An GħSL Policy Paper

AN INSIGHT INTO

EUTHANASIA

AND A MULTI-FACETED EXAMINATION OF VOLUNTARY MEDICALLY-INDUCED DEATH AND PHYSICIAN-ASSISTED SUICIDE

Policy

POLICY

Disclaimer:

GħSL is issuing this policy paper for research and legal studies purposes. In its paper GħSL does not intend to influence the legislators decision as to whether the introduction of this medical procedure is to be legal and enforceable at law. One fully understands the moral and ethical background of this procedure and as such the team feels that it should be up to the legislators, following the opinion of the majority of the people, to decide whether Euthanasia should become legal in the Republic of Malta.

Introduction

DEAR READER...

It is my pleasure to present GħSL's Policy Paper on Euthanasia, a paper worked on and set by the Policy Committee whose work was essential for the positive outcome of this report.

As an organisation GħSL has always had the drafting of policy proposals at heart, and we have strived to be pro-active in our work and make sure to discuss topics which have an impact on the student body, legal practice and society as a whole. GħSL's history in policy speaks for itself, following the enormous success after publishing our paper giving an insight on the Legalisation of Prostitution, this paper will definitely be nothing short of that and more.

When compiling this paper we sought to have a multi-facetted paper as to present a complete insight when discussing this controversial topic. Being an organisation representing Law students we focused on the legal aspect of Euthanasia, along with why and how it should be tackled. We looked into the notion to present all possible aspects ranging from the legal approach, to those topics which allow for a more in-depth study inclusive of the ethical, medical, psychological and economical aspects. In doing so it is our belief that we have managed to meet our goals, whilst presenting a paper that is comprehendible by students who are both knowledgeable of the law, as well as those who have yet to have a clear understanding of it.

Finally, the team presenting this paper would like to thank all of the professional contributors who have looked into, analysed and vetted our work. The standards set in this policy paper would not have been possible without their contribution. Special thanks to Dr. Ishmael Psaila, Dr Anthony Zahra, Dr Mario Zerafa and Dr Clyde Caruana for their review of this paper.

On behalf of the Policy Committee, the GħSL Executive and its members, thank you and we hope to leave an impact on an ever developing society.

SINCERELY,

LARA ATTARD
GħSL Policy Officer 2016/17

Foreward

DEAR STUDENTS...

As an organisation, with every passing year, Għaqda Studenti Tal-Liġi has continued to grow and expand. This has made it possible for us to take on new initiatives, tackle different subjects and strengthen our relevance both locally and internationally.

Our main objectives have always been to include as many law students as possible in the organisation, increase the overall participation of law students and make opportunities available that will in turn help them in their studies, future careers and in society as a whole. This work has helped students gain something more than just the normal day to day University academic life. As students, we should all be pro-active, and we should appreciate that we are in an incredible position where we are actively encouraged to ask questions others may perhaps fear to ask, and therefore ultimately instilling further discussion and debate nationally.

When different policy issues are brought to the table for discussion, one should not consider students as simply one of the many stakeholder, rather, students are to be consulted in these discussions because our opinion should and does matter, both as present citizens and as future leaders of our nation. Student and voluntary organisations are at the forefront of all this:

As a generation, we must appreciate all the opportunities that we have been given and respect all the hardships that our previous generations have gone through to make our lives a little bit better. In return, let us create debate and put forward the policy issues affecting of our society and future generations. Let us be pro-active!

As an organisation, as students and as active member of society we will not shy away from our role to put forward issues that may not always be favourable or ones that people may fear to bring up because of the stigma surrounding them. It is therefore our duty to listen, to keep an open mind, to respect the opinion of each and every person and to ultimately educate and act!

In conclusion, it is with great pride that we present our policy paper on Euthanasia. I would personally like to thank and congratulate Lara on her work and leadership as Policy Officer. A heartfelt

congratulations goes to all the policy committee members who have worked tirelessly to compile this paper. Your incredible work and dedication to this cause should inspire us all.

BEST REGARDS,

JACOB PORTELLI

GħSL President 2016/17

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Euthanasia - a definition...

As the main definition states Euthanasia is the 'desire to end ones life voluntarily due to medical illness'. However what one must take into account is that when one looks into the actual medical definition/s of Euthanasia, one can come to notice that there are two forms of Euthanasia or Assisted Suicide. These mainly consist of Voluntary Euthanasia and Non-Voluntarily Euthanasia, **both of which have diverse effects on the psyche of the individual which the medical practitioner or family member is dealing with.**

VOLUNTARY EUTHANASIA

In itself, Voluntary Euthanasia means that the individual is willing and wants to end his or her life due to the suffering and pain that they have been enduring. This is what most individuals refer to when debating Euthanasia between themselves.

Voluntary Euthanasia includes cases of:

- asking for help with dying
- refusing burdensome medical treatment[1]
- asking for medical treatment to be stopped, or life support machines to be switched off
- refusing to eat
- simply deciding to die

NON-VOLUNTARY EUTHANASIA

This form of Euthanasia, has rarely cropped up in the ongoing national debate. Though it is one that legislators, medical practitioners, politicians and people who will be submitting others to it need to take into consideration even more so when one is dealing with the life of a vulnerable person.

Non-Voluntary Euthanasia is normally defined as: 'a person cannot

1 Refusing Burdensome medical treatment is usually the most common reason given by individuals who opt for Euthanasia. In doing so it is their belief that they will be relieved of living in pain.

make a decision or cannot make their wishes known and accordingly it is their next of kin who decide as to whether they should end the patient's life.'[2]

The latter form includes cases where:

- the person is in a coma
- the person is too young (e.g. a very young baby)
- the person is senile
- the person is mentally retarded to a very severe extent
- the person is severely brain damaged
- the person is mentally disturbed in such a way that they should be protected from themselves[3]

2 Reference: http://www.bbc.co.uk/ethics/euthanasia/overview/volinvol.shtml

3 Ibid.

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Current Maltese Legal Approach

THE ARGUMENTS FOR EUTHANASIA AND ASSISTED DEATH: A COMPARISON BETWEEN THE FOREIGN AND LOCAL SCENE.

With regards to the local scene, there are certain misconceptions as to whether suicide is a criminal offence or not under Maltese Law. Suicide and attempted suicide do not result in a criminal offence. However, providing assistance to commit the act is considered to be an offence punishable at law[1]. It is not evident whether the dolus directus of the patient wanting to die is a mitigating factor or not to lessen the punishment of who assisted the suicide. Although this proviso in the law looks quite straightforward, there is much more to it than one might actually believe. A number of questions arise with regards to scenarios where a Maltese Citizen provides assistance to a person who is not bound by Maltese jurisdiction and where such act is not deemed to go against local law. Courts do not have precedent to punish criminal offences which are committed outside Maltese territories even though the offence, in this case assisted suicide, is a crime against the person, a group of offences which include willful homicide and grievous bodily harm.

The European Court of Human Rights has dealt with a number of end of life care cases within the past decade. Ironically, most cases dealt with the decriminalisation of assisted suicide in Member States which do not contradict with the right to life. This decriminalisation has led to sustaining the individual's integrity which focused more

1 Article 213 of the Criminal Code states that 'Whosoever shall prevail on any person to commit suicide or shall give him any assistance, shall, if the suicide takes place, be liable, on conviction, to imprisonment for a term not exceeding 12 years.'

on the protection to the individual's right to life than to his right to end it.[2] The Courts have recently been aware of the delicate subject and how different Member States tackle the issue from a legal and ethical perspective. Individuals are entitled to file a complaint in front of the European Court of Human Rights if no remedies are available in their residing member state. In most cases, pleas from individuals with their wish to commit the act are sufferers of unbearable pain where the right to life is no longer a practical option.

A person who has gone through great lengths to introduce the legalisation of euthanasia in Malta is Mr. Joe Magro. He has been diagnosed with Amyotrophic Lateral Sclerosis; a progressive neurodegenerative disease that affects nerve cells in the brain and the spinal cord. On the 12th of September 2016, GħSL had the opportunity of interviewing him personally together with his wife, Mrs Marlene Magro with the hope of raising enough awareness for the prospective legalisation of mercy killing. **Together with other professionals in their respective sector, Mr Joe Magro will also be mentioned throughout the paper to represent his arguments in favour of euthanasia.**

The definition of the right to life under Article 33 of the Constitution of Malta and under Article 2[3] of the European Convention of Human Rights must be wide enough to acknowledge (or recognise) that living in a vegetative state (**or close to being paralysed**) **without no scope of existing does not fall under these articles.** Dr Robert Thake, a Maltese lawyer practising with law firm Desira and Thake Advocates, believes that with the right to live, there is a right to die, and that criminalising euthanasia vioaltes the right to life of the individual when life becomes excruciating or undignifying.

Accepting the right to live would also entail accepting the right to die. However, in the case of ***Pretty v. the United Kingdom***[4] , the Court did not take into consideration that Article 24 of the Convention also includes in it the right to die. Individuals are entitled to file a complaint in front of the ECtHR if no remedies are available in their residing Member State. **In most cases, pleas from individuals who wish to commit the act are sufferers of unbearable pain where the right to life is no longer a practical option.**

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2 Haas v. Switzerland, 2011

3 . Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law. 2. Deprivation of life shall not be regarded as inflicted in contravention of this Article when it results from the use of force which is no more than absolutely necessary: (a) in defence of any person from unlawful violence; (b) in order to effect a lawful arrest or to prevent the escape of a person lawfully detained; (c) in action lawfully taken for the purpose of quelling a riot or insurrection

4 29th April 2002 (EcHR, Chamber Judgment)

In Malta this topic is very controversial especially due to the strong catholic influence in our Country, a belief which is enshrined in Article 2 of the Constitution of Malta. The Maltese Bishops drafted an open letter to the Members of the Maltese Parliament on this issue. The Church has a strong believe that the human life must be respected from the day the person is born up until the day the person dies of a natural death. This argument is backed by the fact that the Maltese law should provide protection to the vulnerable and the disadvantaged and not aid them in the termination of their life. The church believes that to aid the vulnerable one must not provide them with the opportunity to terminate their life, but the country must invest in palliative care. It argues that a medical professional assisting a patient with euthanasia would go against the Hippocratic oath taken; that of preserivng life. The Church further states that should Euthanasia be legalised, it would be immoral and accordingly it will go against the religious teachings of the Church. The Church believes that one's dignity and value of life does not depend on the person's physical incapabilities or illness and euthanasia might not be the best solution. In the Bishops' open letter to Parliament it advises medical professionals not to go against their good consciousness and morality. It also asks the latter to preserve the value of life which must continue to be cherished even in difficult times. In addition, the Church hopes that the families and loved ones of these people giving up on life continue to take care of them and give them courage to keep on living. The Church ultimately wants to pass on the message that the community must strive to build a better society where people with a chronic illness would not be disregarded.[5]

However there are individuals which do not agree with the Church's plea. In fact Magro claimed that the Church should not impose their opinion on euthanasia on the public and that the decision should be taken solely in Parliament. Magro believes that it would be discriminatory if the Catholic faith engraved in Article 2 of the Constitution of Malta were to have a role in the legalisation of Euthanasia since it should not intervene in the population's personal views and distinct moralities. It may be assumed that persons are discussing their wish to be assisted with end of life care privately to their doctor and to the patient in a respectful manner. The State has a duty to take into consideration the mental and physical health of these patients who are in a vulnerable position to continue with their everyday life.

Since Euthanasia is still criminalised in Malta, patients suffering from certain diseases and who wish to end their life, must bear the pain and continue to depend on advancements in medicine attempting to lengthen their lifetime or defeating their condition. Mr Joe Friggieri,

5 The Church in Malta, 'Bishops' Open Letter to the Members of the Maltese Parliament on medically-assisted dying' (Maltadiocese, 24th July 2016) <http://thechurchinmalta.org/en/posts/60956/bishops-open-letter-to-the-members-of-the-maltese-parliament-on-medically-assisted-dying>

a Maltese philosophical scholar, argues that although with the right to live there is the right to die, it is still not a sustainable argument to seek Euthanasia as an option for a person wh o is permanently ill or paralysed. In contrast, he believes that medicine and other treatments should be vital options which one should be able to resort to as a pain reducing measure, and eventually keep the individual alive without necessarily depending on machines or other artificial mechanisms. Mr Magro has specifically expressed that if Euthanasia is not legalised in Malta, he is ready to attempt suicide: 'A person who is in my condition should not be in a state where he has to wait naturally to die, but he is entitled to have the means to die decently'.

In addition, Mr Magro believes that there is no reason why a person should not opt for euthanasia if he is of a sound mind. Euthanasia should only be available to people where there is confirmation that a person with a certain illness or condition has no sustainable cure. Dr. Thake argues that euthanasia should be legalised. However, the decision must be backed up by a medical and a pyschological expert and it is they who must give the go-ahead to begin the procedure. Dr. Mario Zerafa, a professional anaesthesiologist, asserts that doctors like him do their utmost to provide a pain-free death. For patients, whose treatments are futile, doctors will eventually stop the treatment so that the patient would be able to die naturally when euthanasia is not a possible option. The concerned patient may also 'refuse treatment that is offered to him, provided such refusal is endorsed by his signature.'[6] Although Dr. Zerafa experiences several situations where patients wish to die on their consent, he still struggles to resolve whether euthanasia is the best alternative or not to end one's life. Instead of perceiving the right to life with the right to die, Dr. Zerafa prefers to believe that the latter right shall be complemented with the obligation[7] to give others a comfortable way of living.

Most of the professionals who gave their opinion about this subject, collectively agreed that if euthanasia were to become legalised, it should be the case because the legislators took the people's opinion into account. The main argument upholds that Parliament should have the sole responsibility and competence to put the bill upon this matter forward. Many have concluded that euthanasia is a delicate subject which requires respectful legislation and not the kind of reductive approach required by a referendum. In February of 2016, Mr Magro publicly spoke out to the media about how the legalisation of euthanasia in Malta should be constructed, specifically mentioning Swiss, German and Canadian Law. In Switzerland, euthanasia and assisted death are only criminalised if the intent to kill or be killed

6 Article 28(f) of the Health Act as amended in 2013

7 This Obligation shall be exercised by professional medics. However, the government shall pursue that treatments and other options to reduce pain and agony shall be of a low cases or if possible, free of charge

is deceiving or egotistical[8]. Citing a comparative viewpoint as will be pointed out even further in this paper, is of an added value to the understanding of what one must look into for the tabling of the bill; should it come to it. Its legal framework shall be rigid and available to those patients who truly believe that this will help them suffer less from what can be considered to be a terminal illness. This prospective law shall be specific in its meaning including accurate provisions of which methods to end the life concerned are allowed and what methods are not[9]. Although0 there is still no clear indication as to what one intends to include in the bill, Mr Magro has expressed that Parliament, specifically the Family Affairs Committee are still discussing this issue for there to be a potential legislation of the subject The drafting of a bill must go through a hefty and thorough process, including representation, organisation, sections and basic principles to prevent the abuse of the statute.

Nevertheless, it should be up to Parliament to decide what regulations should restrict the exercise of euthanasia, following regulations similar to those of Switzerland or more liberal regulations like euthanasia law in the Netherlands.[10]

As previously discussed, the final decision to go through with this decision must be solely that of the concerned patient. As things stand one can suggest that main elements which may constitute full consent are as follows:

- That the patient takes the decision on a voluntary basis
- Any decisions made are not being enforced on the person
- The patient must be aware of all the risks and possible benefits of end of life care and must be willing to commit the act nonetheless. It is the responsibility of the medical profession to help and guide his patient and to make him aware of his condition and what natural course it might lead to.

This advanced healthcare directive must also make clear the rights and obligations of both the patient and their doctor who will be assisting the former with the procedure of euthanasia. These rights and

8 Article 115 of the Swiss Penal Code states that ''Inciting and assisting suicide: Any person who for selfish motives incites or assists another to commit or attempt to commit suicide shall, if that other person thereafter commits or attempts to commit suicide, be liable to a custodial sentence not exceeding five years or to a monetary penalty."

9 Euthanasia can be active (where medical assistance with drugs or any other treatment intervenes to procure death) or passive (the removal of treatment which is necessary for the patient to keep on living).

10 Dutch law allows the exercise of active euthanasia where one can be provided with medication like sedatives upon request of the patient concerned.

obligations must be written down and codified for the main reason that certain doctors play the role of 'conscientious objectors' and may refuse to go on with the procedure due to reasons which may be moral, religious or ethical. Hence, the prospective directive would allow another doctor to go on with the procedure. However, if the living will of the patient would eventually have the force of law[11] then the patient's statement and wish for euthanasia would prevail over what his doctor thinks is morally correct or not. The relationship between the doctor and the patient must also be taken into consideration since the patient will seek to find confidentiality when talking to his doctor who would eventually proceed with the process of euthanasia.

A private setting is one of the main rights a patient should have since ''surveys suggest the practice of euthanasia occurs covertly, most likely involving assertive patients who are able to convince the doctor to perform euthanasia in a private setting.''[12]

The law is frequently being adjured and amended to re-interpret the frontiers of life and death. Case Law has over time proven that in many situations self-worth prevails over rigid legal provisions. That in turn, the interpretation of the law is applied on a case by case by case basis.

11 This is only a hypothesis since in Malta the living will is not legally binding yet. It is an issue which is currently being discussed.

12 R Hunt, ''Approach of the GP to End-Life Decisions'' (1997) The RGGP Members' Reference Book 1997/8 p 266,267

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Comparative Legal Approach

One cannot delve into the making of laws without looking at their legal counterparts, the laws of other countries with a legal system both similar or different to their own. It is because of this that GħSL has chosen to fully understand the way their law works with respect to Euthanasia, to understand in what they differ and accordingly what can be proposed for our national legislation.

