

For & Against

Death be



for

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As humanists, we start from the principle that our lives are our own, not a gift from, nor owing anything to, any higher power. We decide our own destiny and values, provided that does not cause harm to others. Of course, all are free to adhere to religious beliefs - but not to impose them on those who think differently.

Competent adults have the right to control their own lives, including how they should end. Euthanasia is a broad term, covering:

Assisted Suicide (a medical practitioner providing a patient with the knowledge, means or both to commit suicide);

Voluntary Euthanasia (a medical practitioner administering a lethal drug to a patient with the patient's consent);

Passive Euthanasia (a medical practitioner allowing a patient to die by the withholding of futile treatment) - whether or not formally acknowledged, this is common in many countries including, as we understand it, Malta.

We focus on the first two, jointly "Assisted Dying", as a matter of choice for the patient rather than a pragmatic medical judgement. Justice and compassion must require cessation of suffering, if that is what the patient wants, having made a clear, considered and voluntary decision that their life has come to its proper end and they want to choose how, when and where they die.

International Human Rights legislation recognises the right to life, but no law imposes a duty to live under any circumstances. Assisted Dying is not considered a human right under international law, but is increasingly recognised in various jurisdictions. Both Voluntary Euthanasia and Assisted Suicide are legal in Belgium, Luxembourg, The Netherlands, Spain, Canada, New Zealand and Colombia, and under discussion in

Chile, Portugal and France. Assisted Suicide is legal in Austria, Switzerland, Germany, Australia and 10 US States, and under discussion in Scotland and Jersey.

It seems Voluntary Euthanasia is becoming more acceptable in Malta, particularly for the terminally ill (Assisted Suicide is rarely mentioned here; perhaps seen as one element of euthanasia). While many cases do involve the terminally ill, we see no moral case to limit Assisted Dying to people with, for example, six months left to live. We would include those who are incurably suffering; in many ways, worse than being terminal, facing longer periods without prospect of relief.

It is often argued that better palliative care would obviate the need for Assisted Dying. We agree - to an extent. Patients must, of course, be informed about their options for palliative care and pain management, and we support calls for better end-of-life and palliative care. Many would choose good palliative care towards the end of their days, and to die under that care rather than act, or expect others to act, to end their lives. But improvements in such care do not negate the need for a right to Assisted Dying for those who have a positive wish that their body should not be kept functioning when they are without independence, quality of life and hope.

Of course, laws on Assisted Dying could be abused, with pressure on the sick and vulnerable to act against their wishes for the convenience of families or medical services. All laws can be and are broken, and there are a few euthanasia cases in which that has happened, including in relation to a patient's mental capacity to choose, and failure of monitoring or enforcement. This underlines the need for strict regulation. But the possibility of misuse by others does not justify withholding that right to those who need it; if it did,

much more than euthanasia should be banned (for example, in the US, about 30 die every day in drink-driving crashes). And covert abuse will surely remain possible with or without regulation.

If formulated and enforced correctly, with the strongest safeguards against coercion and abuse, legalisation of Assisted Dying could protect the vulnerable as far as is possible within any legal structure. Safeguards vary between jurisdictions, including whether available only to the terminally ill; to those 'only' unbearably suffering; and to those suffering from mental, rather than physical, disorders. They should, at the minimum, include tightly-policed protocols ensuring that:

- a request is expressed, not implied, voluntary, informed, considered over time, and revocable;
- if there are any doubts about a patient's capacity to make a clear choice, a psychiatrist must confirm such capacity;
- two independent witnesses confirm the request was made willingly and free of coercion;
- two doctors, independent of each other, give written agreement the patient has an incurable, grievous and irremediable condition;
- at least two independent doctors, trained in medical ethics, agree that all legal criteria, including that the patient is informed of all options (including the benefits of palliative care), have been met;
- cases of Assisted Dying must be reported to a central body following the procedure.

Various academic studies have concluded that where Assisted Dying is legal, people acting under the law were generally free from coercion, and abuse of the vulnerable was not

evident.

Finally, there must be a debate about conscientious objection. We would prefer not to allow for conscientious objection to the fulfilment of a patient's wishes, because we do not agree a doctor should make moral judgements on behalf of others, but recognise that medical professionals have their own human rights.

For background information on some of the points we have raised, please visit <https://maltahumanist.org/assisted-dying/>



comes us

against

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We share here some reflections on euthanasia from the perspective of a disabled female activist and of a male social worker who shared the suffering and death of both parents and close relatives. Ours is not an academic or exhaustive thesis on euthanasia; rather, we voice the concerns of those who, like us, would not like to see euthanasia become a public policy and cultural reality in Malta.

We understand euthanasia, including physician assisted suicide, medically assisted dying or death, or any other of its euphemisms, as the active intervention by medical professionals to bring about the death of a person.

