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Between Safeguard and Constraint: Navigating Patient Autonomy in Protective Laws for Medical Assistance in Dying

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ABSTRACT

There has been an increase in the number of jurisdictions legalizing or decriminalizing Medical Assistance in Dying (MAiD). Legal frameworks worldwide strive to balance respect for autonomy with regulatory safeguards that both operationalize voluntary choice and prevent access to MAiD in cases of remediable despair or coerced decision-making. However, the implementation of such an equilibrium diverges. Some legal systems prioritize personal autonomy and informed consent as the main criterion to access MAiD (e.g., US jurisdictions), while others also add the alleviation of suffering (e.g., The Netherlands). Using the lens of relational autonomy and focusing on Spain's MAiD legislation as a case study, this article poses the question of what notion of autonomy is implied in this system, and whether the imposition of certain safeguards might inadvertently undermine or restrict autonomy, in some specific cases. To that aim, we first analyze its stringent requirements for assessing the so-called "euthanasic context" which establishes eligibility conditions to access MAiD; then, we highlight how some of its assessments can interfere with the person's autonomy. The analysis highlights how protective measures (e.g., three external assessments before the request is either granted or denied) may imply forms of pathogenic vulnerability, in which safeguards meant to protect autonomy could paradoxically heighten an individual's vulnerability while diminishing autonomy through forms of epistemic injustice. We conclude that these highly protective laws might fall into the "trap of protection," illustrating the tension between safeguarding autonomy and respecting individuals' capacity for self-determination in the context of MAiD.

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1 | Introduction

There are currently 32 jurisdictions in the world, distributed across Europe, America, and Oceania, where some form of assisted dying has been decriminalized [1]. Medical Assistance in Dying (MAiD) presents a complex intersection of ethics and law around individual autonomy. A central debate revolves around the role of legal frameworks designed to protect individuals during their decision-making. Depending on local regulations and constitutional options, each country lays the foundation for the right to MAiD based on different concepts. In some legal systems (e.g., in Austria and Germany), personal autonomy and the assurance that the patient's decision is free from coercion and based on informed consent are fundamental. However, in other legal systems (e.g., in Canada and The Netherlands), the primary focus is to alleviate suffering, and the legislation emphasizes compassion rather than solely focusing on the right to make decisions about their lives. Differential emphasis on one condition or the other has direct implications on the eligibility criteria for MAiD. This has a tangible impact on some conditions, such as dementia. In the Netherlands, for example, patients with mild dementia who have previously requested MAiD through an advance directive are not eligible if they are not perceived to be experiencing unbearable suffering.

Regardless of where the focus is placed, legal systems establish guarantees and safeguards to protect persons' autonomy while accessing MAiD. A protective legal framework for MAiD might both foster and or restrict patient autonomy. This question is critical, as numerous countries strive to design and implement protective legal frameworks for the legalization of MAiD. Therefore, it is imperative to critically examine the benefits as well as the potential risks these protective laws pose, both to prevent such outcomes and to enhance access to safe MAiD within existing models.

This article analyzes the legislation on MAiD from a relational autonomy perspective, understood as the view that individual autonomy is shaped and enabled by social relationships, power structures, and social conditions, rather than exercised in isolation [2, pp. 3–31]. First, together with this theoretical framework, we incorporate and explain the lenses of *epistemic injustice* and *pathogenic vulnerability*. According to Miranda Fricker [2], epistemic injustice refers to the harm inflicted on individuals in their capacity as knowers. In healthcare settings, epistemic injustice occurs when prejudice leads patients' testimony to be unfairly dismissed, or when they lack the conceptual resources to properly understand and communicate their health experiences. Pathogenic vulnerability is a form of vulnerability that is created or intensified by social, institutional, or policy responses, where attempts to protect or assist individuals paradoxically increase their exposure to harm instead of reducing it [3]. These concepts serve as the basis for analysing what we describe as the potential *trap of autonomy protection* in the context of MAiD.

We then examine what makes a MAiD law "protective". After that, we describe the Spanish legislation on MAiD and specifically the legal requirements for assessing the "euthanasic context" (a concept under Spanish law referring to the framework of conditions within which the decision to request MAiD is made). We then explore the question of what notion of autonomy (procedural or substantive) is implied in this system and discuss in what terms autonomy is defined, enhanced, or restricted. From that analysis, we conclude that the Spanish legislation on MAiD is a highly protective model due to its access conditions to MAID.

Then, we defend that, intendedly or not, the need to assess certain criteria (e.g., the existence of unbearable suffering) negatively affects the person's autonomy. Hence, the imposition of safeguards in the design and restrictiveness of access conditions might inadvertently undermine or restrict autonomy (by generating or reinforcing forms of epistemic injustice and pathogenic vulnerability) instead of enhancing it. From that analysis, we conclude that highly protectionist regulatory frameworks may not effectively fulfill a protective function at all. We propose a fictitious case to illustrate the implications of this paradox.

