A Broader Academic Perspective on Assisted Voluntary Euthanasia in Malta

1. Introduction

A position paper (Agius et al., 2025) signed by roughly one-tenth of the University of Malta's academic staff advocates against introducing Assisted Voluntary Euthanasia (AVE) in Malta. Amongst the various concerns raised, the following stand out: (1) the potential for subtle pressure on vulnerable individuals; (2) the negative impact on palliative care services; (3) the possibility of a "slippery slope" toward ever-wider eligibility criteria; and (4) a potential rise in wider, non-assisted suicide rates.

These warrant careful consideration but do not exhaust the moral reasoning or empirical evidence available on this complex topic. The aim of this paper is to consider an alternative view, supportive of the AVE framework being proposed.

2. An Alternative Ethical Starting Point

The academics' paper grounds its opposition in an ethic that prioritises the inviolability of life above all else. An alternative ethical framework, however, can be constructed from principles of autonomy, dignity, compassion, and justice, which offers a different yet equally defensible perspective on end-of-life choices.

First, the principle of **autonomy and self-determination** holds that every mentally competent adult has the right to make decisions about their own body and life, especially when facing a terminal or incurable illness that causes unbearable suffering. While the value of life is universally acknowledged, that value is ultimately subjective to the person living it. When an individual, with full capacity and information, judges that their quality of life has fallen below a personally acceptable threshold due to irreversible decline, respecting their autonomy means honouring their freedom to choose a hastened death (Beauchamp & Childress, 2019; Colburn, 2020; Braun, 2023). This is not an absolute right but one exercised within a robust framework of confirmed mental capacity and informed consent.

Second, the principles of **dignity and compassion** compel us to alleviate suffering. The World Health Organization (2020) defines the goal of palliative care as improving the quality of life for patients facing life-threatening illness, through the prevention and relief of suffering by means of early identification, correct assessment and treatment of pain and other problems, physical, psychosocial and spiritual. When a dying patient endures extreme distress that cannot be remedied by even the best palliative care, a reality for a small cohort of patients (Lucena & Yuguero, 2024), compassion may mean respecting a request for AVE as a preferable option to the suffering experienced.

Third, in a pluralistic society, **freedom of conscience** requires that the law accommodates diverse, deeply held moral and religious beliefs. Those who object to AVE must remain free not to choose it, and healthcare providers must have the right to conscientiously object to participating. However, a legal prohibition imposes one moral viewpoint on all citizens, denying individuals the ability to act according to their own conscience at the end of life. Legalisation, with stringent safeguards and a robust framework for conscientious objection, would enhance personal and professional freedom without infringing upon the rights of those who object.

Finally, the discussion can be framed in terms of **patient well-being and rights**. The right to life, as enshrined in various legal instruments, is not a mandate to force the prolongation of life regardless of suffering. A competent person already possesses the legal and ethical right to refuse or discontinue medical treatment, even if that decision hastens death. Permitting AVE at an individual's considered and voluntary request is a logical extension of this respect for their right to avoid needless suffering. International human rights bodies have acknowledged this balance. Notably, in *Mortier v. Belgium* (2022), the European Court of Human Rights found that a carefully regulated AVE framework did not, in itself, violate the fundamental right to life under the European Convention, provided strict safeguards against abuse are in place. This judgement affirms that states have the discretion to legalise assisted dying without breaching their human rights obligations, reinforcing that a voluntary death in defined circumstances can be consistent with respect for life and dignity.

3. Empirical Evidence and Responses to Key Objections

3.1 Vulnerability and a "Duty to Die"

Evidence from jurisdictions in North America and Europe show that individuals opting for AVE are not associated with vulnerable populations. On the contrary, individuals opting for AVE are more likely to be individuals with higher levels of education and better socio-economic status (Battin et al., 2007; Health Canada, 2024). Where patients mention "being a burden" on others, official reports show this motive ranks well below autonomy-related reasons like the loss of ability to engage in enjoyable activities and the loss of dignity (Oregon Health Authority, 2024; Washington

State Department of Health, 2024). Furthermore, modern statutes create symmetrical legal protections, criminalising the act of pressuring someone to request AVE and the act of pressuring them to withdraw a request, providing robust safeguards against coercion (Queensland Parliament, 2021).

3.2 Palliative-Care Trajectory

A core argument is that AVE implementation leads to a decline in palliative care services. Contrary to this, evidence from multiple jurisdictions shows the opposite trend. After AVE laws were enacted in Belgium, the Netherlands, and Victoria (Australia), key indicators for specialist palliative care, including public spending, workforce numbers, and the timeliness of hospice referrals increased (Chambaere & Bernheim, 2015; House of Commons Health and Social Care Committee [HSC Committee], 2023, Q80). When legislation couples access to AVE with requirements for a mandatory palliative-care consultation and specifically allocated funding, the two streams of care can complement, rather than replace, one another (Riisfeldt, 2023).

3.3 The "Slippery Slope" Narrative

The academics' paper warns that initial safeguards will erode over time, citing the expansion of eligibility in Canada as an example. It is important to note that where eligibility has been broadened (e.g., Belgium's 2014 amendment for certain minors or planned changes in Canada), the change came about only through new parliamentary acts, preceded by significant and often lengthy public and political debate. No jurisdiction has expanded eligibility by stealth or administrative fiat. Embedding a statutory review clause and a requirement for transparent, publicly available annual data in any future Maltese law would ensure that any proposal for future widening remains firmly under democratic control.

3.4 Suicide-Rate Concerns

Longitudinal time-series studies from jurisdictions with long-standing AVE laws, including Oregon, Washington, and Switzerland, have not demonstrated a causal link (Doherty et al., 2022). The academics' paper cherry-picked the one study in line with their narrative and ignored all other evidence. The wider data shows that, after adjusting for sociodemographic variables, the increase in non-assisted suicides is largely not statistically significant.

3.5 Primary Patient Motives

The most frequently cited reasons for requesting an assisted death are not centred around pain relief but are, rather, existential. The primary motives listed by patients are "loss of autonomy," "loss of ability to engage in activities that make life enjoyable," and "loss of dignity" (Oregon Health Authority, 2024; Washington State Department of Health, 2023). Uncontrolled pain ranks much lower on the list of reasons. Any comprehensive ethical appraisal of AVE must take these prevalent dignity-based and autonomy-based motives seriously, rather than focusing exclusively on failures in analgesia.

4. Conclusion

The arguments against the introduction of AVE provide an important, but ultimately partial, assessment of the ethical and empirical landscape. A wider reading of the available evidence suggests that a narrowly framed, well-audited AVE law can successfully protect vulnerable people, coexist with and even strengthen palliative care services, and respect the deeply held values and autonomy of the small minority of people whose suffering at the end of life remains otherwise unrelieved. From an ethical perspective, consensus about the right approach has not been achieved. The existence of genuine scholarly disagreement on this topic should not be a cause for legislative paralysis, but rather an invitation to develop careful, compassionate, legislation with robust safeguards that are independently monitored and reviewed.

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