transcripts. All participants choose to make use of the English language. A document with prompting questions was then given to each participant.[21]

The first section of the discussion was directed at analysing respondents' knowledge of concepts related to the end of life. The second section provided participants with a case vignette, followed by questions on how they would manage such a hypothetical scenario.[22]

The recording was stored in a secure electronic depository and was accessible solely to the research author for manual transcription.[23]

The transcript was uploaded into the software *Atlas.ti*. Thematic analysis was subsequently employed to study the content of the transcript in further detail, as shown in Figure 1.

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21. Refer to Appendix 4. The aim of the document was to structure and direct the respondents accordingly. Participants were informed that the research author would not be part of the discussion and would only serve to respond to technical questions related to the exercise. This was done in order to reduce the group's dependence on the study author, thus promoting an autonomous and unhindered discourse on the subject.

22. "An Example of Assisted Suicide | The World Federation of Right to Die Societies," accessed May 17, 2020, https://www.worldrtd.net/example-assisted-suicide. The case was adopted from the official website of the World Federation of Right-to-Die Societies where it is was used as an example to explain right-to-die scenarios to readers visiting the site.

23. Care was taken to accurately transcribe the conversation; visual footage was used to ensure that transcribed text is accurately assigned to its actual interlocutor. When in doubt on the emotional tone of the statements being made, visual assessment of gestures and facial expressions was used to determine their speakers' intended emphasis.

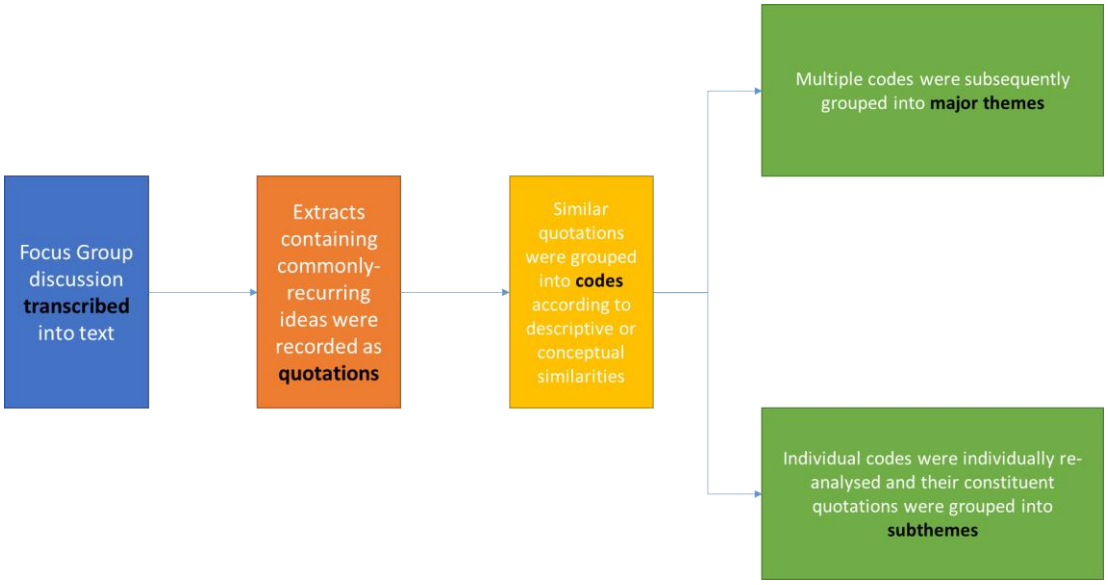

Figure 1 Thematic analysis of focus group transcript

This thematic overview was used to create a conceptual model which outlines the salient factors taken into account during the discussion.

Chapter 3: Results

This chapter provides an overview of the findings elicited from this study. It proceeds to outline the general characteristics of the questionnaire participants, the quantitative results, the impact of demographic variables on these results, and finally, the findings elicited from the focus group discussion.

Demographic characteristics of participants

204 professionals (33.9%) participated in the online questionnaire out of a total population of 601.The majority of respondents were female (N=132, 64.7% of the respondent cohort), whilst the rest were males (N=72, 35.3%) (Figure 2).

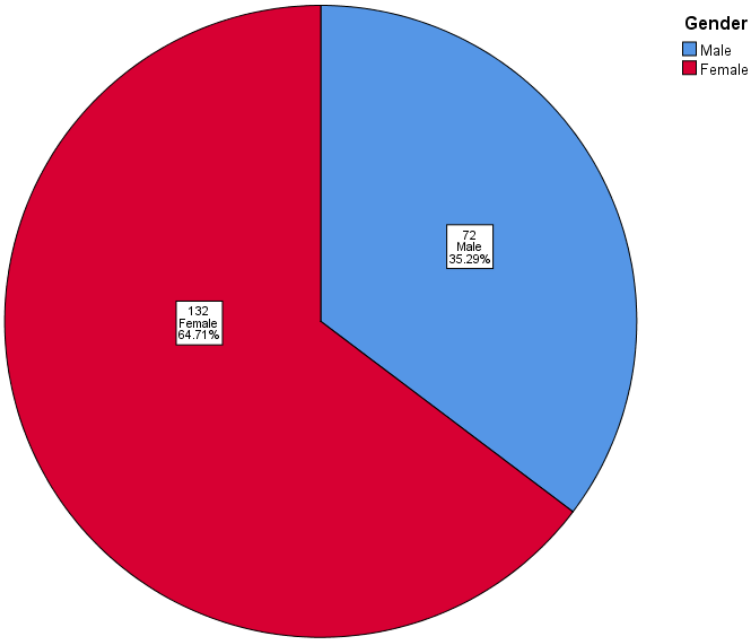

Figure 2 Gender of Respondents

N=112 (54.9%) of respondents, were less than 40 years of age when participating in the study. Only N=10 (4.9%) of respondents, were over 60 years of age (Figure 3).

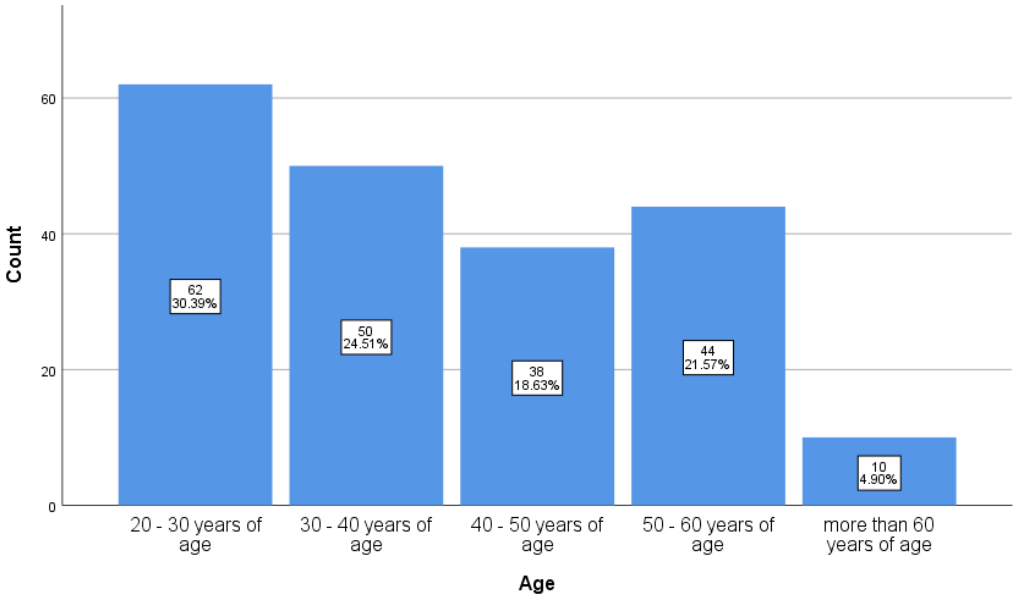

Figure 3 Age of Respondents (grouped)

As expected, nurses, including nursing assistants and carers, comprised the majority of respondents N=119 (58.3%) (Figure 4). This was followed by the medical professionals, encompassing psychiatric consultants, specialists, trainees and foundation doctors, N=39 (19.1%) of the respondents. The remaining N=46 (22.6%), comprised the multitude of other professionals, including occupational therapists, psychologists and social workers. N=4 physiotherapists, N=2 podiatrists and N=1 public health physician also participated in the study and were grouped into the unnamed category "other".[1] Interestingly, when considered specifically, these figures amount to an uptake of 26% of the targeted nursing profession (N=119, out of 458), 66% of the medical and psychiatric profession (N=39, out of 59) and 51% of the ancillary professions (N=43, out of 84).[2]

[1.] Podiatrists and public health physicians, although partially involved within the mental health sector, were not directly targeted in this study, indicating that there was uptake of the study questionnaire by professionals outside the intended cohort. This was surmised to indicate added interest towards the topic of study since these professionals could only have participated in the questionnaire after a link was sent externally to them from one of the originally-intended recipients.

[2.] This was calculated based on the workforce statistics provided by management, and outlined in page 64. A total of 458 nursing professionals, including 377 nurses, 10 carers and 71 nursing aides, were targeted through this study. This explains the relatively large number of participants from this group. Another 59 medical professionals and 84 multidisciplinary professionals were also targeted, with the latter including 45 psychologists, 22 occupational therapists, 6 physiotherapists and 11 social workers. Another 3 health professionals (2 podiatrists and 1 public health physician.) were not specifically targeted to participate in the study, given that their clinical duties include services outside the mental health system. Nevertheless, they were

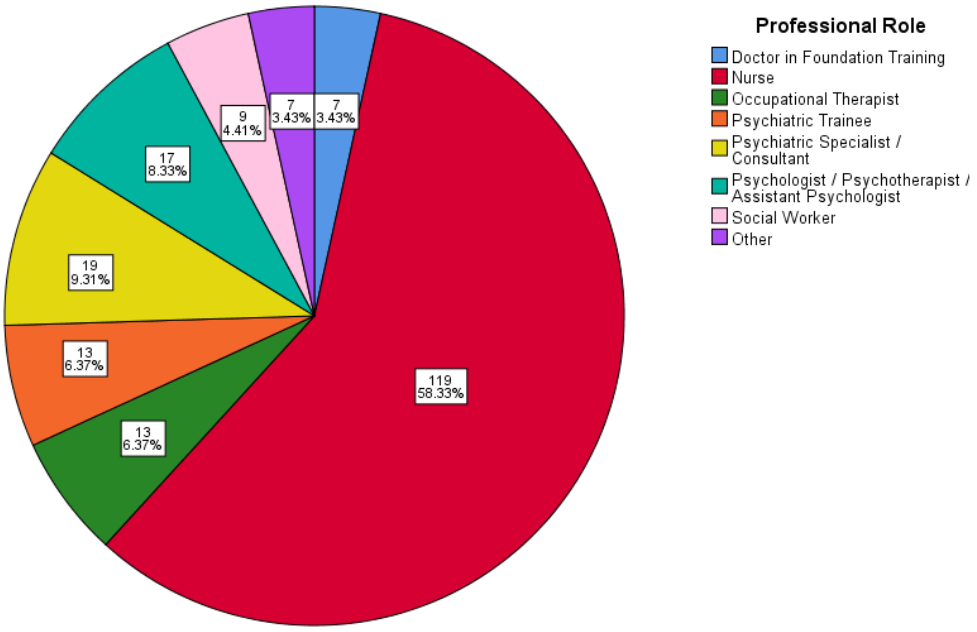

Figure 4 Professional Role

The absolute majority of respondents, amounting to N=106, or 52%, reported less than 10 years of professional experience within the mental health sector (Figure 5).

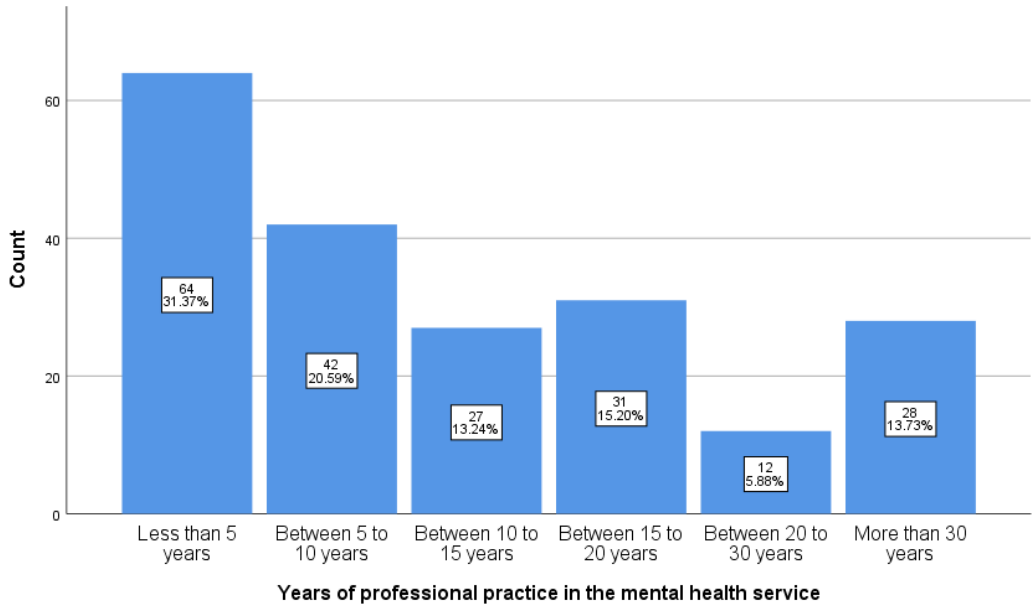

Figure 5 Years of Professional Practice

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also found to have completed the questionnaire, possibly sent to them via their colleagues, who were part of the targeted cohort.

Views on the various dimensions of suicide

Respondents' views on statements related to dimensions of suicide are shown in Figure 6. Table 1, in turn, highlights the different dimensions being studied.

Table 1 Dimensional perspectives on suicide

Dimension	Description	Study purpose
1	Situation-specific acceptability of suicide	Aimed to study the position of professionals on suicide in complex or sensitive real-life situations
2	General acceptability of suicide	Aimed to study the position of professionals on suicide as a general and abstract concept
3	Perspectives on suicide as a mental illness	Aimed to assess congruity to the epistemological definition of suicide as a consequence of mental illness
4	Spiritual perspectives on suicide	Aimed to assess broader, non-material world-views and whether they impact professionals' suicide perspectives
5	Perspectives on the communication of suicidal behaviour	Aimed to study whether professionals agree with the communication of suicidal plans and attempts, and whether this also applies to the communication of psychological problems
6	Perspectives on the hiding of suicidal behaviour	Aimed to study attitudes towards the concealment of suicidal behaviour at the community level
7	Perspectives on the open reporting of suicidal behaviour	Aimed to study attitudes towards the concealment of suicidal behaviour at the broader social level, through mass media

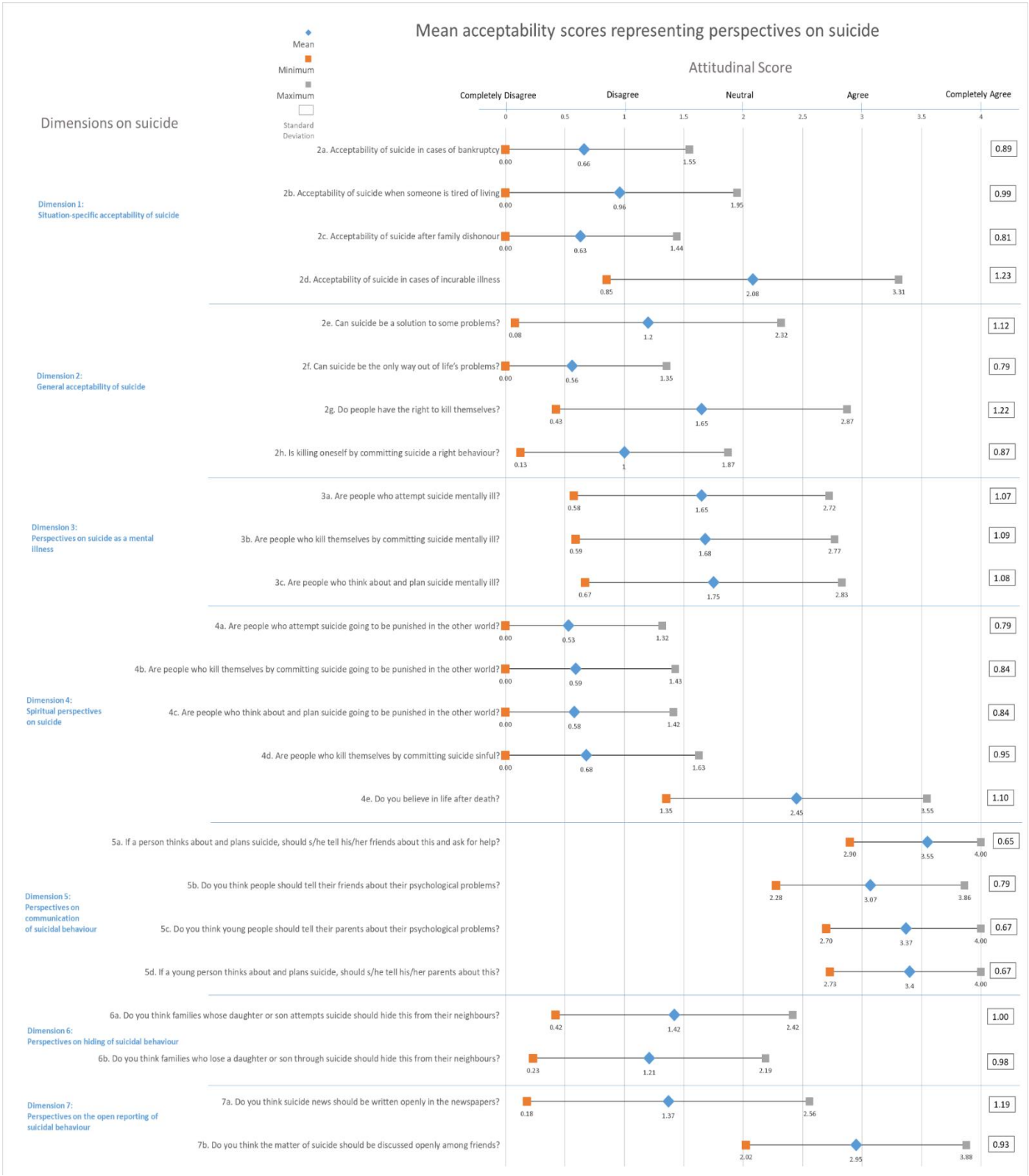


Figure 6 Bar graph showing mean acceptability scores, stratified by dimensions, on perspectives on suicide[3]

3. All generated dimensional scale scores were given arbitrary values, ranging from 0 to 4, where 0 corresponds to strong disagreement and 4 corresponds to strong agreement/

As shown in Figure 6 (Dimension 1), suicide in cases of family dishonour registered an acceptability rating of 0.63, with a standard deviation of 0.81, while suicide in bankruptcy registered a rating of 0.66, with a standard deviation of 0.89. Of the four situations considered, the situation of suicide due to family dishonour was the one which elicited the least varied response.