As strengthening patients' autonomy is particularly important in contexts of potential power asymmetry, sensitizing policymakers and healthcare professionals involved in the development and application of MAiD laws seems necessary. Finally, we offer practical considerations to avoid the paradox of undermining autonomy while trying to protect it.

1.1 | Relational Autonomy in the Context of MAiD

Relational autonomy emerged within feminist bioethics as a critical response to individualistic conceptions of autonomy that did not consider the impact of people's social contexts in decision-making [2, pp. 3–31]. Rather than understanding autonomy as an individual's innate isolated capacity for self-determination, relational autonomy emphasizes that human beings are socially embedded and that autonomy is constituted, exercised, and sustained through relationships and social conditions. As Susan Dodds argues, relational accounts of autonomy are concerned with safeguarding the relational conditions that make substantive autonomy possible, thereby redirecting attention from isolated acts of choice based on non-interference from third parties to include an analysis of the structures of support, recognition, and power that shape and constrain agency [4]. According to this view, in healthcare contexts, respecting autonomy requires more than just a procedural action of informed consent: it demands attentiveness to patients' values, lived experiences, and networks, as well as to how professional practices shape decision-making processes [5]. Relational autonomy is thus best understood as a capacity that needs to be developed within supportive relationships and caring practices, which highlights healthcare professionals' responsibilities to actively foster patients' agency under conditions of illness, dependency, and power asymmetry [6].

From this perspective, vulnerability is no longer understood solely as a limitation on autonomy but rather as a relational condition that can be mitigated or, conversely, exacerbated by social, institutional, and professional structures themselves. Given that autonomy depends on recognition, trust, and meaningful participation in shared interpretive practices, a change in these conditions has direct implications for individuals' agency and, consequently, for their ability to make autonomous choices. This perspective invites us to pay closer

attention to two interconnected risks that are particularly prominent in healthcare contexts: epistemic injustice and pathogenic vulnerability.

On the one hand, the generic characterization of epistemic injustice in the classic work of Miranda Fricker takes as a reference the harm caused to a person as an agent capable of producing and transmitting knowledge [2]. This harm may have two origins: (1) in the listener's prejudice, which diminishes the credibility of the speaker's words (testimonial injustice); or (2) in the absence of the interpretative resources necessary for the disadvantaged subject to be able to give a full account of their condition (hermeneutical injustice). Medical expertise prevails over patient experience, which leads to a limitation of epistemic authority to those in health professions.[1] The condition of vulnerability generated by disease and power relationships can affect trust and epistemic capacities, jeopardizing the autonomy necessary for epistemic agency.[2] In that sense, people with health problems are considered to be at greater risk of hermeneutic injustice, to the extent that they are forced into an epistemically marginal role in consultations, or labeled as "difficult", "irritating", and even "self-destructive" patients [7]. Consequently, the experiences and meanings of those with any disease might be misunderstood or ignored. The looks of skepticism, the constant interruptions, and the questioning of what is said or meant in silence limit or distort the discourse of the speaker [8], in this case, of the ill person. When someone's intelligibility is questioned, their capacity to testify is restricted, and unfair pressure is placed on their capacity to generate and share meaning.

On the other hand, the concept of vulnerability in bioethics has often been linked to protecting those more susceptible to harm [9–11]. Still, this view risks associating vulnerability mainly with an inability to exercise autonomy [12, 13] and fails to reconcile the obligations arising from vulnerability concerning the person's actual capacity for autonomy [3]. To better understand the dynamics of vulnerability and try to avoid the traditional classification of vulnerable groups, Rogers, Mackenzie, and Dodds proposed a distinctive taxonomy [4, pp. 24–25], categorizing vulnerability into different forms and states. They identify three primary types: inherent vulnerability, situational vulnerability, and pathogenic vulnerability. *Inherent vulnerability* is intrinsic to the human condition, rooted in our corporeality and dependence on others. It is a universal and ever-present aspect of being human. *Situational vulnerability* arises from the specific context of an individual or group. It is influenced by personal, social, political, economic, and environmental circumstances, highlighting the sociological dimensions of vulnerability. *Pathogenic vulnerability* is more complex, and arises from morally dysfunctional or abusive social relationships, socio-political oppression, or misguided policy interventions. This type of vulnerability is paradoxical: it is often created by attempts to mitigate other vulnerabilities, yet these attempts instead increase or exacerbate them. For instance, policies intended to protect vulnerable individuals may inadvertently perpetuate new vulnerabilities due to power imbalances or systemic biases. Pathogenic vulnerability is inherently political, as it stems from disparities in power between those who design protective measures and those subjected to them.

