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Perspective

Reevaluating Autonomy in Physician-Assisted Dying Legislation: A Call for a Broader Ethical Framework

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DESCRIPTION

As Physician Assisted Dying (PAD) becomes increasingly legalized across jurisdictions, the discourse surrounding it has largely centered on the principle of autonomy. The right to choose the timing and manner of one's death is heralded as the ultimate expression of self-determination. However, while autonomy is a backbone of bioethics and liberal democracies, an overreliance on this principle risks oversimplifying complex moral terrain and obscuring other essential ethical considerations.

The argument for PAD often begins with the individual's right to avoid unbearable suffering and to exercise control over their dying process. This framing has been instrumental in shifting public opinion and legislative action. In Canada, the Netherlands, and parts of the United States, laws have been crafted with stringent safeguards to ensure that decisions are voluntary, informed, and made by individuals with full decision-making capacity. But autonomy in practice is rarely absolute. It is shaped by social conditions, cultural expectations, access to healthcare, and emotional and psychological states. A person may request PAD not simply because of unremitting pain, but due to loneliness, depression, or a sense of being a burden. These are not failures of the individual but signals of systemic and social neglect. In such cases, is the decision truly autonomous? Ethicists have long proposed a more relational understanding of autonomy one that acknowledges that people make decisions embedded within families, communities, and care systems. A purely individualistic notion of choice neglects the interplay of influences such as coercion (subtle or overt), internalized ableism, or economic hardship.

In this light, legislation must do more than assess competence and voluntariness at the surface level. It must ensure robust support systems, mental health care, palliative services, and social interventions are available so that PAD is one option among many dignified ends not the only perceived escape from suffering or neglect.

Another risk of autonomy-centric PAD laws is the potential normalization of assisted death for people with disabilities, the elderly, and those with chronic but non-terminal illnesses. When autonomy is used as the primary ethical yardstick, the unique vulnerabilities of these populations can be sidelined. Countries such as Belgium and the Netherlands have faced criticism for expanding PAD access to individuals with psychiatric conditions or existential distress. While intentions may be compassionate, these cases challenge the integrity of informed consent and blur the line between respecting autonomy and enabling despair. Legislation must carefully guard against structural ableism and ensure that PAD does not become a mechanism through which society indirectly communicates that some lives are less worth living.

Rather than abandoning autonomy, this commentary calls for its recalibration within a broader ethical framework that includes:

- Equal access to end-of-life care, and protections against discrimination in PAD eligibility.
- Ensuring that PAD is offered in the spirit of reducing suffering, not as a substitute for adequate care.
- Vigilance against unintended harms, including pressure to die or premature recourse to PAD in the absence of alternatives.

Recognizing suffering in its many forms physical, psychological, existential and responding with holistic care, not only medical solutions. Physician-assisted dying is a morally complex issue that cannot be reduced to the language of rights and choice alone. While autonomy remains a vital principle, laws that lean too heavily on it risk overlooking the societal and interpersonal dimensions of dying. Future legislative efforts must integrate a richer ethical analysis one that addresses the realities of vulnerability, inequality, and relational interdependence. Only then can physician-assisted dying be truly compassionate, just, and humane.

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