When asked on the acceptability of suicide when one is tired of living, an acceptability rating of 0.96 was registered, with a standard deviation of 0.99.

The situation which registered the highest acceptability score was that of the individual who is facing an incurable illness. The responses varied considerably, such that this last statement registered the highest standard deviation attained in the study, at a value of 1.23. For such a scenario, mental health professionals' acceptability scores ranged from clear disagreement, at a value of 0.85, to clear to strong agreement, at a value of 3.31. Indeed, the mean score for such a statement was 2.08, a value which marginally exceeds the midline score of 2.00.

Respondents disagreed with the possibility that suicide is ever a solution to life's problems, with a mean Likert score of 1.2 (Figure 6, Dimension 2). Note was however made of the large standard deviation for this statement, with 68% of replies ranging from 0.08, indicating complete disagreement, to 2.32, indicating a neutral-to-accepting attitude.

Nevertheless, the position of disagreement was made more even more pronounced when professionals were asked whether suicide can ever be the only solution to life's problems. Respondents greatly disagreed with the idea that suicide can ever be the exclusive solution to life's problems, registering a mean dimensional score of 0.56, with a standard deviation of 0.79. This mean score was the lowest acceptability score attained for any statement in the questionnaire.

Respondents tended to adopt a more accepting attitude towards the statement on suicide as a right in itself, registering a Likert score of 1.65, with a standard deviation of 1.22 and common replies ranging from 0.43 to 2.87, the latter indicating a position of agreement. However when asked specifically on the correctness of the act of suicide itself the level of agreement was markedly less, with a score of 1.00 and a standard deviation of 0.87.

Interestingly, although mental health professionals deal with suicidal patients in a mental health setting, the vast majority of respondents disagreed with identifying those who plan, attempt or commit suicide as 'mentally ill' (Figure 6, Dimension 3). The mean acceptability score on the prospect of defining individuals who attempt suicide as "mentally ill" was 1.65, with a standard

deviation of 1.07; the score for individuals who succeed in killing themselves via suicide was 1.68, with a standard deviation of 1.09; the mean score for those who think about and plan suicide was 1.75, with a standard deviation of 1.08. Evidently, all values for standard deviation exceed the value of 1, indicating considerably divergent positions on suicide.

Responses to questions on spirituality elicited a strong attitude of disagreement with the notion that suicidal individuals will be chastised in the afterlife (Figure 6, Dimension 4). Planning of suicide was deemed not punishable, with a mean score of 0.58 and a standard deviation of 0.84. The prospect of divine punishment for having attempted suicide also elicited an attitude of disagreement, with a Likert score of 0.53 and a standard deviation of 0.79. The notion that there is punishment in the afterlife for those who passed away through suicide evoked significant disagreement, with a mean score of 0.59 and a standard deviation of 0.84.

A similarly strong position of disagreement was expressed at the notion that the person committing the act of suicide was to be deemed as "sinful", with a mean score of 0.68 and a standard deviation of 0.95. Conversely, a more positive attitude was registered when professionals were asked whether they believe in life after death, with a mean score of 2.45, which represents a stance between neutrality and agreement. A standard deviation of 1.10 was however registered, indicating that professionals replied to this statement in a more varied manner than when compared to previous statements.

When considering attitudes towards the communication of suicidal behaviour, mental health professionals registered a strong attitude of acceptance to all statements (Figure 6, Dimension 5). This dimension was mainly intended to assess two facets of this important aspect on suicidality.

Firstly, two statements inquired on attitudes towards the position that all suicidal people should speak about their suicidal plans, or their psychological troubles, to their close friends. For both scenarios, the response was strongly positive, with attitudes towards disclosure of suicidal plans to friends registering a mean acceptability score of 3.55, with a standard deviation of 0.65, the lowest standard deviation in the entire study. Thus, this statement generated the most unified response compared to all other statements being investigated. The attitude on the disclosure of psychological problems to friends was still positive, albeit less, with a mean score of 3.07 and a slightly larger standard deviation of 0.79.

The second facet being studied in this dimension involved considerations on the position of young people who have to decide whether to disclose their suicidal thoughts or psychological

problems to their parents. When considering the prospect of young people choosing to divulge their suicidal thoughts to their parents, positions were generally positive, with a mean acceptability score of 3.37. A standard deviation score of 0.67 was obtained in this regard, indicating a strongly uniform response across the entire cohort. Similarly, a mean acceptability score of 3.40 was obtained when considering the situation whereby the young person is deciding on whether to disclose his psychological problems to his parents, with a similarly low standard deviation score of 0.67. Of note, this finding diverged from the one elicited for the adult patient's disclosure of psychological problems to friends, where the acceptability score was less.

Mild disagreement was elicited when considering statements on the hiding of suicidal behaviour. When asked on whether they agree with parents choosing to hide their child's suicidal attempt from their neighbours, a mean acceptability score of 1.42 was obtained, with a standard deviation of 1.00 (Figure 6, Dimension 6). The mean acceptability score of professionals to the prospect of parents hiding their child's completed suicide registered an even lower acceptability score of 1.21, with a standard deviation of 0.98.

Despite the general stance against the hiding of suicidal behaviour, note is made of the standard deviation values, which indicate a significant variance in responses, such that the range of common responses for the statement on suicidal attempts range from 0.42, indicating strong disagreement, to 2.42, indicating a stance bordering between neutrality and agreement. A similar disparity was also noted for the second statement, which focuses on the public disclosure of completed suicide, and whose responses ranged from a markedly low score of 0.23, indicating complete disagreement, to a value of 2.19, indicating neutrality.

Finally, when considering Dimension 7, mental health professionals were found to mostly disagree with the prospect of having suicide reported openly in the media. As shown in Figure 6, such a statement led to a mean acceptability score of 1.37, with a standard deviation of 1.19. The statement on whether suicide should be discussed openly with friends evoked a positive response, with an acceptability score of 2.95 and a standard deviation of 0.93.

Variables which influence perspectives on suicide

Demographic traits: age, gender, professional role and experience

Statistical analysis was employed to determine whether respondents' demographic characteristics were related to their attitudes towards suicide: tests were not performed on Dimension 7, since the statements in this dimension were found to lack internal consistency.[4] Results are displayed in Figures 7 to 10, along with their relevant p-values.

[4.] In order to analyse for possible statistically significant relationships between variables, the internal consistency of the questionnaire statements was measured using the Cronbach's Alpha test. Statements were grouped into dimensions as described previously (Figure 6). Dimensions 1 to 6 had a Cronbach's alpha exceeding 0.7 indicating good internal consistency between the statements. Dimension 7 had a Chronbach's Alpha of less than 0.5 indicating unacceptable internal consistency between statements. It was thus excluded from further data analysis. As described in page 65, the Shapiro-Wilk test was subsequently employed. All dimensional scores for dimensions 1 to 6 were found to have p-values of less than the 0.05 level of significance. All six score distributions were thus noted to be skewed and did not satisfy the normality assumption. For this reason, non-parametric tests were subsequently used to analyse the data.

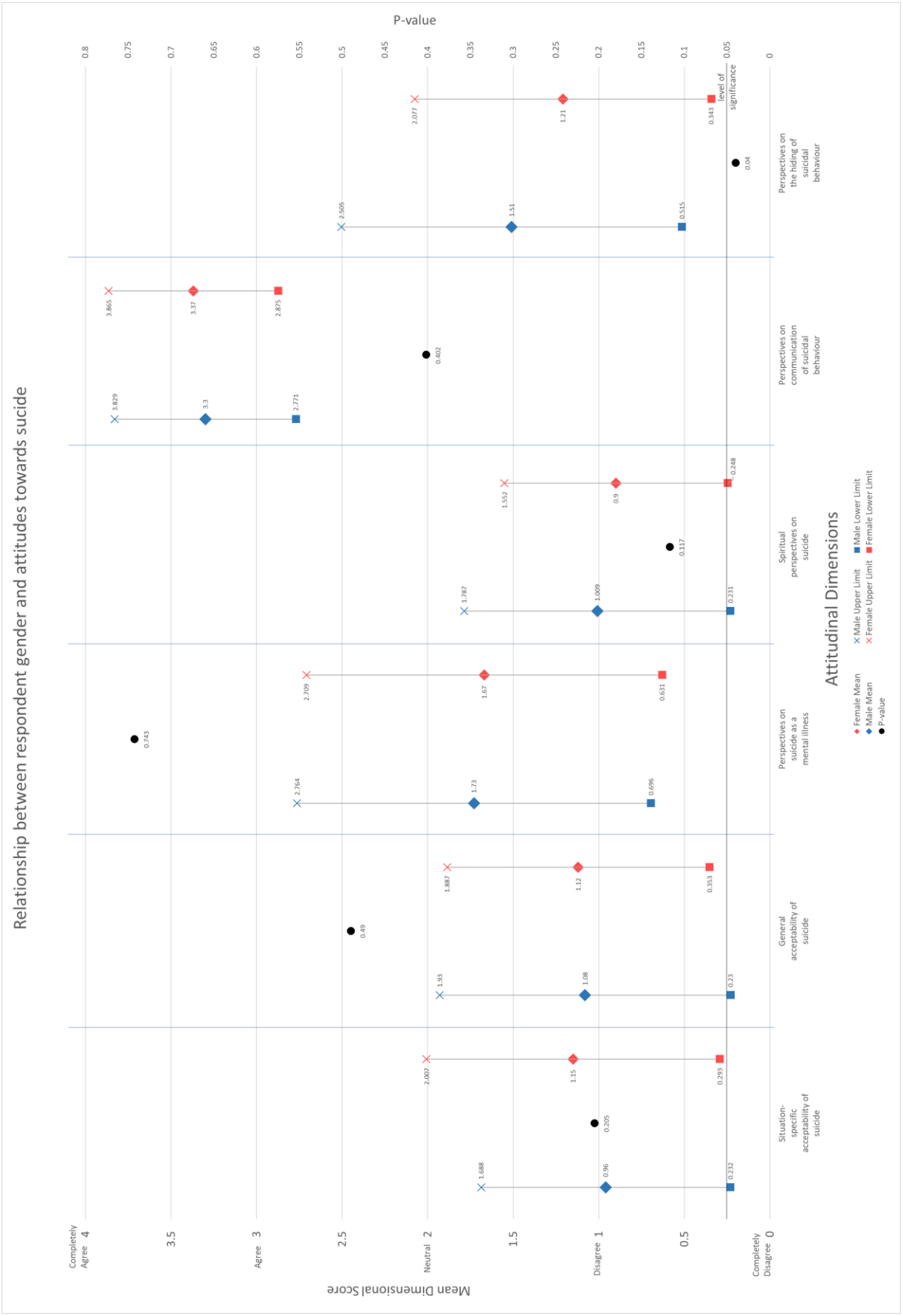


Figure 7 Relationship between respondents' gender and attitudes towards suicide

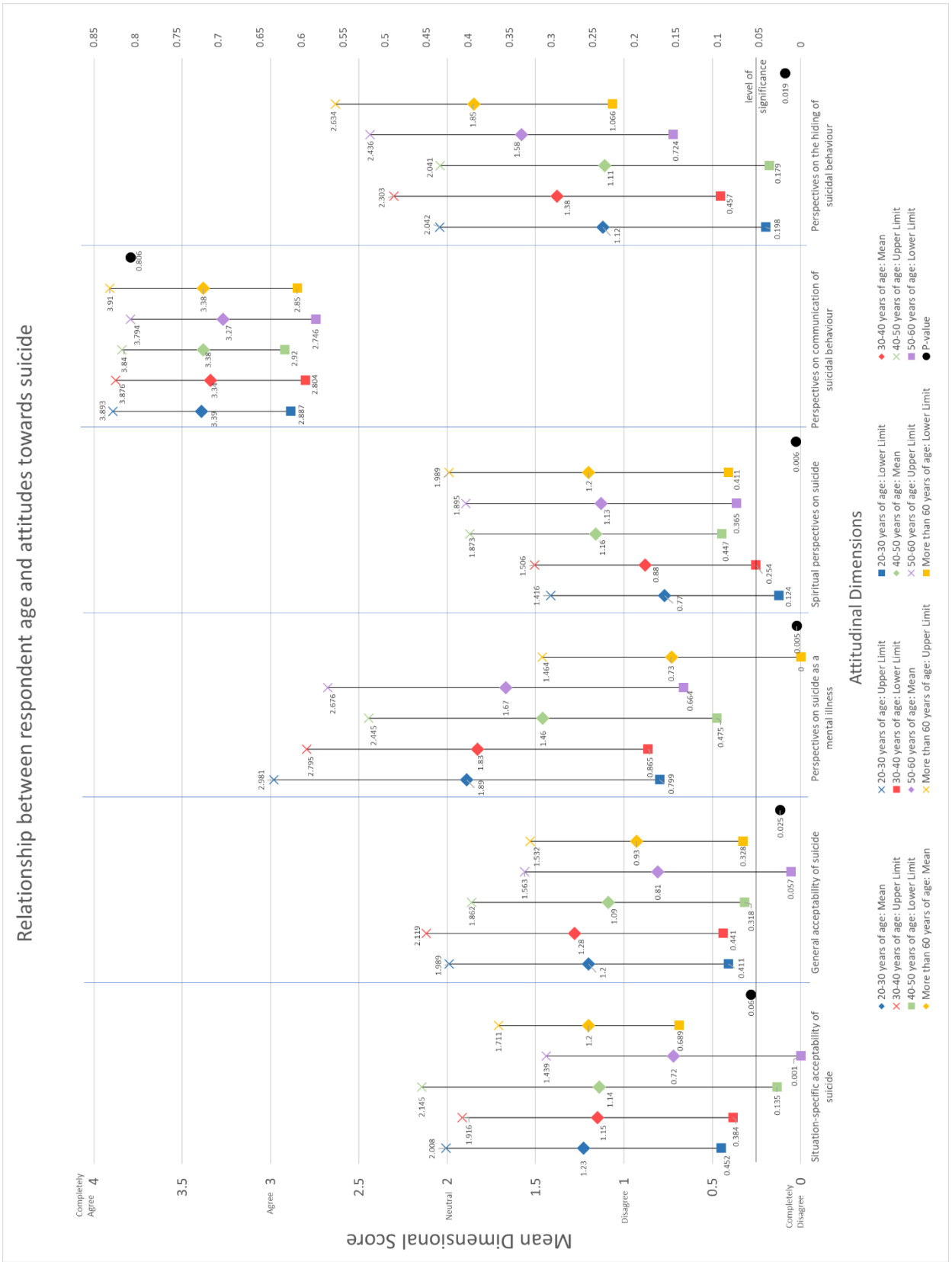


Figure 8 Relationship between respondents' age and attitudes towards suicide

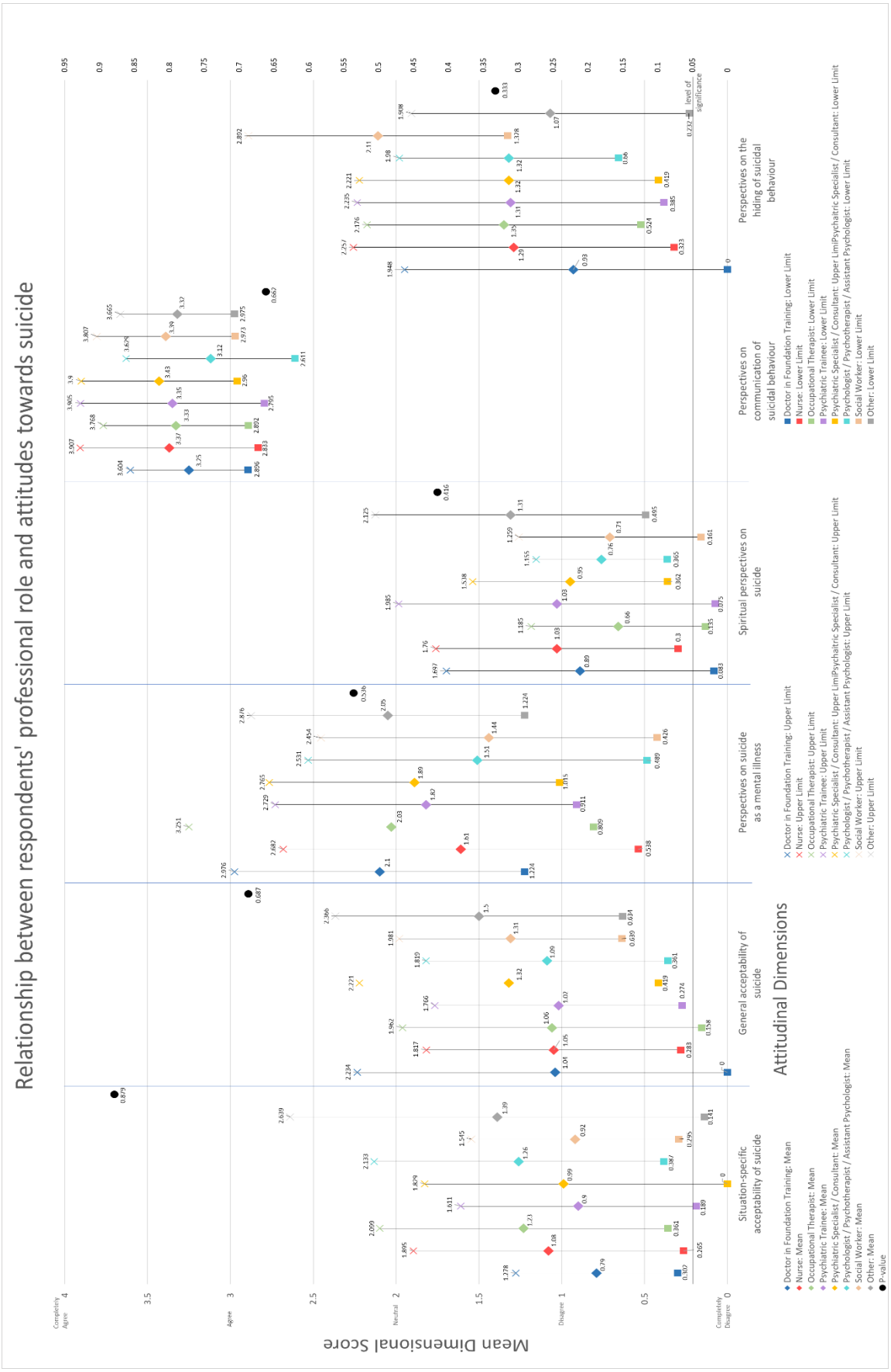


Figure 9 Relationship between respondents' professional role and attitudes towards suicide

Figure 10 Relationship between respondents' years of professional experience and attitudes towards suicide

Figure 11 describes the relationships outlined in Figures 7 to 10.[5]

Age was found to be the most influential variable, impacting views on four out of six dimensions. Years of professional experience, which is a natural derivative of age, was the second most influential variable, affecting two dimensions. Gender was deemed significant in only one dimension. Interprofessional differences in clinical role was found to have no significant impact on perspectives on suicide.