COUNTRIES WHERE EUTHANASIA IS LEGAL

THE NETHERLANDS

Euthanasia and assisted suicide is legal in the Netherlands. However, this was not always the case. In the past, these practices were illegal according to articles 293 and 294 which punished anyone who committed euthanasia by up to 12 years' imprisonment or a fine. Despite the illegality of the act, euthanasia has been regularly practiced in the Netherlands since 1973.[1]

The 1971 case of **Gertuida Postma** is an illustration of such practices. In this case, Dr. Geertuida Postma injected her mother with morphine and curare which resulted in the mother's death. The mother had on multiple occasions asked her daughter to end her life because she was suffering from a brain haemorrhage after which she could barely speak, hear and sit up. Dr. Postma was charged under article 293 and found guilty but was only given a one-week suspended sentence, along with one years' probation. The court argued that the physician could administer such drugs leading to the death of the patient as long as the goal of treatment was relief from physical or psychological pain. However, in this case, the goal was to cause the death of the patient, hence this was the reason for which Dr Postuma

1 http://www.catholiceducation.org/en/controversy/euthanasia-and-assisted-suicide/current-euthanasia-law-in-the-netherlands.html

why she was found guilty.[2]

In the same year, the Royal Dutch Medical Association held that article 293 should remain in force with the exception of the administration of pain relieving drugs and the withholding of treatment could be justified even if these resulted in death. Thus, following a number of court cases on the issue, doctors were no longer prosecuted for practicing euthanasia as long as they followed a set of guidelines.[3] Some guidelines which were mentioned include that the patient must be conscious and voluntarily request death. Moreover, the patient must be going through unbearable pain, has been given alternative solutions rather than euthanasia and sufficient time to consider these other alternatives, rather than being pressured to take a singular option. Furthermore, there must be no other reasonable solution, and the patient's death must not inflict any suffering on others and great care is to be taken in making this decision. Euthanasia can only be carried out by a physician and there must be more than one person involved in making the decision.[4]

Although the doctors were not being prosecuted if they followed these guidelines, there was still a low rate of euthanasia cases being reported. The government felt that this was due to doctors still being afraid of breaking the law. Thus, this brought about the introduction of the Draft Bill in the year 2000 which legalized euthanasia, bringing about the **Termination of Life on Request and Assisted Suicide (Review Procedures) Act.**[5]

According to this act, the guidelines that the doctors had to abide by before still applied and they are re-stated in Chapter II (Due care criteria), section 2 (1) (a-f). This act also goes into the enigma of minors requesting euthanasia and states in Chapter II, Section 2 (2) and (3) that minors who are over 16 years of age may request euthanasia but a parent or guardian must be involved in the decision although they need not agree or approve. When it comes to children who fall in the bracket of 12-16 years, the approval of a parent or guardian is a must.

An interesting thing to note is that while one of the requirements to be eligible for euthanasia is unbearable pain, according to Chapter II, section 2 (1)(b), there is no requirement that the suffering is physical or that the patient is terminally ill. The only requirement is that the doctor certifies that the patient's suffering is lasting and unbearable.[6] Prior to this Act, the burden of proof was on the physician to justify

2 http://www.patientsrightscouncil.org/site/rpt2005-part3/

3 http://www.patientsrightscouncil.org/site/holland-background/

4 Ibid

5 http://www.patientsrightscouncil.org/site/wpcontent/uploads/2012/05/Dutch_law_04_12.pdf

6 Ibid

the termination of life. However, under this new act, there has been a shift of the burden of proof onto the prosecution, for it is they who must prove that the termination of life did not meet the requirements set forward under Chapter II – Due Care of the Act.

There is then a Regional Review Committee for the Termination of Life on Request and Assisted Suicide to review the reported cases. This committee is made up of at least one legal specialist, one physician and one ethical and/or philosophical expert. Then there is the question of 'euthanasia tourism'. Although it is claimed that only Dutch residents will be able to receive euthanasia or assisted suicide, the law does not prohibit doctors from carrying out euthanasia on non-residents.[7]

In 2015 there were approximately 5000 reported euthanasia deaths. The country even has a special clinic called the Amsterdam End of Life Clinic run by Steven Pleiter. This clinic even provides mobile euthanasia teams across Holland to help patients die in their own homes. Mr Pleiter says that one of the reasons why he got into the 'right to die' business and set up the clinic was to help the forgotten ones such as those suffering from dementia, elderly with no medical diagnosis and those which psychological problems. Mr Pleiter uses his own mother as an example; she suffered a stroke at 80 years old and this left her half-paralysed. She had always expressed to her son that if she were to end up in that situation, he would help her die. However, her son couldn't do anything to make her wishes come true at the time. She ended up suffering for four more years before dying of pneumonia. Thus, Mr. Pleiter says 'what our clinic provides is a miracle for some people… they find it is a big relief to let go because it is the end of their suffering. '[8]

However, euthanasia cases are not always so straight forward. A very delicate scenario came into the public eye earlier this year - when a 45-year old woman, the victim of child abuse, wanted to end her life in one of the aforementioned lcinics. She quit her job and is suffering from depression as a result of the unforgettable memories of her abuse. She tried to commit suicide but failed as she was saved at a hospital. As suggested by the psychiatrists, she underwent electric shock treatment but both her mental and physical states worsened. She stopped talking, even to her family and became practically bedridden. She approached the End of Life Clinic and was put on a waiting list, which immediately lightened up her mood, as she took comfort in the fact that there is a near end to her suffering.

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7 http://www.patientsrightscouncil.org/site/hollands-euthanasia-law/

8 http://www.dailymail.co.uk/news/article-3589929/The-woman-killed-doctors-obsessed-cleaning-Horrifying-Yes-s-just-one-growing-numbers-Dutch-men-women-given-right-euthanasia-mental-not-terminal-illness.html

When faced with a similar case of a woman in her 20s wanting to end her life due to depression stemming from her having been a victim of child abuse, the Dutch Euthanasia Commission which oversees all euthanasia requests held that the woman was suffering from incurable post-traumatic stress disorder, therapy resistant euthanasia, suicidal mood swings, hallucinations and chronic depression. Thus, not being able to find a cure, they granted euthanasia by lethal injection after having certified that she was competent to take such a decision to end her life.[9]

Therefore, it can be said that in the Netherlands, the law regulating euthanasia has been extended to various cases, not just the typical terminal illness such as cancer. They have embraced the right to die and understood how important it may be to a person to die with dignity. This is very much reflected in Paulan Stärcke's speech entitled 'Condemned to live with unbearable psychiatric suffering or allowed to die?' This is a very complex question, one that can only be fully understood by individuals who have in some way come into contact with such a delicate situation. In fact, Ms. Stärcke spoke with the parents of a 34 year old woman who suffered post-traumatic stress disorder, chronic depression and personality disorder who chose euthanasia. The parents stated that they were grateful that their daughter's life ended in this way and not by suicide because choosing euthanasia means that you can prepare, you can say goodbye.[10]

Having said all this, one cannot ignore the fact that the statistics for deaths by euthanasia is on the rise and whilst many of the cases involve terminally ill cancer patients, there has been an increase in the requesting of euthanasia because of other cases.[11] Thus, when legalising such a delicate matter, one must make sure to not widen its scope too much because this would most likely lead to abuse. There should always be strict enforcement of the guidelines set out in the law and every case should be monitored and reviewed thoroughly on a case by case casis before it is granted. Doctors should not feel 'untouchable' and the penalties for doctors carrying out irregular euthanasia and assisted suicide should be strictly enforced.

BELGIUM

The law legalising euthanasia in Belgium for adults and emancipated minors took place in 2002 through - The Belgian Act on Euthanasia of May 28th 2002.[12] The guidelines that this Act puts forward in

9 Ibid

10 http://www.dutchnews.nl/features/2016/05/dutch-conference-on-euthanasia-discusses-controverial-reasons-such-as-depression/

11 http://www.dyingforchoice.com/resources/fact-files/netherlands-2015-euthanasia-report-card

12 http://www.ethical-perspectives.be/viewpic.php?LAN=E&TABLE=EP&ID=59

Chapter II: Conditions and Procedures, section 3 includes that the person is conscious and competent at the time of the request and that this request is voluntary, well considered and repeated. Furthermore, the patient must be suffering from a terminal illness or incurable disorder of constant unbearable pain whether mental or physical and that there is no cure.

If the above conditions are satisfied, then it is up to the physician to inform the patient about his or her life expectancy, discuss the request for euthanasia and provide alternative solutions. The physician must be sure, together with the patient that there is no other alternative and that the request is a genuine one and completely voluntary. The physician must always be certain of the patient's constant suffering through talking to the patient and monitoring his behaviour and progress or regression over time. Similar to the Netherlands, Belgium also impose the condition that the decision is taken by a number of people and not just one and hence, the physician should consult another physician just to make sure and reaffirm the incurable state of the patient.

This same chapter of the act puts forward a rather interesting distinction that is between patients suffering from an illness which have short life expectancy and those which the physician believes are not expected to die in the near future. When it comes to the latter, the physician is required to consult a second physician and allow at least one month between the patient's written request and the act of euthanasia.[13] In this way, Belgium makes sure that a person who is suffering from some incurable illness or disorder but is not expected to die in the near future has time to reflect upon his or her decision and thus the physicians are able to monitor his behaviour and make sure that his is sure of his request.

In 2014 there was an addition to the 2002 law. The legalisation of euthanasia was extended also to minors. Belgium removed age restrictions after a very difficult and emotional discussion on how to treat a terminally ill child who wants to end his life. It was agreed that children should have the same right as adults meaning that they should have the right to ask to die with dignity. Obviously, there must be certain guidelines and these include that the child must be terminally ill, close to death and deemed to be suffering beyond medical help. Also, the children must be able to ask for euthanasia themselves and must be fully aware of their choice and must be deemed fully capable of understanding their decision. The request will then be reviewed by a team of doctors and psychologists amongst others and a decision to grant or deny is taken.[14] Thus, one can still draw a distinction

13 http://www.patientsrightscouncil.org/site/belgium/

14 http://time.com/7565/belgium-euthanasia-law-children-assisted-suicide/

between adults and children wishing to be euthanised. It is still not possible to euthanise children unless they are on the verge of dying unlike the situation in adults. Furthermore, it is not possible for the parents of a child to request euthanasia for their child if the child is unable to make the request and has never expressed such wish in his or her right mind.

Although the law on child euthanasia was passed in 2014, the first case happened only recently, in 2016.[15] The case entailed a 17-year-old terminally ill patient who according to the head of the federal euthanasia commission was 'suffering unbearable physical pain.' It is reported that Belgium is the only country which grants the possibility of euthanasia without any age restrictions. The Netherlands also allows euthanasia on minors in rare cases but there is a minimum age of 12 years.[16]

In Belgium, as is the case in the Netherlands, the right for euthanasia and assisted suicide has become less strict and it is now being used not only in the cases of terminal illnesses but also certain mental anguish and unbearable mental or physical pain that is 'unfixable'[17]. In fact, the 2013 report (the last one published) showed an increase in the number of euthanasia cases which reportedly rose by 27% to the preceding year, bringing it to a total of 1,807 deaths by euthanasia.[18]

However, despite the increase in reported deaths which occurred through euthanasia, its legalisation can be seen through another perspective. In 2015 a 24-year-old woman's request for euthanasia was accepted on the grounds of her being in a state of unbearable psychological suffering. Her last months were filmed for a documentary and in what would have been the last hour of her life, she changed her mind and thus, to this day is still alive. Her case was used as an argument in favour of legalising euthanasia because it was argued that when a person is going through unbearable pain and sees no possible end to her suffering, then death is desired more than anything. However, it is when faced with the possibility and choice of death, the person's mind is put at rest because she knows that its within her reach.[19] Thus, such as in this case, legalising euthanasia might actually save a life rather than the other way around because had euthanasia not been legal, the person, feeling trapped with no way out may resort to other alternatives such as suicide. Therefore,

15 http://www.dailymail.co.uk/news/article-3794054/Belgium-reports-case-euthanasia-minor.html?ito=social-facebook

16 http://www.bbc.com/news/world-europe-37395286

17 http://www.brusselstimes.com/opinion/4101/where-does-belgium-s-legalisation-of-euthanasia-leave-belgian-prison-inmates

18 Ibid

19 https://www.lifesitenews.com/opinion/depressed-belgian-woman-chooses-life-moments-before-scheduled-euthanasia

rather than looking at just euthanasia levels, one must take under consideration the rate of suicide which will decrease because people now have another solution for justified, unbearable cases.

Having said that, it is important that euthanasia laws are drawn up with care and precision and that every detail and scenario is taken under consideration. Furthermore, once the law is passed, the government must ensure that they are strictly enforced. This would reduce the abuse that people may take. Belgium seems to be having this problem especially when considering that according to the proposed rules, doctors who are treating patients who request euthanasia must approve or deny the patient's request within 7 days or refer them to someone who will. Also, the proposed rules require doctors to treat euthanasia cases as urgent and carry it out in the least possible time. This thus blocks the possibility of the doctor or any other person such as religious group talking the patient out of going forward with his request. Such proposals are not ideal and in fact, there is opposition.[20]

Furthermore, it is claimed that euthanasia laws have led to unnecessary deaths of people who as a result of suffering depression opted for euthanasia rather than fighting back to regain their strength. The chairman of the federal euthanasia commission in Belgium in fact stated that around 50-60 euthanasia deaths each year are done on psychiatric patients. Ironically, there has never been an attempted prosecution for abuse of euthanasia laws in Belgium.[21]

Obviously, such wide interpretation of euthanasia laws would be going a step too far than what the legislator intended when passing euthanasia laws. When people do away with not following the guidelines, this can only result in chaos. Therefore, every state must ensure that if euthanasia laws were to be passed, that any commission or review board entrusted to look into euthanasia cases before granting the 'go-ahead', carries out thorough research, provide all possibilities of cures and maybe appoint a social worker to closely work with the patient. That way, one can minimize and further guarantee that all approved cases are in line with the guidelines set out in the law and that there is really no other way out, no cure. Most importantly that it is really what the patient wants to do and that he has no doubt.

20 http://www.lifenews.com/2016/03/16/new-belgium-rules-would-force-doctors-to-euthanize-patients-or-refer-to-a-doctor-who-will/

21 Ibid

LUXEMBOURG

Luxembourg was the third country to legalise euthanasia, back in 2009 after the Netherlands and Belgium. Lydie Err, one of the drafters of the Bill held that 'this bill is not a permit to kill… it's not a law for the parents or doctors but for the patient and the patient alone to decide if he wants to put an end to his suffering.'[22]

There are certain guidelines that the doctors must follow and these are the following; the patient must be certified as being competent to make the request at the time that the request is made. Also, if the patient is between 16 and 18 years of age, he requires the authorisation of his parents or legal guardians. It is important that the request is voluntary, the wish is expressed repeatedly and is not a result of any external pressure. Furthermore, the patient must be suffering from an incurable condition and is constantly in pain, whether physical or mental pain. Lastly, the patient must respect all the conditions and procedures stated by law.[23]

Some other conditions would include that the physician must inform the patient of his life expectancy, discuss any alternative options. It must be clear that there is no other option for the patient and that he has no doubt that this is the only option for him to end his suffering. In addition, in order to ensure that a fair decision is reached and that the patient should be granted euthanasia in accordance with the guidelines set by the law, it is important that the physician consults another physician.[24]

If one takes a look at the conditions required in all three countries, namely; the Netherlands, Belgium and Luxembourg, it becomes quite evident that there are a number of similarities. It seems that the most important conditions would be that the person must be going through unbearable pain and has an incurable condition and that he must be of sound mind when making the request. With reason, these two conditions are and should be the foundation of all present and future euthanasia laws.

Another similarity between the three countries is that there is set up a commission in each country with reviews and oversees all euthanasia cases. In Luxembourg this is called the **National Commission of Control and Evaluation to Assess the Implementation of the Law**. A physician who performs euthanasia must within four days from performing it, send an official declaration to the commission. However, in Luxembourg, contrary to what we might have seen

22 https://www.lifesitenews.com/news/luxembourg-legalizes-euthanasia

23 http://www.loc.gov/law/foreign-news/article/luxembourg-right-to-die-with-dignity/

24 Ibid

in the other countries, in Luxembourg the physician is not obliged to perform euthanasia or assisted suicide.

It was reported that in two years (2013-2014), only 15 people were euthanised in Luxembourg. The majority of these cases involved terminally ill cancer patients. Then there were three cases of patients suffering neurodegenerative diseases and one which had suffered a stroke. It seems that the number of requests received by the Commission and the number of euthanasia deaths has managed to remain stable in Luxembourg when comparing 2013-2014 with 2011-2012 in which there were 14 cases.[25]

It seems that from the three mentioned countries, Luxembourg's euthanasia laws are the most restrictive. A particular difference between Luxembourg and Belgium to the Netherlands is that the former countries try to prevent suicide tourism by banning it for non-nationals but in the Netherlands, there is no such restriction. On another note, when it comes to euthanising children, it is also Luxembourg which is the most restrictive.[26] Luxembourg law only mentions minors aged 16 to 18 who may request euthanasia with the consent of their parents whereas in Belgium, there is no age restriction although there needs to be the consent of the parents and in the Netherlands, children above 12 can be euthanised, with the consent of parents if under 16 years of age.

One must point out that when comparing the three countries together, it seems that Luxembourg is handling the matter the best. This is because being too liberal such as is the case in the other two countries may lead to abuse. Although one must not deny the right to die with dignity, there must be a balance struck between the genuine cases and other patients such as those suffering from depression who although might not see any other option at the time, can be offered other alternative help and care which could lead to their recovery.