From the perspective of relational autonomy and being aware of the risks posed by both epistemic injustice and pathogenic vulnerability, we argue that overly protective laws (in the sense that their high restrictive conditions to access) can, unintentionally, create what we call the *trap of autonomy*, especially in those cases in which there is more uncertainty about patients' right to access the practice (e.g., patients with chronic pain). Paradoxically, in the attempt to ensure that the autonomy of MAiD applicants is respected and protected, these regulatory frameworks can have the opposite effect: reinforcing dynamics of epistemic injustice and generating forms of pathogenic vulnerability by questioning the credibility or rationality of those who request MAiD. Instead of strengthening the agency of applicants, certain eligibility assessments place them in a position of suspicion and epistemic delegitimization. Hence, MAiD requesters may end up finding themselves in a position of vulnerability, not because of the fact of requesting MAiD, but because of the questioning by the very structures and frameworks designed to protect their interests and/or mitigate their situational vulnerability.[3] In the following section, we analyze what a protective legal model in the field of MAiD consists of and what its main characteristics are.

1.2 | What Is a Protective Law in MAiD?

One of the main concerns when any country considers permitting MAiD is ensuring that the practice is adequately regulated, and that careful medical practice is guaranteed. All Council of Europe members, having ratified the European Convention on Human Rights (ECHR), must ensure their laws respect its principles. The jurisprudence of the European Court of Human Rights (ECtHR), as the highest interpreter, is crucial in identifying the elements that make an assistance in dying law protective.

In its 2011 *Haas v. Switzerland* judgment [14], the ECtHR emphasized that the right to life under Article 2 of the ECHR requires States to establish a procedure that ensures that a decision to end one's life reflects the individual's free will. While the 2015 *Lambert v. France* judgment acknowledged that States have discretion in determining how to meet this obligation, it stressed that this discretion is not absolute and that end-of-life laws must be clear [15]. Similarly, in the 2022 *Mortier v. Belgium* judgment, the Court highlighted that MAiD laws must ensure the individual's decision is made freely and with full understanding. The Court also emphasized that euthanasia requests should reflect a considered and constant wish, particularly in cases involving patients who are not terminally ill, which require enhanced safeguards. One such safeguard is a waiting period between the request and the administration of lethal substances, with the Court considering Belgian law's stipulation of a mandatory 1-month interval as appropriate. The Court also found it appropriate for a second independent doctor to review MAiD requests. While the Court did not deem an *ex-ante* commission review essential, it insisted that substantive and procedural safeguards and an independent evaluation system were necessary. In Belgium, the Court affirmed that the proposed system, which includes a multidisciplinary commission appointed by a legislative assembly, ensures independence and the expertise required for proper evaluation.

Having examined the ECtHR's jurisprudence, it becomes clear why any assisted dying legislation in a Council of Europe

member State includes measures to ensure that the decision to die is made freely, autonomously, and without coercion. Notably, since Article 2 of the ECHR obliges States to protect individuals' lives even against their own actions [16], jurisdictions that legalize MAiD must guarantee that requests for MAiD stem from the patient's genuine and autonomous decision. The UN Human Rights Committee similarly holds that States parties to the International Covenant on Civil and Political Rights, allowing assisted dying, must comply with Article 6, which protects the right to life. Accordingly, such States "must ensure the existence of robust legal and institutional safeguards to verify that medical professionals are complying with the free, informed, explicit and unambiguous decision of their patients, with a view to protecting patients from pressure and abuse" [17]. Therefore, according to the ECtHR and the UN Human Rights Committee, a MAiD law is considered protective insofar as it establishes safeguards to ensure decisions are made freely and autonomously.

A key tool for this goal is the establishment of an Evaluation Commission (EC).[4] Such commissions are designed to ensure that MAiD is performed under strict legal, medical, and societal due care requirements. The primary objectives of the EC are (1) to provide legal certainty for doctors facing conflicting obligations, (2) to ensure transparency in the practice of MAiD and enable public scrutiny, and (3) to safeguard, monitor, and promote the careful consideration involved in medical decisions about terminating life on request. These commissions aim to maintain the quality of such decisions and to apply uniform criteria to MAiD requests [18].

In the Netherlands, Belgium, and Luxembourg, the EC reviews notified cases of MAiD *a posteriori*—after the procedure has been completed—to determine whether it complied with the legal due care requirements. If the EC concludes that the requirements were met, the case is closed. However, if the EC identifies a violation, the case is referred for further investigation. In contrast, Spanish law mandates *ex-ante* verification by the EC, requiring compliance with legal requisites to be confirmed before the MAiD procedure takes place. This approach aims to ensure rigorous safeguards by triple-checking that access criteria are met and that the patient's autonomy is fully upheld, guaranteeing the decision is entirely their own. To this end, the Spanish process includes a prior review conducted by two EC members—a doctor and a lawyer—who must verify that all procedural steps have been appropriately followed before MAiD is provided [19].