[5.] Note that the coloured arrows represent the influence of demographic variables on each respective dimension, represented by means of blue circles. The absence of arrows indicates the lack of any significant variable affecting the respective dimension.

Figure 11 Relationship between demographic variables and mean dimensional scores on suicide

Dimension 1: Situation-specific acceptability of suicide

Less experienced professionals agreed with suicide in specific situations more than their more experienced colleagues

- This contrast is evident when comparing the mean acceptability score for those having less than 5 years of professional experience, registering at 1.20, with the score for the most experienced group, registered at 0.74.

Dimension 2: General acceptability of suicide

Younger professionals registered a greater acceptability of suicide in general

- The youngest respondents were more accepting of suicide, with a mean score of 1.2, when compared to their eldest peers, with a score of 0.93.

Dimension 3: Perspectives on suicide as a mental illness

Older professionals disagreed with describing suicidal individuals as "mentally ill"

- Respondents above the age of 60 years had an acceptability score of 0.73, indicating significant disagreement. Their score was markedly lower than the mean scores of all the other age groups.
- In fact, the 40 to 50 year age group, whose score was the second lowest, had a mean score of 1.46, which is twice the acceptability score of the sexagenarians.
- Years of professional experience, which is a natural derivative of age, was also deemed significant, albeit that when seen through this demographic lens, no particular cohort registered strong disagreement.
- Indeed, professionals with 10 to 15 years of experience even reached a mean score of 2.02 indicating a more neutral stance on the subject

Dimension 4: Spiritual perspectives on suicide

Younger professionals were more inclined to disagree with statements on the sinfulness of suicide

- Professionals from younger age groups, on average, were more inclined to refute the notion that suicidal behaviour is sinful and punishable in the afterlife, when compared to their older colleagues

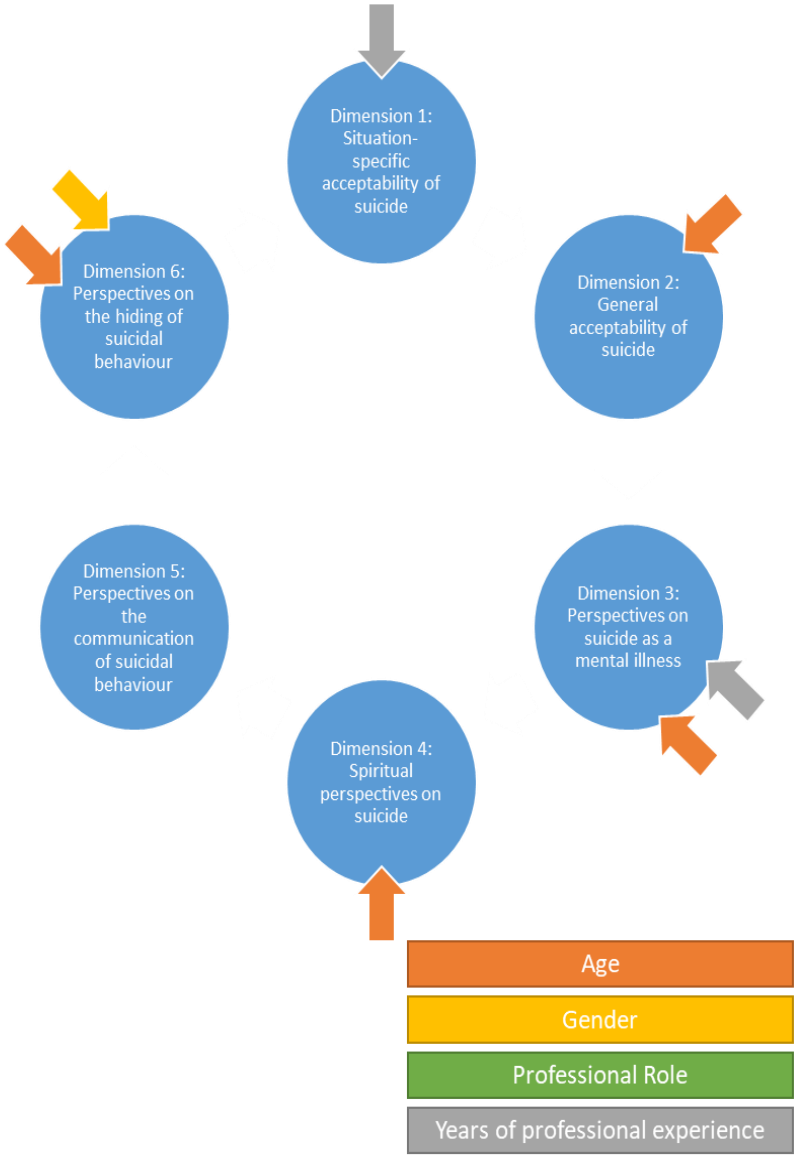
Dimension 5: Perspectives on the communication of suicidal behaviour

No variables were found to be significant

Dimension 6: Perspectives on the hiding of suicidal behaviour

Male and older respondents were more inclined to hide suicidal behaviour from neighbours

- Males registered a mean dimensional score of 1.51, compared to the female score of 1.21 (Figure 7). This was the only instant where gender was deemed as a significant variable.
- The youngest age group, on average, disagreeing more strongly with the hiding of suicidal behaviour (mean dimensional score of 1.12) when compared with their eldest counterparts (mean dimensional score of 1.85.



Inter-dimensional variability

Figure 12 highlights how perspectives towards one particular dimension affected respondents' position towards other dimensions.[6]

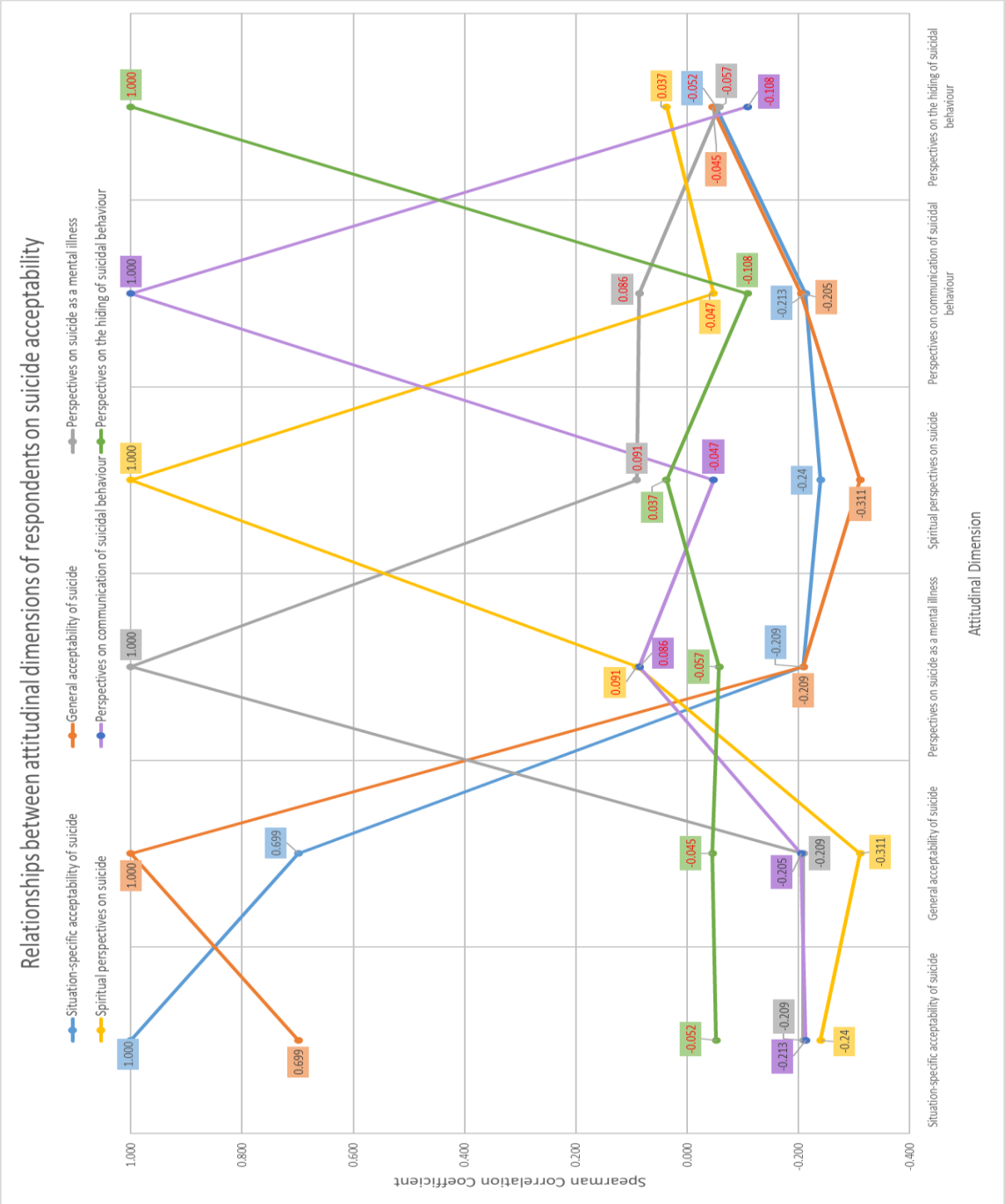


Figure 12 Line graph representing relationships between attitudinal dimensions of respondents on suicide acceptability

6. Spearman's rank correlation coefficient was used for this purpose, as detailed on page 65. All scores coloured in red had a p-value exceeding the 0.05 level of significance, and were thus deemed to lack statistical significance, favouring instead the null hypothesis.

Professionals' views on suicide in specific situations was found to be directly related to their views on the general acceptability of suicide and vice versa, such that if they agreed with one, they are more likely to agree with the other. The converse was also noted to be true.

Their views were however negatively related to views on suicide as a mental illness, spiritual views on suicide and views on the communication of suicidal behaviour. Professionals who regard suicide as a mental illness are less accepting of suicide in general and in specific situations. Professionals who believe in an afterlife, and who deem suicide as punishable, are more likely to disagree with suicide. Similarly, professionals who advocated open communication of suicidal behaviour were more likely to disagree with suicide in both general and specific situations.

Finally, there was no statistically significant relationship with regards to how professionals regard the concealment of suicidal behaviour, when compared with their views to all the other dimensions being studied.

Qualitative findings from the focus group discussion

A total of six mental health professionals participated in the closed focus group session. They included two psychiatric specialists, a psychiatric trainee, an occupational therapist, a psychologist and a mental health nurse.[7]

Themes elicited

When considering the hypothetical case of a person requesting physician-assisted suicide, a number of themes were elicited. These were subsequently grouped into major themes, which are subsequently divided into a number of subthemes related to the major theme itself.

These are presented in Figures 13 to 20.

[7.] A total of 128 respondents, or 62.7% of the entire participating cohort, expressed interest in participating in the focus group discussion when asked to reply to the final question of the study questionnaire, indicating veritable interest (refer to Appendix 1). Nevertheless, when asked to send their expression of interest via email, only 9 participants contacted the author, of which 6 eventually took part.