25 http://www.wort.lu/en/politics/15-cases-in-2013-and-2014-luxembourg-euthanasia-report-finds-no-abuses-of-the-law-5537989d0c88b46a8ce57d97

26 http://www.irishexaminer.com/viewpoints/analysis/special-report--euthanasia-271385.html

COUNTRIES WHERE EUTHANASIA IS ILLEGAL

UNITED KINGDOM

Currently in England, both euthanasia and assisted suicide are illegal according to The Suicide Act 1961 which punishes any person 'aiding, abetting, counselling or procuring suicide'.[27] Therefore, if a doctor were to give a patient with terminal cancer an overdose of painkillers to end their life, this would be euthanasia. If a relative of someone with a terminal illness obtains powerful painkillers whilst being aware that the patient intended to take an overdose, then that would be assisted suicide. Cases of euthanasia are assessed individually and based on the merits of the particular case, it may be considered either as manslaughter or murder, punishable with a maximum punishment of life imprisonment or assisted suicide, punishable with a maximum of 14 years imprisonment.[28]

Euthanasia goes beyond the act of ending someone's life to end suffering. As already mentioned, there are different types of euthanasia; active euthanasia and passive euthanasia. The difference between the two is that whilst the former entails killing someone for example giving them a large dose of medicine, the latter entails letting them die such as withholding treatment which is needed to maintain life.[29] Furthermore, euthanasia can be split into voluntary euthanasia, (when it is the patient who is making the request and decision to end his life), and involuntary (when the patient is killed against his wishes and non-voluntary which occurs in cases where due to a coma state amongst others, the patient is unable to request euthanasia and a decision is taken for him by his family for instance.)[30]

Although euthanasia is illegal in England, however, any patient who is terminally ill and is on the verge of dying, has a right to palliative care meaning has a right to control pain and other symptoms. You are entitled to decide what treatment you are given at such stage. Under English law, all adults have a right to refuse medical treatment as long as the patient refusing such treatment is in his right mind and competent to make such a decision. Since one has to be in his right mind in order to refuse care, if a person knows that he may become mentally unstable, he may draw up a legally binding advance decision and this would be accepted.[31]

27 http://www.legislation.gov.uk/ukpga/Eliz2/9-10/60

28 http://www.nhs.uk/conditions/Euthanasiaandassistedsuicide/Pages/Introduction.aspx

29 http://www.bbc.co.uk/ethics/euthanasia/overview/forms.shtml

30 http://www.bbc.co.uk/ethics/euthanasia/overview/volinvol.shtml

31 http://www.nhs.uk/conditions/Euthanasiaandassistedsuicide/Pages/Introduction.aspx

In 2015 a bill on assisted suicide was put forward and if passed would state that a terminally ill patient may request euthanasia if he has a clear intention to end his life, has made a declaration that he wants to end his life and he is aged 18 and over and has been and ordinary resident in England or Wales for at least a year.[32] To further specify terminally ill patient, it was stated that patients with less than six months to live could request euthanasia. Therefore, even if the bill passed, euthanasia would be illegal for children and non-residents as well as people with more than six months of life expectancy. Therefore, the bill was very thought out and well planned, not too liberal but beneficial enough to help the patients who truly needed it. The bill was however rejected with 118 MPs voting in favour and 330 voting against.[33]

FRANCE

In France, active euthanasia and assisted suicide are both illegal. In 2003 there was the case of Vincent Humbert who was left blind and paralysed following an accident in three years before. This case was one which sparked a debated on euthanasia in France. This is because his mother was arrested after she put an overdose in his drip following her son's wishes, wishes he himself expressed by writing to the President at the time, Jacques Chirac to allow him to end his life. After a short period in prison, she was then put into psychiatric care. Many French citizens expressed their sympathy and believed that the mother was right to carry out her son's request.[34]

As of 2006 however, under French law, it is illegal to give patients medicine that kills them but legal to give them certain pain killers which will shorten their life. Furthermore, France also adopts the palliative care option, that is the stopping of treatment for terminally ill patients upon request – the right to refuse treatment. This is often referred to as **Leonetti Law.**[35] Therefore, passive euthanasia is legal in France. Thus, when talking about euthanasia being illegal in France, 'euthanasia' this is always referring to 'active euthanasia'. An interesting case on palliative care came about in 2014 in which a 38-year-old man, **Lambert**, was left in a coma after a motorcycle accident in 2008. In 2014, his doctors in agreement with his wife and siblings made a decision to stop the intravenous food and water keeping him alive. This was in line with the 2005 passive euthanasia law which was passed allowing doctors to stop care.[36] However,

32 http://www.publications.parliament.uk/pa/bills/lbill/2014-2015/0006/lbill_2014-20150006_en_2.htm#l1g1

33 http://www.bbc.com/news/health-34208624

34 http://news.bbc.co.uk/2/hi/europe/3142246.stm

35 http://en.rfi.fr/europe/20121218-no-euthanasia-france-says-new-report

36 http://en.rfi.fr/france/20150605-european-rights-court-ruling-angers-french-anti-euthanasia-cam-

his parents who were devoted Catholics took the matter to court and won an injunction against the decision by arguing that it was a case of active euthanasia and not passive since their son was not brain dead but just handicapped. The case ended up in front of the European Court. An important point which was stressed is that a person should write down what he would like to happen if he were to end up in such a scenario because if Lambert had written down his wishes, then all this would not have arisen. Thus, since Lambert did not write this down, it fell on his wife, a person who is not eligible to make such a decision because its not her life. The European Court held that since the doctor who made the original decision is no longer working with him, it is less likely that Lambert is taken off life support immediately. Therefore, it is up to the new team of doctors to reach a decision and in the case that Lambert's parents do not agree with the new decision, then they can take it to court again.[37]

A recent compromise on euthanasia was reached in France earlier this year which is called Sedated Dying Law. The French parliament approved a bill that states that doctors are allowed to keep terminally ill patients sedated until death. Therefore, euthanasia and assisted suicide are still illegal and hence, doctors cannot help terminally ill patients die, but in such a case, in order to ease their suffering, they are allowed to keep them sedated until their time of death arrives. This 'sedation' entails that patients are able to request that they are put into a 'deep, continuous sedation altering consciousness until death' unless their condition is lengthened more than is expected.[38] However, there is a condition which is similar to euthanasia conditions in countries where it is legal, that is that the patient must have a short estimated life span meaning that the condition is likely to lead to a quick death. Furthermore, the doctors are allowed to stop life-sustaining treatments, including artificial hydration and nutrition. It is also permissible to use strong painkillers to help with the patient's suffering, even if this will lead to a shorter life span.[39] The co-author of the bill, Jean Leonetti said that 'at end of your life, if the suffering is unbearable, you'll be allowed to get to sleep, soothed and serene.' Finally, the bill states that patients can choose to be sedated even at home and is not something which is only provided in hospital.[40]

Although the Sedated Dying Bill seems to be the first step towards legalising active euthanasia, it was stressed that this new law is not

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37 Ibid

38 http://www.epictimes.com/01/28/2016/france-parliament-blocks-euthanasia-allows-sedated-dying/

39 https://www.theguardian.com/society/2016/jan/28/france-adopts-sedated-dying-law-as-compromise-on-euthanasia

40 Ibid

a pathway to euthanasia or assisted suicide but is simply an amendment of the Leonetti law which has been in force since 2006.[41]

France seems to be a middle country meaning that although it does not allow euthanasia in its widest form, that is doctors killing patients who are suffering, it finds very useful and reasonable compromises through passive euthanasia and now even through this sedated dying law. Despite the Sedation law not being a 'pathway' to active euthanasia, it seems that active euthanasia is something which can be very much envisioned in France's future, especially when considering Francois Hollande's presidential program which held that any adult which is in an advanced terminal illness and is suffering unbearably, can request under strict conditions to benefit from medical assistance to end his life with dignity.[42] It is now a matter of whether Hollande intends to honour his presidential proposal.

ITALY

In Italy, there is no specific law on euthanasia. However, it is still not considered legal and in fact, active euthanasia is covered by the field of Criminal Law under premeditated killing, *omicidio volontario* which holds a minimum penalty of 21 years in prison. In euthanasia cases, the accused may then benefit from certain mitigating circumstances such as acting out of moral or social motives defined by values. If the patient requested death, *omicidio del consenziente* the punishment may be from 6 to 15 years' imprisonment. In the case of passive euthanasia with the consent of the patient, this would fall the right of self-determination meaning that no one can receive medical treatment by force.[43]

When there is no consent on the part of the patient, then passive euthanasia would be punishable under the law of active killing because it is in principle considered to be the same as killing by omission. The only exception that is made is in the case of a patient being brain dead. In this case, the termination or omission of life-sustaining is allowed as long as the physicians, pathologist and relatives agree.[44]

The debate on the Right to Die has been going on for quite a long time when it was raised by the story of **Piergiogio Welby** who was diagnosed with muscular dystrophy who battled for his right to die the way he chooses. The issue then started to be properly debated

41 http://www.west-info.eu/france-still-undecided-on-euthanasia/

42 http://www.huffingtonpost.fr/2015/03/17/fin-de-vie-francois-hollande-tenir-promesse-campagne_n_6878102.html#

43 http://www.drze.de/in-focus/euthanasia/legal-regulations

44 Ibid

after the Eluana Englaro case which sparked a constitutional crisis in Italy. Although 7 years have passed from the Englaro case, Italy is nowhere near the Netherlands or Belgium on the euthanasia aspect. In fact, ever since the Englaro case, hundreds of people who were terminally ill, had to travel to other countries to be euthanized and set free from their pain and given a dignifying death.[45] A clear case in point was the case of **Oriella Cazzanello**, an 85-year-old Italian woman who in 2014 paid €10,000 for an assisted suicide in a Swiss Clinic.[46]

The Eluana Englaro Case was a very popular one in Italy. Eluana was a 21-year-old girl who lost control of her car going back home after a party. As a result of this, she suffered serious brain damage and broke his spine. By the time she was in the ambulance, she was already in a coma.[47] The injuries she suffered would lead to total paralysis and the first few hours, her life was hanging in the balance. Eluana did not come out of the coma. Proceedings were initiated to obtain permission to stop feeding Eluana arguing article 32 of the Italian constitution which states:

"No one can be forced to a specific medical treatment unless required by law. The law can not under any circumstances violate the limits imposed by respect for the human person."[48]

After 17 years of being in a vegetative state, 11 years of trials, 15 years of judgments of the Italian courts and the European Court, Eluana's feeding tubes were removed and she could finally rest in peace. Her father said that it is the worst possible thing to see your child die, but still fought Italy's most senior politicians and the Catholic Church for a number of years to allow his child to at least pass away in dignity.[49]

Therefore, it is clear that Italy is very rigid when it comes to active euthanasia and quite frankly is even very specific on passive euthanasia, particularly when there are such delicate situations as was in the **Englaro** case. Although they have in their constitution the right to refuse treatment, the Italian authorities are still very careful and make sure to examine every case on its own merits, sometimes leading to long, endless and extreme measures and disapprovals.

It is seen that almost all countries agree with passive euthanasia and agree that patients should at least have the right to refuse treatment

45 http://www.liberties.eu/en/news/free-until-the-end-legal-euthanasia-in-italy

46 http://www.dailymail.co.uk/news/article-2564023/Italian-woman-85-ends-life-Swiss-Dignitas-clinic-upset-losing-looks.html

47 http://www.ilpost.it/2014/02/09/eluana-englaro/

48 Ibid

49 https://www.theguardian.com/world/2009/feb/08/eluana-englaro-assisted-suicide

especially when they are terminally ill. Although there are still a number of countries who oppose euthanasia, it is clear that it active euthanasia is slowly embedding itself into the laws of countries.

Therefore, it is most likely that all countries will legalise euthanasia in the future. The important thing is that a balance is always stuck between fair and unfair cases and that there is no abuse, that is that euthanasia is not granted as an alternative to suicide when someone is fed up of his life, but that it is monitored and only granted when absolutely necessary and according to the guidelines stated by the law of the country.

The Medical Approach

Euthanasia is the practice of intentionally ending a person's life in order to relieve the person from pain and suffering. The word 'Euthanasia', is a Greek word meaning, 'the good death'.[1]

There are several aspects of euthanasia. Along with the important implications of the legal and ethical elements of Euthanasia, it is also important to look into the medical aspect of the Euthanasia.

When discussing Euthanasia it is essential to distinguish it from assisted suicide. Euthanasia and assisted suicide are defined by the State Commission on Euthanasia. Euthanasia is the intentional termination of life by somebody other than the person concerned at his or her request. Assisted suicide means intentionally helping a patient to terminate his or her life at his or her request. Assisted suicide is a form of euthanasia. It involves an individual who desires to commit suicide, but does not feel capable to perform the act. This might be due to a physical disability or lack of knowledge about what are the most effective ways to do so. The participation of doctors and health professionals in assisted suicide is controversial. An individual who assists in a person's suicide may or may not be held responsible for that person's death, depending local legislation.[2]

The difference between euthanasia and assisted suicide is based on the degree of involvement and behaviour of the individuals concerned. Assisted suicide includes, both physician-assisted suicide as well as voluntary active euthanasia. Physician- assisted suicide consists of making available lethal means to the patient to be used at the time of the patient's own choosing. On the other hand, voluntary active euthanasia refers to when the physician takes an active role in carrying out the patent's request to end his own life. This usually involves the delivery of a lethal substance to the patient. Physician-assisted suicide is seen to be considerably easier emotionally for the physician than euthanasia, as the physician does not have to directly be the cause of a death. He or she merely just has to supply the means for the patient's own use. Those who support physician-assisted suicide claim that it carries the added benefit of permitting the patient

1 http://www.medicinenet.com/script/main/art.asp?articlekey=7365

2 http://medical-dictionary.thefreedictionary.com/assisted+suicide

to decide the time of his death and also provides the chance for the patient to change his or her mind up until the last moment. It could be argued that this possibility similarly exists in cases of voluntary active euthanasia, and may even allow a physician to discuss topics of motive and options with the patient one last time. Using self-administered oral lethal drugs may provide a certain liberty of timing, but it also does carry the risk of error. It needs to be consumed while the patient is still well enough to swallow, hold down substances and metabolically absorb the medication. Patients tend to fear this risk and therefore some may choose to act earlier than necessary to avoid it. By contrast, euthanasia contains a much smaller chance for mistakes and may be essential in situations where a patient is too sick to take the self-administrative drugs, or no longer able to swallow, keep down food, or absorbing oral medication. If a patient is aware of the possibility that a physician can always intervene, the act of assisted suicide may be postponed permanently.[3]

For centuries, doctors and health professionals have mastered the art of medicine, but the art of dying, ars moriendi, has proven to be more difficult for them to master and put into practice. There are at least four classifications of euthanasia. The first is active euthanasia, the second is passive euthanasia, the third is statutory euthanasia and the fourth is legitimate medical euthanasia. One type of euthanasia is uniformly illegal, and the other three have varying acceptability.
Active euthanasia, or mercy killing, is illegal in most countries. Anyone who ends the life of another intentionally, commits a murder. This type of euthanasia is an accepted practice with respect to dying animals, but is completely forbidden in humans. No person is allowed to end the life of another even if the person is suffering excruciating pain and is terminally ill.

Passive euthanasia, which is legal in countries such as United States, refers to the permitting of a patient to die a natural death, as a result of the terminal illness, with or without limited and modicum support by the medical physician. This type of euthanasia is based on the concept of 'self determination', where every capable adult is free to exercise control over his or her body without the right to refuse the treatment of the medical physician. The death may not necessarily be a good or easy death. Advanced medical or health care directives, or so-called living wills, are used to expressly communicate the patients' informed and witnessed requests and desires to the medical professionals.

3 http://www.worldrtd.net/qanda/what-difference-between-assisted-dying-and-euthanasia

Statutory euthanasia is legal in very few parts of the world. Here, the terminally ill patients take intentional active measures to end their lives prematurely, assisted by physicians, hence the term physician-assisted suicide. The aim of statutory euthanasia is preventative in nature, in that the intent of the dying patient is to avoid the pain and suffering of the terminal illness. The assistive role of the physician is to provide the dying patient with the medical knowledge, expertise, and compassion in accomplishing the drastic and deadly task.

Legitimate medical euthanasia is legal in a lot of countries, such as the U.S. It is based on the doctrine of 'dual-effect', and concerns the use of lethal dosing, or terminal sedation, by some medical professionals when practicing the art of dying, *ars moriendi*. Arguably, the terminal sedation or lethal dosing in some cases may represent active euthanasia or physician-assisted suicide. Nevertheless, lethal dosing is ethical and legal as long as a physician truthfully claims that the intent of the medical treatment is to relieve the pain and suffering and not to hasten death or kill. It is incumbent upon physicians to master the *ars meriendi*, the art of dying, and to provide the terminally ill patient with the choice of a good and easy death, so long as the potent medications prescribed are for a currently accepted medical use and for a legitimate medical purpose. Physicians on countries such as the U.S are increasingly, although gradually, becoming familiar and comfortable in prescribing lethal dosing to the suffering and dying patients. Lethal dosing involves the administration to the terminally ill patient of increasing doses of painkiller, intended to relieve pain but knowing that it will probably hasten death. The position of the physician in practicing *ars moriendi* is essential in achieving the desired dignified, good and easy death of the terminally ill patient.[4]

There are several methods for initiating Euthanasia and each method can have different outcomes, some of which are very painful. Some of the methods include withdrawn or withheld treatment, injections, drugs, dehydration and the Nitschke's 'Peaceful' Suicide Pill. According to Dr Tricia Briscoe, former Chairman of the New Zealand Medical Association

'The right to refuse treatment flows from a right to inviolability - a right not to be touched, including by continuing treatment, without one's consent - not from a right to die. Withdrawal of treatment will mean death, but it will result from the patient's underlying illness.'

Competent adult patients have the right to refuse medical treatment. Such refusals of treatments are morally and ethically different from euthanasia, and should remain legally different.

4 http://www.ablminc.org/editorial_classification_of_euthanasia_sss_06.pdf

When, however, an action or medication is withheld from a patient for the main purpose of causing or hastening death, this is passive euthanasia. These measures may include the with-holding or withdrawal of ordinary measures such as food, water and oxygen. Examples of passive euthanasia are, when food and water is withheld from sick or disabled new-born babies who might otherwise have lived, with-holding or withdrawing food and water from someone who is diagnosed as being in a 'persistent vegetative state,' has dementia, or who is not improving fast enough (e.g. from a stroke) and 'do not resuscitate' orders written on patients' charts.

In countries or states where euthanasia is legal, a doctor can write a prescription for drugs that are intended to terminate the life of the patient. When the prescription is filled, directions centre on making sure that the patient understands that taking the pills would result in his death.

There have been occasions were people have awoken from comas after vomiting up the supposedly fatal drug doses that they took. To reduce the chances of the euthanasia drugs being vomited up, an anti-emetic must be given to the patient. Sometimes when patients have tried to kill themselves using drugs prescribed by a doctor, the medication did not work as expected due to technical problems or unexpected side effects.

Problems surface so often that doctors tend to feel compelled to intervene in some of the cases, even when the doctor directly performed euthanasia, complications have been known to develop. Patients either took longer to die than expected or have woken up from a drug-induced coma that was supposed to be fatal.

In the Netherlands, the most common method for inducing euthanasia is an injection to render the patient comatose, followed by a second injection to stop the heart. First a coma is induced by intravenous administration of barbiturates, followed by a muscle relaxant. The patient usually dies as the result of anoxemia caused by the muscle relaxant. When death is delayed, intravenous potassium chloride is also given to hasten cardiac arrest.

Right-to-die activists often advocate the withdrawal of food and water in order to hasten death. Proponents of euthanasia recommend the use of what is known as "Terminal Sedation" in combination with the withdrawal of food and water. Terminal sedation allows for the measured use of sedatives and analgesics for the necessary control of symptoms such as agitation, intolerable pain, and anxiety, in order to relieve the distress of the patient and of family members. If all food and fluids are removed from a person, death is inevitable. That

death will occur because of dehydration. Dr. Helga Kuhse, a leading campaigner for euthanasia, said in 1984:

'If we can get people to accept the removal of all treatment and care - especially the removal of food and fluids - they will see what a painful way this is to die and then, in the patient's best interest, they will accept the lethal injection.'

The method, referred to as 'Self-deliverance,' is most commonly advocated by right-to-die activists such as Derek Humphry and Dr Philip Nitschke. In Humphry's book 'Final Exit', he describes the method of 'Self-deliverance' and has written in detail about people who have used the method to commit suicide. Dr Nitschke developed what he calls the 'CO Genie'. This is an apparatus that produces lethal carbon monoxide and that can be made at home. Nitschke has held workshops in Australia and New Zealand teaching people how to manufacture such devices for themselves. Dr Nitschke's latest initiative is a barbiturate-based 'peaceful pill.'[5]

Thirteen countries in which euthanasia is legal in are Belgium, Colombia, India, Ireland, Luxembourg, Mexico, Netherlands, Canada, Albania, Japan, the U.S, Germany and Switzerland. However, they may differ in the medical procedures that they make us of in initiating euthanasia and how euthanasia is regulated in their respective countries.