In general terms, once we have briefly analyzed some of the jurisprudence, the following elements can be identified as key to defining the characteristics that make a MAiD law more protective:

1. Laws can establish follow-up and monitoring mechanisms either prospectively, which can be considered more protective, or retrospectively (to determine whether there was any irregularity).
2. Laws can be more protective depending on the number and type of professionals involved in assessing the request. Thus, the greater the involvement of multidisciplinary professionals, the lower the risk of biases that any one of them may have.
3. Some laws set deadlines for applicants to reconsider their decisions, ensuring that their choices remain free and consistent over time. We consider laws that allow more time for decision-making to be more protective.

The Spanish law is a perfect example of a highly-protective regulation, as it has a triple external evaluation before the performance of MAiD, an *ex ante* commission, and longer periods to assess the stability of the person's wish to die.

1.3 | The Case Study of the Spanish Law as a Highly Protective Regulation

This section analyzes the underlying definitions of autonomy, capacity, and freedom in the Spanish Organic Law on the Regulation of Euthanasia (henceforth LORE). Both freedom and autonomy are related to guarantees and safeguard rationale in MAiD legislation. Nevertheless, whether the law assumes procedural or substantive approaches to autonomy and whether it uses negative or positive notions of freedom utterly changes how safeguards are understood.

Previous literature on autonomy in end-of-life care laws highlights that this rich ethical concept is underdeveloped and poorly defined in law [20], leading to narrow interpretations based on a right to non-interference. These concerns can also be applied to the LORE. In Preamble I, it is said that the law:

> *"seeks to legislate to respect the autonomy and will to end the life of those who are in a situation of serious, chronic and incapacitating suffering or of serious and incurable illness, enduring unbearable suffering that cannot be alleviated in conditions that they consider acceptable, what we call a euthanasic context. To this end, the present Law regulates and decriminalizes euthanasia in certain clearly defined cases, subject to sufficient guarantees that safeguard absolute freedom of decision, ruling out external pressure of any kind." [21]*

A first careful reading shows that the law restricts the possibility of accessing MAiD to certain specific criteria defined by the "euthanasic context." The euthanasic context covers two circumstances: the existence of a serious, chronic and incapacitating suffering (chronicity) or of a serious and incurable illness (terminality), causing the requester to endure unbearable physical or psychic suffering that cannot be alleviated under conditions that they consider acceptable, and by the person's moral convictions about their life situation being incompatible with personal dignity. Hence, the Spanish law does not follow a solely autonomy-based approach [22]. Conversely, there is a need to verify that requesters meet some criteria and medical conditions first. If guarantees are justified to safeguard absolute freedom of decision, two questions arise: (1) How is autonomy understood? (2) Can safeguards be an obstacle for absolute freedom?

1.3.1 | Procedural Individual Autonomy

Procedural accounts of autonomy are considered content-neutral in the sense that the content is irrelevant, and what

ensures the autonomous act is whether the agent has subjected their desires, values, beliefs, and motivations to appropriate critical reflection [23]. By critical reflection, we mean cognitive processes of reflection (self-rule) that are not interfered with by illegitimate external influence, such as manipulation or coercion, or by forms of external pressure (including unfavorable socioeconomic environments). A possible interpretation of the aforementioned Preamble I is that autonomy is to be respected as long as the conditions for the euthanasic context are present. In that case, once it is proved that the underlying medical condition exists and that cognitive capacities are preserved, the will of the requester should be enough to accept a MAiD request. If that is true, autonomy would be understood in procedural terms [24]. As we see it, the law intends to use the notion of autonomy in procedural terms.

In Chapter 2, Article 4.2 of the LORE, an autonomous decision is defined as "one that is grounded in the knowledge of the person's medical situation, after they have been adequately informed by the healthcare team in charge" [21]. In the subsequent Article, it is said that "persons requesting the provision of MAiD should receive information, inform and express their will, give their consent and communicate and interact with the environment, in a free manner, so that their decision is individual, mature and genuine, without interference, meddling or undue influence" [21]. Moreover, sections b and c from Chapter 2, Article 5, which defines the criteria to access MAiD, refer to the need for patients to receive written information of their medical situation and alternative procedures (including palliative care) included in the public health system, and to formulate two voluntary, written requests, that are not the result from any external pressure, with at least 15 natural days between them.

However, it is unclear whether this is in fact the case. Although it is never recognized as such in the law, the evaluation of the euthanasic context involves a substantive approach to autonomy in which values, beliefs, and motivations are judged to be correct or not. Hence, a disharmony exists between the procedural account of autonomy described and the factual, unintended, substantive account of autonomy required.