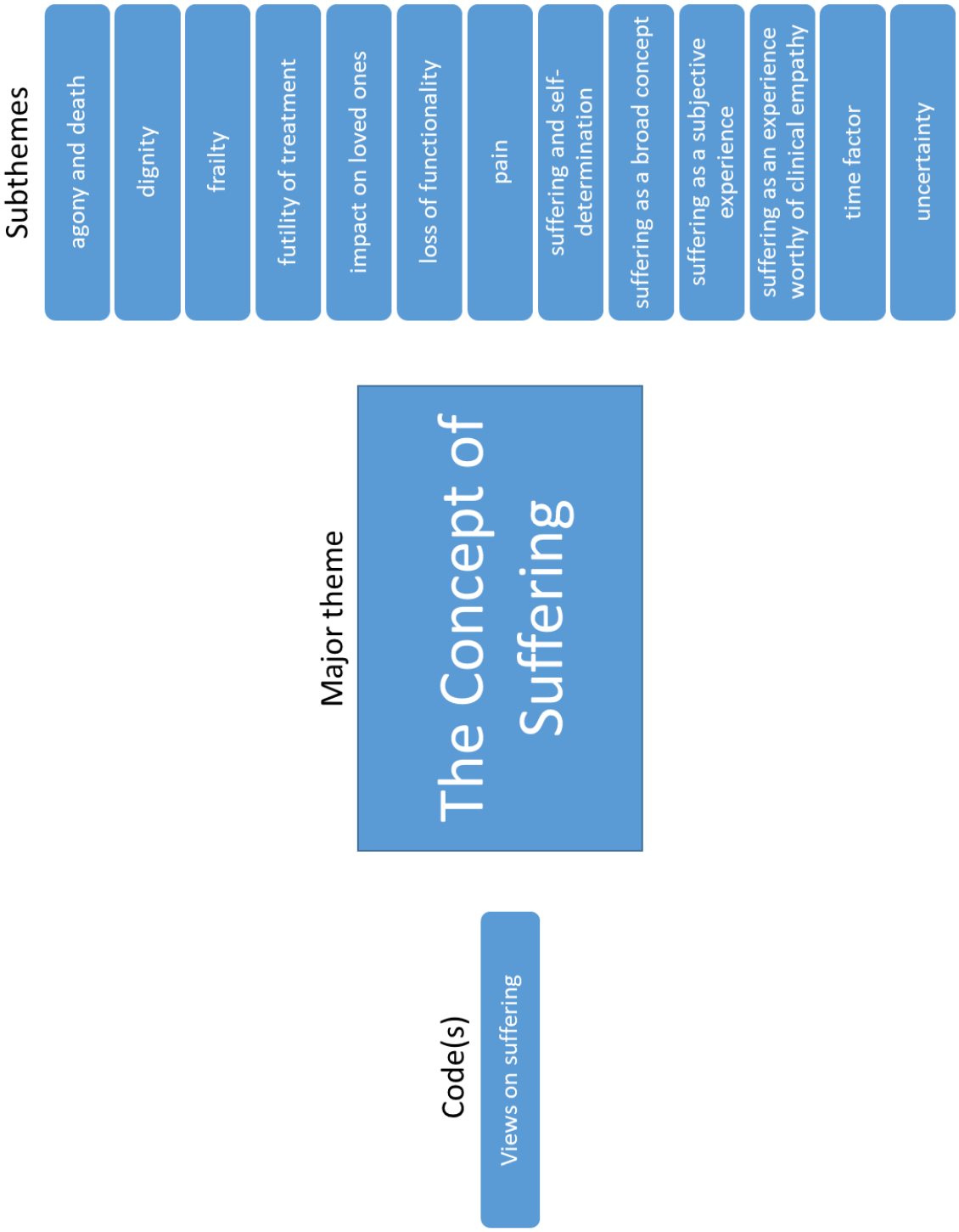


Figure 13 The concept of suffering as a theme, with its related subthemes

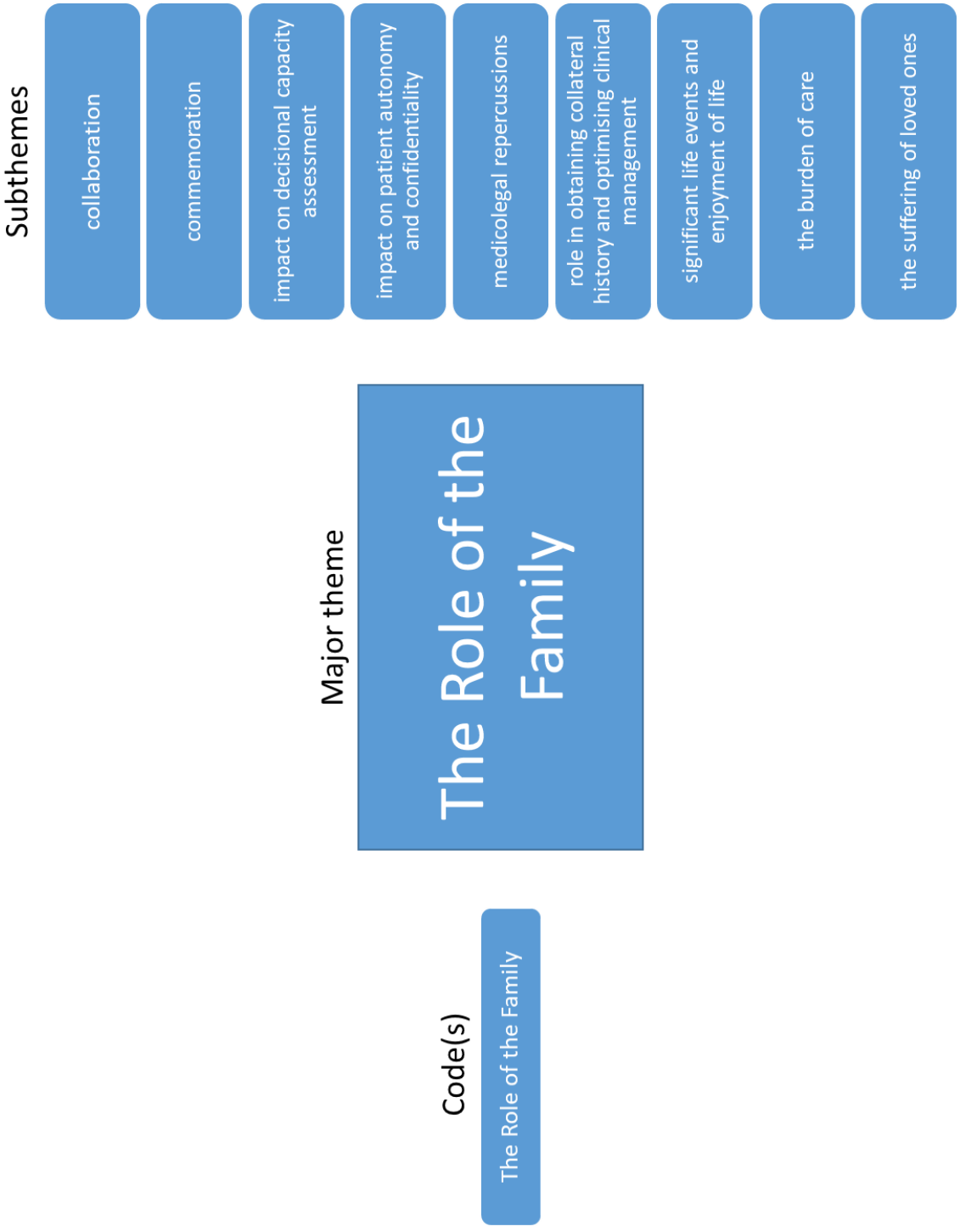


Figure 14 The role of the family as a theme, with its related subthemes

Figure 15 Psychological factors and mental illness as a theme, with its related subthemes

Figure 16 Human dignity as a theme, with its related subthemes

Figure 17 Autonomy and free decision-making as a theme, with its related subthemes

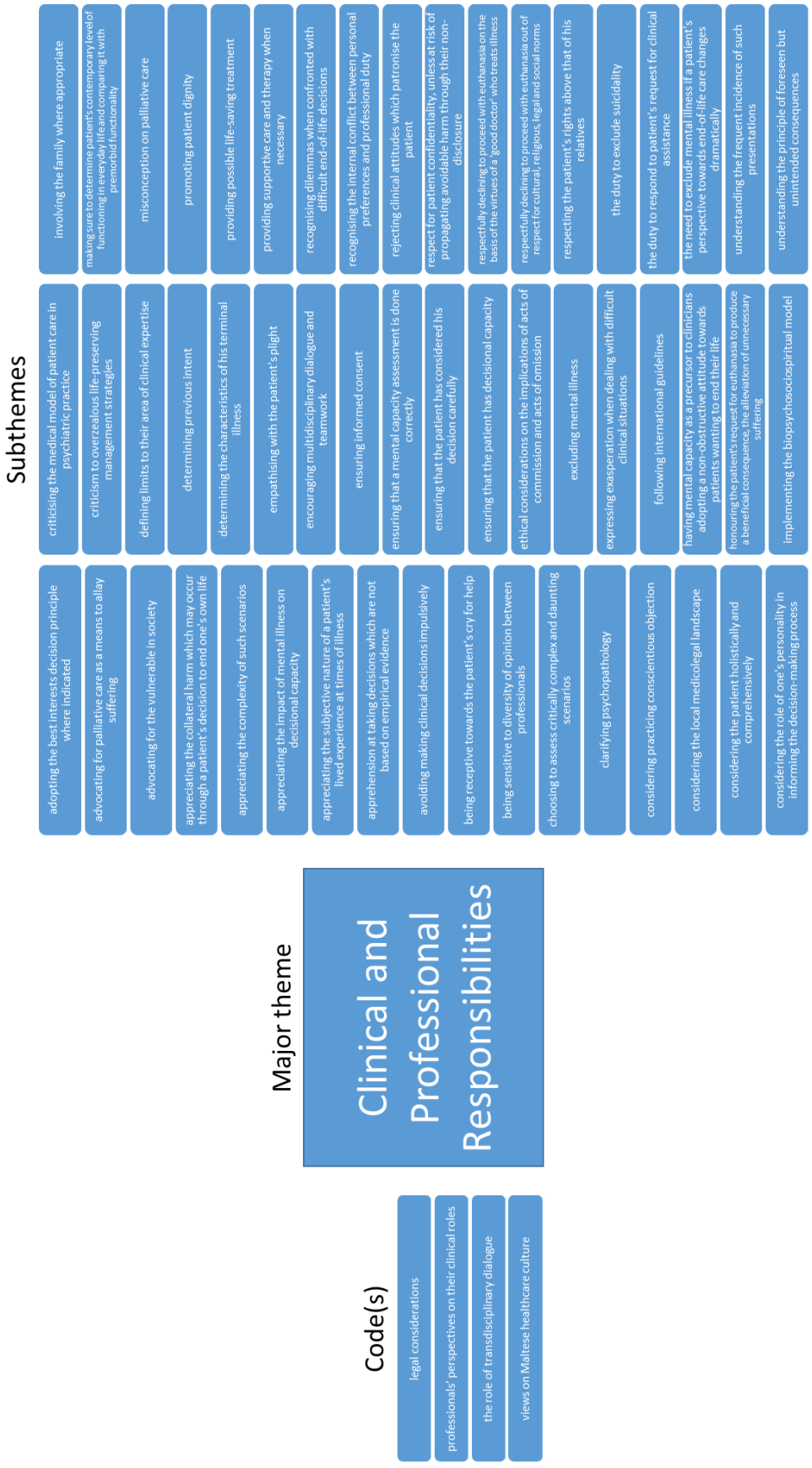


Figure 18 Clinical and professional responsibilities as a theme, with its related subthemes

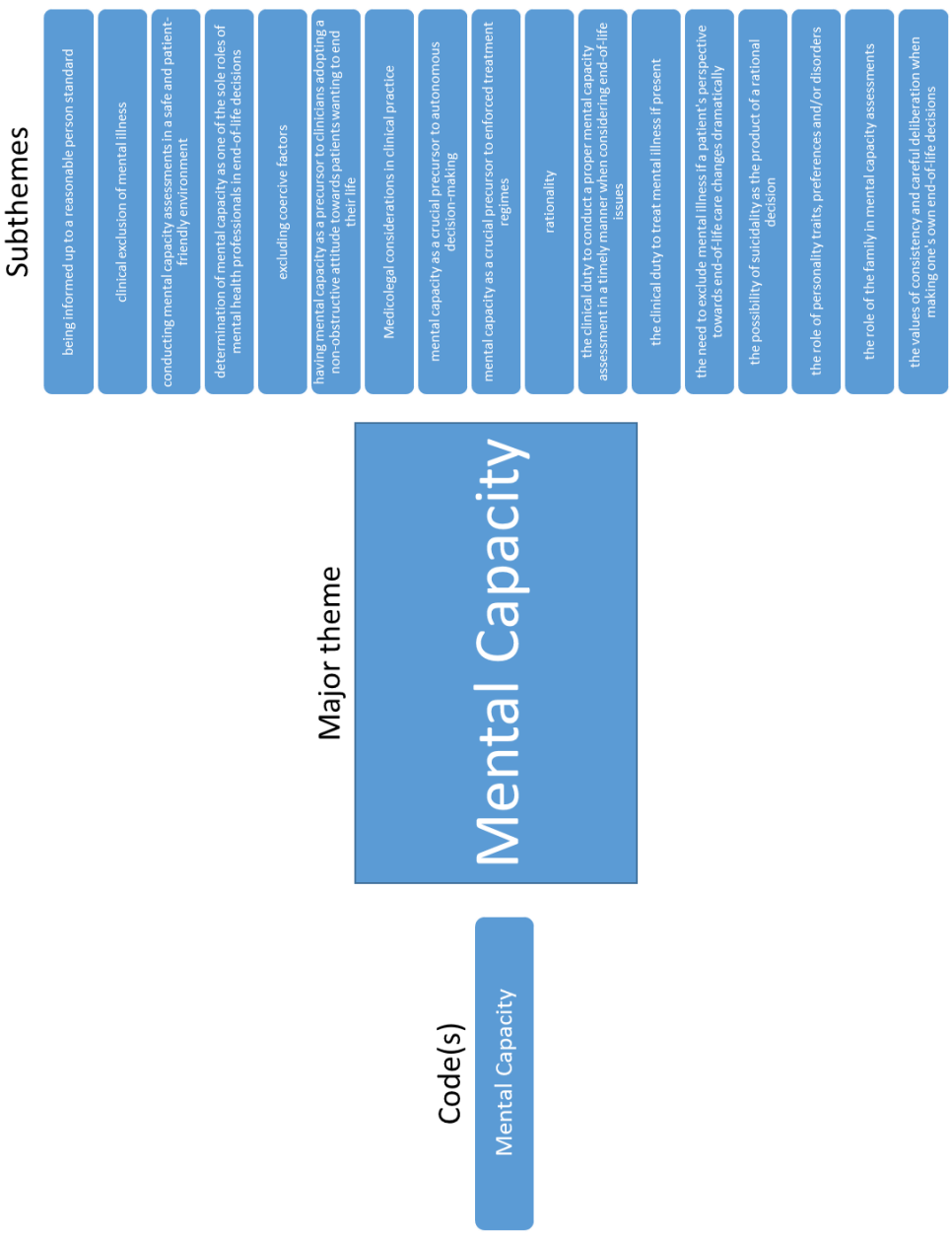


Figure 19 Mental capacity as a theme, with its related subthemes

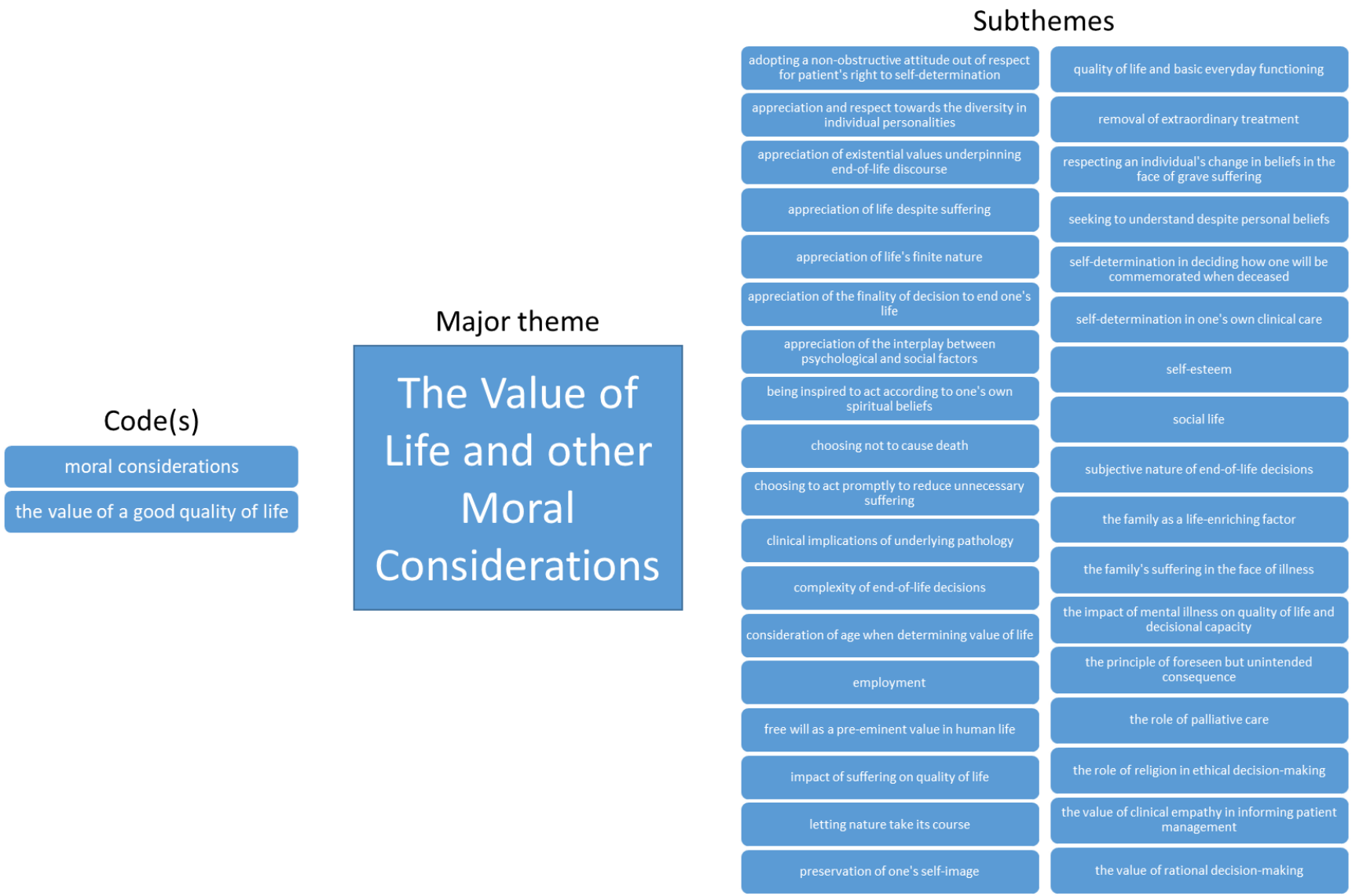


Figure 20 The value of life and other moral considerations as a theme, with its related subthemes

Sequential overview of key factors

When a group of mental health professionals discussed the hypothetical case of a patient which, due to terminal illness, was asking for assisted suicide, they approached the situation by analysing a number of themes, outlined previously. Figure 21 illustrates the concepts which were observed to have determined their thought process in a sequential manner, proceeding from the bottom upwards, to finally reach a conclusive decision.

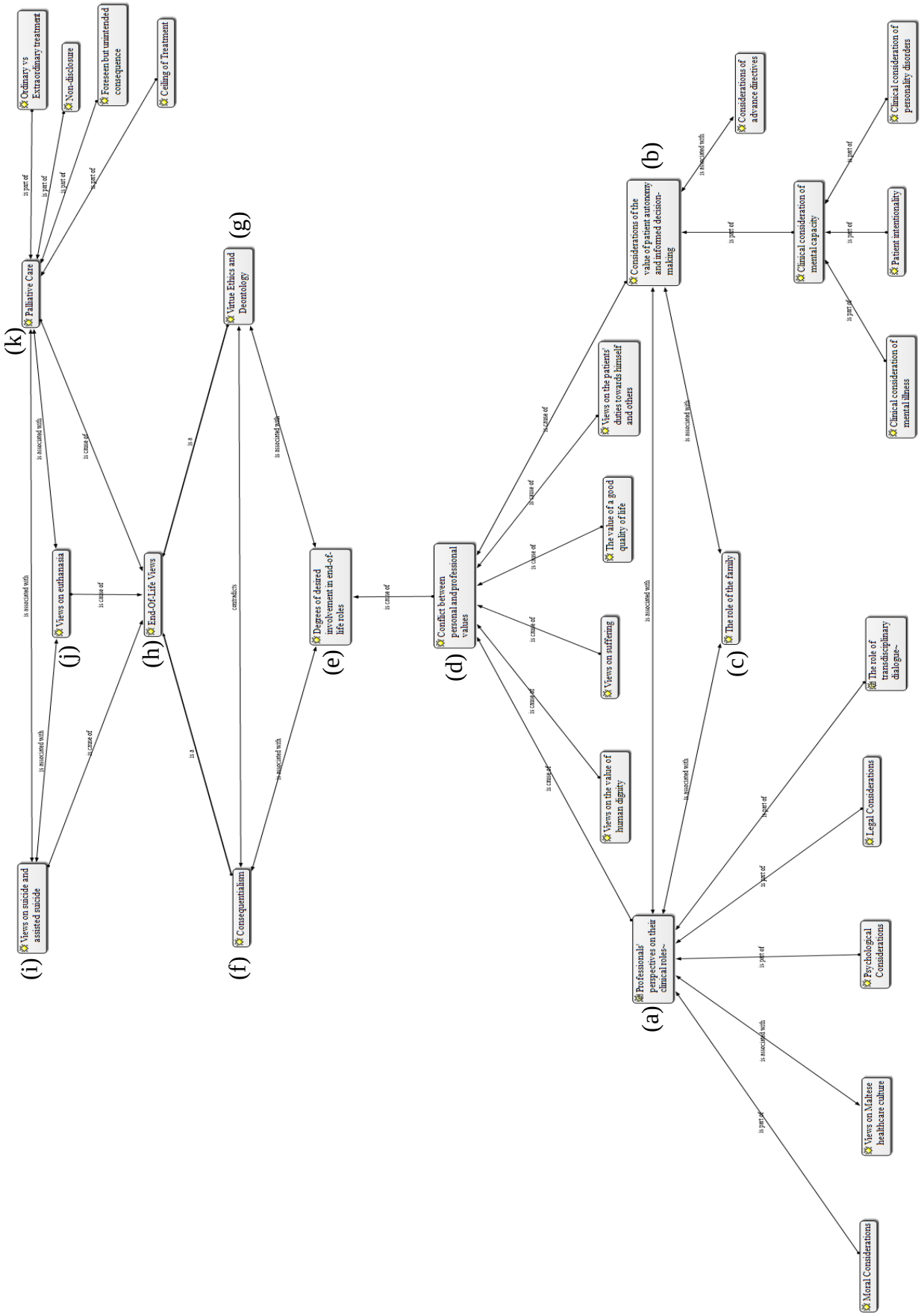


Figure 21 Conceptual model summarising process through which mental health professionals discuss right-to-die issues

As marked by (a), professionals first considered their intended role. This involved the contemplation of a multitude of factors, including the moral consideration of what is expected of them, which physicians in the group identified through the ethical standards set out in the Hippocratic Oath or equivalent pledges.