In Belgium euthanasia has been legal since September 2002. The country's euthanasia laws are extremely comprehensive and to some seem very progressive; to others Belgium's euthanasia laws are seen as dangerous. The law in Belgium states that two doctors need to be involved in the process, together with a psychologist if the competency of the patient is in doubt. Both the patient and doctor decide on the best course of action to take in terminating the patient's life and this could be through a lethal injection or prescribed overdose. As of now, any patient with a "futile medical condition of constant and unbearable physical or mental suffering that cannot be alleviated" may request euthanasia. In 2013 the government opened a debate, and then voted in favour, to extend the administration of voluntary euthanasia to terminally ill children in unbearable pain who are able to fully comprehend the meaning of euthanasia. The parents of the ill child and the child's doctors must also support the decision of the young patient in order to uphold the voluntary euthanasia. The frequency of performance of euthanasia is rising very rapidly, having more than doubled in the last few years. Moreover, although the prevalence of euthanasia remains highest in patients with cancer, a clear shift is visible in the characteristics of patients who request eu-

5 http://www.life.org.nz/euthanasia/abouteuthanasia/methods-of-euthanasia/

thanasia and whose requests are granted by the capable authorities. The largest increases are among women, and those aged 80 or older, with lower education levels, and those dying in nursing homes.[6]

In Columbia, when a terminally ill patient, (defined in their law as a patient with cancer, AIDS, kidney or liver failure and other terminal diseases that come with extreme suffering) wants to die in Colombia and that patient can 'give clear authorisation to do so,' then they have the right to assisted suicide. The Constitutional Court of Colombia ruled in favour of assisted suicide 6-3 on May 20th 2010, ruling that no one can be found criminally responsible for aiding in the death of a terminally ill patient. Though the law is progressive in Colombia, some have protested what diseases constitute being terminally ill, as the assisted suicide laws in Colombia also expressly excluded degenerative diseases such as Alzheimer's, Lou Gehrig's disease and Parkinson's disease to be included in the definition of terminally ill.

India is yet another country where euthanasia is legal. However, the law only recognises passive euthanasia as legal. This law was passed by the Supreme Court of India in 2011 as a means to legally withdraw life support in patients who are in a permanent vegetative state. Active euthanasia is however still illegal and this includes using lethal compounds to end a person's life.

In Ireland, active euthanasia is illegal. However, it is not illegal to withdraw life support or other treatments if the patient or a next of kin requests for it. According to a poll published on the Irish Times, 57 percent of adults want to see doctor assisted suicide legalised if the patient were to request it.

Although much of the medical community in Luxembourg was in fact against the legal precedent, in 2009 Luxembourg still became the third nation in the world to fully legalise euthanasia. The law was passed in a parliamentary bill that allowed doctors to end the lives of a terminally ill patient. A patient in Luxembourg has the right to die if they are terminally ill and have asked to do so more than once. After seeking the right to die, the patient's request has to be approved by two different doctors and also a panel of experts who will judge the patient's understanding and rational ability to make such a decision.

6 http://hir.harvard.edu/blogalasdair-nicholsoneuthanasia/

Although active euthanasia is illegal in Mexico, the law allows for passive euthanasia to take place. Close relatives of a terminally ill, unconscious patient as well as the patient himself could refuse further treatment. This law has been applicable since 2008 and a similar law which sought to have some extended provisions that decriminalise active euthanasia is pending approval.

In the Netherlands, euthanasia and doctor assisted suicide are both legal. The Netherlands was the first country in the world to legalise euthanasia; although the law was passed in 2002, the courts have permitted the practice since the 1980s and doctors are generally not obligated to keep patients alive contrary to their wishes. For over 20 years, the Netherlands courts have not been prosecuting physicians who facilitated voluntary euthanasia, and although anyone 12 years of age or older can request euthanasia, the requirements for euthanasia are very strict in the Netherlands, and only apply to patients suffering from a terminal condition who are living in unbearable pain. Furthermore, the patient must be in full control of their mental faculties when they make a request for euthanasia, although this is only after a second doctor has also judged each case beforehand.After the death of the patient, a committee consisting of a doctor, a medical ethics expert and a legal expert review the particular case. Studies show that most of the patients receiving euthanasia are mostly women of differing ages, with various chronic psychiatric conditions, accompanied by personality disorders, social isolation and physical problems.[7]

Canada is an interesting case in regards to euthanasia. While active euthanasia is illegal in Canada, the act whereby one intentionally takes part in the killing of someone to relieve suffering, passive euthanasia is legal. Passive euthanasia is the process by which a family member or caretaker knowingly withholds the necessities of life, such as food and water, in order to aid in the termination of someone's life. Assisted suicide is illegal in Canada as well, though there has long been a strong movement to legalise both euthanasia as well as assisted suicide in the country, with various high profile court cases highlighting the argument in favour of legalising euthanasia. Several regions have also either struck down federal legislation outlawing doctor assisted suicide as in British Colombia in 2012, or recently passed measures to legalise assisted suicide as Quebec have done recently.

Assisted suicide and euthanasia remain controversial in Albania, in large part due to the involvement of the church, though assisted suicide has been technically legal in Albania since 1999. Passive euthanasia is also legal if a patient is incapacitated from making the

7 http://hir.harvard.edu/blogalasdair-nicholsoneuthanasia/

decision to die, like being in a coma, as long as three family members all agree on the decision together and give legal consent.

Japan has no official policy, or legislation for that matter, regarding euthanasia and doctor assisted suicide. There have been cases of passive as well as active euthanasia in the country that have been brought before the courts and had contradictory rulings. De facto assisted suicide generally doesn't end up in court, but euthanasia has remained a far murkier debate. As such, the Japanese government has finally created a legal outline dictating the appropriate criteria for both passive and active euthanasia to become legal:

'In the case of passive euthanasia, three conditions must be met:

1) The patient must be suffering from an incurable disease, and in the final stages of the disease from which he/she is unlikely to make a recovery.

2) The patient must give express consent to stopping treatment, and this consent must be obtained and pre served prior to death. If the patient is not able to give clear consent, their consent may be determined from a pre-written document such as a living will or the testimony of the family.

3) The patient may be passively euthanised by stopping medical treatment, chemotherapy, dialysis, artificial respiration, blood transfusion, IV drip, etc.'

For active euthanasia, four conditions must be met:

'1) The patient must be suffering from unbearable physical pain.

2) Death must be inevitable and drawing near.

3) The patient must give consent. (Unlike passive euthanasia, living wills and family consent will not suffice.)

4) The physician must have (ineffectively) exhausted all other measures of pain relief.'

In the U.S state laws, not the federal government, generally decide the legality of euthanasia and assisted suicide as the federal government has been hesitant to wade into the debate on end of life legislation. Passive euthanasia is legal throughout the United States as patients are legally entitled to refuse treatment if they want, but active euthanasia is illegal in all American states. Assisted suicide is legal in some states and these include, Oregon, Washington, Montana, Vermont, and California.

In Oregon, physician-assisted suicide was legalised under the Death With Dignity (DWD) Act, which was implemented in 1997. The law allows patients with terminally ill or hopelessly ill conditions to request for lethal medication, but the requirements are that the patient must have made two verbal requests and another in writing, with a witness for the doctors to end his or her life. Two doctors also need to agree on both the diagnosis, the prognosis of the disease and the capability of the patient, while the patient will have to self-administer the medication.

Washington became the second state to legalise physician-assisted suicide after Oregon in 2008, and this was done via the Washington Death with Dignity Act. The Washington law is very similar to its Oregonian conterpart, as it also requires that the patient puts forward two oral requests along with a written one. The requests need to be 15 days apart and the patient must be suffering from a terminally ill condition with a life expectancy of six months or less.

In December 2009, in Montana, the physician-assisted suicide law was passed in the Montana First Judicial District Court, in the **Baxter v. Montana** judgement. The ruling stated that a competent patient had the right to die with dignity, and it allows the physician to assist the patient by providing prescription lethal medication which the patient will then self-administer.

In May 20th 2013, Vermont also joined the list of states that have legalized physician-assisted suicide. The law was introduced through Act 39 of the End of Life Choices, and it requires the patient to provide two oral requests and one written request. On the 6th of October, the Governor of California, Jerry Brown, signed a bill making physician assisted suicide legal from 2016 under the End of Life Act.[8] The act requires that it can only be implemented when the patient is expected to die within 6 months or less, and it also requires patients to provide two oral requests that are at least 15 days apart and one written request.[9]

8 http://petrieflom.law.harvard.edu/resources/article/california-euthanasia

9 http://www.newhealthguide.org/Where-Is-Euthanasia-Legal.html

In Germany, a terminally ill patient has the legal right to refuse, by written order, any medical treatment that a doctor may believe will prolong or even save their life. Furthermore, assisted suicide is semi-legal in Germany, where a doctor, again upon written order from the patient, is legally capable to supply the ill patient with drugs that will shorten their life. Doctors are also allowed to take a patient off life support with the patient's consent, but it is important to note that doctors are not permitted in any way to actively end the patient's life. Therefore both passive assisted suicide and passive euthanasia are legal, but active assisted suicide and active euthanasia are not legal in Germany.

While assisted suicide has been legal in Switzerland since the 1930s, active euthanasia remains illegal. In Switzerland, it is legal for doctors to prescribe a lethal dose of drugs to a patient, as long as the patient is the one taking the active role in administering the dose. In the country, not only the Swiss can benefit from a doctor's prescription of lethal medication to end an ill patient's life, but terminally-ill foreigners also can travel to Switzerland in order to die on their own terms. Furthermore, when it comes to the administration of the lethal drugs to terminate one's life, a physician does not even need to be involved in the actual suicide, making Switzerland's assisted suicide laws the most unique on the planet.[10]

10 http://www.therichest.com/rich-list/most-influential/10-countries-where-euthanasia-and-assisted-suicide-are-legal/

The Psychological Aspect

Having examined some of the reasons to introduce Euthanasia, it is essential that the government, along with the rest of the legislators do take the psychological effects into consideration. This is especially so since one would be taking a decision which in itself is irreversible. Accordingly they should be well aware of what they are about to face and what is ahead for their next of kin.

THE PERCEIVED PSYCHOLOGICAL & EMOTIONAL EFFECTS OF EUTHANASIA

The effects of euthanasia are mostly felt by the family and the physician[1] assisting the patient who is opting for Assisted Suicide or Euthanasia, in order to prepare the patient for what is to come, even more so if said patient has a fast-deteriorating medical condition.

THE PSYCHOLOGICAL AND EMOTIONAL EFFECTS OF EUTHANASIA ON THE PATIENT

The psychology of the patient and its understanding is an essential because they are the individuals who must be prepared for the consequences that will ensure.

However what is interesting to note is that the patient most of the time is ready to take on the necessary steps, though at times there are some patients who look into the option of euthanasia as an idea

1 Also referred to as PAS - Physician Assisting Suicide

or process which provides comfort. It provides comfort duly because they are aware that this option is a means and a way which is available to them, should their suffering become too much to handle. It is in fact because of this that studies carried out over the years have shown that most patients tend to apply for the medicine which help in the comfort of the patient, but rather ask for mediine that actively leads to their death.

PSYCHOLOGICAL EFFECTS OF EUTHANASIA ON THE PHYSICIAN OR MEDICAL PROFESSIONAL ASSISTING THE PATIENT

To be able to understand such effects we shall be taking the example of two main states - The Netherlands and the United States[2].

THE NETHERLANDS

Over the years euthanasia has come to force even more often in the Netherlands, which however have led to several cases like the one underneath:

'I was giving consultations in several situations like this, when the GP was calling me about a patient with gastrointestinal obstruction. He said, The problem is that the patient is refusing euthanasia.' I said, 'What happened?' He said, 'In the past, all these kinds of situations, when people were intractably vomiting, I solved by offering euthanasia. Now this patient does not want it, and I do not know what to do.' That was really striking. Providing euthanasia as a solution to every difficult problem in palliative care would completely change our knowledge and practice, and also the possibilities that we have . . . . This is my biggest concern in providing euthanasia and setting a norm of euthanasia in medicine: that it will inhibit the development of our learning from patients, because we will solve everything with euthanasia."

THE UNITED STATES OF AMERICA

Another Country wherein the process of Euthanasia is carried out in few of the states[3] in the United States, the same country which has been at the forefront of medical innovation and vast research. Even in a country like the U.S,. the physician still goes on to present an argument similar to that presented by the Dutch. It therefore means

2 Reference: http://www.pccef.org/articles/issues_law_medicine_stevens_article.pdf

3 These states are; California, Colorado, Oregon, Vermont and Washington.

that just like the Dutch, the Americans physicians are concerned that the patient is in fact treated objectively rather than subjectively, that euthanasia will be the solution offered to each patient suffering from a terminal illness as a carte blanche option, rather than on a case-by-case basis. This may inhibit the development of medical innovation, medical research and the necessity of development in bio-medical science, without mentioning the averse effects caused to the human psyche.

Having said that, it is also interesting to note that even though the same physicians are concerned with a possible lack of development in the medical sphere, 53% of those physicians performing Euthanasia find comfort knowing that their patient did not suffer. This was an outcome of a survey carried out following the enforcement of the DWDA of Oregon in 1994[4] , thus making Oregon the first State in the U.S. to support Euthanasia in their law and medical practice.[5]

In a structured in-depth telephone interview survey of randomly selected United States oncologists who reported participating in euthanasia or PAS, Emanuel reported 53% of physicians received comfort from having helped a patient with euthanasia or PAS, 24% regretted performing euthanasia or PAS, and 16% of the physicians reported that the emotional burden of performing euthanasia or PAS adversely affected their medical practice.

In a mail survey of physicians who had acknowledged performing PAS or euthanasia, Meier reported the following responses pertaining to the most recent patient who had received a prescription for a lethal dose of medication or a lethal injection among the 81 physician respondents (47% were prescriptions, 53% were injections): 18% of the physicians reported being somewhat uncomfortable with their role in writing a prescription, and 6% were somewhat uncomfortable with the lethal injection; <1% were very uncomfortable with their role in writing the lethal prescription, and 6% were very uncomfortable with the lethal injection.

The emotional trauma experienced by some Oregon doctors is noted in the following responses obtained in Oregon in December 2004 by the British House of Lords committee:

4 In 1998 the first case of effective Euthanasia in Oregon and subsequently in America was performed

5 The **Oregon Death with Dignity Act**, which legalises physician-assisted dying with certain restrictions, making Oregon the first U.S. state and one of the first jurisdictions in the world to officially do so. The measure was approved in the 8 November 1994 general election in a tight race with the final tally showing 627,980 votes (51.3%) in favour, and 596,018 votes (48.7%) against.[11] The law survived an attempted repeal in 1997, which was defeated at the ballot by a 60% vote.[12] In 2005, after several attempts by lawmakers at both the state and federal level to overturn the Oregon law, the Supreme Court of the United States ruled 6-3 to uphold the law after hearing arguments in the case of *Gonzales v. Oregon.*

Question by Baroness Finlay: '*In a conversation after we had taken evidence this morning from David Hopkins, he said that, at the beginning, he had the feeling that doctors needed to tell the whole story because they were very traumatised by having been involved, but that, in the last year, that is not happening as they have become used to it. I wondered whether you felt that was echoed within your research.*'

Response by Dr. Goy: '*Again, anecdotally, yes. This was a monumentally difficult experience for a doctor early on, even considering changing the direction of care from preserving life and extending life to helping someone end it. For many, they have done it maybe for one patient and cannot reconcile that they have done it and they are very uncomfortable with it.*'

Another physician went on to explain that he finds it strange to comprehend the eventuality that the patient becomes a subject of death, from a family person, and one surrounded by people who love him. A person that he was once getting familiar with, to an individual whose death is written on paper following his specific with to die in peace.

Following an analysis of the psychological and emotional pain that physicians perform assisted-suicide, one may come to conclude that the physician is centrally involved in PAS and euthanasia, and the emotional and psychological effects on the participating physician can be substantial. The shift away from the fundamental values of medicine to heal and promote human wholeness can have significant effects on many participating physicians. Doctors describe being profoundly adversely affected, being shocked by the suddenness of the death, being caught up in the patient's drive for assisted suicide, having a sense of powerlessness, and feeling isolated. There is evidence of pressure and intimidation of doctors by some patients to assist in suicide. The effect of countertransference in the doctor-patient relationship may influence physician involvement in PAS and euthanasia. Furthermore, the many doctors who are participant in Euthanasia and/or are adversely affected emotionally and psychologically by their expenses.

ANGER AND INTIMIDATION OF THE PHYSICIAN FOLLOWING REFUSAL OF PAS

It is found that the doctors describe their patients as very forceful and adamant on their request for assisted suicide, even in those cases where in the physician is unwilling to participate, to the extent that in itself the majority of patients want the medicine rather than its administration. This is even more so because many patients have a common belief that the simple possession of such a medical cocktail is an option to end their suffering. Even though this is the case, doctors report that in countries wherein the medicine is handed out to the patient, the same individual may not necessarily decide to use this option.

In those cases wherein the doctor chooses to refuse to be part of this procedure, patients may tend to perceive the medical practitioner as an obstructionist and become quite resentful towards him/her.

Emotional experiences for psychiatrists who are called upon to evaluate potential assisted suicide patients' mental competency, appear to be more genuine, concerning and profound when they disqualify patients. Where the physician decides to disqualify patients, there is an extraordinary pain for the patient and the family alike because they have an understanding that euthanasia will help resolve emotional issues, rather than complicate them. An example of such anger was energetically expressed by Kate Cheney,[6] an Oregon PAS Patient whose evaluating psychiatrist had told her; 'You cannot make the decision for yourself and your life, because you are not in your right mind.' To which the patient responded 'Get out of my house you have no right to tell me this!' The same anger expressed by the patient was also expressed by her daughter who in turn made it clear that this should be her mother's choice as she was the individual who knows what she is feeling.

Physician participation in assisted suicide or euthanasia may have a profound harmful emotional toll on the involved physicians. Doctors must take responsibility for causing the patient's death, thus creating a huge burden on the physician's own conscience, tangled emotions and a large psychological toll on the participating physicians. Many physicians describe feelings of isolation, or ingraining the likelihood of patients and others to pressure and intimidate doctors to assist them in suicides. Some doctors feel they have no choice but to be involved in assisted suicides. Oregon physicians are decreasingly pres-

6 B. C. Lee, compassion in dying 77 (2003) (As related by Kate Cheney's daughter, Erika, in chapter entitled "Kate Cheney")

ent at the time of the assisted suicide. There is also great potential for physicians to be affected by countertransference issues in dealing with end-of-life care, and assisted suicide and euthanasia.