Essentially, euthanasia challenges one fundamental issue, the value of human life. It conceptualises human life as valuable if healthy, beautiful, useful and fruitful. Euthanasia wants us all to believe that "our lives are not worth living unless one is fit and productive". It represents the triumph of a consumeristic society, obsessed with autonomy, independence and productivity, with no room for anyone considered as a liability to society. It conveys the message to persons who are on the margins of life that they are a burden to both society and to oneself.

Proposing euthanasia as a public policy solution is dangerous in more ways than one. Effectively, the introduction of euthanasia as a public policy enacts by statute the maxim that there are types and situations of life which have no value, and that the public and personal good is enhanced by the termination of such lives. Such a public policy clusters together those whom society deems as not satisfying the prerequisites of a healthy life, and proposes as a solution their accelerated purging. It discards a universal commitment to provide all that is required for society's most vulnerable members to experience the security and belonging that renews their sense of purpose and human flourishing till the end of life.

Over the past half a century, disabled

persons' reality has diverted the gaze from their individual impairment to the collective, societal and environmental barriers they face. They are disabled not only because of their biological impairment but more so because of the lack of opportunities and services that deny them living a full and meaningful life. We call this understanding the social model of disability, and it is an extremely useful paradigm to help us reflect upon the complex and sensitive dilemmas represented by euthanasia: Are we going to focus on the individual's medical situation and, if it cannot be fixed, support the elimination of the individual? Or should we focus our attention on the state of our health and social care services, and do our utmost to create and distribute our resources in a manner that no one is compelled to see their life as having no value?

Euthanasia quashes all disabled persons' efforts of the past 70 years to change the mentality towards their rights and the rights of other persons on the margins of life. It promotes a public policy that again reverts to short cut solutions ... instead of offering to adapt your house, to provide you with personal assistance, with supportive technologies, as your needs change with the progression of your illness or impairment, you are offered a quick way out in the form of medical assistance to end your life. By embracing euthanasia, society chooses to make it easier for vulnerable and marginalised populations to kill themselves rather than engaging in actively seeking all that is necessary to accompany them as they experience the limits of human life, and to transform their vulnerability and suffering in an opportunity to experience the best of human compassion, connection, accompaniment and solidarity.

A euthanasian culture is the antithesis of a caring society. We have heard numerous stories of euthanasia being offered for a multitude of reasons, including for fixing the trauma of a

Dutch victim of sex abuse, to a Belgian person devastated by breaking with her partner, to a Canadian disabled person requesting personal assistance, and many others. It is considered as a solution to rationalising health and social services, and in harvesting organs from persons designated as brain death. It starts with individual stories, but it quickly opens wide the gates to the systematic elimination of lives who for some reason or other are deemed not fit to live.

In the course of our work, we have been blessed with precious human beings who have taught us so much about what it is to be human. Consider the story of a young man who acquired quadriplegia following a traffic accident. While being interviewed on television on the occasion of I-Istrina, to the question: "What would you like most?" he replied without batting an eyelid, "To live". Here is a young man, unable to do anything on his own except move from his neck upwards, who in the eyes of a euthanasian society in a prime candidate for euthanasia, claiming that his uppermost wish is to live. To live, however, with all the human and technological support he needs for a full and dignified life. And the mother of a young woman born with multiple and complex impairments. Coming out of the Intensive Care Unit, her face lit up as she recounted how her daughter had overcome the danger of losing her life and would soon be coming back home. Here is this woman, whose life was wholly dedicated to caring for her daughter, ecstatic at the thought that her daughter was alive. In the eyes of a euthanasian culture, she would have been much better off had her daughter passed away, and unconcernedly offered medical assistance to get there. After all, she would have been able to take her life back, free from the 'burden' of caring for her severely disabled daughter. Two stories, one lesson we will never forget – who are we to decide on the value of anybody's life?

And here lies the danger of euthanasia for disabled people and other persons on the margins of life, especially for those who are unable to speak for themselves or who because of their cognitive impairments are unable to decide for themselves. Who is going to decide for them? Where do we draw the line? How are we going to decide whose lives are worth living and whose are not? And even when the claim is in support of those making fully autonomous decisions, how autonomous can a decision be when it is made out of fear, when feeling lost or abandoned, when having no one to turn to, when suffering a mental illness, when life-saving medication is unaffordable, when comprehensive and flexible personal assistance is not available, when the right to privacy is disregarded in all our residential homes, when community services are disjointed and sparse, when our psychiatric hospital and mental health services are found wanting in key areas, when the lived experience of the most vulnerable members of our society is nothing we can be proud of?

We need to listen to what the people who will be most affected by the introduction of euthanasia have to say, before we start going down this slippery slope.

Euthanasia does not only involve health and social care professionals. It is not only about moral values. It is about what type of society we want to live and grow old in, the type of society we want to leave for our children and future generations.

Instead of engaging the introduction of euthanasia, Maltese society needs to acknowledge the inadequacies and gaps in health, mental health and social care services, and aggressively ensure that all our efforts go at addressing suffering, access to hospice and palliative care, society's disabling barriers, and all that is necessary to give value and add life to, rather than assisting in the death of, society's most vulnerable members.