They also highlighted the need to consider their role within their encompassing culture, specifically the Maltese healthcare culture, stating that the practices and norms of any healthcare system should informed by the demands and values of the community it serves.

Moreover, they underpinned the need to be receptive to the psychological needs of their patients, particularly since they practice within the mental health setting: this is of added relevance in this scenario, whereby the patient is in distress and requesting to end his life. Professionals frequently also mentioned the need to abide to the legal framework of the country, since this encompasses what is legally and contractually demanded of them, and also serves to protect them against any form of legal reprisal. Finally, they emphasised the role of multidisciplinary dialogue, which they deemed imperative in all clinical practice, especially in such a sensitive and complex situation.

The professionals then proceeded to discuss their respective views on the value of patient autonomy and informed decision-making as shown through (b). Autonomy was unequivocally deemed as the superlative factor in all clinical decisions, and all mental health professionals agreed that they should respect the patient's wish, provided that it is made autonomously. They thus proceeded to highlight how they would ascertain that such autonomy exists, mainly by ensuring that the individual has the mental capacity to make decisions on his healthcare. They described the process of mental capacity assessment, in keeping with the one suggested by the Royal College of Psychiatrists.[8] In doing so, they emphasised the need to diagnose or exclude mental illness, and if present, to determine whether it is impairing the individual's decisional capacity. Similar considerations must also be made with regards to personality disorders, which professionals' regard with due caution, particularly since certain disorders may cause a person to decide impulsively or to be ambivalent about his decisions. A factor which may help in this regard is to consider how the patient intended to pass away in the preceding years of his life, when he was still unaffected by illness. They cited the benefits of advance directives in this regard, particularly since they allow the patient's autonomous request to be known and

8. Refer to page 14.

respected even if clinically he would have lost the mental capacity to presently decide on his care.

In these considerations, mental health professionals highlighted the invaluable role of the family in obtaining a clearer picture of the patient's previous preferences and values, his psychiatric history, his personality predispositions and also in obtaining a concise awareness of his premorbid functioning in everyday life. This is represented via (c). Professionals however advised due caution in this regard, since there may be instances when relatives may mislead the clinician for secondary gain, such as in the case of disputes over inheritance. Moreover, the role of the family was also considered as a determining factor when considering the clinician's professional role since they felt that they also have to consider the needs of the patient's family, while keeping in mind the possibility of legal proceedings initiated by the family in the event of the patient's demise.

Having considered all these elements, the professionals proceeded to weigh and prioritise them according to their specific personal values. In such a process, highlighted by (d), professionals considered their personal views on the value of human dignity, on the impact of suffering, on what contributes to a dignified life and on the patient's role in society and the impact which would be caused if he were to neglect his duties by committing suicide. These values were explored in depth in preceding sections and were given different importance by different participants.

Through prioritisation and careful deliberation, the professionals resolved this conflict of values and thus proceeded to report the degree by which they would assist the patient in committing suicide, or by proposing viable alternatives. This degree of desired involvement in end-of-life roles, shown by (e), highlighted the different priorities which professionals conferred to different facets of this ethical dilemma.

On the one hand, one of the professionals preferred to ultimately consider the final consequence of one's actions, in this case, the irreversible and definite alleviation of suffering, and thus justified the means by which such a desired good consequence may be achieved. As evidenced by (f), such an approach is in keeping with a consequentialist line of thought.

Other professionals tended to give greater importance to fulfilling their envisioned idea of the "good clinician", suggestive of virtue ethics, while also placing considerable emphasis on what is expected of them. The legal code and the Hippocratic Oath were commonly cited in this regard, characteristic of deontological ethics. Indeed, both normative theories were made

manifest in the majority of participants, as shown in (g), such that a clear demarcation between whether they held one or the other could not be made. For the mental health professionals discussing this complex issue, being a "good clinician" also entailed conforming to the rules and duties expected of one's own profession.

These ethical positions thus influenced the professionals' end-of-life views, shown by (h), with a single professional choosing to assist the patient in terminating his own life, even by administering the treatment itself, illustrated by (i). The other professionals made it clear that, if such a scenario were to take place, they would respect the patient's decision and adopt a permissive attitude, choosing not to assist, but also not to hinder him.

Other professionals cited the role of euthanasia in such situations, as shown in (j), although conflicting views on what defines euthanasia were noted throughout the discussion. Such professionals held the mistaken belief that by withdrawing treatment and letting nature take its course, then the professional would have been actively performing euthanasia. Professionals appeared to lack conscious awareness of the Thomist principle of double effect, although it was later revealed that some of them were aware of contemporary local palliative care practices, shown by (k), whereby ordinary treatment is still administered but excessive or inappropriate (extraordinary) treatment is purposefully omitted. In such circumstances, professionals advocated for a "ceiling of treatment" which they described as a pre-emptive clinical decision which would instruct the attendant physician on where to draw the line if the patient's condition starts to fatally decompensate. In this regard, mental health professionals revealed an understanding of the moral difference between acts of commission and acts of omission. They subsequently proceeded to highlight and agree with instances whereby physicians allow nature (in this case, the illness) to take its course, and how the administration of morphine in such settings, for palliative purposes, may unintentionally hasten the dying process, even though this effect was foreseen yet unintended.

Consequently, the final conclusion of most professionals would be to refrain from assisting the suicidal individual with the intended suicidal act, seeking instead to advocate for palliative care practices. If the suicidal act were to go ahead, after being deemed autonomous, most professionals would choose to conscientiously object to giving the lethal drug but would respect the individual's wishes and choose not to intervene. Nevertheless, they would still seek to advocate for the provision of palliative care, as a reasonable alternative to suicide.

Chapter 4: Discussion

In this chapter, the findings outlined previously are discussed at length, and interpreted with consideration of the socio-cultural and philosophical paradigms detailed in Chapter 1.

Study limitations

The quantitative stage of the study

In order to maximise response rate, the study was designed in such a way as to address all intended recipients. The questionnaire tool chosen for this study had a readability level suitable for readers aged 11-13 years of age and was sent in two separate instances via work email, allowing participants to reply at their convenience.[1] In order to avoid any responder bias during distribution, direct contact with the researcher was minimised, with the questionnaire being disseminated in a top-down approach by the respective heads of department of each mental health profession.

This method led to a response rate of 34%, with satisfactory engagement across all intended respondent cohorts, as seen in Figures 2-5. Respondents came from varying age groups. Understandably, a fair proportion of study participants were nurses, which reflects the higher prevalence of nursing staff within the healthcare sector. Nevertheless, the response rate categorised by profession indicates a higher relative uptake by the medical staff and ancillary professions, possibly due to the smaller size of these groups, which may have helped optimise the dissemination of the questionnaire.

Unavoidably, the interest shown through the participation of questionnaire respondents may not be fully representative of the non-participating cohort. The efforts made to increase response rate were thus also intended to minimise potential participation bias.

[1.] The readability level was generated using an online tool which was accessed from https://readabilityformulas.com/. It made use of the following instruments (individual scores included): Flesch Reading Ease score: 57.3; Gunning Fog: 7.3; Flesch-Kincaid Grade Level: 7.4; The Coleman-Liau Index: 10; The SMOG Index: 6.8; Automated Readability Index: 5; Linsear Write Formula: 4.5. A Grade Level 7 composite score was obtained, commensurate with the average reading capabilities of 11 to 13 year olds.

The qualitative stage of the study

Despite initial interest from more than a 100 respondents, only 6 professionals ultimately participated in the group discussion.[2] This stark contrast is possible due to the nature of the discussion, which was to be conducted face-to-face: it may have prompted issues related to time restrictions, a desire for complete anonymity and fear of reprisal by peers if their views on the subject are controversial.[3]

Furthermore, while it is desirable to have focus group participants who are actively interested in the subject, potential selection bias was also taken into account prior to the study's commencement. Care was taken to ensure that all participants understand what is expected of them and that they were being asked to discuss the matter from their own personal point of view, in a safe and non-judgemental environment. Confidentiality and non-disclosure were thus given paramount importance, in order to foster a culture of openness and goodwill intended to facilitate respectful discourse on the subject.

Finally, efforts were made to minimise any potential observer bias. The study author only observed the discussion at a distance and intervened only to clarify any technical or procedural concerns. It was emphasised that attention will be given to the subjects discussed and not to the individuals discussing them.

[2.] More details on page 78.

[3.] Julius Sim and Jackie Waterfield, "Focus Group Methodology: Some Ethical Challenges," *Quality and Quantity* 53, no. 6 (November 1, 2019): 3003–22, doi:10.1007/s11135-019-00914-5.

The views of mental health professionals on suicide

Strong and unified disagreement to suicide, with some exceptions

Mental health professionals generally disagreed with suicide. They strongly disagreed that suicide can ever be the only solution to life's problems; their disagreement was less pronounced when considering situations in life where suicide may be a viable option to consider. For such a statement, in fact, the response was more varied, albeit still generally in disagreement.[4]

Speaking broadly, therefore, some professionals propose that there are instances when suicide is a solution, although in itself, it is never the exclusive resolve to the problem at hand. Indeed, this concurs with the ethos of the work done in mental healthcare, which invariably involves clinicians assisting the suicidal person in considering alternative options, refusing at any point in time to give up and consider suicide as the only way out.

A varied response was also elicited when considering suicide as a right in itself, despite a general disagreement. This contrasts with the more uniform disagreement to the statement that suicide is "correct". Therefore, in an effort to safeguard the right to autonomous self-determination, the professional appears less inclined to disagree with suicide if it is an individual decision, even if the same professional personally and internally holds that suicide is a morally reprehensible act. This trend is more pronounced when comparing younger professionals with their older colleagues.[5]

A relativistic interpretation of suicide within a hierarchy of values

A general sentiment of disagreement to suicide was also registered when professionals were asked about its acceptability in distressing situations.[6] This questions invited professionals to empathise with the suicidal individual and prioritising values from a practical standpoint.

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4. Norheim, Grimholt, and Ekeberg, "Attitudes towards Suicidal Behaviour in Outpatient Clinics among Mental Health Professionals in Oslo." Indeed, and similar to the findings from the Maltese cohort, the Norwegian study revealed how mental health professionals in Oslo tend to regard suicide as a preventable behaviour; thus they concur with their Maltese counterparts that it is rarely the exclusive solution to life's problems.
5. Blackhall et al., "Ethnicity and Attitudes towards Life Sustaining Technology." This was expected and conforms to the findings and interpretations of Blackhall et al.
6. The situations are outlined in Figure 6.

When compared with the general acceptability of suicide, most replies on suicide in specific situations elicited the same attitude of disagreement. Mental health professionals were found to consider suicide due to family dishonour as even more unacceptable than suicide in situations of financial adversity, even though they strongly disagreed with both. Professionals inarguably disagree with determining the value of life according to one's family honour or financial success.

In comparison, while still in a position of disagreement, the acceptability of suicide in situations of extreme hopelessness was significantly higher than the one attained for suicide in situations of family dishonour, and the responses were more varied. These professionals are constantly exposed to situations of hopeless loss. In fact, depression, as a mental health condition, leads to a state of hopelessness and tiredness of life, especially in its more severe and debilitating forms. It is possible that mental health professionals were thus identifying with the position of their most depressed patients, including those whose life had been lost to suicide.

Mental health professionals were in the least agreement when it comes to discussing suicide in situations of incurable illness. Indeed, opinion in this regard appears to be divided symmetrically, with some disagreeing while others more willing to embrace it as an acceptable criterion for suicide. The empathy involved in clinical care undoubtedly allows clinicians, in varying degrees, to view life through the individual lens of their suffering patients, hence the divergence; thus value-based decisions on life and death may in turn be taken from a patient-centred mind-set.[7]

When demographic variables were taken into account, years of professional experience was the sole impactful variable when considering situation-specific acceptability of suicide: less experienced professionals were found to be generally more accepting of suicide in specific situations. One can surmise that, given the advances in resuscitation technology, younger

[7.] Derek W. Braverman et al., "Health Care Professionals' Attitudes About Physician-Assisted Death: An Analysis of Their Justifications and the Roles of Terminology and Patient Competency," *Journal of Pain and Symptom Management* 54, no. 4 (October 1, 2017): 538-545.e3, doi:10.1016/j.jpainsymman.2017.07.024. The article highlights the preponderance of healthcare professionals to endorse "patient-centred justifications" when dealing with situations of suicide and euthanasia.

generations are increasingly being exposed to these difficult end-of-life situations during their training, which in turn have an impact on their end-of-life views.[8]

Therefore, when considering suicide in practical terms, mental health professionals appear to prioritise the ailments of the terminally ill, and the psychological burden of those in irreconcilable hopelessness, over the impact of family dishonour and financial adversity. Interestingly, the latter two appear more community-oriented then the former; once again, suicide is considered from the individualist perspective.

For professionals, suicidal individuals are not 'mentally ill'

Contrary to what was expected, a considerable proportion of professionals disagreed with the statement that suicidal individuals are "mentally ill", contradicting the ample epidemiological data which proves the high prevalence of mental illness in the suicidal population.[9] A proposed explanation for these findings is that professionals attributed varied connotational interpretations to the phrase, possibly believing that it may betray an underlying pejorative tone.

Professionals in mental health naturally accept that those who exhibit suicidal behaviour may be affected through a diagnosed mental illness, hence their work in treating psychiatric disorders in suicidal patients. However, it is being proposed that they do not identify them with the label "mentally ill" simply because this is tantamount to stigmatisation. The phrase may have been interpreted as a threat to the very ethos of the mental health profession.

Interestingly, older professionals more strongly opposed the description of suicidal individuals as 'mentally ill' when compared with their younger peers. A possible interpretation for this finding is that older professionals may recall instances when mental illness led to archaic

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8. Martha E. Billings et al., "Determinants of Medical Students' Perceived Preparation to Perform End-of-Life Care, Quality of End-of-Life Care Education, and Attitudes toward End-of-Life Care," *Journal of Palliative Medicine* 13, no. 3 (March 1, 2010): 319–26, doi:10.1089/jpm.2009.0293. The greater bedside-training time with such delicate cases is in fact deemed as an influential determinant in shaping medical students' perspectives on end-of-life care.

9. Barraclough et al., "A Hundred Cases of Suicide: Clinical Aspects." A detailed overview of these findings may be found in page 5.

treatment methods reminiscent of an age when mental illness had been highly stigmatised.[10] Younger professionals may be less prone to interpreting the phrase negatively.

Furthermore, given their relative maturity, older professionals may have come to terms with the finality of life: to them, suicide may indeed be one of the ways in which one chooses to end his life, and that this does not necessarily signify mental illness, but rather a serene acceptance of life's terminal nature.

Interestingly, years of professional experience' was also found to be significantly related to attitudes on suicide as a mental illness, but this did not reveal the same attitude of disagreement which had been elicited with age. This was interpreted to suggest that the strongly disagreeing sexagenarian age group was either uniformly spread across the different cohorts of years of professional experience or the number of sexagenarian respondents was insufficient to have any effect when years of experience are considered. Therefore, in this case, age and experience produced divergent dimensional scores, despite their logical relatedness.

Belief in a merciful afterlife

When focusing on their spiritual beliefs, professionals were asked to consider the prospect of divine retribution for those individuals who plan, attempt or commit suicide. In so doing, they were asked to stratify suicidal behaviour by degree of action, while also indirectly reflecting on the existence of God, the concept of divine justice and on the afterlife.

The results show considerable agreement between professionals. All degrees of suicidal behaviour were deemed not punishable in the afterlife; with high uniformity in responses. Conversely, most respondents agreed with the statement that they believe in an afterlife, although with a greater divergence between individual respondents.

These findings imply that the majority of mental health professionals in Malta believe that a merciful afterlife awaits those who plan, attempt or commit suicide. This finding was expected, given the non-judgemental attitude which these professionals advocate towards the mentally

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[10.] Wulf Rössler, "The Stigma of Mental Disorders," *EMBO Reports* 17, no. 9 (September 2016): 1250–53, doi:10.15252/embr.201643041. The author describes how the treatment of the mentally ill transformed over the centuries and how institutionalisation may still contribute to a stigmatising attitude towards the mentally ill.

ill. It also reflects an innate belief that God is merciful and understanding.[11] This non-judgemental attitude was also reflected through professionals' strong disagreement with the proposition that suicidal individuals are 'sinful'.

Some professionals uphold inner conflicting religious beliefs

Interestingly, and as expected, age was the only demographic variable which influenced spiritual perspectives on suicide. Younger generations were less likely to believe in the afterlife than their older counterparts. This was taken to represent the current positivist culture, whereby one believes only that which can be proven empirically.