These significant adverse 'side effects' on the doctors participating in assisted suicide and euthanasia need to be considered when discussing the advantaged and disadvantages of legalisation.

THE EMOTIONAL & PSYCHOLOGICAL ASPECTS OF THE FAMILY

A patient seldom comes to a physician to request assistance with suicide unless the decision has first been discussed within the family, or unless the family setting has in some way influenced the decision. Advocates of legalising physician-assisted suicide tend to view the family relationship among the potential safeguards which assure that a right to suicide assistance will not be abused. Presumably the family will help to assure that the patient's choice is truly voluntary and that the patient has appropriately sought out other care options before concluding that death through suicide is the only effective way to avoid further suffering. While admittedly some families are abusive or neglectful, proponents assume that other safeguards, such as mandatory mental health evaluations, will successfully identify these exceptional cases.

By contrast, opponents of physician-assisted suicide tend to assume that the family's influence will make it highly likely that the patient's choice of death cannot truly be said to be 'rational.' Since caring for a person with a terminal or incurable disease is extremely economically straining, the family will almost inevitably come to harbour wishes that the patient's death will occur sooner rather than later so that their ordeal may end. Even if these wishes are consciously suppressed or denied, they may subtly influence the communication between the family members and the patient. The end result may well be that the patient will come to feel that his life is no longer worthwhile, and that he would be performing an act of generosity toward his family were he to speed up the process of his dying.

Euthanasia is unlike normal suicide, and this is mainly because in a typical case of suicide, the surviving family members experience anger and prolonged, abnormal grieving, leaving a lot of unanswered questions and a feeling of loss through the notion that one might have failed to notice those signs which were evident. Euthanasia on the other hand is such a case wherein the family is well aware of the patient's wishes along with the fact that this wish is to be expressed solely at his discretion, even though as has previously been outlined

the family may indeed have an effect on the final decision taken by the patient. This is even more so when the patient wants to relieve the family of added burden, though this might not always be case or thoughts of the family members.

Physician assisted suicide is unlikely to yield feelings of anger or rejecting action directed at themselves. Perhaps this is because in this particular scenario, at this point the patient is suffering of a terminal illness thus making his or her death far more understandable than suicide which is triggered by depression or any other mental illness, or in part because the individuals being feel a sense of comfort in knowing that the physician will be participating, making it more acceptable. Acceptable to both family and society as a whole.

Therefore, though euthanasia in itself is a difficult process the family tends to take an empathic and sympathetic approach to what the patient might be passing from, whilst trying to fulfil their wishes in the best way possible. Furthermore, the same members will try to ease the suffering of the patient, a view point taken in the best interest of all parties involved.

EMOTIONAL AND PSYCHOLOGICAL ASPECT - THE OVERVIEW

The Psychological aspect of Euthanasia, is a vital aspect to consider as the analysis presented rigorously shows. It is necessary to draft such a law or policy which may express the opinion of the general public.

Furthermore, such an assessment is mandatory when drafting a policy in this regard duly because the psychology of it is an essential part since all parties involved can be effected directly by it, from physicians to people close to the patient along with the patient himself or herself. It is because of this that in the proposals to follow in this policy paper we have proposed matters directly linked to the psyche of the patient, a mental state which needs to be evaluated as it helps determine whether or not the express will of the patient is to be take into consideration and thereby executed.

Euthanasia is and always will be a topic which yields moral debate, though it is a subject which legislators must debate due to the progress of time, of medicine, and of law. A debate that can help prove vital for the formation of a law, above all it help set a clear line as to whether the introduction of such a law is necessary - especially since people, as is the case in Malta, directly plea to the government and law makers to implement it.

The Ethical Approach

ATTITUDES TOWARDS EUTHANASIA

The pivotal issue surrounding both Voluntary Euthanasia and Assisted Death is whether or not these actions are ethically permissible, and if they are, what should be the criteria for a patient to undergo such procedures. Both Voluntary Euthanasia and Assisted death are driven by the same intentions and lead to the same consequence, the only difference between them is that Voluntary Euthanasia is performed by a qualified physician, whilst in assisted death the means are provided by a physician but are self-administered.

In the following passage various ethical issues are going to be discussed, such as:

- What are the required criteria for a patient to start undergoing a particular treatment and what are the \ criteria for a person to refuse said treatment.
- The Doctrine of Double and the repercussions that follow when a physician follows this doctrine.
- The Doctrine of Doing and Allowing
- The Ethics behind Voluntary Euthanasia and Assisted Death

The aforementioned matters attempt to shed light on the ethics of the controversial topics of Voluntary Euthanasia and Assisted Death. Every argument that will be put forward during this passage will most likely have a counter-argument and therefore a lot of discretion and interpretation are left to the reader to formulate a view and opinion.

CONSENT

The concept that patients must consent to a treatment is one of the fundamental principles of bioethics. The Nuremberg Code[1] , dating to the 1940s, gave rise to the basic principles of consent which where later applied to the clinical setting. The Court after recognising the importance of such principles adjusted these principles accordingly and used them to rule Court Cases brought forward by the various plaintiffs against the Health Care system. This dogma stated that the voluntary consent of the patient is of an essence. What this means was that the person involved should have legal capacity to give consent, and should be given the opportunity to exercise his free power of choice, without undergoing any hindrance such as deceit, fraud, duress or any other sort of constraint and coercion. Apart from the previously aforementioned points, the person should be sufficiently informed and knowledgable on the matter at hand in order to be able to make an informed decision.

A valid consent given by a patient must follow these essential criteria:

ASSENT

When a person gives their assent, this means that the person has officially agreed to what is being proposed to the patient. Assent might be given via an oral, written or any other sort of gesture showing acceptance. The patient might personally ask for the to undergo the treatment or else he might agree to undergo the treatment when this is proposed to him. There are some contexts where the assent might be assumed by the mere fact that the patient has turned up and does not object once the procedures have stated. Regardless of whether the assent is a tacit one or not, what matters is that the assent is given from the patient and not from a third party on behalf of the patient.

CAPACITY

The patient must be able to make an informed decision on whether to accept or decline a treatment, and must understand both the consequences of declining and accepting the aforementioned treatment. When the patient is an adult it is assumed that one has the required capacity to understand what one is undergoing, however this assumption can be rebutted by giving evidence of a mental illness or disability which impairs the cognitive behaviour of the individu-

1 The Nuremberg Code is a set of research ethics principles for human experimentation set as a result of the subsequent Nuremberg trials at the end of the Second World War.

al. The disorder does not need to be permanent but it can also be a temporary disorder, such as alcohol or drug intoxication. Commonly young children are viewed as being incapable of giving informed consent. The criteria needed is the ability to make a reasoned decision at the time that the decision has to be taken, and at a prior stage, also the capability to make other decisions, such as those relating to finance or other relationships does not presume that you are capable of deciding upon your treatment.

VOLUNTARINESS

Apart from giving his consent, the patient must undergo a specific treatment voluntarily. This means that his consent should not derive from influence, deceit or undue persuasion from third parties. Since a person can be easily influenced from the opinions of third parties, it would therefore be a very difficult task to exclude any influence from the patient's decision making, so the issue of voluntariness should be regarded only when there is an undue influence.

DISCLOSURE

This element carries with it the presumption that the patient is given all the necessary information required on the treatment he is to undergo, and what would be the consequences should the patient decide to either go forward with the treatment or decline. Apart from that the patient should be given an overview of other possible cures and what they would entail. The general rule for disclosure is that it should include all the information that a reasonable person[2] in these particular circumstances would need to make a reasoned and informed decision, also the information must be communicated in a manner that the patient can understand.

REFUSAL OF LIFE SUSTAINING TREATMENT

The refusal of life sustaining treatment, is the right of a patient to decide not to undergo treatment, and ask for such treatment to cease immediately. Also it is important to note that the notions which surround the issue of consent are the same notions which surround the refusal of Life Sustaining Treatment. Whilst the vast majority of medical treatment would be ordinary treatment, there would be cases where the refusal to undergo treatment might be the equivalent to

2 A reasonable person is considered to person who acts in a prudent manner and normally exercises due diligence and while does not perform action with extreme recklessness does not at the same time apply extreme caution. The concept of a reasonable man is used as a teat to measure the liability of an individual in cases of negligence.

a life-threatening scenario. Even though this procedure might mean that the patient will cease to live, this concept is nowadays engraved both in Law and Bioethics.

Allen Buchanan[3] and Dan Brock[4], have devised a sliding scale as to determine the decisional competence of the patient. The aim of this sliding scale was that to formulate a standard of competence, which according to these researchers should vary according to the effects that the withdrawal of the treatment would leave on the patient. This means that if there is a low risk scenario, then the level of competence should be relatively low, whilst on the other hand if the withdrawal of treatment would result in the endangering the patient's life, leading to his death then the level of competence must also be high. The aim behind raising the threshold is to introduce more certainty in the decision making process, however one must keep in mind that the decision of the patient must ultimately be respected. This sliding scale approach will sometimes result in imposing a higher standard of capacity for refusing a specific treatment, and a lower standard capacity when it comes to accepting the aforementioned treatment. This is done with the final aim of ensuring that the patient is certain about his decision especially when this decision will result in irreversible consequences. When life-sustaining treatment is being refused it might be favourable to advise the patient to undergo therapy sessions as to see if there are any ulterior factors effecting the patient's decision making.

3 Professor of Philosophy and Professor of International Law

4 Philosopher and Bioethicist

INDIRECT DEATH

A death can be a peaceful one, however there are case scenarios where the dying process is accompanied by pain and anxiety, with a high vulnerability for the patient to suffer from depression. To help make this process more bearable both for the patient and for their family members, there has been the introduction of palliative care . As to make sure that palliative care is as effective as possible, it is made sure that this area of medicine has at hand a vast array of analgesics and sedatives. The World Health Organisation came up with an 'analgesic ladder', this ladder was drafted as to gradually progress from weaker to stronger opioids. When the patient requests pain relief, the Doctor must ascend the analgesic ladder, to the point where the patient is no longer in pain, or the pain suffered is tolerable. High doses of opioids and sedation are standard procedures in palliative medicine, however both tend to hasten death in the process of alleviating pain due to their side-effects. Even though the above mentioned techniques tend to hasten the life of the patient they are still considered as ethically permissible.

One might argue, why is this procedure considered as perfectly ethical, whilst Euthanasia is not considered as justifiable. Justice Sopinka[5], stated in one of his Judgements, that the administration of drugs to relieve pain does in fact hasten the death of the patient undergoing the treatment, however what differentiates this from Euthanasia is the fact that in the former the intention is to relieve the patient from pain, whilst in the latter scenario the intended result is the death of the patient. This means, that the Judge here is putting forward the idea of different intentions, which both lead to the death of the patient. These main difference between the two effects, is that when commissioning Euthanasia the death of the patient is intended by the agent, whilst the prescription of analgesics and sedatives does not intend to result in the death of the patient, however this result is foreseen as probable.

Others argue that the correct use of morphine can prolong the life of a patient due to the fact that he will be more rested and pain-free.

Timothy Quill[6], stated that some dying patients, tend to have an increase in pain prior to dying and consequently they would need an increasing does of analgesics. Physicians who have administered possibly lethal doses of opioids to their patients, stated that their life was not shortened due to the effect of the drugs, whilst others stated that the life of their patients was only shortened by a couple of days and at the same time a third group of physicians stated that they

5 Justice Sopinka, was a Canadian lawyer and a Judge of the Supreme Court of Canada.

6 Timothy Quill is an American physician who's main focus is palliative care.

cannot identify by how much the life of their patients was shortened due to the administration of the aforementioned drugs.

Like the administration of opioids, terminal sedation is believed to be a cause of death. A large number of physicians that administered this palliative treatment stated that the life of their patient was shortened from a period raging between a day and a month. However one must note that terminal sedation is usually accompanied by the withholding of nutrition and hydration, therefore this factor must be also taken into consideration.

Therefore from the above considerations, one may come to the conclusion that it is not safe to assume that a large level of opioids and sedative hasten death, however this presumption can be rebutted, since on the other hand it is not safe to assume the contrary. Finally, whether these drugs actually hasten death or not, there is a widespread belief that they do and this belief is somewhat justified. Those who believe that pain-killers do in fact hasten the death of their patient's rely on the Doctrine of Double Effect to justify this action.

THE DOCTRINE OF DOUBLE EFFECT

When a physician has to treat a patient via Terminal Sedation this treatment will have two effects; It will relieve the patient from suffering and it will hasten the patient's death. For the Doctrine of Double Effect to be applied in the above situation, we must assume that one of the effects is good - the relief from pain, whilst the other effect is bad - the hastening of the patients life.

The Doctrine of Double Effect states that the treatment is only permissible, if it follows three criteria:

- Proportionality - A proportionately good reason for bringing about the bad effect, must be provided.
- Intention - When the physician is administering the treatment he must be doing so with the aim of achieving the good effect and not the bad effect.
- Causation - The bad effect is nothing but the cause of the good effect.

The three Criteria are necessary for there to be terminal sedation, however they are not sufficient since they omit other necessary conditions. The Doctrine presupposes a strong respect for the sanctity of life principle. The Doctrine is applied to find a justifiable exception to this general prohibition.

The Sanctity of Life principle stated in the Doctrine of Double Effect,

may but need not be absolute. It may have been formulated as to prevent the human life from being taken away in situations such as the death penalty, under this case scenario the Doctrine of Double Effect cannot be used to justify the act.

In order to apply the Doctrine of Double Effect one must take into consideration two aspects of the situation. The primary reason for a Doctor to administer sedatives to his patient is to relieve such patient from pain. This may then result in the shortening of the patient's life, however one can argue that the death of the patient does not necessarily account to a bad thing. One has to see the circumstances surrounding the death of such a patient. Whether the death of the patient is harmful or beneficial wholly depends on the circumstances surrounding the persons life, particularly the quality and duration of the patient's life. In situations where the life prospects of the patient are considered to be very bleak, death can be considered as a beneficial outcome.

Generally speaking, one might state that there are two aspects to look at when subjecting the person to this treatment; the harm you are doing to the person by ceasing their life earlier and the violation of the person's autonomy. These two criteria would be fitting for circumstances such as murder, however when a patient states that they are willing to end their life at an earlier stage and there are clear signs that the patient will not be harmed by their death, then the above mentioned criteria can be over-looked. Therefore when both criteria of harm and the violation of the person's autonomy can be disregarded, because they are no longer applicable since the patient would have given her consent, one can state that death no longer has to be viewed as a negative outcome.

THE APPLICABILITY OF THE DOCTRINE OF DOUBLE EFFECT:

PROPORTIONALITY

This is an important aspect of the Doctrine of Double Effect, otherwise one might justify terminally sedating a patient due to minor suffering. However it is not an easy task to state when the condition is serious enough and also when it is sufficiently serious to justify the patient's death. The Consequentialists[7] , would measure the seriousness of the reason in terms of the value of the good effect that arises, and make sure that the value outweighs the bad effect incurred by the patient. On the other hand, the Deontologists[8] argue that the Doctors have a duty not to harm their patient, especially when the harm will lead to the patient's death. For the Doctrine of Double Effect to rebut the presumption that terminal sedation violates this duty not to cause harm. Also for the Doctrine of Double Effect to abide by the principle of proportionality, the agent must make sure that he has exhausted any other method which would have caused less harm. When considering both schools of thoughts, a proportionality condition was formulated stating that, 'the agent has proportionally grave reasons for acting, addressing his relevant obligations, comparing the consequences, and considering the necessity of the evil, exercising due care to eliminate or mitigate it'.[9]

INTENTION AND CAUSATION

The difference between the Doctrine of Double Effect and Euthanasia is the link between the cause and effect. The immediate cause of terminal sedation which renders the patient unconscious as to relieve them from pain, where unconsciousness might either lead to an effective relief from suffering or in the worst case scenario death. On the other hand when the agent performs Euthanasia the medicine is administered to cause the agents death, and from the death of that agent there will be the relief of suffering. Therefore when discussing terminal sedation one can conclude that the negative effect is the consequence of the good effect, whilst when looking into Euthanasia the good effect is the consequence of the negative effect. Also one must look at the intention behind the agents actions and not only at the causation of that effect. It is said to make a very big difference,

7 The Consequentialists follow the Consequentialism doctrine, which states that the consequences of one's action are the ultimate ground to decide on the rightness or wrongness of the agent's actions.

8 The deontological school states that the morality of an action is based upon the action's adherence to a rule, duty or obligation.

9 The formulation of the condition of proportionality according to T. A. Cavanaugh

whether in offering terminal sedation the agent intends to relief the patient from suffering and to hasten its death or only intend to relief the suffering and foresees the possibility of hastening the patient's death.

It is not clear whether or not the physicians fully understand the difference between intending an outcome and foreseeing said outcome, and sometimes physicians are either unwilling or unable to state whether the death of the patient was foreseen or intended. Therefore the Doctrine of Double Effect does not effectively draw a distinction between permissible and impermissible end of life measures. However if on the other hand we assume that the Doctrine of Double effect, does draw a clear line between permissible and impermissible end of life treatments, then one might state that if Euthanasia is considered as impermissible, then even the removal of a ventilator and feeding mechanisms should be considered as impermissible. However the latter statement does not coincide with the Conventional point of view. One can consider a narrower sense to the notion of intention, which would be that of wishing or welcoming a certain action. However this definition of intention is not exhaustive, since the act which is being committed is not necessarily an act which is wanted or sought for but it can be an element in a larger plan. This would therefore imply that the agent's end is an intended one, however the intermediate steps required to achieve that goal are not always wanted by the agent. This ideology is clear, when a patient and the physician both agree to a certain treatment in order to alleviate the patients pain, the first step to do so is that of administering the patient a sedative in order to render the patient unconscious. The death of the patient is not the goal of this action and neither is it part of the plan, in addition the fact that this treatment will hasten the patient's death is not the reason why the treatment is being administer. If the sedation does not result in the patient's pain relief, then that would be considered as a failure, however if the sedation does not hasten the patient's death, then that would not be considered as a failure of the treatment since the latter was not the intended goal but the former scenario was.

An alternative scenario is one where the patient asks the physician to undergo terminal sedation, since this will both relieve suffering and hasten death. Therefore the difference in this case, is that terminal sedation is not only being administered with the intention to relief pain, but also with the intention to hasten the patient's life. So now hastening the patient's death is within the scope of the action, and the fact that sedation will hasten the death of the patient is now one of the reasons why this plan of action was chosen. However this should not create an ethical problem, since neither the procedure nor the outcome would be any different, whether or not there is the

intention to hasten the patient's life. This distinction is being made because harm can easily ensue if aimed at, rather than when it is simply foreseen and anticipated.