1.3.2 | Absolute Freedom of Decision?

Expressions of freedom in the Spanish law can be found in terms of decision-making (e.g., "absolute freedom of decision") or related to a person's state (e.g., "absolute freedom," "free person"). Preamble I asserts that "When a fully competent and free person is faced with a life situation that, in their judgment, violates their dignity, privacy, and integrity, such as the one defined by the euthanasia context [...], the good of life may decline in favor of the other goods and rights against which it must be weighed." However, there is a difference between freedom to make decisions and freedom as a personal state.

If we consider freedom as a personal state, we cannot claim that "absolute freedom" exists, as the law constrains the freedom of citizens regarding how and when to die by determining a euthanasic context [25]. Then, instead of complete freedom, we must understand it as a form of agreed conditioned freedom. Now, if we consider "absolute freedom of decision", it is usually mentioned in the law related to "external pressure" or "coercion". Hence, although, as previously mentioned, the LORE briefly alludes to positive freedom by requiring certain cognitive and communicative agencies for decisional capacity, the text primarily emphasizes a negative conception of freedom, and focuses instead on coercion and non-interference.

When freedom is mostly understood in this sense of non-interference in the decision-making process [20, 26], which is considered key to ensure an autonomous decision, all safeguards and protective measures taken are directed to avoid any kind of coercion. In the Spanish case, the law requires an external assessment—by a referring physician, a consultant physician, and an *ex-ante* EC—that verifies (1) a sustained will over time and (2) the protection from external pressures.

In practice, though, the inclusion of specific clauses within the 'euthanasic context' that allow them to exercise their will may act as a hindrance to the person's freedom and autonomy, as we will see below.

1.3.3 | Validation of the Euthanasic Context

Preamble II highlights two key elements in external assessment: evaluating the requester's capacity, and the euthanasic context. However, neither the law nor the Guide of Good Practices in Euthanasia (GGP) [27] describes specific evaluation methods. According to the GGP, the referring physician must inform the patient, offer alternatives, and confirm legal criteria, while the consultant physician verifies the euthanasic context. Then, the EC must review all information before MAiD is performed.

On the one hand, the evaluation of a requester's "full capacity to act and decide" must be understood in terms of preserved cognitive capacities, which shouldn't be problematic, except in some cases (e.g., in the initial or middle stages of dementia or in cases of mental illness). Nevertheless, assessing competence is not merely a factual process; it also involves an evaluative judgment in which healthcare professionals may bring their moral perspectives into play, which may then compromise the requester's autonomy in some cases [28, 29].

On the other hand, there are several reasons why evaluating the euthanasic context is not as easy as filling out a checklist of information. The three external evaluators (referring physician, consultant physician, and EC) must check (1) that the person is considered to be experiencing either serious, chronic and incapacitating suffering or a serious and incurable illness, enduring unbearable physical or psychic suffering, (2) whether there are alternative possibilities to alleviate suffering, (3) whether the personal moral conditions of the requester regarding dignity are incompatible with their life conditions, and (4) autonomy and freedom from interference, as a means and guarantee of safety use of the right to MAiD.

Considered together, these four conditions that need to be validated by three external assessors before MAiD is performed can pose a threat to autonomy understood in procedural, instead of in substantive terms—as a value-laden notion in which the contents of the agent's values and preferences are relevant [23]. Let us first focus on condition 3, that is, whether the personal moral convictions around dignity are incompatible

with their current life conditions. This requirement exceeds any verification of autonomy understood in procedural terms—as the law seems to do. Thus, we can affirm that the evaluation of a MAiD request includes a notion of substantive autonomy. Another example that supports this interpretation is condition 1. Determining what constitutes "unbearable suffering" involves value-laden elements of verification. Suffering is a subjective experience that might involve emotional, social, or existential suffering related to loss of agency, loss of engagement with society, and loss of personhood [30], which relate to moral values and principles. When healthcare professionals are required to assess the existence of such forms of suffering, they are indirectly requested to evaluate a person's autonomy in substantive terms, too, as we will unfold in the following sections. This particularity is unique in countries that include value-laden notions in their criteria to access the practice.

Although these criteria are not exclusive of highly protective regulations, their coexistence with the extra safeguards previously mentioned (triple external evaluation before MAiD, an *ex ante* commission, and longer periods to assess the constancy of the person's wish to die) increases potential overquestioning of the "validity" of their reasons to request MAiD. We will unfold two examples of how the assessment structure of the euthanasic context can challenge the person's decision-making capacity and autonomy.