Nevertheless, despite this trend, when considered holistically, the results indicate at least some of the participating professionals harbour an underlying conflict of beliefs. While there was disparate agreement with the existence of an afterlife, the disagreement to punishment in the afterlife was strong and unified. If one were to refute the existence of an afterlife, then it is only logical that one would be averse to commenting on the nature of punishment in the afterlife, since a reply to such statements would indirectly infer that the afterlife does in fact exist.[12] To maintain objectivity, such respondents should have replied neutrally to statements on divine punishment in the afterlife. Evidently, this was not the case. Such professionals indirectly commented on the nature of justice, particularly divine justice, while concomitantly refuting the existence of an afterlife; on the one hand they commented on justice as an absolute value, while invoking plurality of opinion on the afterlife.

It is difficult to surmise the exact reason which led to this ambivalent outcome. It may be representative of a culture where faith is given less attention, leading to beliefs which lack logical congruence and thus warrant further personal contemplation.

One may also infer that given their exposure to human suffering, professionals would feel that it is unjust that suicidal individuals are punished for their actions. In so doing, their perspective is shaped by their conscience, or their inner sense of right and wrong. However, they may be

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11. Given that major religions attribute dispensation of justice to God, or the supreme deity.
12. Indeed, one cannot comment on the quality of that which is not there.

reluctant to profess a belief in the afterlife, since this would imply that they uphold the cosmological views of theistic religions.[13]

Professionals agree that people should open up on suicide

As expected, mental health professionals uniformly agreed with the need for people to communicate their suicidal thoughts or psychological problems. After all, one of the main precepts of mental health care is the empowerment of troubled individuals to open up on their mental health concerns.

Questions in this regard were based on four different scenarios: the need to disclose suicidal thoughts or psychological problems in two different situations, that is, between adults, and, for those who have not yet reached legal maturity, between the youngster and one's parents.[14]

There was strong agreement to the need to communicate suicidal thoughts in both the adult and the youngster's situation. Mental health professionals therefore prioritise the timely disclosure of suicidal thoughts, since this facilitates prompt intervention when needed.

The situation was less clear when communication of psychological problems was considered. Indeed, when discussing youngsters, the trend was more in agreement than with adults. Professionals may consider the young person as less independent, relying on their parents' support in times of need. They may also infer that youngsters may be more vulnerable to psychological problems and less capable of coping effectively with life's stresses.

In the adult case, professionals still agreed with the need to open up on psychological problems, but less strongly. Their reply may have been shaped by an appreciation of an adult individual's right for autonomy and confidentiality, and by the assumption that those of age should be more attuned to coping with the stresses of life.

However, despite this difference, the replies to this dimension of suicide remain that of general agreement, irrespective of demographic factors. This is in keeping with what was expected, given that the mental health profession, by virtue of its calling, is aimed at fostering a culture

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13. Which may be deemed as non-material and thus unable to be confirmed through empirical study. This is reflective of an underlying positivist mind-set.

14. One must note that the dynamic between two mature adults is implied to emphasise autonomy, equality and acceptance. The relationship between parents and their child, even if of age, is expected to be one of mutual respect and loving care.

of sincere and timely openness, particularly with those undergoing considerable psychosocial difficulties.[15] Given that openness relies on the non-judgemental attitude of the listener, it also builds up on the findings from the replies to previous dimensions on suicide.

Mixed response when asked on hiding of suicidal behaviour

While the general response was one of mild disagreement to the hiding of suicidal behaviour, a considerable diversity of attitudes was also revealed. Many mental health professionals disagreed with the prospect of having parents hide their children's suicidal attempts or completed suicides, although this stance was marked by considerable diversity of opinion.[16] When considering the adult population, the degree of divergence in opinion was even higher, although professionals generally disagreed with the hiding of suicidal behaviour.

Stigma is believed to have contributed to these results: the hiding of suicidal behaviour in itself may be a response to a culture of shame, guilt, slander and ostracisation if such behaviour were to be revealed.[17] By hiding suicidal behaviour one may try to minimise this feared socio-cultural harm. Conversely, others may uphold the position that the hiding of suicidal behaviour is in itself the catalyst which fuels the stigma in the first place. Divergence of opinion on the subject represents a disagreement between professionals on which approach causes the least harm to the individual and their loved ones.

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15. Royal College of Psychiatrists, "Core Values for Psychiatrists," 2017. This document, revised every five years, provides an exhaustive outline of the values expected by psychiatrists and indirectly reflect the shared ethos of the mental health profession in general.
16. The standard deviation in this case was close to, or exceeded, 1.
17. Rössler, "The Stigma of Mental Disorders."

Males more inclined to advocate hiding of suicidal behaviour with their patients

Age and gender were both noted to be significant in determining attitudes on hiding of suicidal behaviour. Male respondents were less in disagreement when compared with their female peers, while older professionals also tended to disagree less with the hiding of suicidal behaviour when compared with their younger counterparts.

A possible explanation for these findings relates to gender stereotypes, which are still prevalent in Maltese society.[18] Male respondents may be more predisposed to regard suicidal behaviour as a personal failure; female respondents may be more open to the prospect of compassion, and as such would advocate opening up on such matters since this would recruit invaluable social support.[19]

When interpreting the results in terms of age, the exact reason behind this trend is possibly based on the professional's personal stigma towards suicide. Older respondents may be more wary of disclosing suicidal behaviour to neighbours for fear of social retribution: their views may have been shaped by their earlier life experiences.[20] Younger age groups, whose perspective on mental illness has been fostered with the belief that the community should be compassionate and understanding, may be more attune to having families disclose these circumstances, in the hope that this further decreases stigma.

Professionals disagree with the reporting of suicides on the media but agree with discussing suicide between friends

Professionals disagreed with the prospect of having suicide openly reported by the media; contrastingly they tended to agree with discussing suicidal behaviour between friends.[21] Differences in the intended audience for each scenario may explain this clear contrast.

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18. European Institute for Gender Equality, "Gender Equality Index 2017: Malta," 2017, https://eige.europa.eu/publications/gender-equality-index-2017-malta. The latest (2017) index for gender equality in the European Union in fact ranks Malta below the EU-28 average.
19. Fhionna Moore et al., "The Gender Suicide Paradox under Gender Role Reversal during Industrialisation," *PLoS ONE* 13, no. 8 (August 1, 2018), doi:10.1371/journal.pone.0202487.
20. Rössler, "The Stigma of Mental Disorders."
21. Relatively large values of standard deviation were obtained in this dimension, which indicates that many respondents professed varied preferences to the statements being discussed.

The media is implied to be far-reaching and possibly prone to misunderstandings and bias. For this reason, reporting suicidality on the news may lead to a grave misinterpretation of facts and may heighten stigma.[22] Furthermore, being aware of the suggestibility of human nature, professionals may fear that the open reporting of such news will inspire those who are already contemplating suicide.[23]

When discussing with friends, the audience is implied to refer to a small and intimate group of people. Friends would be sensitive to each other's predispositions and would adapt their speech accordingly, avoiding distressing subjects if this may cause more harm than good. The statement also included the use of the term "openly", which further bolsters the idea that suicide should not be treated as a secretive matter, but should be discussed compassionately, and without fear of reprisal. These features may explain the generally positive attitude towards open reporting of suicide between friends.

Suicide acceptability shaped by views on spirituality, openness and suicide as a mental illness

The attitudes of professionals on certain dimensions of suicide were found to be linked with their attitude towards other dimensions. This link was not present for all dimensions, but when indeed proven, it satisfied previous assumptions related to suicide perspectives. As detailed in page 76, views on suicide in general was significantly related to views on suicide in specific situations. Furthermore, views on spirituality, the communication of suicidal behaviour and on suicide as a mental illness were all negatively related to acceptance of suicide.

As expected, for those professionals who uphold a belief in the afterlife, and who, to a certain extent, regard suicide as an immoral act, then the act itself would be morally and spiritually reprehensible. The converse is also true. Despite the non-judgemental attitude which the profession entails, one's personal views are shaped by one's innate beliefs. The questionnaire was aimed at elucidating a personal response by each and every professional, according to their

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22. Merike Sisask and Airi Värnik, "Media Roles in Suicide Prevention: A Systematic Review," *International Journal of Environmental Research and Public Health* 9, no. 1 (January 4, 2012): 123–38, doi:10.3390/ijerph9010123. Media may indeed sensationalise the suicidal act and the reporting bias, whereby more dramatic suicides are reported, may convey a polarised perspective on suicide to the general public.

23. Ibid. This effect is scientifically termed "modelling" and is of great importance within the behavioural sciences.

reason and their faith. This link proves that respondents felt comfortable sharing such personal beliefs, and that within the studied cohort, these beliefs were related to views on suicide.

A similar paradigm may also be used to understand the impact of perspectives on suicide as a mental illness. Professionals who view suicidal behaviour as a mental health issue understandably disagree with suicidal behaviour, since their action is deemed to be the product of an irrational mind, and would not be the consequence of an informed and autonomous decision.[24] On a similar note, being open on matters related to suicide is a fundamental prerogative to the seeking of the necessary professional support, thus enabling prompt clinical intervention.[25] The position of professionals on the disclosure of suicidal behaviour conforms to the paradigm of suicide as a mental illness and thus bears a negative effect on the overall acceptability of suicide.

These findings continue to highlight how these mental health professionals view the suicidal act as an individual decision, which for the most part is shaped by an underlying mental illness. The emphasis on individuality is clear, particularly through the inverse relationship between suicide acceptability and mental illness, which is inherently defined as a condition which distorts rational thought.

In this sense, autonomy, individuality, rationality and suicidal behaviour are all intrinsically linked, and spiritual beliefs, although relevant, are placed in the background and reserved for personal contemplation. This paradigm thus emphasises the role of the mental health professional in excluding and treating mental illness, particularly when confronted with suicidal individuals. Indeed, this was manifestly evident when considering the findings of the qualitative stage of the study.

[24.] Refer to the section on rationality and its relationship to mental illness and suicide, as detailed in page 10.

[25.] Royal College of Psychiatrists, "Core Values for Psychiatrists." Prompt intervention is indeed of crucial importance and the value of "timeliness" is in itself enshrined within the report on the core values for psychiatrists; "timeliness" is here defined as "good access to the appropriate service based on clinical need for assessment and treatment"

In practice: mental health professionals in right-to-die cases

The questionnaire provided a comprehensive overview of mental health professionals' beliefs on the subject of suicide. However, in order to understand how these beliefs shape their clinical practice, the second stage of the study provided clinicians with a hypothetical clinical vignette. As a multidisciplinary team, they were asked to deliberate on the case of a terminally-ill man who is requesting physician-assisted suicide.[26]

A situation of daunting complexity

Interestingly, all professionals chose to assess the terminally-ill man, even though they immediately made it known that such a case would give them considerable apprehension, particularly due to its inherent complexity. Some cited that considering such a plea represents a divergence from common clinical practice, which is informed through evidence-based decision-making. Conversely, they argued that this scenario revolves on ethics-based decision-making, which some described as non-prescriptive, and thus subjective, so prone to scrutiny and medico-legal liability.[27]

The issue of ethics as a subjective moral compass was also highlighted through the inference that ethical decision-making reflects internal biases, which may also stem from one's upbringing, worldview, or religious beliefs on the value of life and death. No specific mention was made of the 'sanctity of life' argument, possibly because disclosing such a position would be deemed as unacceptable within a scientific discussion. However, at specific and varied instances, some professionals explicitly clarified that they are against killing, even via physician-assisted suicide, since this goes against their moral beliefs and their sworn professional duties. Religious upbringing was cited as a possible contributing factor for this attitude, although this was expressed shyly and in a digressive manner.[28]

[26.] Refer to Appendix 4 for more details on the case presented for discussion.

[27.] Refer to Figure 18 on page 96, which outlines medico-legal issues as one of the main concerns of mental health professionals when confronting such ethical dilemmas.

[28.] This hesitation in clearly demarcating how one's spiritual beliefs may affect attitudes on the subject was evident throughout the discussion, with many a professional showing discomfort at explicitly stating that suicide goes against their religious beliefs, only doing so at the very end of the discussion, when confronted directly.

Shared responsibility in sensitive clinical decision-making

Given the daunting nature of right-to-die scenarios, professionals unanimously agreed that such decisions should be taken only as a clinical team, after holistic assessment, cautious involvement of the patient's loved ones, and ultimately following thorough interdisciplinary discussion.

While it may be argued that this emphasis on shared decision-making may be a product of the structure of the discussion, which was structured in a group format, the arguments raised by participants further confirmed the belief in the value of shared responsibility, not merely as a means of allaying medicolegal concerns, but also as a method by which a thorough assessment of the case can be conducted. All professionals agreed that in this day and age different mental health professionals have invaluable roles to play in comprehensive patient assessment. The psychologists argued in favour of personality assessments when considering such controversial pleas; psychiatrists highlighted the need to assess decisional capacity, exclude distorting mental illness and subsequently alleviate any mental health issues which may be diagnosed; the occupational therapist emphasised the impact of patient function on quality of life; the nursing profession described at length the suffering which the gravely ill go through, particularly at the end of life.[29]

Sharing of responsibility was thus not simply a means to divert medicolegal scrutiny if legal confrontations ensue, but also as a means to offer the best possible care to the ailing patient.

Suffering does not necessarily preclude a dignified life

Much emphasis was also placed on what it means to be human and on the need to ensure that every patient is treated with dignity and respect, even at the moment of death.[30] No professional argued against this ethical premise, although different professionals highlighted various elements which constitute suffering in such a situation. Some emphasised the psychological ailments of those contemplating suicide, and how these may exacerbate one's suffering, while also possibly distorting one's faculty for rational thought.[31] Others recounted how physical pain

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[29.] These are also highlighted explicitly in various points of the discussion transcript, and represented graphically in Figure 18.
[30.] Refer to Figure 16 on page 94.
[31.] Refer to Figure 15 on page 93.

predisposes to an undignified death, and should thus be allayed, possibly through palliative care, but certainly through immediate action.[32] In this respect, physician-assisted suicide was proposed as a possible means to decisively allay incurable and futile suffering.[33]

Nevertheless, despite the unanimous emphasis placed on suffering as a possible detriment to the dignified life, professionals proceeded to highlight that a life of value transcends the mere exclusion of suffering. They argued that there are instances when life is of great value even if there is considerable suffering. Some even stated that this suffering may enrich the overall value of life and give dignity to the suffering individual, who chooses to endure it for the attainment of a greater cause. While remarking that this is a personal paradigm, citing the example of a terminally-ill man who instead of choosing to escape pain through suicide would bear it to live through an anticipated family experience, they outlined various factors which shape such a perspective, including the person's existential views on life, their spirituality and their attitudes towards their clinical care. [34]

The emphasis placed on the subjective worldview of each patient further confirmed the empathic premise from which mental health professionals choose to deal with such intricate scenarios.

The exercise of clinical empathy in the defence of patient dignity

Despite differing concluding views on the matter at hand, all mental health professionals agreed that their main call is that of understanding the patient, not merely from a superficial standpoint, but rather at a deep and personal level. This aspired level of connectedness can only be achieved

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[32.] Refer to Figure 13 on page 91. There was a natural consensus that the suffering individual necessitates prompt care and that, as clinicians, they have a role to minimise unnecessary suffering as soon as possible. Divergences on how to achieve this common aim subsequently ensued.

[33.] All participants agreed that physician-assisted suicide may be considered as a means by which suffering is irreversibly terminated. However, a considerable number of professionals refused to admit that this is ever the only means of relieving suffering in such scenarios. This conforms to the findings of the first stage of the study.

[34.] Refer to Figure 20 on page 98.

through diligent, compassionate and non-judgemental inquiry into the patient's mental state, the reasons behind one's plea for suicide and one's previous intentions on the subject.[35]

The role of the family was highlighted as an important step in ensuring complete understanding of the individual's position.[36] They described the family as an indispensable source of much-needed information on the individual's mental state and prior psychological predispositions, since the input provided by loved ones broadens the clinical picture. They also recognised that the family is frequently of vital importance to the individual, and bears a great significance on one's quality of life, personal aspirations and dignity at the deathbed.

Interestingly, all participants argued that the family should only be involved cautiously, and that their obligation towards the family depends on the expressed wishes of the individual requesting suicide. Nevertheless, they affirmed that the family is also suffering with the suicidal individual, and as thus should be afforded the necessary care, though not at a cost to the individual's right to self-determination.[37]

A staunch rebuttal of paternalism

Professionals vehemently opposed the attitude of their older colleagues, whom they allege are more prone to adopt a 'paternalistic' attitude when dealing with their patients, particularly in such delicate scenarios They claimed that this attitude is endemic within the Maltese culture, whereby the clinical profession assumes to know "what's best" and to impose its beliefs on the patients under its care, through clinical authority.[38] It is presumed that such a reaction to alleged earlier clinical models of care is a product of contemporary civil values, which place individual self-expression and self-determination as absolute values. In this respect, the clinician becomes

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35. These criteria, and a multitude of others, were highlighted in various instances of the discussion and were categorised under a multitude of themes, represented in Figure 15, Figure 17, Figure 18 and Figure 19.

36. Refer to Figure 14 on page 92. Note that the term 'family' is being used to refer to the loved ones of the individual requesting suicide, and does not exclusively include blood relations, spouses or partners. For ease of reference, even close friends were deemed as family, in as much as their involvement is valued dearly by the person requesting suicide.

37. Refer to Figure 14, where emphasis is also placed on the burden of care which loved ones may have when supporting the suffering individual, as well as the pain which they may have to endure if the individual goes through with the request to end one's own life.