The crucial elements between the two aforementioned scenarios is whether you intend or simply foresee the harm that might ensue from a specific treatment might cause an ethical problem. The two plans are identical in nature. The motive of both actions is compassion for the patient and the end-result is the unconsciousness of the patient to relief them from suffering which eventually might lead to their death. The difference between them lies only in the fact that in one plan of the action the death of the patient is intended whilst in the other the death of the patient is simply foreseen.

After discussing the three criteria necessary for the Doctrine of Double effect, one can see the strong link that there is between the intention and the causation of the action. The proportionality criteria is the most important one since, proportionality dictates what treatment should be given according to the illness and the effect which will arise when administering such a treatment.

THE ETHICS OF ASSISTED DEATH

The first question to ask when discussing the Ethics of Assisted Death, is whether or not the physician is doing something ethically wrong when helping his patient in committing this act. There is an argument based on the Right to life and this entails the right not to be killed by another individual and your duty not to kill another individual. Therefore one could state the Euthanasia is violating the patient's right to life. The main difference between Voluntary Euthanasia and murder, is that when a person commits murder he is killing the other person against his will, on the other hand in Voluntary Euthanasia involves the ending of a person's life against this request or consent.

The argument that if you have consent of the person, then you can proceed with Voluntary Euthanasia can be argued on the basis that the right of life is absolute. Joel Feinberg[10] stated that there are two ways in which the right of life can be alienated, namely when the person waives his right. Therefore this would mean, that the person would annul the other person's duty not to kill him. The implication would be that this person would have no protection against the others, and no one in the future would have the duty not to kill him, however one might waive his right to life only to one particular other or else on a particular occasion. Most rights have the feature that they can be waived by their holders in circumstances when it is

10 Joel Feinberg was a legal philosopher, known for his work in Philosophy of Law.

more beneficial for them to waive such right than to sustain it. It is such power that would therefore allow the physician to exercise Voluntary Euthanasia on his patient, and by receiving the consent from the patient the physician is not over-riding his duty not to kill when he is performing this action on the informed and consenting patient.

A counter-argument to what was previously stated is the scenario where the right of life cannot be waived, and therefore Euthanasia would be an impermissible action. However one can argue that the presumption that the right of life cannot be waived would be harmful to patients who would indeed be in their best interest and exercise of autonomy. Denying a person to waive his right to life seems inconsistent with the very function of the right itself. There are two theories that back the function to waiver right, which are that rights protect choices and that rights protect interests. The intention behind the power to waiver a right, is so the right holder will have more options.

The main justification behind this act is the well-being and the autonomy of the patient. The argument behind the well-being of the person is that suffering is bad and provokes harm to the patient, and therefore suffering should be removed or relieved to be bearable to the patient. Assisted death will eliminate the suffering that the patient is undergoing. It must be made clear that the concept of pain and suffering, even though very similar in nature, they have to be considered as two distinct concepts. Pain can be considered as a feeling or sensations which normally people have a strong dislike towards. Pain causes us to suffer, however so do other physical sensations, such as fatigue, dizziness and nausea, even though none of these sensation cause as much discomfort as pain, they are still considered as components of suffering. Also there is a psychological form of suffering, which might take the form of anxiety, depression, despair and more of the sort. Therefore one might consider defining suffering as any experience or condition to which a person will be averse to. No one argues the fact that pain and suffering are bad for the patient, and this is the reason for palliative care and the assumption that if a patient states that he is suffering then the Doctors should make use of all resources at hand to make sure that his suffering is relieved.

When taking into consideration the well-being of the person to justify the execution of assisted death on a patient, one might take the consequentialist approach to the situation and state that this was the best option for the patient, since it avoid great evil from them. However this does not mean that this, above from all other option had the best outcome, since it might negatively affect others.

There is also a deontologist arguments towards the duty to relieve

suffering. The duty might either be role specific, meaning that this duty falls with in the tasks of the physician as part of his more general duty to take care of the patients or it might apply generally, applying to every person who is in the position of relieving that person's suffering. In either case this duty must not be prohibited by other duties.

An ethically important argument is that the patient would want to resort to Voluntary Euthanasia because they are suffering and therefore they want to hasten their death as to avoid further suffering. Even though the patient does not resort to Voluntary Euthanasia death is still foreseeable in the future, but they would like to die sooner by means they have control over rather then have their death dictated by their illness. It is crucial that the patient fully informed on their condition and prognosis and fully competent to make a decision by themselves. Therefore a request for Voluntary Euthanasia can be considered as an exercise of their autonomy. Autonomy can be considered as the active management of once life, in order to achieve a set goal. Autonomy is one of the requirements for one to give an informed consent to treatment. When a physician accepts the request of a patient to perform Voluntary Euthanasia on him one can argue that the physician is doing so in the best interest of the patient as to relief him from suffering, whilst letting the patient make use of his right of self-determination.

The arguments of well-being and autonomy provide the ground of justification for Assisted Suicide and Voluntary Euthanasia, however they cannot show that this practice is always justified. However these conditions might justify this practice only under certain conditions. Also it must be stated that for a patient to request assisted suicide or voluntary euthanasia, one must make sure that all other treatment options must have been exhausted or have been refused by the patient. This is due to the fact that hastening a persons death is obviously an irreversible process. When one is discussing assisted suicide or voluntary euthanasia, one might state that the well-being of the patient should supersede the need for the patient to be autonomous.

Both Assisted Death and Voluntary Euthanasia give rise to many ethical questions and controversies which are difficult to answer and which most probably one will always find a counter-argument to that question.

THE DOCTRINE OF DOING AND ALLOWING

An argument in favour of Euthanasia is that, if it is considered ethically permissible to refuse treatment then it should permissible to perform Euthanasia on a consenting patient. The argument against this statement is that there is a distinction between doing and allowing. This distinction depends on the fact that there are two ways of bringing about the same effect, one way is that of letting it happen and the other is that of making it happen. In the case where a bad or harmful effect will occur, the Doctrine of Doing and Allowing states that it is permissible to let it happen but it is not ethically permissible to make it happen. Therefore this theory draws a distinction between the permissibility of Active Euthanasia and Passive Euthanasia.

It is a known fact that there are occasions where physicians administer a high dose of opioids and sedatives to their patients and such treatment, may in some instances hasten the patient's death. In this instance the ethical significance of the intending/foreseeing distinction is brought into play. This procedure is only considered as ethically permissible because it merely foresee the possibility of hastening the patient's death but does not intend it. On the other hand when the physician is performing Voluntary Euthanasia on a patient he is not merely foreseeing death but he is intending it.

However unfortunately this Doctrine of Doing and Allowing, does not always mark a clear cut line between permissible and impermissible end-of-life measures. If we make the assumption that the administration of a lethal medicine is the cause of death in Euthanasia, then one may be urged to state that it is plausible to state that the administration of sedatives can be the cause of death in terminal sedation or that the removal of a feeding tube can be the cause of death of a patient due to lack of hydration and feeding. From this statement therefore one might conclude that, if the Doctrine of Doing and Allowing supports the conclusion that Euthanasia is impermissible then it will equally support the statement that terminal sedation, the removal of the feeding tube or ventilator are equally impermissible. However this does not support the Conventional View.

James Rachels[11] , once stated that in both of the above mentioned cases, the agent's motive, intentions and the consequences of the actions or inactions, gave rise to the same consequences. The only difference between the two is that one is killing and the other is letting die. Rachels concluded that active means are neither better nor worse than passive ones. This statement was quickly rebutted by Kagan[12] and stated that this reasoning was unjustified, and that one cannot simply draw a general conclusion. Kagan proposes the Ubiquity Thesis, this thesis states that if there is a variation in a particular factor that makes a moral difference anywhere then it must make a difference everywhere, whilst if it doesn't make a difference everywhere then it doesn't make a difference anywhere.

Therefore even though the aim of the Doctrine of Doing and Allowing was established as to set a line between permissible and impermissible end of life measure, it still lacks in fully creating a distinction between the two.

11 James Rachels was an American Philosopher who specialised in Ethics.

12 Shelly Kagan is a Professor of Philosophy at Yale University, he is also well known for his writing on moral philosophy and ethics.

The Economical Aspect

POLICY

Assisted Suicide is a subject brimming with controversy, open to moral opacity and ethical questions that, conveniently remain unanswered and vehemently opposed by statesmen and legislators alike. As with a very large number of social issues that tend to upend the apple cart, the moral aspect on euthanasia has been widely-documented and seemingly never-ending, as the rest of this policy paper tries to explain in detail.

With this in mind, it would be an excellent idea if such moral questions are set aside for a momeny, while the focus is shifted towards the economics behind Euthanasia, both as a microcosm of the current health system in Malta and abroad, as well as a measuring indicator of whether euthanasia does leave an impact of sorts from the monetary side of things.

While it helps that such mathematical assertions are less ambiguous, and the question seems to be posed a number of times, multiple assumptions, projections and calculations have to be based and utilized by these predictions. This is due to the fact that the statistics available on a national scale are insufficient, and even foreign literature has tried its hardest to fill in the gaps with presumptions and economic models, rather than cold statistics.

To misquote a nefarious political catchphrase: “It’s the economy, stupid.”

THE MALTESE HEALTH SYSTEM – PRESENT SITUATION, AND FUTURE PREDICTIONS

"In this insanity of economics of healthcare, the patient always loses," Peter Van Etten, President and Chief Executive Officer of Stanford Health Services

The Maltese Health System, which is based on the Beveridge[1] model, means that most health expenditure is paid for by the Government through direct and indirect taxation, alongside the existence of medical professionals who open up their own practice. The Maltese Government spends an enormous amount of money on the Health Sector: According to the 2010-14 NSO Expenditure of General Government Sector by Function document, in 2014 the Maltese Government had spent an estimated €486 million on health-related matters, with the sheer majority of that sum (€325 million) solely on Hospital and hospital-related services. This was an increase over the previous year (€434 million), and it seemed that the expenditure was adhering to an incremental trend over the previous years. (2010: 347 million; 2011: €370 million; 2012: €395 million). Moreover, the 2014 sum was equal to about 13.9% of the total Government expenditure of that same year, and equating to about 6% of the National Gross Domestic Product.

Such a mammoth expenditure and its exponential rise shouldn't surprise many. Like many countries on this side of the Atlantic, Health Care is deemed to be an absolute priority on behalf of the state, and while different models do exist (such as the Bismarck, National Health Insurance and Out-of-Pocket Models), the end result is basically the same: Healthcare is essential for the running of any civilised state and in the Maltese state of affairs it is given the utmost priority.

1 http://www.pnhp.org/single_payer_resources/health_care_systems_four_basic_models.php

The problem of such a mammoth expenditure, however, is in terms of feasibility: Although Malta's health sector has had a number of controversies and skirmishes up till now, it is still considered as a success story, especially when you consider the scenarios in Britain (where the current British Health Secretary Jeremy Hunt, is seemingly unable to balance out between the needs of the staff and the cost-cutting exercise the Government is attempting on the NHS), the United States (where even though the US pays more in healthcare in terms of GDP to any other country in the OCED, it is still unable to emerge out of their current for-profit system) and other countries, especially in less-developed regions scattered around the globe. Nevertheless, the future of the Maltese health sector might be in peril, sooner rather than later, thanks to the expected demographic changes of the country's citizens, and hence, the expected exponential hike in health expenditure reaching its eventual breaking point.

POPULATION AGED 60+ vs. TOTAL POPULATION FORECAST			
YEAR	60+ Population	Total Population	Percentage
2013	*105, 068*	*425, 384*	*24.7 %*
2025	*132, 500*	*450, 000*	*29.4 %*
2035	*139, 700*	*461, 000*	*30.3 %*
2050	*155, 400*	*469, 000*	*33.1 %*
2060	*163, 500*	*477, 000*	*34.3 %*
2070	*161, 800*	*481, 000*	*33.65 %*

According to the National Statistics Office's most recent demographic survey, the total population of the Maltese islands at December 2013 was that of 425, 384 people, with the percentage of the population being 60+ years of age equal to 24.7%. According to the projections created by the same NSO, based on the same trends, this ration was set to increase in the oncoming years:

With this in mind, it's an obvious correlation that the more ageing the population becomes, the higher the medical costs go, and higher the pressure on the state to deliver. While an increment in health expenditure might seem the most obvious answer, truth be told, such an answer might not be pleasant, if not at all acceptable and financially feasible, for future governments.

EUTHANASIA: A POSSIBLE FINANCIAL SOLUTION ?

"Think about it: Legal euthanasia is the ultimate cost control measure for the health care industry." Charlie Sprague, writing for the Claremont McKenna College Forum.

With the above financial statements and future predicaments in mind, multiple sources have brought forward ideas about how to ensure the effectiveness and feasibility of the Maltese Health System, both on a national and on a personal scale. And while delving further on this area would deviate from the argument at hand, after explaining the background, it should come as no surprise that even here, the Euthanasia and Assisted Suicide debates are playing a key and integral role in the discourse.

However one may view terminal and incurable illnesses, and irrespective of whoever the person may be and whatever the financial situation one finds himself in, the fact of the matter remains that terminal illnesses are financial drains on both patient and doctor alike. Such illnesses, more than any other, make use of highly-expensive medicine that is either aimed at comforting the patient, or aggressively but vainly combating the effects of the disease. The purchase, maintenance and depreciation of all the medical and surgical equipment of the patient, not the mention the wages of those who watch over the patient until their timely passing comes at a large cost to both the stakeholders and health care providers, but more importantly on the patient receiving such care and the relatives to the patient.

If you take an accounting perspective of the situation, the enormous expense on both an individual and general manner is massive; to make matters worse, however, is the absolute lack of revenue. Most patients suffering from these types of disease and requesting euthanasia are the point where they're physically unable to contribute economically in any way, both towards their self-maintenance, that of their close relatives, or to the providers themselves. Sprague goes as fall as calling these types of terminal diseases 'resource sinks for society', commenting that the patient's 'continued existence may be personally meaningful to those who love them, but from an economic perspective they're all cost and no benefit.'

In an article published on the San Francisco Gate newspaper, economist Robert Leeson, lecturer at Australia's Notre Dame University and jointly ranked n. 17 of the World's top Economists, argued that 'a large proportion of health care resources are allocated to a system in which the dying have their bodies – but rarely their lives – prolonged…. A prolonged death can drain more than societal resources.' He adds that even "if some final-year expenditures produce measurable benefits, these have to be weighed against alternative uses.'

THE ECONOMICS OF EUTHANASIA – ARGUMENTS IN FAVOUR (AND CRITICISMS)

'Under any new system of health care delivery, as at present, it will be far less costly to give a lethal injection than to care for a patient throughout the dying process." New York State Department of Health, report entitled "When Death is Sought', April 2011.

Just how cost effective is assisted suicide? Well for starters, both the surgical equipment used in life-prolonging procedures, the medicines that come with said procedures, and the amount of dedicated staff needed to properly use and maintain said procedures amount to large amounts of money. The New Zealand Life Information Website for example, estimates that while the cost of proper health care for a terminally-ill patient ranges around the $35,000 to $40,000 mark, the cost of the drugs used in assisted suicide amount to $35 dollars, a hundred times less. According to a CNN Money survey, 'one out of every four Medicare dollars – over $125 billion – is spent on care near the end of life. Yet, aggressive treatment too often fails to improve or lengthen the lives of the terminally ill.'

Secondly, if one takes euthanasia from a societal, if not administrative point of view, euthanasia may help in creating a more efficient use of the medicines on hand. Such a utilitarian application of the Pareto optimality concept will allow other patients, who are in need of the medicine but are not suffering from a terminal illness, to be able to use the medicine and actually achieve an amelioration purpose, rather than delaying the inevitable. As Sprague again put it: 'Any money saved by allowing geezers [sic] to choose euthanasia frees up more health care dollars for the needy.'

Leeson, in his aforementioned article, goes forward and proposes a system by which terminally-ill patients can gain from their plight: 'At the beginning and the end of a working life, individuals should be free to decide about such matters. At the beginning, there might be a choice of between buying end-of-life insurance (maybe with pre-tax dollars) in return for a reduction in Medicare tax; or accepting that end-of-life costs will be charged to – and recouped from – their estate. And at the end of a working life: a choice between receiving end-of-life care, or allocating those funds to grant oneself a metaphorical "immortality.'

'For those opting out, such "immortality" could be provided through an annuity - an eternal income to a worthy cause of the individual's

choosing (a "named" scholarship, an annual charitable contribution, etc.). The end-of-life privately insured could be offered a cash payout in return for surrendering their policy. (Or public and private insurance could offer both choices.)'

But if the economic benefits are so much, don't health care professionals and institutions try to actively pursue such an efficient measure at each possible scenario, thereby using the economic argument to overcome any moral ones? The Death with Dignity National Center (DDNC), an organisation whose mission statement is 'to promote Death with dignity laws based on the model Oregon Death with Dignity act [sic] both to provide an option for dying individuals to stimulate nationwide improvements in end-of-life care' argued in their 2012 'Frequently Asked Questions about Death with Dignity': 'No one is encouraged to use the [Oregon and Washington Death with Dignity] law. To date, persons who have chosen to use the law have been well educated, have had excellent health care, have had good insurance, have had access to hospice and have been well supported financially, emotionally and physically. Absolutely no HMO or insurance company participates in this process.'

THE CALCULATED COST – EMMANUEL & BATTIN

'What is true on a national scale is also likely to be reflected in the potential savings for individual managed-care plans. Physician-assisted suicide is not likely to save substantial amounts of money in absolute or relative terms, either for particular institutions or for the nation as a whole." Emmanuel & Battin, 'What Are the Potential Costs from Legalising Phyisican-Assisted Suicide?'

As examined beforehand, obtaining factual statistics about the change in costs and expenditures from both a general and personal point of view is difficult, both due to the very nature of the subject at hand, and due to the fact that not enough research has been done on the very few examples that we do currently have.

One standout examination on the economics of assisted suicide is the 1998 paper by Ezekiel J. Emanuel M.D., Ph.D and Margaret P. Battin, Ph.D, entitled 'What are the Potential Cost Savings from Legalising Physician-Assisted Suicide?', published on the 16th of July, 1998[2]. Emanuel and Battin decided to use as much data as they could from the Netherlands, together with several costings from the United States, in order to come up with a total sum of just how much the Health Sector would benefit on a nationwide scale if Euthanasia or Physician-Assisted Suicide was allowed on a Federal Level.

'Computing the likely cost savings from legalising physician-assisted suicide is based on three factors: (1) the number of patients who might commit suicide with the assistance of a physician if it is legalised, (2) the proportion of medical costs that might be saved by the use of physician-assisted suicide, which is related to he amount of time that a patient's life might be shortened, and (3) the total cost of medical care for patients who die.'

