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Dear Editor:

In their recent paper, Mendz and Kissane¹ highlight an important and often neglected issue in the ongoing debate regarding the role of assisted suicide and euthanasia in medical practice. They highlight the impact of suffering on autonomous choice and decision-making, particularly the elements of despair, demoralisation and existential distress experienced in the face of the threat of death. Furthermore, their important contribution emphasises the limits confronted when applying familiar principles of autonomy and decisional capacity in this context.²

Beauchamp's commentary³ refers to the assumption of autonomous choice and capacity to make autonomous decisions as a key principle underlying biomedical ethics. The underlying debate and tension regarding application of such principles, as they apply to euthanasia and assisted suicide, is indicative of the complexity of any effort to navigate the clinical context of end-of-life care for patients, families and their doctors. Assisted suicide, as legislated in many jurisdictions, embeds suicide as an intervention to be provided by clinicians when certain conditions are met. The debate and previous evidence highlight the challenge of achieving these conditions. What is a standard of capacity for such a decision? The issue remains unresolved for many clinicians.⁴

Moreover, what does autonomy mean in circumstances that, like many instances throughout life, can compromise individual agency and serve to emphasise an individual's interdependence on others and the interpersonal nature of our life choices? The evidence from studies of patients requesting assisted suicide or a wish to hasten death have highlighted the interpersonal underpinnings of such decisions — fear of burden on others and as highlighted by Mendz and Kissane, family relationships and cohesion.⁵ Furthermore, concern about loss of dignity features prominently in such studies, itself an attribute so often bestowed by the reactions of others to the dying person.⁶ Others have also highlighted the cultural bias in this focus on autonomy alone, a specific feature of so-called western or industrialised societies that is at odds with the dominant values of interdependence and communitarianism in other cultures.⁷

The involvement of the medical practitioner in the act of assisted suicide is itself a critically important dimension — the nature of medical practice, and its important boundaries and moral frameworks have historically enabled doctors to navigate the emotionally tumultuous terrain of end-of-life care with a clear understanding of what is and what is not permissible, with a responsibility to work to understand and address, where possible, sources of suffering and distress.⁸ As Pellegrino⁹ and others¹⁰ have argued, such

an approach is not at the expense of authentic emotional engagement with a patient. On the contrary, such a professional framework is more likely to facilitate a true empathy bounded by the security of clear professional boundaries and limitations on the actions a clinician is permitted to undertake. This is important as the emotional climate of care at the end of life can blind the clinician to the factors driving a patient's desire to die. This is exemplified by the clinician who assumes that a "rational" choice (i.e. one that the clinician can understand as reasoned) equates with "capacity". This is illustrated in the impact of depression on evaluation of risks and benefits of treatment choices — to underestimate benefits or value through a depressive lens of pessimism, loss of meaning and self-worth.

A key element to the clinical context of end of life decision making is the psychology of the doctor-patient relationship at end of life, providing as it can the fertile ground for enactment of clinician biases about what constitutes quality of life and meaningful continuation of life.¹¹ As Hendin has argued, deciding when a patient is to die can be "seductive" in giving the clinician the illusion of mastery over the disease and (their) accompanying feelings of helplessness.¹² This is especially relevant alongside the ample evidence indicating the difficulties experienced by clinicians in discussing death, existential concerns and assessing the psychological needs of their dying patients.

Contrary to Beauchamp's assertion regarding the "good doctor," this does not mean refusing to help, but most importantly, helping the patient through the often difficult task of supporting physical comfort, adapting to the personal upheaval invoked by advancing disease, the fears and concerns for themselves and their families, and the deep but often unspoken existential dread of facing death. This is done, over centuries, without necessitating the doctor's actions to intentionally end a patient's life. To consider the ethical issues in isolation from these critical clinical

perspectives and realities will confront the very limitations in the practical application of such ethical principles so aptly highlighted by Mendz and Kissane.

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Response to a 'Commentary' and Letters

Dear Editor,

It is surprising that Professor Beauchamp in his 'Commentary'¹ states that "The article contains little on agency, autonomy, assisted suicide, or euthanasia" when a whole section in that study² is devoted to describe agency, including a definition (p. 556), and another section discusses the concept of autonomy

and a definition is given (p. 557). Human agency involves the exercise of freedom in self-governance to achieve competent control and the unencumbered intentionality as we initiate actions in our lives. Agency is always subject to internal and external influences. True agency is only realized when these influences are explicated by the exercise of judgement, with insight into these influences and related choices, and by an appreciation of how any decision impacts upon the life of the person.