38. Refer to Figure 18, where professionals criticise paternalistic clinical attitudes by affirming that they prioritise the individual's decision above that of his relatives, and where they emphasise the need for informed consent.

a learned advisor, who proposes the best treatment options, but refrains from imposing, unless absolutely necessary. Individual autonomy is thus deemed paramount, and given that paternalism is a threat to autonomy, it is strongly rebuked. Interestingly, however, many professionals still referred to the suicidal individual as a "patient". This may thus betray an underlying predisposition to view self-destruction as an infirmity which needs to be corrected.

Mental illness as a threat to individual autonomy

All professionals undoubtedly expressed their commitment to promoting and safeguarding patient autonomy and subsequently inferred that mental illness is a veritable threat to individual self-expression. While they reprimanded some of their elder colleagues' practices as condescending and paternalistic, they unequivocally agreed that a suicidal individual, when asking to commit suicide, may be acting irrationally and thus, not autonomously.[39]

Without second thought, all professionals thus assumed that individuality is paramount and that it is made manifest through autonomous self-expression. They confirmed that it is their professional duty to ensure that mental illness does not distort individual autonomy, which they describe as inherently dependent on the presence of rationality[40]. Professionals thus surmised that in right-to-die scenarios, it is their duty to perform a decisional capacity assessment to ensure that the request made by the suicidal individual is indeed being made rationally.[41]

In this respect, Western philosophical influence is clear: rationality is considered as the superlative precursor to autonomous self-expression. This diverges from alternative ways of looking at suicidality, particularly when compared with the perspectives gleaned from Eastern cultures.[42] However, for Maltese mental health professionals, the premise of rationality was assumed to be natural and self-evident: only a rational request for suicide can ever be deemed to be an autonomous choice, worthy of further consideration.

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39. Refer to Figure 17 where, according to mental health professionals, rationality, autonomy and free decision-making are intimately linked. Lack of autonomy is deemed to be a serious cause of indignity.
40. This is also clearly highlighted when analysing how mental health professionals spoke about their clinical and professional responsibilities, shown in Figure 18.
41. Refer to the emphasis placed on mental capacity, as outlined in Figure 19.
42. This is discussed at length in page 43, where differences between Eastern and Western views on suicide are detailed.

Decisional capacity assessment as the only way forward

Therefore, when confronted with such a dilemma, mental health professionals agreed that a decisional capacity assessment is in order, since this would definitively confirm whether a person's request for suicide is indeed his own, free choice.[43] While all professionals went into considerable detail on how the capacity assessment should be conducted, all agreed that they would follow internationally-accepted assessment methods and would exclude mental illness through similar, internationally-recognised, diagnostic criteria.

When considering this professional predisposition to assess decisional capacity, it is intriguing to note that no professional even contemplated the possibility that asking to terminate one's life may be an inherently irrational request, since the agent of such an act would be requesting to end his very own sense of self-agency. While this philosophical interpretation of suicide is a matter for further debate, its absence throughout this lengthy discussion was striking. A possible interpretation for such an absence may be related to the empirical and positivist mind-set of clinicians, who when confronted with a problem, are inclined to pursue it deductively, instead of taking a preliminary step back to consider whether the matter should be studied in the first place. In their pursuit to ensure rationality, mental health professionals would choose to conduct an assessment which may ultimately proclaim that the individual is rational and can thus proceed to commit suicide, which would irreversibly compromise the same person's faculty for further rational thought.

A subjective understanding of the value of life

An interesting finding from the qualitative stage of this study reveals that, for the most part, mental health professionals accrued value to life according to the preferences of the individual living it.[44] A suffering individual who manages to tolerate pain would value life more than the ailing individual who is giving up on living a dignified life in such a tormented state. These subjective standpoints are entertained as plausible criteria when determining the value of life, relegating its value to an individual relativistic measure. Indeed, factors such as one's social life, one's functionality or one's relationship with loved ones were discussed when considering

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43. This was explored at length and the subthemes related to mental capacity assessment are detailed in Figure 19.
44. Refer to Figure 20 for a complete list of themes related to the value of life.

the suicidal person's plea for suicide. While such considerations surely determine the quality of life, and confer added dignity to the person living it, they may also lend to the belief that the value of life is a product of one's level of human activity. No explicit mention of life as an absolute value was made, although it was inferred from the concluding remarks of some of the professionals. Similarly, no professional adopted the 'sanctity of life' point of view when clarifying the final position on the matter.

The permissive, non-interventionist approach

Following the uniform consensus that the plea for suicide has to be rational, professionals diverged on what to do next.[45] Most professionals continued to advocate for palliative care in the face of a person requesting suicide due to terminal illness. However, when confronted with the prospect that the individual is found to have decisional capacity, they adopted a permissive stance, choosing not to intervene by assisting or preventing the individual from committing suicide.

This stance was adopted for two main reasons, as explained by the professionals themselves. On the one hand, they felt conflicted by their sense of duty towards honouring the patient's wishes while also their duty to uphold the precepts of their respective professional pledges, most notably the dictum "first do no harm".[46] On the other hand, they felt that their professional calling compels them to act virtuously and as such, they will have to choose their actions through the paradigm of the "good clinician". In this respect, while the first reason lends itself to a deontological mind-set, the second is more reminiscent of virtue ethics. Professionals subsequently agreed that by not intervening to halt or encourage the patient in the act of suicide, they would be respecting the person's wishes without being the ones to inflict the final blow. One clinician summarised this position eloquently by stating that their clinical role entails prescribing medicine, which by definition are substances with curative properties: as such, lethal drugs can never be considered medicine, given their intended effect.

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45. Note that the thought process throughout the focus group discussion was mostly uniform until professionals were asked to conclusively comment on their final positions on the matter. At that point, their role towards the suicidal individual's end-of-life elicited different levels of desired involvement. This is explained in more detail in page 94 and by means of Figure 21.
46. This is explained in page 98.

While this stance holds promise, it also reveals an underlying sense of uncertainty when faced with such sensitive issues. Despite the explicit reference of the dictum cited by these professionals, to "do no harm" may also be taken to infer a preventative measure. One might argue that the clinicians, upon being informed of the intended suicide, is indirectly and jointly responsible for allowing the act to ensure. By non-intervening, they may be deemed complicit, and thus they would have gone against the same dictum they were trying to uphold.

Nevertheless, this position summarises the internal conflict which such professionals face in such difficult scenarios, which undoubtedly leave an indelible mark on their spirit. By confining duties and virtues within the paradigm of individuality, they are unconsciously seeking to absolve themselves from responsibility related to the suicidal act while concomitantly respecting their patients' right to self-determination. The latter has been given boundless precedence throughout the discussion.

The choice to assist in suicide

It is surely not easy to choose to adopt a stand whereby, as a mental health professional, one would assist the suicidal individual in the act of suicide. Such a position may lead to considerable prejudice from colleagues and a sense of shame or fear if confronted by the family. Furthermore, given the irreversibility of the act itself, the assisting professional would be left alone to bear the brunt of the social repercussions of the suicide, given that the patient who requested it would be unable to defend the decision once taken.

These considerations were surely entertained when one of the professionals decided to assist the ill patient with the suicidal act. Priority was given to the ultimate consequence of the action itself, and not to the means by which it was to be obtained. Life, through this consequentialist approach, was valued according to the subjective views of the person living it; individuality was placed in the forefront, and the ultimate goal was to decisively allay suffering.

Interestingly, when compared with the position of other professionals, this stance permeates a greater degree of conviction. Here, the professional is convinced of the superlative value of individualism when confronted with such ethical decisions. The other professionals, by adopting a non-interventional approach, avoided direct involvement: through their stance, based on the premise of a respect for individuality, they unintentionally left the patient to commit suicide alone, at the risk that, if no other assisting clinician is found, the patient may commit the suicidal act ineffectively, possibly leading to an agonising demise.

The role of palliative care and misunderstandings on euthanasia

Throughout the discussion all professionals alluded to the value of palliative care measures. Some commented that it is simply a means to hasten the dying process without appearing politically or morally incorrect. Others subsequently sought to clarify this definition by introducing the concepts outlined in Figure 21 (k)

It is worth noting that all the professionals who had adopted a non-interventional stance when asked to decide on the matter of assisted suicide, indirectly also advocated in favour of palliative care if the individual's hypothetical decision could be changed. Their decision to adopt a non-interventional attitude was thus taken out of necessity, envisioning a situation where physician-assisted suicide would be a legal right. If no such external forces exist, most mental health professionals would advocate for palliative care, and not for suicide, even if the patient appears to be choosing suicide autonomously.[47]

Furthermore, when discussing 'euthanasia', a number of misunderstandings were noted, particularly when some professionals claimed that 'euthanasia' is simply a "politically correct" way of describing 'assisted suicide'. This was subsequently clarified, in order to ensure objective and factual discussion.

Incidentally, however, it also revealed the impact of connotational biases for the terms being used. By forgoing to consider the differences in agency of the act itself, suicide, in itself, was seen to imply a negative connotation, whereas euthanasia was deemed to be a more acceptable term for such delicate matters. Indirectly, through this misunderstanding, mental health professionals revealed an inherent stigma against suicide, possibly due to its association with mental illness.

[47.] Note that in this case 'palliative care' is being mentioned since the hypothetical clinical scenario was that of a terminally-ill patient. It is inferred that when advocating for palliative care, the professionals were indeed advocating for any remedial means by which the state of the suicidal person may be improved, in order to foster hope towards a better future.

A comparison with views of professionals abroad

While no identical studies were carried out in countries abroad, various facet of this research can be compared with the findings from other studies worldwide.

Firstly, Maltese mental health professionals expressed a general disagreement with suicide ever being a solution to life's problems, a finding which is in stark contrast with observations from some other countries, particularly in Europe and the United State of America, where the notion of physician-assisted suicide has become culturally accepted and professionally acknowledged.[48]

A notable finding in this Maltese study is that when compared with the cultural expectations of certain Asian cultures, who place considerable value in their family honour, the Maltese tend to strongly disagree with suicide in cases of dishonour, a finding indicative of Malta's western culture. Maltese professionals tend to agree more with suicide in terminal illness when compared to suicide in other situations. This finding is significant and is in keeping with those of Hammond and Deluty, in their 1992 study in the United States, where suicide in terminal illness was more widely accepted when compared to other situations.[49] Unfortunately no such studies were carried out in Malta at the time.

When analysing the influence of demographic variables, however, the American study found notable differences in attitudes towards suicide between different professional roles.[50] This is also in keeping with the findings of Osafo et al. which revealed a clear distinction on suicide acceptability between nurses and psychologists in Ghana.[51] Conversely, no significant relationship between different professional roles and attitudes towards suicide was found when investigating the Maltese cohort of professionals, even across all attitudinal dimensions being studied.

Nevertheless, there were instances when studies in other countries produced a similar relationship between certain demographic traits and suicide attitudes. A case in point is the Australian study by Gagnon and Hasking, where younger psychologists were found to be more

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48. This is described in more detail in pages 60 and 61.
49. Hammond and Deluty, "Attitudes of Clinical Psychologists, Psychiatrists, and Oncologists toward Suicide.", 291
50. Ibid.
51. Osafo et al., "Attitudes of Psychologists and Nurses toward Suicide and Suicide Prevention in Ghana: A Qualitative Study.", 696

likely to accept a patient's right to die.[52] This conforms to the findings shown in Figure 7, whereby age of respondents was associated with a greater acceptance of suicide in specific situations.

With regards to the communication of suicidal behaviour, the 2014 study of Jiao et al. found that Chinese psychiatrists feared discussing suicide lest this leads to an increase in suicidality.[53] While this study on Maltese professionals did not specifically ask on attitudes on communication of suicide between patients and psychiatrists, findings revealed strong agreement with statements promoting communication of suicidal behaviour with parents or close friends (Figure 6).

Finally, in their study on attitudes towards suicide, Levy et al. had concluded that considerations on voluntariness and autonomy led to psychiatrists being more conservative when asked on their position on assisted suicide.[54] This conforms to the attitude of Maltese mental health professionals on the subject, and in turn diverges from the community-centred approach to suicide discussed previously when contemplating Eastern tradition.[55]

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52. Gagnon and Hasking, "Australian Psychologists' Attitudes towards Suicide and Self-Harm.", 79

53. Jiao et al., "Cross-Sectional Study of Attitudes about Suicide among Psychiatrists in Shanghai.", 5

54. Levy et al., "Attitudes towards Euthanasia and Assisted Suicide: A Comparison between Psychiatrists and Other Physicians.", 406

55. Refer to page 43 for an overview of the salient differences between Eastern and Western perspectives on suicide.

Conclusion

Mental health professionals in Malta are strongly against actively participating in physician-assisted suicide basing their position on the dictum “first, do no harm”. They would however ascertain that the person requesting suicide is acting autonomously, by assessing for mental illness and treating it if necessary. In this respect, autonomy is given superlative value, as is predominantly characteristic in contemporary Western culture.

Indeed, through an online questionnaire, this study has shown that mental health professionals in Malta strongly deny that suicide may ever the only solution to life’s problems. They appear less inclined, however, to disagree with suicide as a solution to particular circumstances. While suicide in cases of bankruptcy, family dishonour or psychological despair was met with strong disagreement, a neutral response was obtained when asked on suicide in cases of terminal illness.

Through the questionnaire, such a scenario elicited a widely diverse range of opinions and a subsequent group discussion revealed that, if faced with a request for physician-assisted suicide in terminal illness, the majority of professionals give paramount prerogative to individual autonomy. They would call for a thorough and multidisciplinary assessment, choosing to consider the person's decisional capacity, one's family and the possible medicolegal repercussions of suicide. Maltese mental health professionals believe that mental illness may contribute to the request for suicide and that, if so, it may cause the individual to request suicide in a state of impaired autonomy. They thus affirm that mental illness needs to be diagnosed, treated or excluded when such requests are made.

If however, physician-assisted suicide is legalised, and the person's request for suicide is deemed autonomous, only a small minority would choose to assist the suicide. A non-interventional stance appears to be the most favoured approach, with professionals choosing neither to obstruct nor to assist the person in committing suicide. These professionals base their argument on the values enshrined in the original Hippocratic Oath, or similar professional pledges, thus invoking their right to conscientious objection. Mental health professionals in Malta would also seek to advocate for timely palliative care, with the provision of a ‘ceiling of treatment’ and the avoidance of ‘extraordinary’ methods of treatment.

Interestingly, when asked on the attributes of a suicidal person, most professionals disagree with describing those who commit suicide as ‘mentally ill’, possibly because of the pejorative

connotation of such a statement. This reveals a deep-seated conflict, whereby professionals reject the label of mental illness but then choosing to discuss requests for suicide through the mental illness paradigm, as highlighted through the group discussion.

Most mental health professionals in Malta believe that there is an afterlife, while the overwhelming majority strongly disagreed with the notion that suicide is ever punishable after death. They strongly encourage communication of suicidal thoughts or plans to parents and friends, although they are less inclined to advocate for the disclosure of past suicidal behaviour. They strongly disagree with the open reporting of suicide on the media, although they agree that suicide news should discussed between close friends.

Demographic traits were found to have a significant impact on attitudes to suicide. Younger professionals are more likely to agree with suicide overall, while those professionals with less work experience, when compared with their veteran colleagues, are more likely to agree with suicide in specific circumstances, such as in terminal illness. Interestingly, male respondents are more likely to agree with the hiding of past suicidal behaviour, a trait shared with some of the older professionals.

Age was particularly influential when considering spiritual aspects of suicide, with older professionals disagreeing with statements describing suicide as punishable, but to a lesser degree when compared with their younger colleagues; the latter were in turn less convinced of the existence of an afterlife when compared with their elders. A conflict of beliefs was made evident, with some professionals expressing strong views that suicide is not punishable in the afterlife while concomitantly rejecting the belief in an afterlife in the first place. Age also determined attitudes on suicide as a mental illness, with younger professionals more accepting of the statement that suicidal individuals are ‘mentally ill’.

In conclusion, when confronted with right-to-die situations, mental health professionals in Malta base their ethical stance on a mixed deontological and virtue ethics approach, choosing to abide by the principle of non-maleficence, which, they believe, makes them “good clinicians”. Due consideration is however given to individual autonomy, which is considered as a superlative and absolute value, such that in order to compromise between the duty of non-maleficence and the respect for individual autonomy, a non-interventional stance is favoured when faced with legal and autonomous requests for assisted suicide. A minority of professionals would however actively assist the legal suicide of the terminally-ill and consenting individual, justifying their decision from a consequentialist paradigm.

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Appendices

Appendix 1: Online Questionnaire

Appendix 2: Invitation to Participate in Focus Group Discussion

Appendix 3: Online Form requesting Focus Group Availabilities

Appendix 4 - Focus Group Case Discussion

Appendix 1: Online Questionnaire

The Right to Die: Perspectives of Mental Health Professionals in Malta

Researcher: Dr Gabriel Joshua Ellul
Supervisors: Dr Nadia Delicata & Dr Nigel Camilleri
*Required

Invitation to participate in brief online questionnaire

Dear mental health professional,

My name is Gabriel Ellul. I am a doctor pursuing my core training in psychiatry and also reading for a Masters degree in Bioethics at the University of Malta.

I am presently conducting a dissertation on how mental health professionals perceive the concept of "the right to die".

By filling in this questionnaire, you will be contributing to this interesting field of ethical and psychiatric research.
Your opinion on this matter will be of immense value, particularly given your exposure to sensitive clinical situations, where you encounter individuals who are going through painful experiences, as well those who have attempted or intend to attempt suicide.

I wish to know why we decide to protect life, and whether this decision stems from the legal framework or from a deeper sense of moral obligation. I also wish to study whether you, as mental health professionals, consider certain situations as possibly warranting a different approach, particularly when confronted with fatal and debilitating illnesses and the patient is requesting euthanasia or assisted suicide.

Feel free to get back to me or my supervisors if you require any further details.
Your help in this regard is greatly appreciated.