The authors commented 'that only limited data [was] available on the costs of care… however, by combining data on physician-assisted suicide and euthanasia in the Netherlands, where these interventions are openly performed and have been studied, and available US data on costs at the end of life, we can estimate the cost savings that would be realised if physician-assisted suicide were legalised.'

2 (N Engl J Med 1998 339:167-172 DOI: 10.058/NEJM199807163390306)

Emmanuel and Battin argued that irrelevant of the data they presented, they still had to base their calculations on a number of assumptions:

1) That the doctors would fulfil the patients' requests at the same rate that Dutch physicians do. (In the Netherlands, prior to the report, a consensus in 1998 showed that 53% of Dutch doctors had previously provided assistance with suicide beforehand. Meanwhile in Malta, the latest MaltaToday[3] polls showed that over 90% of Maltese doctors were against the notion, but only 6% would hasten the death of their patient.)

2) The average amount of life foregone by patients who die as a result of PAS was calculated at four weeks. However, statistics showed that such a number varied from a single day to eight weeks, while the average was actually 3.3 weeks, less than the number used. Moreover, half of those who decided to forego treatment were calculated as having shortened their lifespan by about a week.

3) The medicinal and medical costs calculated were those for cancer patients, which have some of the highest medical and medicinal needs. Other patients suffering from other fatal diseases such as ALS or Huntington's Disease, could have lesser costs, so euthanasia would actually save less.

4) Many people have requested physician-assisted suicide even though it wasn't legal at the time, with the number of such people being unknown at the time.

5) Additional costs may come into play if a patient decides to be euthanised, as established by the legislators at the time, including but not solely related to a second physician as a witness to her condition, a psychiatric evaluation of the patient, mandatory coun selling, possible litigation and even damages for any violation of these safeguards, which in turn reduces net savings.

3 http://www.maltatoday.com.mt/news/national/67007/12_of_doctors_polled_say_they_have_faced_requests_for_euthanasia#.WBIEgeB9602

The authors then established their findings into their calculation: the percentage rates of people who died because of either euthanasia or physician-assisted suicide in the Netherlands represented around 2.3% and 0.4% of all deaths in the country respectively, which was a very minuscule amount. For the sakes of their calculation, they also used their presumptive estimation that each patient had about four weeks left of life, and that the medical costs for each person amounted to $10,000.

Emmanuel and Battin estimated the United States health system would save a total of anything between a sum of approximately $627 million, in 1995 dollars. This amount, although seemingly huge in quantity, represents less than 0.07% of the total US Health Care Expenditure, which goes beyond the $900 billion mark. They also proposed other scenarios, including a least case scenario where the total savings were reduced to $336 million, or the best case where the savings amounted to around $4.67 billion.

So if we were to take the exact same percentage on the 2013 Maltese health expenditure estimates as aforementioned and leaving everything else in place (which of course do not comply in their entirety to the Maltese situation, especially in relation to the percentage of patients with terminal illnesses and medicinal costs), the total amount of money that the Maltese government would save would be anything between $181,440 to $2,478,600, with the most reasonable amount (using the same exact criteria established by the authors) being that of $340,200.The amounts that are presented by the report show that while the introduction of euthanasia and/or physician-assisted suicide do provide a cost-cutting effect on the health sector, the scale of such an effect may have been over-exaggerated, due to the fact that the number of terminally-ill patients are less than generally perceived to be. And while the total amount will undeniably fluctuate depending on both a personal and a societal level, even highly-optimistic calculations of this policy's cost-cutting effects prove that such a measure is not as substantial as one might have thought. The authors of this paper conclude that such a low sum might originate from a number of factors, including:

1) The frequent overestimation of how much is spent on medical care at the end of life. Percentages vary, but it was concluded that expenditures related to medical care involving patients with terminal illnesses amount to only about 10% of the total expenditure.

2) An overestimation of the people who die each year: The authors calculated that only 1 percent of Americans die each year (the United States population death rate is

estimated to be about 8.2 per 1000 , Malta's estimates are even less at 7.8 per 1000.[4]

3) Out of these ill patients, such a percentage actually shrinks considerably. Emmanuel and Battin estimated that only 0.027% out of the whole American population would choose physician-assisted suicide, with the other 99.97% receiving health care at the usual cost.

4) Lastly, it's a rarity that patients opt for physician-as sisted suicide not long before their natural death. Given that most patients ask for such a procedure after all treatments have been tested, so less than four weeks before their natural death, such a period still only represents an average of only 33% of all medical expenditures during the last year of life.

However, Emmanuel and Battin make it a point to focus as well on the financial effects on the individual and family members of the terminally-ill patient: They argue that while the cost-savings to the government and most insurance plans are going to be minute when compared to the rest of the spending, 'it is important to recognise that the savings to specific terminally ill patients and their families could be substantial. For many patients and their families, especially but not exclusively those without health insurance, the costs of terminal care may result in large out-of-pocket expenses.'

So is Physician-assisted suicide the economic miracle needed to boost up health-care on both a national and international scale? Emmanuel and Battin seem to answer the question in the negative: The massive reduction in health expenditure that proponents of Euthanasia were expecting did not materialise (which is considerably more important in the Maltese Health Care System), but for alternative systems the notable reduction in costs for families and individuals alike provide enough benefits for any state governments to consider such a controversial alternative.

4 http://www.cdc.gov/nchs/fastats/deaths.htm

THE ECONOMICS OF EUTHANASIA – ARGUMENTS AGAINST

"Compassion & Choices", whose mission statement is "to improve[e] care and [expand] choice and he end of life, wrote: "Studies have shown that Health Management Organisations have no financial incentive to pressure terminal patients to end their lives because there are no cost savings… End of life choices are relevant only AFTER all curative and other treatments have been tried."

Maxwell J. Mehlman, in an article for 'The Doctor Will See You Now. Com' entitled 'Economic Motives for Physician-Assisted Suicide', listed down the economic objections to physician-assisted suicide and grouped them in three main arguments:

1) 'First, it is feared that physicians and other health care providers… faced with financial incentives to reduce health care spending, will pressure patients to request assisted suicide…Confronted with these financial pressures, physicians may turn to assisted suicide as a means of reducing the costs of caring for enrolees.'

2) 'The second type of economic objection to physician-assisted suicide focus on the role of the patient's family. Families, it is feared, may pressure patients to choose assisted suicide to avoid spending money that the patient could leave to the family. Or, family members may exert pressure because they are spending too much of their own money.'

3) 'Finally, even without overt pressure from others, patients may opt for assisted suicide to save money. They may feel it is their duty to their loved-ones. They may feel they owe it to society.'

Rita Marker and Kathi Hamlon, of the International Task Force on Euthanasia and Assisted Suicide, wrote in an article that "savings to governments could become a consideration. Drugs for assisted suicide cost about $75 to $100, making them far less expensive than providing medical care. This could fill the void from cutbacks for treatment and care with the 'treatment' of death… Legalised euthanasia or assisted suicide raises the potential for a profoundly dangerous situation in which the 'choice' of assisted suicide or euthanasia is the only affordable option for some people.'

Subsequently, Mehlman also addressed the argument about whether people who are financially disadvantaged, 'who goes on living faces the prospect of not being able to leave her family enough to live on decently', and laments that 'there is something wrong with someone being in such a situation. We ought to object to it and to a society that places people in such a predicament. We ought to work tirelessly to achieve a better social system.'

'But in the meantime, should we deny the poorer patient the ability to make her choice? Indeed, some might say that the poorer patient's ability to choose physician-assisted suicide is all the more valuable to her because of her predicament that, precisely because so much more is at stake for their families, it is more important for this option to be available to poorer patients than to richer ones.'

NOT ANSWERING IS NOT SOLVING

1) Economic Factors Alone Are Not Conclusive, and Neither Should Be

It seems blatantly obvious, and it is. But the economic factors, however large or small they are believed or assumed to be, cannot be the over-riding concern for any public policy, let alone one which meddles with the most unfortunate of unfortunate situations. Euthanasia and physician-assisted suicide deals with a life-or-death situation, and while in each possible scenario there is a possible economic transaction of some type, this shouldn't be the ideology behind why such a measure is introduced.

Having said that, denying the economic effects, whether they'll be positive or negative, of such a subject matter is a mistake of equal gravitas. The inevitability, both on a societal, legal and individual level, of having to come to grips with such a situation in the future, if not the immediate present, exists. It would do a great disservice to anyone facing this situation if we refuse to address the choice at hand, and not take a bold step forward when the time comes.

2) What's Worse Than Negating? Not Knowing

One of the main hurdles facing this study is the complete lack of information on such an issue. While in philosophical and ethical circles such an issues has been examined, re-examined and scrutinised considerably, tangible information and statistical argumentation is immensely lacking, both on an international but more especially, on a local scale.

The Emmanuel and Battin study was conducted in 1998, roughly eighteen years ago. Since the turn of the millennium, more countries have decided to allow or legalise euthanasia under certain conditions, including Belgium, Luxembourg and Canada. Before any policy decision is made, it would be essential for the relevant authorities to make a detailed case-study on these countries and make a detailed projection for the Maltese scenario, prior to making any implausible or false claims on the economic benefits (or lack thereof).

3) The Data We Have? As Yet, Inconclusive

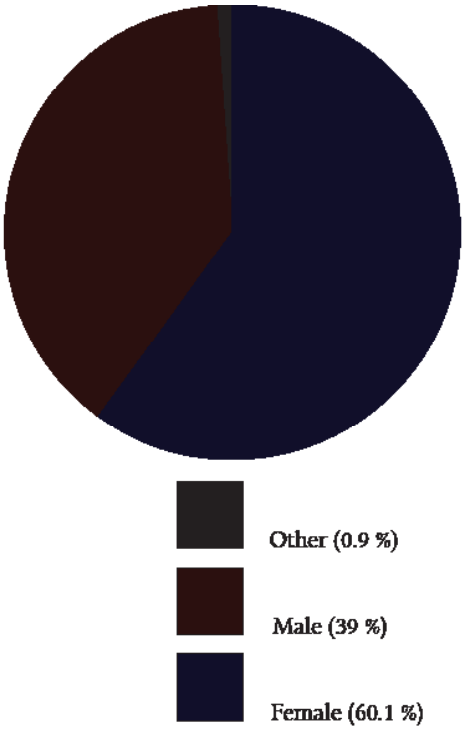
Numbers and figures have been exaggerated and manipulated on both sides of the argument, which in turn has condemned the subject matter to be a taboo subject, rather than a probably policy argument that deserves the recognition it deserves in academic circles. Part of the reason behind such a situation is that the statistics that have emerged till now have not satisfied neither argument: Emmanuel and Battin's projections and costings have showed that Euthanasia is neither a magic cost-effective tool, nor a completely insignificant possibility. The financial, economic and emotional consequences are there and exist, but they have only managed to add more fire to the controversy, rather than cool it down. Whatever hopes that the author might have had in numbers, statistics and projects, evaporated as soon as he was unable to find any concrete examples of either.

Survey Analysis

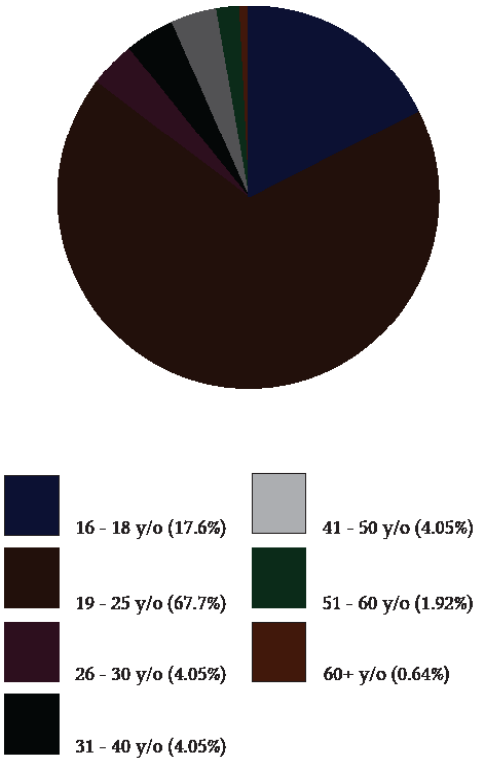
THE QUANTITATIVE RESEARCH OF PUBLIC OPINION ON EUTHANASIA AND ITS ANALYSIS.

The survey's main purpose was to get a small insight about whether the general public is knowledgable about what Active Voluntary Euthanasia is, and also what they think about it. We thought that such a survey was the best way to get about it. The two dominant biases with regards to this survey were global under-coverage and non-responsiveness. One must note that apart from posting it on our official GħSL Facebook page we didn't share it on any other social media pages, therefore limiting our reach. For this survey, we gathered a sample of about 313 responses. The scope was that whoever sees our page could easily respond to it, and moreover we attract more of the pool that we wanted to target furthermost, which was that of University students.

Right: Figure One Gender of Respondants



The following examination of results is the tip of the iceberg. We analysed the results and responses by way of basic common knowledge, rather than delving into the more deep, philosophical and ethical reasonings as to why respondents answered in the way they did.

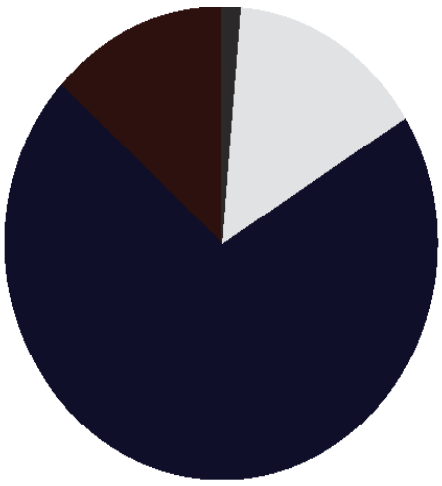


This brief overview however, brings out results we expected to come across, and others that were definitely unanticipated and eye-opening.

Left: Figure Two
Age of
Respondants

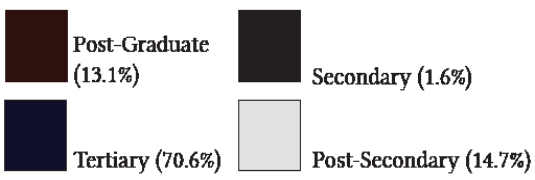
Had this survey been shared on more popular and even platforms the results will have most definitely varied. Having said that, it does not render this present one insufficient, or slightly biased one way or the other, considering the audience we aspired to engage. Nevertheless we feel that the answers are concrete and real and cannot be ignored.

The survey starts off by gathering the gender, age group and education level of our respondents. With regards to gender, the absolute majority of respondents (60.1%) were female, whilst 39% were men and 3 individuals decided to choose "Other" (1%).



Right: Figure Three
Education Level
of Respondants

The age of respondents reflects what we initially sought, with the absolute majority of them aged "16-18" (17.6%) and "19-25" (67.7%) amounting to



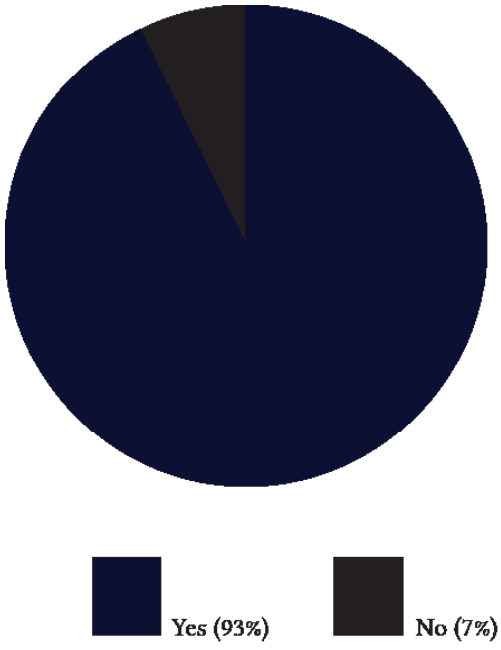
a total of 85.3%. Our team obviously assumed this was going to be the case as these age groups are the most we are most closely associated with.

Although we wished that we could get their opinion more than anything, there is an obvious response bias here. We acnkowledge it: had it not been our intention it would have been a problem, but cardinally, we wanted the opinion of people who have at least Post-Secondary education if not Tertiary Education Level. The simple reason is that euthanasia itself we thought would be a subject that not every Tom, Dick or Harry knows about. Or at least if they have heard of it, they would not be able to define it and essentially differentiate between Voluntary and Involuntary Euthanasia, Active and Passive. The rest of the age group percentages is almost equally distributed between the age groups "26-30", "31-40" and "41-50". Only 6 respondents fell within the "51-60" category and only 2 within the "60+".

The education level showed us that none of our respondents had only "Primary Education," but in fact the sheer bulk of respondents have "Tertiary Education" (70.6%) or "Post-Graduate" (13.1%). 14.7% have "Post-Secondary Education" whilst only a mere 1.6% have "Secondary Education".

Obviously one must take into consideration that apart from being a more student based survey, the survey was only available online, thus one must have access to the internet and to a computer or mobile phone to answer
the survey.

Right: Figure Four Do You Know What Active Euthanasia Is?



In Malta, although the number of households with internet access is about 80%,[1] whihc is a high percentage, we have to consider them having a Facebook account, and further them actually following GhSL's Facebook Page, which although

1 http://www.independent.com.mt/articles/2015-03-03/local-news/80-of-Maltese-households-have-internet-access-73-of-adults-use-internet-6736131526

has a far reach, is obviously not all-encompassing. Having said, we reiterate that the results from this were expected and fairly satisfactory.

From now on is where it gets interesting. We commenced by questioning whether or not they know what active voluntary Euthanasia is.

The best part of the respondents (93%) answered in the affirmative, whilst only 22 stated that they did not (amounting to a minority of 7%). Those 22 who did not know what AVE was, were automatically directed to submitting the survey, as opposed to the rest which continued the survey. We structured the survey in this way to ensure that we did not influence them in any way and keeping them unbiased. Whether they proceeded to get to know what it's all about was entirely up to them. Moreover, once the form is submitted no one could go back and change their answers.

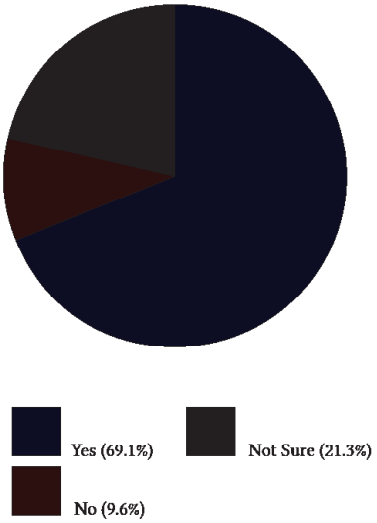
The further 291 respondents who continued the survey were given the chance to tell us, in their opinion what the definition of Active Voluntary Euthanasia is. The reason why we included this was twofold: apart from wanting to realise opinions, we wanted to ensure that they actually knew what they were talking about. Furthermore, it was essential to us that they had a more in depth familiarity with the topic as opposed to a simple, vague definition. The obvious problem might have occurred where the respondant actually searched the definition online whilst answering, or asked anyone close to them if they know the answer, but going through the answers one by one, we could see the vast array of different answers, such as in the samples put forward soon.