Let us just focus first on the time frame. According to Chapter 2, Article. 5.1, MAiD requesters must voluntarily formulate two written requests with at least a 15-day gap between them, and the referring physician must initiate a deliberation process with the patient between the first and second requests [21]. Compared to other laws around the world, this unusually long gap aims to make sure that the decision is made freely and autonomously. Deliberation must include information on the patient's diagnosis, treatment options, and foreseeable outcomes, to ensure an informed decision. The deliberation continues after the second request to resolve any doubts and to confirm the patient's will. These could be seen as classical approaches to autonomy defined by the Belmont Report (1978) or by Beauchamp and Childress [31]. Nevertheless, most people requesting MAiD have already discussed their general death wishes with the physician at some point, deliberated and arrived at an autonomous decision even before writing the first official request with the referring physician [32]. The existence of extra safeguards that require the evaluation of second and third parties before MAiD is granted or denied implies longer periods that are estimated to last, at least, around 2 months. As a result, this protective measure might end up being a limitation in patients' autonomy and freedom, which could mean that in order to protect autonomy, autonomy can be hindered. Further studies are needed to check if this hypothesis responds to reality.

Let us now turn to the evaluation of unbearable suffering. The Spanish law recognizes the subjectivity of each person's experience of suffering and notion of dignity. However, as the law also requires the external assessment of the unbearability of suffering, which means that some kind of negotiation must exist between the person requesting MAiD and healthcare professionals who must assess the fulfillment of the euthanasic context. Due to its subjectivity and link to personal moral values, an assessment of the existence of unbearable suffering can, once more, be understood as a validation of the request in terms of substantive autonomy, that is, the validation of the reason behind the decision.

Suppose that healthcare professionals are *de facto* evaluating autonomy in substantive terms. In that case, a protective system can be positive in the sense that moral judgment on the patient's autonomy does not depend on one single agent who could be biased, but on three agents. Nevertheless, this same factor can be negative—and even damaging—, especially in populations suffering social stigma or a historical lack of credibility, as in cases of mental illness or gender biases [33] when patients' and professionals' perspectives differ.

Now, according to the definition of autonomy provided by the law, autonomy must be evaluated in procedural terms. Nevertheless, the law also seems to require an underlying evaluation of autonomy, understood in substantive terms, when it demands healthcare professionals to validate the euthanasic context. As the law does not contemplate autonomy in these terms, it fails to see how its highly protective model can affect people's autonomy and cause some negative side effects.

1.4 | Widening the Scope of Autonomy: Antonio's Case

Antonio is a 52-year-old patient who was diagnosed with Amyotrophic Lateral Sclerosis (ALS) 3 years ago. Although he partly retains his speech, some functionality in his hands, and cognitive ability, the disease has progressed, resulting in significant loss of mobility, wheelchair dependence, and the need for oxygen therapy for 12 h per day.

Aware of the irreversible nature of his disease and after a long period of reflection, Antonio has submitted a request for medical aid in dying as a means of securing control in the face of a progressive and unpredictable deterioration that he perceives as inevitable. Antonio expresses intense discomfort at the immediate prospect of total dependence and possible invasive interventions, such as a tracheotomy, scenarios that he considers "incompatible with his values, his conception of quality of life, and his personal dignity". This distress is accompanied by significant suffering, encompassing both the physical limitations already present and the experience of progressive loss of autonomy leading to total dependence.

After passing an interview with both the referring and the consultant physician, who hold different views of his request, he has a third interview with two members of the Guarantee and Evaluation Commission to elucidate his case. Antonio presents a calm, cooperative, and at times smiling attitude, in keeping with his usual coping style, especially in front of his minor children. According to Antonio, this demeanor is met with skepticism by the evaluators. He perceives that they implicitly question the intensity and legitimacy of his suffering due to the absence of visible signs of extreme distress or terminal decline.

The patient experiences the interview as one marked by distrust and scrutiny. For Antonio, this interaction echoes his previous

encounter with the consulting physician, during which he had already perceived that his suffering was being called into question. He believes that his testimony regarding both current and anticipated suffering, as well as the progressive loss of dignity, is invalidated for failing to conform to a typical clinical narrative of a terminally ill patient. Rather than validating his decision, the interaction generates a profound sense of being misunderstood and emotional distress.

Antonio's vignette allows us to humanize the issue we seek to examine in depth: namely, the extent to which eligibility safeguards in Medical Assistance in Dying (MAiD) regulation may undermine patient autonomy.

The distinction between procedural and substantive conceptions of autonomy captures the central dilemma of highly protective MAiD regulations. In a model such as the one in US jurisdictions, where the person must have a terminal illness but no requirement of unbearable suffering exists, autonomy can be understood as a purely formal procedural idea. Some have considered this problematic, as there might be subtle kinds of "internalized external pressure" on some patients who may feel they are not worthy [34]. However, substantive conceptions of autonomy lead to assessing patients' "real" motives to request MAiD. On the aforementioned premise, the Spanish protective model defends a procedural account of autonomy, but actually assesses a substantive account of autonomy, which can compromise some people's autonomy by demanding the validation of the euthanasic context without further explanation of how to go about it. If we are correct, then we need a different approach to autonomy to comprehend it in substantive terms.