Yours truly

Dr. Gabriel Joshua Ellul
in part fulfillment of MA (Bioethics) at the University of Malta

Email: gabriel.j.ellul.10@um.edu.mt / gabriel-joshua.ellul@gov.mt
Supervisors: nadia.delicata@um.edu.mt / nigel.a.camilleri@gov.mt

Consent Form

Kindly complete this consent form prior to starting the questionnaire.

By ticking the check-boxes below, you shall be confirming that you agree with the corresponding statements.

1. I confirm that I have read and understand the scope of the study. *

Tick all that apply.

- [ ] I confirm

2. I have had the opportunity to consider the information, ask questions and, where so, have had these answered satisfactorily. *

Tick all that apply.

- [ ] I confirm

3. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. *

Tick all that apply.

- [ ] I confirm

4. I understand that the information supplied through this questionnaire will be treated confidentially and will not be given to third parties but will be used solely for the research purposes outlined above. *

Tick all that apply.

- [ ] I confirm

5. I also understand that the details supplied through this questionnaire will not be used to trace my identity or to obtain any other personal information. Any demographic data will be used solely for statistical purposes. *

Tick all that apply.

- [ ] I confirm

6. I therefore agree to take part in the above study. *

Tick all that apply.

- [ ] I agree

1. Demographic Data

7. 1a. Age *

Mark only one oval.

- ◯ less than 20 years of age
- ◯ 20 - 30 years of age
- ◯ 30 - 40 years of age
- ◯ 40 - 50 years of age
- ◯ 50 - 60 years of age
- ◯ more than 60 years of age

8. 1b. Gender *

Mark only one oval.

- ◯ Male
- ◯ Female
- ◯ Prefer not to say

9. 1c. Professional Role (in alphabetical order) *

Mark only one oval.

- ◯ Doctor in Foundation Training
- ◯ Nurse
- ◯ Nursing carer
- ◯ Occupational Therapist
- ◯ Physiotherapist
- ◯ Psychiatric Trainee
- ◯ Psychiatric Specialist / Consultant
- ◯ Psychologist / Psychotherapist / Assistant Psychologist
- ◯ Social Worker
- ◯ Other: _____

10. 1d. Years of professional practice in the mental health service *

Mark only one oval.

- Less than 5 years
- Between 5 to 10 years
- Between 10 to 15 years
- Between 15 to 20 years
- Between 20 to 25 years
- Between 25 to 30 years
- More than 30 years

2. Perspectives on the Acceptibility of Suicide

adopted from Eskin, M. (2004). The effects of religious versus secular education on suicide ideation and suicidal attitudes in adolescents in Turkey. Social Psychiatry and Psychiatric Epidemiology, 39(7), 536-542.

11. 2a. In your opinion, does someone who has gone bankrupt have the right to kill him/herself? *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

12. 2b. In your opinion, does someone who is tired of living have the right to kill him/herself? *

Mark only one oval.

- ◯ Strongly Disagree
- ◯ Disagree
- ◯ Neutral
- ◯ Agree
- ◯ Strongly Agree

13. 2c. In your opinion, does someone who dishonoured his/her family have the right to kill him/herself? *

Mark only one oval.

- ◯ Strongly Disagree
- ◯ Disagree
- ◯ Neutral
- ◯ Agree
- ◯ Strongly Agree

14. 2d. In your opinion, does someone suffering from an incurable illness have the right to kill him/herself? *

Mark only one oval.

- ◯ Strongly Disagree
- ◯ Disagree
- ◯ Neutral
- ◯ Agree
- ◯ Strongly Agree

15. 2e. In your opinion, can suicide be a solution to some problems? *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

16. 2f. In your opinion, can suicide be the only way out of life's problems? *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

17. 2g. In your opinion, do people have the right to kill themselves? *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

18. 2h. In your opinion, is killing oneself by committing suicide a right behavior? *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

3. Perspectives on "suicide" as a sign of mental illness

adopted from Eskin, M. (2004). The effects of religious versus secular education on suicide ideation and suicidal attitudes in adolescents in Turkey. Social Psychiatry and Psychiatric Epidemiology, 39(7), 536-542.

19. 3a. In your opinion, are people who attempt suicide mentally ill? *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

20. 3b. In your opinion, are people who kill themselves by committing suicide mentally ill? *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

21. 3c. In your opinion, are people who think about and plan suicide mentally ill? *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

4. Perspectives on punishment after death

adopted from Eskin, M. (2004). The effects of religious versus secular education on suicide ideation and suicidal attitudes in adolescents in Turkey. Social Psychiatry and Psychiatric Epidemiology, 39(7), 536-542.

22. 4a. In your opinion, are people who attempt suicide going to be punished in the other world? *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

23. 4b. In your opinion, are people who kill themselves by committing suicide going to be punished in the other world? *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

24. 4c. In your opinion, are people who think about and plan suicide going to be punished in the other world? *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

25. 4d. In your opinion, are people who kill themselves by committing suicide sinful? *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

26. 4e. Do you believe in life after death? *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

5. Perspectives on the communication of suicidal problems

adopted from Eskin, M. (2004). The effects of religious versus secular education on suicide ideation and suicidal attitudes in adolescents in Turkey. Social Psychiatry and Psychiatric Epidemiology, 39(7), 536-542.

27. 5a. If a person thinks about and plans suicide, should s/he tell his/her friends about this and ask for help?? *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

28. 5b. Do you think people should tell their friends about their psychological problems? *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

29. 5c. Do you think young people should tell their parents about their psychological problems? *

Mark only one oval.

- ◯ Strongly Disagree
- ◯ Disagree
- ◯ Neutral
- ◯ Agree
- ◯ Strongly Agree

30. 5d. If a young person thinks about and plans suicide, should s/he tell his/her parents about this? *

Mark only one oval.

- ◯ Strongly Disagree
- ◯ Disagree
- ◯ Neutral
- ◯ Agree
- ◯ Strongly Agree

6. Perspectives on the hiding suicidal behaviour

adopted from Eskin, M. (2004). The effects of religious versus secular education on suicide ideation and suicidal attitudes in adolescents in Turkey. Social Psychiatry and Psychiatric Epidemiology, 39(7), 536-542.

31. 6a. Do you think families whose daughter or son attempts suicide should hide this from their neighbors? *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

32. 6b. Do you think families who lose a daughter or son through suicide should hide this from their neighbors? *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

7. Perspectives on the open reporting and discussion of suicide

adopted from Eskin, M. (2004). The effects of religious versus secular education on suicide ideation and suicidal attitudes in adolescents in Turkey. Social Psychiatry and Psychiatric Epidemiology, 39(7), 536-542.

33. 7a. Do you think suicide news should be written openly in the newspapers? *

Mark only one oval.

- Strongly Disagree
- Disagree
- Neutral
- Agree
- Strongly Agree

34. 7b. Do you think the matter of suicide should be discussed openly among friends? *

Mark only one oval.

- ◯ Strongly Disagree
- ◯ Disagree
- ◯ Neutral
- ◯ Agree
- ◯ Strongly Agree

8. Interest in participating in focus group on the topic

Brief multidisciplinary focus groups will be organised, where discussions will be held on the topic of suicide and the right to die. The groups will be discussing complex cases which require a holistic clinical and ethical approach.

If you wish to participate, you may send an email to gabriel.j.ellul.10@um.edu.mt.

35. Would you be interested in attending a brief multidisciplinary focus group on the topic? *

Mark only one oval.

- ◯ Yes
- ◯ No

Thank you for completing this questionnaire

If you have any questions, feel free to get in touch on gabriel.j.ellul.10@um.edu.mt.

Thank you for your time,

Dr. Gabriel Ellul

Appendix 2: Invitation to Participate in Focus Group Discussion

L-Università ta' Malta

Gabriel Joshua Ellul <gabriel.j.ellul.10@um.edu.mt>

Invitation to participate in focus group study on patients' right-to-die

Gabriel Joshua Ellul <gabriel.j.ellul.10@um.edu.mt> 18 December 2019 at 14:36
To: gabriel.j.ellul.10@um.edu.mt
Bcc: **Respondents' emails intentionally removed**

Study Title:
The Right to Die: Perspectives of Mental Health Professionals in Malta

Dear Sir / Madam,

I trust this email finds you well.

First and foremost, I would like to thank you for finding the time, in the past weeks, to fill-in my research questionnaire. Your feedback was immensely appreciated.

I am now writing after you had expressed your wish to participate in a brief focus group discussion. The discussion will make use of a simulated multidisciplinary team setting, where participants can discuss how to deal with a clinical scenario which involves an end-of-life question. Your participation will be treated with strict confidentiality, and no identifiable information will be conferred in the final research paper.

More details can be found in the link below.

I hope you are still interested in participating in this focus group. If so, please follow the link where you may indicate your availabilities. I am planning on holding the discussion in the last week of January and/or the first week of February.

Link: https://forms.gle/shkRk5qUZKheP6Aa7

I look forward to your reply

Gabriel

Appendix 3: Online Form requesting Focus Group Availabilities

Focus Group Availabilities

Thank you for expressing interest in participating in a group discussion on a complex bioethical scenario.

The aim of this part of the study is to assess the qualitative aspects of our bioethical reasoning and why we take certain stands in end-of-life decisions.

I will be presenting you with a case which would require a multidisciplinary discussion, with the final scope of reaching a consensus decision on how to deal with a sensitive scenario. The case details will be revealed at the time of the focus group discussion, to avoid any bias.

The group will consist of no more than 8 professionals from a variety of backgrounds, but who all have a role in our mental health service. No patients will be included in this study.

With your consent, the discussion will be recorded audiovisually, for ease of later reference, as part of the study methodology. The recording will be kept in strict confidentiality and will not be shared with third-parties. The discussion will subsequently be analysed through the use of thematic analysis.

Any reference to the group discussion within the final study text will be anonymous and individual positions will be made strictly non-identifiable. My aim is to ensure that each participant is free to express his or her opinion on the subject tackled.

I thank you once again for expressing your interest to participate in this part of the study, and I look forward to meeting you in person in the coming weeks.

Sincerely

Gabriel

Dr Gabriel J. Ellul MD, MRCPsych (UK)
in part fulfillment of an MA in Bioethics, at the University of Malta
M. 7924150
Email: gabriel.j.ellul.10@um.edu.mt

*Required

Full Name and Surname *

Your answer

Professional Role *

Your answer

Please select the most suitable date for you to attend a 1.5 hour group discussion. *

Feel free to choose more than one date. The prospective venue is Mt Carmel Hospital. More details as the date approaches.

- [ ] Tuesday 28th January, 2pm - 3.30pm, MCH
- [ ] Thursday 30th January, 2pm - 3.30pm, MCH
- [ ] Monday 3rd February, 2pm - 3.30pm, MCH

Submit

Appendix 4 - Focus Group Case Discussion

The Right to Die: Perspectives of Mental Health Professionals in Malta

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Focus Group Case Discussion

Introduction and Request for Consent **5 minutes**

Dear participant

Thank you for offering to participate in this focus group. Through your participation, you will be contributing to my study on how mental health professionals perceive the concept of "the right to die".

Your opinion on this matter will be of immense value, particularly given your exposure to sensitive clinical situations, where you encounter individuals who are going through painful experiences, as well those who have attempted or intend to attempt suicide.

I wish to know why we decide to protect life, and whether this decision stems from the legal framework or from a deeper sense of moral obligation. I also wish to study whether you, as mental health professionals, consider certain situations as possibly warranting a different approach, particularly when the patient is requesting euthanasia or assisted suicide.

The group discussion will be divided into two main sections, linked through a common case presentation. Following this brief 5-minute introduction, you will be asked to proceed to the first section. Section A, along with the time allotted to reading the case, will take approximately 25 minutes to complete. It will be followed by a longer Section B, which will take 60 minutes to complete. The proposed duration is to serve as a rough guide, and is written alongside the name of each section of the discussion.

To avoid exerting any undue influence on the group, I will refrain from involving myself in the discussion unless for technical, logistical or clarification purposes. I will remain close by and the discussion will be recorded audiovisually. The video will be used solely for research purposes and will not be given to any third party. Your confidentiality and anonymity will be respected through each stage of the study and its eventual publication.

Feel free to get back to me or my supervisors if you wish to clarify any concerns which you may have, even after the discussion's completion..

Thank you once again for your participation.

Yours truly,

Dr. Gabriel Joshua Ellul
in part fulfillment of MA (Bioethics) at the University of Malta

Email: gabriel.j.ellul.10@um.edu.mt / gabriel-joshua.ellul@gov.mt
Supervisors: nadia.delicata@um.edu.mt / nigel.a.camilleri@gov.mt

The Right to Die: Perspectives of Mental Health Professionals in Malta

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Consent Form

I confirm that I have read and understand the scope of the study.

Initials: _____

I have had the opportunity to consider the information, ask questions and, where so, have had these answered satisfactorily.

Initials: _____

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

Initials: _____

I understand that the information supplied through participation in this focus group will be treated confidentially and will not be given to third parties but will be used solely for the research purposes outlined above.

Initials: _____

I understand that the discussion will be recorded in audio format, which will in turn be used to produce transcripts for further analysis. These recordings will be stored confidentially and will not be given to third parties.

Initials: _____

I also understand that the details supplied through this focus group will not be used by third parties to trace my identity or to obtain any other personal or professional information. Any demographic data will be used solely for statistical purposes.

Initials: _____

I therefore agree to take part in the focus group discussion.

Initials: _____

Signature of Participant	**Name in Block Letters**	**Date**
_____	_____	_____

The Case

10 minutes to read

Excerpt from *World Federation of Right to Die Societies. (n.d.). An example of assisted suicide. Retrieved from* https://www.worldrtd.net/example-assisted-suicide
The page cites the Swiss Medical Forum Supplement 11, dated 12.03.2003

The case is [that] of a man born in 1960 who was suffering from leiomyosarcoma of the left maxillary sinus with tumoral invasion of the superior hemimaxillary, of the orbit and the pterygomaxillary fossa.

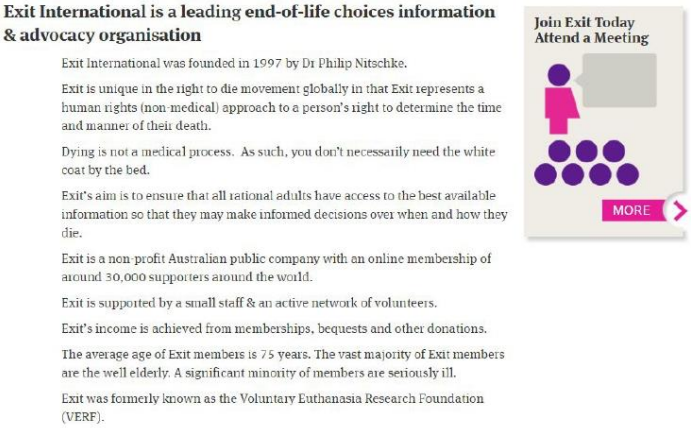
The patient was admitted to the CHUV and on the 13th of September, 1999 he underwent … surgery.

On the 11th October, 1999 a cytopuncture showed up a precocius post operative left jugal recurrence. Another surgical intervention was suggested to the patient but he refused, preferring palliative care.

On 21st October, 1999, he contacted EXIT and formally requested assisted suicide. This request was accepted following a meeting, and after a long discussion in the presence of his wife.

On 6th November, 1999 I went to the patient's home. He was waiting for me and introduced me to his parents. His sister, who had come from Great Britain, and his brother-in-law, from the United States, were both present. After a final discussion, I gave the patient a lethal liquid solution that he administered himself by means of a gastrostomy probe. He went to sleep rapidly and I certified his death 45 minutes later.

Brief note on EXIT:



Screenshot taken from the official website of EXIT International: https://exitinternational.net/about-exit/history/

Section A. Questions on the case itself **15 minutes**

1. What are your comments on the man's state of health prior to contacting EXIT?
2. Do you recognise any factors which might have contributed to his end-of-life decision? If yes, please list the factors deemed relevant and explain how they played a role in his decision.
3. How do you define euthanasia?
4. How do you define assisted suicide?
5. Is there a difference between the two? Please explain your answer.

Section B. Hypothetical scenario:

50 minutes discussion
10 minutes final presentation

Imagine that you and all the participants in this group are actually the man's caring clinical team. You are collectively tasked with assessing the man and managing his health concerns.

He has called you to visit him at his home. When asked to clarify why he is requesting this home visit, he explains that he is suffering from an incurable illness and that he wishes to end his life.

Task:

Appoint a key speaker and then discuss these questions as a team. The aim is to arrive at an answer representative of the group's position on the topic. You may take notes to record the conclusions made.

Once ready, the key speaker can present the team's answers to the rest of the team members as a reflective summary. If there are differing professional opinions, take note of them and mention them in the final presentation, explaining the reasons behind the differing opinions.

1. Would you have chosen to assess him? If so, why and where?
2. Would you have considered his request to end his life? Explain why.
3. Would you request any additional information in order to arrive at a decision? If so, please explain.
4. Can you imagine any factors which, if altered, would influence your final decision? Explain why.

5. Proceed to answer the relevant question, according to the group's position. If there are divergent opinions, discuss both:
    a. If the group decides TO PROCEED with the man's request to end his life:
        i. What method do you think would be appropriate for this situation and why?
        ii. *Imagine you are the clinician next to the patient's bedside and you have at your disposal any treatment, device or instrument which you may require:* On a practical level, would anyone from the team volunteer to assist the man with his request? If so, how and why? If not, who should be tasked with this role?
    b. If the group decides NOT TO PROCEED with the man's request to end his life:
        i. What care would you offer this man and why?
        ii. *Imagine you are the clinician next to the patient's bedside and you have at your disposal any treatment, device or instrument which you may require:* On a practical level, would anyone from the team volunteer to assist the man along the care plan agreed? If so, how and why? If not, who should be tasked with this role?
6. How would you explain the group's decision to the man's loved ones?
7. In answering these questions, do you think that, as a group, you have reached an agreement which represents all the members' positions? What strategy did you use to arrive at a consensus when members held different beliefs?

------ END ------