Each and every single respondent gave accurate answers, and although some were brief, others were more complex. Overall the majority emphasised the element of voluntarility and own's will and desire. Others went further and stressed the Active part of AVE contrary to Passive Euthanasia, although not as many as those who highlighted willingness.

The following are a few snippets of the responses;

- "one's own desire for assisted death"
- "giving a patient medication to terminate his life with consent"
- "when a person is unwell and requests to be killed painlessly"

- "consciously deciding to end your life by choice"
- "ending own life consent-fully in a humane manner"
- "to intentionally seek to end one's life through medication with consent"
- "voluntary euthanasia is the practice of ending a life in a painless manner"
- "when a person is in great pain and believes there is not comfortable future to live in he may choose whether to end his/her life instead of suffering"
- "Tkun għadek f'sensik u volontarjament tagħżel li jitfgħulek il-magni jew medikazzjoni li jzommuk ħaj"
- "When medication is administered/given to a person to end their life, with the full informed consent of the person. The fact that medication is given makes it active, passive would be when life support is removed"
- "Knowingly agreeing to perform a medical practice or stop performing a medical practice which will result in the termination of a patient's life"
- "When a person likely suffering of a terminal or degenerative illness chooses to end his life before his symptoms make it so that the quality of life is significantly reduced."



Left: Figure Five
Do you agree with the legalisation of Active Voluntary Euthanasia?

- "the willingness to end your life (with the go ahead of the doctor) through medical means. This usually occurs when the patient has a minimal chance of leading a healthy life and/or will probably die within a few months or years. It is a way of ending one's life with dignity and avoiding unnecessary excruciating painand/or

living in a hospital"

- "Intentionally administering medications to cause the patient's death at the patient's request and with full, informed consent"

When asked the vital question "Do you agree with the legalisation of Active Voluntary Euthanasia?" the response was one we did not predict. A majority of 69.1% of the respondents answered "Yes" whilst another 21.3% answered "Maybe".

Apart from the fact that 69.1%, the sheer majority of the responsants, gave a concrete, affirmative answer when considering the controversy behing this topic, and that we gave the option of "Maybe" so as to allow anyone who is hesitant to be able to avoid giving a concrete answer, the end result was still a large positive sway in favour, or at least in discussing the issue. This large bracket of people were formerly asked to give a definition of AVE, as previously stated we found no incorrect answers, so it goes to show that not many people object to it on assumptions or incorrect grounds. This could be for many reasons, most probably because our population has either become more acceptable to such life-ending treatment and more open to dicussion on the matter than years ago. Another reason for this could be that being a small country, it is not uncommon for a large share of the population to be on contact with people suffering from terminal conditions which a few years ago we never heard about. News on this island goes around like wild fire. It is quintessential to go back within this same analysis and remember that most respondents had a good background of education and are people who most probably know what's going on with regards to research, illnesses, legislation and as opposed to it, lack of legislation where needed.

The 62 respondents who answered "Maybe" are the amount of people who are either indifferent with regards to the legalisation of AVE or are hesitant to agree. Although a hefty presumption, the people who answered this way are definitely not against it, rather than opposing it they are not well informed about the subject enough to take an objective stand and agree to it without sufficient knowledge on the subject. Although our society is becoming ever more educated and on the whole moving towards having a progressive mentality; there still remains a large strand of the population with a conservative mentality. A mentality that they have a right to express, this may be for many reasons however the main influence cannot not be mentioned, the Catholic Church. This sphere of people predominantly is strict in their opinion, rather than radical they have a deep belief that is difficult to try and sway, let alone stray away from it. Without dis-

criminating against them, this is the case most of the time hence why one can suppose that who is against AVE will say they are against it immediately. There were 28 respondents who disagreed, amounting to a mere 9.6% overall. These were consequently diverted to a question prepared for them only, which was to give a reason why they disagreed. In this way we could get a grasp of why they feel this way, and the reasons behind their answer.

Most answers showed a significant amount of religious influence such as: "it's against God's 5th Commandment: Thou shalt not kill". With deep respect to all opinions, few were the ones with more basis apart from religious ones. Others were more opinionated and delved into the whole debate about how euthanasia is "direct killing", "assisted suicide", "murder" and "suicide" amongst others. Some interesting answers were the following;

We do not have a claim on death; rather, death has a claim on us. Some see the "right to die" as parallel to the "right to life." In fact, however, they are opposite.

- It cheapens and relativizes the value of human life. Look no further than countries like Belgium and the Netherlands, where euthanasia has recently been extended to people suffering from depression. No legislation can avoid the logical conclusions of the so-called "right to die".

A few clearly did not have a clear cut answer as to why they oppose this legalisation. They disagreed to disagree due to the political and social repercussions such legislation may bring about. The following describe what they think will happen or what has happened with the introduction of controversial legislation. With regards to the second reasoning, it is good to remind the reader that Malta was one of the last remaining countries in the world to introduce divorce. Apart from it being such a basic legal opportunity, it has nothing to do with Euthanasia, but nonetheless everyone is entitled to his/her opinion and similarly has a right to express it.

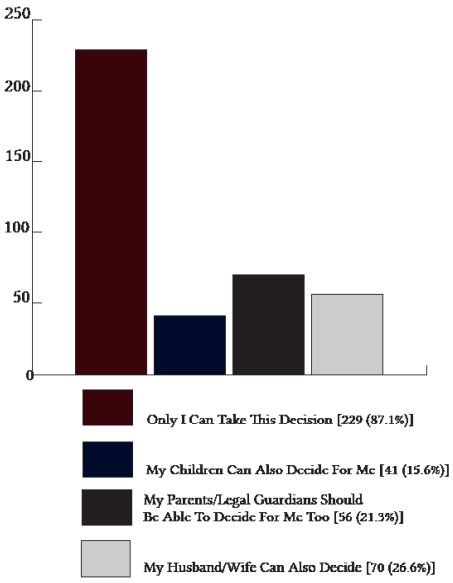
- "Because this leads to a slippery slope."
- "…once divorce was legalised a domino effect will ultimately follow and in approximately 10 years' time we will be a society promoting death with the introduction of abortion and euthanasia"

There were some short answers basing their opinion on the value of life;

- "life is a precious gift"

- "because life is a gift"

The rest of the respondents based their opinion on the fact that there will be people who take advantage of this legislation, as is the reality in almost any country with regards to many laws. There will be those who bend the law for the sake of bending it, others who will take advantage for monetary reasons as stated by one respondent where he/she envisaged that "It will always be difficult to ascertain whether it was an act of mercy or coercion in order to get at the inheritance".



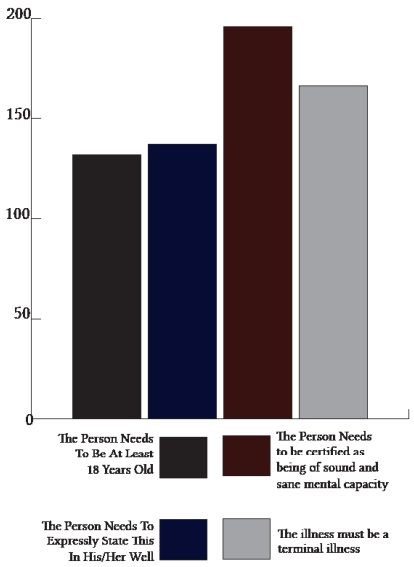
Left: Figure Six
Who Decides?

Others emphasised on the fact that Euthanasia will be available to people who will be passing through a divorce or a bad period in their life and resort to Euthanasia as an answer to their problems. Since in Malta, so far, there have not been an proposals or public debates about this topic with the aim of legalisation of AVE these respondents did not grasp that AVE requires the direct consent of the person to whom it is administered. We are considering voluntary Euthanasia, not involuntary. Had they been aware of this difference, or thought more in-depth recognising the fact that had this been legislated upon, it would need to be heavily scrutinised in Parliament. This is merely a presumption which no one can ensure. It is only a humble anticipation of what a democratic government should do or ought to.

The respondents who agreed or chose "Maybe" were directed to another part of the survey subject to them only. The rest who disagreed then were redirected to the final section of the survey titled "Introduction of Euthanasia in Malta". The former next part of the survey is called "Decision making and criteria for Euthanasia".

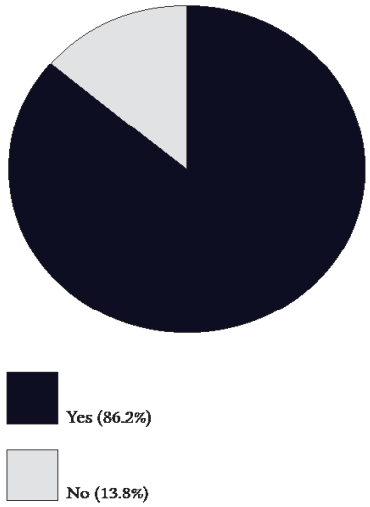
The first question we asked was "Who decides?" We gave respondents the chance to tick one or more of the available answers. As we have discussed the essence of AVE is that the person in question is the one who decides whether or not he would like this form of Euthanasia performed on him/her. Anyone else having a say in this choice is considered involuntary and passive to say the least. The

results of this particular question surprisingly show that a chunk of respondents, although in minority are open to these other forms of Euthanasia. Whether they realised they are approving them or not, we can assume that they comprehended a simple question and thus knowingly or not, they think this way.



It is also good to note that a greater number of people trust their husband/wife more than they do their children and parents. "My children" was the least popular option, probably due to the fact that they would in most cases be the inheritors of the will of the parents in question and there is a greater possibility of other intentions according to popular belief. This is most definitely not the case for the better part of situations but it is the most risky to avoid saying most probable. This reasoning though, could be applied to a husband/wife and to parents if the person was never married and did not have any children.

Above Right: Figure Seven
Which of the following do you think should be crucial requisites for this legislation?

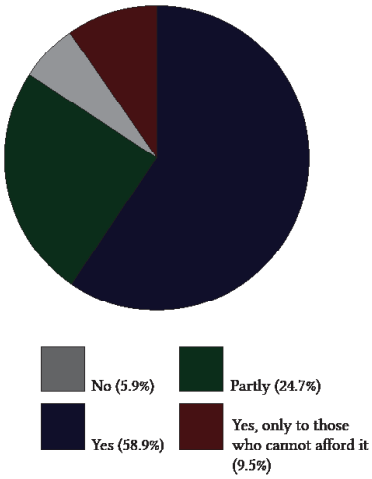


Left: Figure Eight
Do you think that a person with a terminal illness, who is not permitted by law to undergo Euthanasia, will resort to other options to end his/her life?

The next question was with regards to the crucial and fundamental requisites they believe that the legislation pertaining to AVE should include. Whilst it is quite a surprise that not many people believed that the administering of Euthanasia should be expressly stated in one's will to be able to be performed, an even more interesting finding was that nearly half the amount of respondents believed that attaining the legal age of 18 years was not necessary. Does this reflect the fact

that a mass of the respondents also believe in involuntary Euthanasia where the case occurs? Or do they believe that 18 is a high age for this and if so, how low do they think it should go?

Left: Figure Nine



If Euthanasia is introduced in Malta, do you think that the Government should offer this service?

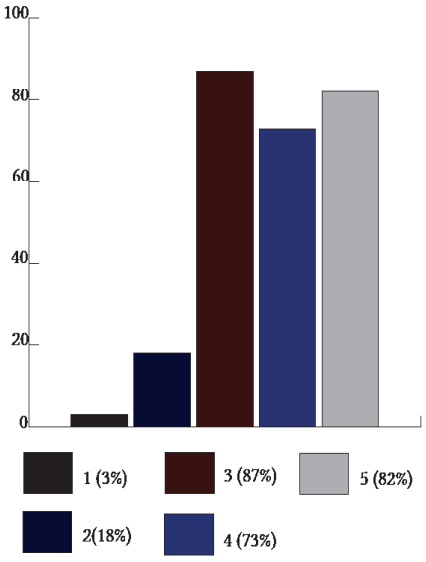
Apart from our unwillingness to make the survey lengthier than it already is, unfortunately we did not foresee this result and did not include the "Why?" that should have followed this question.

We inserted an optional question to which the vast majority still chose to answer. The question was;

"Do you think that a person with a terminal illness, who is not permitted by law to undergo Euthanasia, will resort to other options to end his/her life?"

Right: Figure Ten
On a scale of 1 to 5, one being the least and 5 being the most, how much does Malta need legislation regarding Euthanasia?

The final section of this survey was directed to attain the respondents' view regarding if Euthanasia is introduced in Malta. The first question was if they think that Euthanasia should be offered by the government.



The second question was with regards to the need of legislation pertaining to Euthanasia in our country. 1 refers to no need at all for legislation and 5 the absolute need.

The concluding question was the following; *"Do you think that there should be a referendum to decide whether it should be legislated upon, or should Parliament decide?"*

Whilst the better part think that a referendum should be carried out, 33.3% think that Parliament should be able to go ahead and legislate and 19.6% chose that it does not make a difference. The 19.6% clearly do not think that a referendum is needed and this indicates that they are indifferent as to whether Parliament goes ahead with the legislation or not. Had they firmly believed it should be up to the voting public to decide they would have said so. Adding up the respondents who chose Parliament and those indifferent we get a total of 52.9% who would not mind if Parliament legislates or not.

Proposals

PROPOSAL N.1:

Assessment A Priori

The patient is assessed by a professional prior to committing himself to PAS[1] . This in our humble opinion should be included in the regulation or bill to be presented duly since the patient will be taking on a decision which is in itself irreversible. This is especially the case once the physician expresses the patient's will.

PROPOSAL N.2:

Clarity Of Expression

The law must express the very definition of Euthanasia, whilst expressing that it must be voluntary and the patient's living will. - For this proposal we go further and accordingly we choose to propose that all hospitals have forms available through which the patient can express his wish to die. Such a for would be the DNR Form - thereby the patient is specific about the fact that he does not wish to be resuscitated or placed on any life supporting machines which may prolong his suffering.

1 PAS - This is the acronym for Physician Assisted Suicide.

PROPOSAL NO. 3

RESTRICTING THE YOUNG AND THOSE OF UNSOUND MIND

Euthanasia and the option to apply for such a procedure must not apply for those individuals who have not attained the age of majority.[2] This is the case solely because between the ages of 0 - 9 under Maltese law a child is deemed to be doll incapax and thus they may not possess enough reason to recognise the decision that they are about to take. As with regard to minors between the ages of 10 - 18 they may have enough reason to understand the difference between right and wrong. However, it is our opinion that sometimes they might not necessarily understand the consequences and effects of their decisions.

Furthermore, in our opinion the same should apply to those individuals who are incapable of expressing their will either due to a specific form of mental illness (already recognised in our law) or through mental impairment.

PROPOSAL NO. 4

IDENTIFYING THOSE APPLICABLE

The law is to impose a strict set of conditions such as the following:

1. The patient must be suffering unbearable pain,
2. The illness must be incurable.
3. The demand must be made in "full consciousness" by the patient.

An example a set of strict conditions would be those set in Dutch Law. The law which came into place in 2002 and was the first of its kind, since Netherlands was the first country to legalise Euthanasia and Assisted suicide.[3]

2 The Belgian nation in February became the first country to legalise euthanasia for children. There is no age limit for minors seeking a lethal injection. However they must be conscious of their decision terminally ill, close to death and suffering beyond any medical help. They also need the assent of their parents to end their lives.

3 Belgium passed a similar law later in 2002, making it the second country to legalise Euthanasia and assisted suicide. 'doctors can help patients to end their lives when they are suffering intractable and unbeatable pain. Patients can also receive euthanasia if they have clearly stated it before entering into a coma or a similar vegetative state'. https://www.theguardian.com/society/2014/jul/17/euthanasia-assisted-suicide-laws-world

PROPOSAL NO.5

TIME FOR REFLECTION

There should be a time limit of at least two weeks[4] which allow for a patient to be able to change his mind should he wish to do so prior to the affirmation or signing of any legal documentation. This will serve as a safeguard from ending ones own life, or a wrongful expression of one's own will.

PROPOSAL NO.6

CLARIFYING THE MEDICAL ASPECT

The Bill must list the medical conditions which apply to the possibility of being a patient who may opt for PAS. This in our opinion should be listed as a provision following medical consultation with experts in the field, as well as psychologists who could have patients who opt for the kind of medical treatment.

This in our humble recommendation must be enlisted as it lessens the room for interpretation and all parties concerned can know where they stand.[5]

PROPOSAL NO. 7

HELPING ALL THOSE EFFECTED

Psychological, guidance or / and psychiatric care should be offered to the individuals close to the patient following the act. This helps serve as a form of solace to those whose loved one chose Euthanasia as a way to pass to another life.

4 One chooses the time period of two weeks due to the fact that a greater amount of time can lead to prolonged suffering and thus this will in itself serve as a counter-measure to euthanasia.

5 By parties concerned we make reference to the physician, the family and the patient himself.

Conclusion

Following various research we feel that it is therefore our duty to voice the opinion of those students or individuals who have taken part in this project. It is only through a informed public discussion and the understanding of what is necessary for societal development that the law can truly conform to the world of today.

GħSL would therefore like to call upon the members of the House of Representatives, along with the respective stakeholders to really look into this proposal and into the debate from a neutral legal standpoint. This is even more necessary since one must always observe that the law being billed is objective and non-political. The law is to be enforced upon each person living in or visiting Malta. It is a necessary object to ensure democracy and as such the voice of the people should always be heard.

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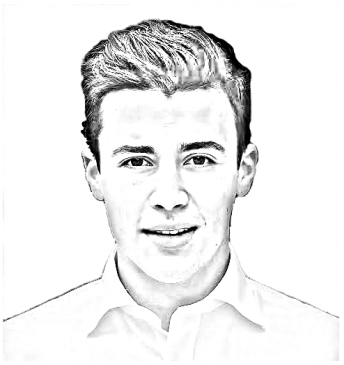

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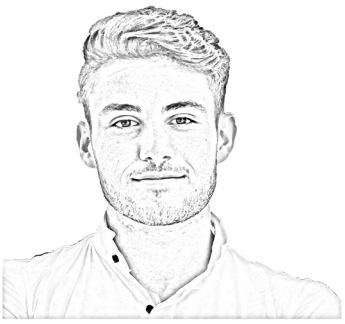

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