We defend that a relational autonomy framework can be a good approach to deal with this problem and help us conceptualize safeguards and constraints of highly protective models, such as LORE. According to Mackenzie [35], relational autonomy involves three dimensions: self-determination, self-governance, and self-authorization. Self-determination involves "having the freedom and opportunity to make and enact choices of practical importance to one's life, that is, choices about what to value, who to be, and what to do" [38, p. 26]. It includes external and structural conditions, especially *freedom* (social and political constraints) and *opportunity* conditions. Self-governance involves having "the skills and capacities necessary to make choices and enact decisions that express or cohere with one's reflectively constituted diachronic practical identity" [38, p. 31]. It is related to internal conditions such as cognitive competence and authenticity (regarding one's motivational structure). Finally, self-authorization involves "regarding oneself as having the *normative authority* to be self-determining and self-governing" [38, p. 35]. In other words, one needs to feel authorized to exercise practical control over one's life and to determine one's own values and commitments.

If we want to maintain the safeguard of three external assessors over a longer period of time, and if we continue to require value-laden elements in the euthanasic context, then these three dimensions of relational autonomy can guide healthcare professionals' tasks in deciding whether a person meets the criteria to access MAiD better than the current framework. Moreover, the use of this model can also help us analyze in which ways self-determination, self-governance, and self-authorization might be currently compromised in the external evaluations, especially in certain cases that are dubious according to healthcare professionals' moral framework. To this aim, we will discuss Antonio's vignette of a MAiD request case shown at the beginning of this paper.

From a procedural account of autonomy, Antonio has been granted the protection of his autonomy and freedom; he has been able to submit the two consecutive requests to his referent physician after being informed of his medical situation and potential alternatives at his disposal. In this sense, he has given explicit voluntary consent to continue with the request after proving a constant wish to hasten death. To ensure that his autonomy is protected from coercion and interference, a consultant physician and two evaluators from the Guarantee and Evaluation Commission have analyzed his case. Hence, from a procedural perspective, there is no problem regarding Antonio's autonomy.

However, if we analyze Antonio's case from the substantive standpoint, as the law, unintentionally, actually requires, the situation changes. According to the vignette, the consultant physician and the two evaluators from the Guarantee and Evaluation Commission have questioned the intensity and legitimacy of his suffering, and his notion of what is a dignified life, according to his values. In their eagerness to assess Antonio's situation, they have dismissed Antonio's testimony because his overall appearance is incompatible with what they consider "unbearable suffering." In this case, the system has committed a form of epistemic injustice (testimonial injustice) based on the delegitimization of Antonio as a source of knowledge. This epistemic exclusion not only ignores his voice but also becomes a source of new "pathogenic" vulnerability: in an attempt to protect Antonio, the process creates a new form of vulnerability. Now, if we analyze Antonio's autonomy from the relational perspective described, we find that his autonomy may have been compromised in different ways. First, Antonio's perception of self-authorization is deeply affected by these external assessments. We can see it in his profound sense of being misunderstood and the emotional distress that he experiences. Second, we can also infer a questioning of his self-governance capacity when the authenticity of his choices and decisions is challenged. According to the vignette, we can see that the evaluators are skeptical about the "legitimacy" of Antonio's suffering. Third, self-determination could also be challenged; even if the law offers an external condition for freedom, the fact that his illness situation does not align with most agreed-upon reasons from terminal patients to request MAiD, can be a structural problem that undermines his self-determination.

As a result, from a relational autonomy perspective, Antonio's autonomy is being hindered by the same highly protective regulation that should enhance it. In other words, we see the "autonomy trap" at work. In consequence, safeguards act less as support for his agency and more as a barrier to his autonomous decision-making. Obligations arising from vulnerability go beyond simple protection from harm, understood in terms of possible violations such as coercion; they imply a duty to strengthen the autonomy of those in that condition [35]. Thus,

those directly involved in MAiD must be aware of the risk that protective scrutiny may undermine patients' autonomy, and must ensure that necessary safeguards are aligned with respectful engagement with patients' accounts of their suffering and values. A relational framework demands attentiveness to patients' values, and lived experiences, as well as to how professional practices shape decision-making processes [5]. Relational autonomy is thus best understood as a capacity that needs to be developed within supportive relationships and caring practices, which highlights healthcare professionals' responsibilities to actively foster patients' agency under conditions of illness, dependency, and power asymmetry.

