

the closing moments should they not be helped to persevere in their lifelong goal, rather than be defrauded in a definitive decision by a faulty concept of decisional ability? Informed consent and freedom from duress or subliminal or liminal influence along with cognition, emotions, conscience and the enormous impact of a life lived over decades all come into play in crucial decision-making at life's closing moment (days, weeks, months). Capacity is only one of these many faculties (and not the most important) involved in late life decision-making.

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An odd choice for an editorial!

It is puzzling that this article by Shaw *et al* received the mantle of an editorial!¹ The authors express opposition to psychiatric interview and psychological questionnaires in the assessment of individuals seeking assisted suicide. In my opinion the article should have been published for debate, with a contrary view presented.

The authors, ethicists in Switzerland, argue that for medical specialists to cause delay to assisted suicide is unethical, if a person with sound 'decision-making capacity' clearly and repeatedly and without any ambivalence expresses a wish for assisted suicide over a period of time.

One has to wonder why the authors oppose psychiatric assessments and psychological questionnaires. Psychiatrists are generally regarded among the most skilled of medical interviewers. In the opinion of many, untreated depression should be carefully excluded by psychiatric assessment before assisted suicide is supported. Sadly, there are countries where this is not the case.

The article acknowledges that relatives may coerce for financial gain. The person may wish to please relatives, be afraid to speak against them, etc – and still demonstrate sound decision-making capacity. But the article does not deal with how this thorny problem is to be tackled. In fact, examination beyond decision-making capacity is required: the person's motivation must be clearly established.

Psychological questionnaires have long been designed to clarify a respondent's unspoken beliefs and wishes. It is not hard to imagine a case of elder abuse in which a person fears to directly express their situation – and through an indirect questionnaire, followed by skilled interviewing, a wrongful death might be prevented.

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Physician beneficence: the last stop for patients requesting assisted suicide

In their editorial, Shaw *et al* argue that current medical practice is overly paternalistic towards patients who are mentally competent and who have a terminal illness (including those with psychiatric illness) who request assisted suicide.¹ They base their general argument on the four principles of bioethics with a special emphasis on patient autonomy and end by asserting that, 'any doctor who attempts to prevent a patient who is mentally competent from accessing assisted suicide is adopting an over-paternalistic stance'.¹

The authors' implicit argument against dissuading a patient from assisted suicide appears to rest on the premise that death is a lesser evil (or a lesser suffering) compared with being alive and suffering. We would hold that this premise merits a closer examination.

Life has always been regarded as the basic right and fundamental good for any human person. Aristotle's distillation of popular wisdom is unequivocal: 'death is the most terrible of all things; for it is the end, and nothing is thought to be any longer either good or bad for the dead'.² The person who has lost the desire to live represents the ultimate instance of suffering – existential suffering; and in seeking medical attention, the existential sufferer accepts *de facto* that the physician is the last instance of help. Ultimately a request for suicide is a request for help to relieve existential suffering. It is not a request to annihilate existence.

We would argue that any doctor who unconditionally accedes to assisting his or her patient to die by suicide is abdicating his or her role as a beneficent protector of the sick and suffering and is instead championing absolute patient autonomy.

The Hippocratic dawn of medical practice with its paternalistic physician–patient relationship is thankfully behind us but the beneficent physician is still the necessary companion for the autonomous patient. Indeed, a total abdication of physician beneficence in favour of patient autonomy is neither called for nor is it in the best interests of patients.³ As Brett & McCullough put it 'if the aim of medicine should be seen as a form of beneficence, then doing harm in the service of autonomy is illogical'.⁴

The authors rightly conclude that 'to impose [one's] values on one's patients is deeply unethical and unprofessional'.¹ Certainly patients must always be free to decide about their own life; but again there is something deeply unethical and unprofessional for a doctor who is traditionally committed to saving life to be instrumental in taking away that very life. The ideal physician–patient relationship should be characterised by the equally important contribution of physician beneficence and patient autonomy operating in a shared environment of justice and non-maleficence. In this regard, an open and sincere shared decision-making process is probably the best context within which a constructive discussion of the meaningful alternatives to suicide for the management of existential suffering can take place.⁵ Such alternatives include, but are not necessarily limited to: meaning-centred therapy, hope-centred therapy, dignity therapy and supportive-expressive therapy.

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