

Letter to Editor

Psychological Support and End-of-Life Care

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Dear Editor,

The recent national legislative proposal on medically assisted suicide in Italy and the call to strengthen palliative care services have reignited public debate on a topic that transcends the boundaries of clinical medicine and jurisprudence. While Law 219/2017 marked a significant step in affirming patient autonomy,¹ the present discussion highlights the urgent need to improve access to comprehensive palliative care. It is precisely in the practical application of self-determination principles, within contexts of psychological and physical vulnerability, that the most complex ethical and clinical challenges emerge.

The psychological dimension remains a fundamental, yet often undervalued, component of legal and healthcare discourse. The present legislative proposal calls for a National Evaluation Committee that includes both a psychologist and a psychiatrist.² This interdisciplinary inclusion reflects a growing recognition of the essential role psychological assessment and support play in an ethically grounded, person-centered decision-making process. End-of-life decisions are never purely clinical or legal; they are profoundly shaped by fear, hope, interpersonal relationships, and the search for meaning.³

However, formal recognition through inclusion in the Committee is only a first step. The challenge lies in ensuring that this presence is not merely symbolic or procedural. Given the path toward death is entangled with existential dimensions, the fear of losing control, the desire for relief, the complexity of family relationships, the psychologist must be empowered to act as both interpreter and guarantor of this multifaceted scenario.⁴

A structural risk lies in reducing the existential richness of these experiences to a checklist of procedural requirements. The psychologist's role is to ensure that each request undergoes thorough clinical exploration, including evaluation of both explicit and latent needs, relational dynamics, and the psychosocial context behind the request for assisted suicide. This must involve systematic assessment of depression, suicidal risk, and the critical distinction between a desire to die and a desire to end intolerable suffering.⁵

Because each decision-making journey about one's death has its own unique temporality, shaped by personal history, family dynamics, and illness progression, the psychological perspective can offer invaluable insights. The goal is not to simply accelerate or delay the process, but to recognize that a definitive decision cannot be constrained by rigid legal deadlines. Respect for the patient's psychological time, distinct from bureaucratic time, is essential.⁶

Despite recent legal advances in Italy, such as Law 219/2017 and the 2019 Constitutional Court ruling (No. 242),⁷ the regulatory landscape remains fragmented. In 2024, the Court further expanded the definition of "life-sustaining treatment" to include care provided by family or caregivers, entrusting individual case evaluations to judges.⁸ Notably, the Region of Tuscany has since passed the first regional law on medically assisted suicide, establishing clear procedures and timelines through a multidisciplinary commission and ethics committee.⁹

Compared to other European countries, the Italian framework appears inconsistent and still in evolution. The Netherlands and Belgium legalized both euthanasia and assisted suicide in 2002, gradually extending access to minors and patients with advanced dementia. Luxembourg followed suit in 2009. Spain enacted similar legislation in 2021, and Austria legalized assisted suicide in 2022 after a constitutional ruling. Germany's Constitutional Court recognized the right to a self-determined death in 2020 and urged the legislature to establish appropriate regulatory mechanisms. Switzerland, meanwhile, has long permitted assisted suicide under specific conditions while prohibiting active euthanasia.¹⁰ Within this broader European context, Tuscany's regional law represents a meaningful, albeit isolated, step toward the development of a coherent and unified national framework.⁹

The decision to receive assistance in ending one's life raises profound existential questions. How do people confront suffering they perceive as intolerable? What meaning is given to the progressive loss of autonomy? To what extent can the desire to die be interpreted as a true expression of self-determination rather than a symptom of unaddressed psychological distress?¹¹ These questions lie at the intersection of ethics, medicine, and psychology and require a nuanced, person- and family-centered approach to care and decision-making.

In this context, psychological support plays a crucial role in guiding patients along a path of awareness, enabling them to express, explore, and integrate emotions that are often ambivalent and complex. This therapeutic process, ideally incorporating elements of thanatological counseling and narrative medicine,¹² fosters a deeper understanding of the individual's values, identity, and lived experience. It helps ensure that end-of-life choices are not mere reactions to suffering but reflect free, informed, and well-considered decisions. Only through sustained psychological support, clinicians can discern whether a request arises from unresolved distress or reflects a mature, autonomous choice.¹³

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In this process, the psychologist serves not only as an evaluator of mental competence but as a guarantor of the deliberative integrity and existential depth of the decision-making process.

It is also essential to consider the psychological impact that end-of-life scenarios have on healthcare providers. Prolonged exposure to suffering and ethically complex decisions imposes a considerable emotional burden on clinical teams.¹⁴ In this context, the psychologist plays a dual role: On the one hand, supporting patients and their families in processing existential concerns; on the other hand, providing healthcare professionals with a protected space for reflection, emotional processing, and clinical supervision.¹⁵ This latter function is vital in mitigating the risks of burn-out, compassion fatigue, and the progressive dehumanization of care. Accordingly, specialized training in palliative care psychology is essential for all professionals involved in end-of-life decision-making and support.¹⁴

Prominent Italian cases, such as those of Piergiorgio Welby, Eluana Englaro, and Fabiano Antoniani (DJ Fabo), have underscored not only the complexity of end-of-life decisions but also the legal, cultural, and relational gaps that often accompany them⁷. These cases continue to resonate in public discourse and underscore the need for ethical, compassionate, and clearly defined legal frameworks to guide end-of-life care and decision-making.

In a society where death remains largely taboo, psychologists are called to create spaces of dialogue, active listening, and meaning-making, contexts where fears, hopes, and desires can be explored without judgment.¹⁶ Only through shared, multidisciplinary, and non-judgmental reflection can medically assisted suicide be considered a truly free and conscious choice, rather than an expression of desperation or untreated suffering. This perspective also underscores the need for structured models, such as the Dutch system of mandatory psychological consultation or the Swiss approach involving longitudinal evaluation, which helps

ensure accurate assessment of decisional competence and a clear distinction between existential suffering and treatable mental health conditions.¹⁷

Ultimately, psychological support is a vital instrument for restoring humanity, dignity, and autonomy at life's most vulnerable moment. It ensures that each decision arises from deep reflection, guided by multidisciplinary expertise and grounded in a compassionate understanding of the individual. The multidisciplinary team must prioritize not only quality of life but also quality of death, recognizing the psychologist not merely as a consultant, but as a co-decision-maker in the process.

As the legislative process remains uncertain, this transitional phase offers a critical opportunity to define the active role of psychology in shaping institutional pathways for end-of-life care. This requires ensuring that interdisciplinarity is not merely formal, but substantive, and that the psychological dimension is not overlooked, rather than being placed at the very heart of a decision-making process rooted in the complex relationship between person, institutions, and law. Psychology is not an accessory to this process; it is essential to its ethical integrity.

CONFLICT OF INTEREST

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