1.5 | Final Remarks

Legal systems establish guarantees and safeguards to protect persons' autonomy while accessing MAiD. Some of them are considered more protective than others based on the existence of specific measures like follow-up and monitoring mechanisms (implemented before or after MAiD), the number of professionals involved, or the time allocated for decision-making. The Spanish LORE is an example of a highly-protective law that includes three different external assessors and longer time periods compared to other existing laws, in order to protect patients' autonomy and freedom of decision. Autonomy is described in procedural terms (having sufficient information, choosing according to one's terms, and giving consent); freedom is mostly understood as freedom from coercion.

Nevertheless, the need to verify eligibility conditions involves a factual, substantive account of autonomy, in which healthcare professionals and a technical commission evaluate the requesters' subjective values, beliefs, and motivations, according to their own criteria, without clear indications on how to do it. In doing so, there is a risk of falling into epistemic injustice, which may reduce patients' autonomy instead of ensuring it. The narrow approach to autonomy contemplated in the LORE and the subsequent safeguard mechanisms has the potential to subject MAiD requesters to pathogenic vulnerability. Hence, although the safeguard protections were aimed at avoiding possible individual biases and protecting potential vulnerability, they could actually threaten autonomy when evaluated in substantive terms.

Autonomy in the context of MAiD should be enriched by complementary perspectives, such as relational autonomy, which challenge and move beyond traditional dichotomies between autonomy and vulnerability. As our analysis shows, certain legal provisions designed to protect vulnerable persons may paradoxically exacerbate vulnerability or even generate forms of pathogenic vulnerability, rather than mitigating them. This finding calls for a more nuanced evaluation of whether highly protective legislative frameworks may, unintentionally, undermine the very autonomy they aim to safeguard.

From this article, two main implications emerge. First, it highlights the need to raise awareness among policymakers involved in the design and implementation of MAiD legislation. In particular, legislators should exercise caution when adopting protective models and balance safeguards and constraints. They should critically assess how specific safeguards may affect individuals' epistemic credibility, moral agency, and effective access to MAiD. This consideration is especially relevant for jurisdictions that currently lack MAiD legislation and are in the process of developing new legal frameworks, as early normative choices may have long-lasting consequences.

Second, these findings underscore the importance of raising awareness among healthcare professionals involved in the assessment process. A relational understanding of autonomy invites professionals to reflect on how evaluation practices may either support or undermine patients' agency, depending on how their experiences are interpreted, validated, or questioned. It is a professional responsibility to ensure that the legal criteria are met; however, attention should also be paid to the ethical risks associated with excessive suspicion or epistemic discounting of patients' narratives and values in life.

Overall, further critical assessment of protective MAiD legislation and its practical implementation is needed to identify and address mechanisms that may inadvertently produce new forms of pathogenic vulnerability, ensuring that safeguards genuinely support, rather than constrain, autonomous decision-making.

Author Contributions

Janet Delgado: conceptualization, investigation, methodology, supervision, writing – original draft preparation, writing – review and editing. **Iris Parra Jounou:** conceptualization, funding acquisition, investigation, methodology, supervision, writing – original draft preparation, writing – review and editing. **Mar Vallès-Poch:** conceptualization, funding acquisition, investigation, writing – original draft preparation, writing – review and editing. **Ramón Ortega-Lozano:** conceptualization, funding acquisition, investigation, writing – original draft preparation, writing – review and editing. **María Victoria Martínez-López:** conceptualization, investigation, writing – review and editing. **Luis Espericueta:** investigation, writing – review and editing. **Maria Isabel Tamayo-Velázquez:** investigation, writing – review and editing. **David Rodríguez-Arias:** conceptualization, funding acquisition, writing – review and editing. **Rosana Triviño-Caballero:** conceptualization, investigation, writing – original draft preparation, writing – review and editing.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

All data shown is retrieved from public online sources and are referenced in the text.

Endnotes

[1]Among these professions, an epistemic hierarchy can also be established (physicians/nurses, for instance); even within the same profession, there are other hierarchies (by specialty or workplace, e.g.).

[2]When we speak of epistemic injustice, the loss of confidence or autonomy is not a direct and univocal consequence of the disease condition but instead of those individual and structural factors that erode the testimonial and hermeneutic capacities of people with health problems [36, 37].

[3]In Spain, the acceptance rate of MAiD requests is less than 50% (44% in 2023) and deaths by MAiD only represent a 0.08% of all deaths, a number significantly lower than in other countries like the Netherlands or Canada (around 5%). The proportion of deaths before finishing a MAiD request (33% in 2024) could be another indicator of the potential harm caused by overprotective measures [38].

[4]We use the term Evaluation Commission (EC), although we acknowledge the existence of other terms such as Evaluation Committee, Euthanasia Review Committee, Control Evaluation Commission, Monitoring and Evaluation Commission, and so forth. which may refer more specifically to commissions charged with conducting ex-post reviews.

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