

A Systematic Review of Stakeholder Perspectives of Dignity and Assisted Dying

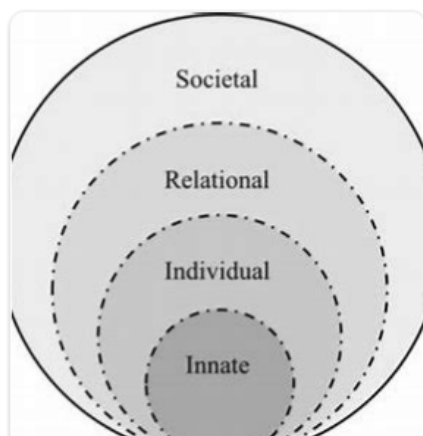
These are excerpts of an article in a medical journal. The full article includes references, more discussion and a lot of methodological details, I am reproducing only the introductory material and the conclusions. If you want to see the full article go to [A Systematic Review of Stakeholder Perspectives of Dignity and Assisted Dying \(jpsmjournal.com\)](http://jpsmjournal.com) The numbers in the text refer to footnotes in the original article.

Introduction Until recently, the debate on assisted dying and its components, euthanasia, and physician-assisted suicide, has been largely influenced by local legal, practical, social and cultural considerations.^{1,2} It has also been largely confined to patients with limited prognoses. Here, euthanasia refers to the intentional administration of lethal drugs by a physician to end a patient's life.^{3–7} Physician-assisted suicide refers to the act of providing a patient with lethal medication and/or the means to end their lives.^{4,8,9} However, the introduction of the right to die and the maintenance of dignity for the terminally ill has seen views and requests for assisted dying change. Hendry et al,¹⁰ Monteforte-Royo et al¹¹ and Rodriguez-Prat et al¹² found that the highly individualised requests by patients and their families for assisted dying were increasingly triggered by **fears or the presence of a loss of dignity**.^{10–12} These include irreversible physical deterioration, immobility, incontinence; failure to manage daily activities; limitations to or a loss of independence and autonomy; and/or compromises to one's personal, familial, professional, and societal roles.^{10–12} **Determinations of intractable and/or 'unbearable physical or mental suffering'** associated with an irretrievable loss of dignity are especially pertinent in the Netherlands, Belgium, Luxembourg, Switzerland, Canada, New Zealand and states such as Oregon, California, Colorado, District of Columbia, Hawaii, Maine, New Jersey, New Mexico, Vermont and Washington where it could lead to legally sanctioned access to assisted dying.⁵

Rodriguez-Prat and van Leeuwen¹³ revealed that concepts of dignity within the assisted dying debate are not static but dynamic, complex, highly personalised, socially informed, and context dependent suggesting that these concepts evolve over the course of a disease and in different care, health, social, relational and personal circumstances. In turn, these postulations demand holistic, longitudinal, and personalised study of dignity. However, such studies have been limited. To help this process of understanding changing self concepts of dignity, the research team built on links between self-concepts of dignity and notions of personhood or how patients conceive "what makes you, you" to posit that the **Ring Theory of Personhood (RToP)** could proffer a better appreciation of ties between self concepts of personhood, dignity, WTHD (*Wish to Hasten Death*) and support or opposition to assisted dying.^{10,14–17} Perhaps more

significantly, these authors suggest that the RToP could map changes in self-concepts of personhood as patients progress along their illness trajectories, providing physicians with a unique opportunity to address changing notions of dignity and direct timely, appropriate and personalised support to stakeholders confronting concerns over losses of dignity. This could prove invaluable in the care of patients in the Netherlands, Belgium and in states like Oregon and Washington where over 60% of requests for assisted dying relate to a loss of dignity.⁵

The Ring Theory of Personhood The RToP posits that concepts of personhood may be represented by the Innate, Individual, Relational and Societal Rings.



Each ring contains specific values, beliefs and principles that inform their corresponding identities. The Innate Identity is derived from the patient's Innate Ring which informs their thoughts, feelings, personality, narratives, conduct, values, beliefs, principles, biases, experiences, and decision-making processes in relation to their **spiritual, religious and/or theist values, moral ideals, and ethical principles**. The **Individual Identity draws on the values, beliefs and principles surrounding the patient's conscious function** contained within the Individual Ring. The Individual Identity is informed and **informs the patient's narratives,**

experiences, and personality. The patient's Relational Identity is born of values, principles and beliefs governing their important personal relationships within their Relational Ring. The Societal Identity is shaped by the values, principles and beliefs informing their interactions with those people whom the patient deems do not share personal nor important relationships with them. The Societal Identity is also shaped by regnant societal, religious, professional, and legal expectations.

[If you want to read a little more, I suggest the Discussion session in the original article, but I'm not reproducing it here]

Conclusions. Concepts of dignity constantly evolve along individual contextual, practical, clinical, emotional, psychosocial, spiritual, relational, familial, sociocultural and legal considerations and continue to fluctuate throughout the patient's end of life journey. These self-concepts of dignity appear to be a proxy for sustaining self concepts of personhood and how patients wish to be perceived by others. A loss of or the fear of a loss of dignity or autonomy are amongst the more prominent sources resulting in the patient's wish to hasten death and their request for assisted dying. However, the import of addressing

patient distress using person-centred dignity conserving measures in a timely manner has been neglected. We believe a tool based on the Ring Theory of Personhood may be helpful in identifying violations to personal concepts of dignity and allow for prompt, accessible, individualised, ongoing and comprehensive dignity-conserving support to be directed to patients and their families. Guided by this tool, holistic psycho-existential support provided by specialist palliative care teams could help to attenuate their distress. As we continue to extend our understanding of suffering, dignity and the wider role of palliative care, we will direct our attention to the design and evaluation of this tool