Peer Review File

Article Information: https://dx.doi.org/10.21037/apm-23-472

Review Comments

Reviewer A

Comment 1:
I think the language needs sharpening up. If on any topic, clarity matters here. For instance, AU writes, 'Furthermore, most countries request that the wish to die is based on unbearable suffering and that this suffering cannot be relieved sufficiently by established treatments.' For starters, countries don't request, they regulate. More importantly though, is this qualifier, 'by established treatments that are acceptable to the patient.' That's the common policy, I think (either way, the claim the authors make isn't referenced, did they investigate how this is regulated across jurisdictions?).
Reply 1:
We have thoroughly reviewed and revised the language of our manuscript, including the corrections mentioned by reviewer A. Regarding legal regulation of assisted suicide, we explicitly refer to the review by Mroz et al. 2021 who provide a detailed overview of euthanasia and assisted suicide regulations around the world. We adapted the wording regarding unbearable suffering according to Mroz et al. 2021.

Comment 2:
The analysis of suicidality and mental disorder is adding valuable new insights to the ongoing conversation on this topic.
Line 132 - earlier, not ealier
Line 139-144 - reference empirical claims.
I am concerned about the charge that the decision might not be free and autonomous. I think this requires a more nuanced analysis. At issue cannot be whether the decision is free and autonomous, because no decision ever is. At issue is whether it is substantially free. There are all sorts of impacts on our autonomous choices (values one has internalised but not autonomously chosen, social determinants of health etc etc). Autonomous as in fully free is an implausible standard.
Line 154-157 - same issue. The authors are correct that this shouldn't be a group-based determination but an individual based determination. The standard couldn't possibly be 'free choice'. What would that even mean? Not influenced by anything?
Reply 2: *It is correct, that decisions are never completely free of any internal and external influences. To clarify this point, we now make explicit reference to established standards of decision-making capacity for consent to treatment (e.g. Appelbaum 2007), which have also been further developed to assess mental capacity in requests for assisted suicide (Stewart et al. 2011).*
Appelbaum PS. Clinical practice. Assessment of patients' competence to consent to treatment. N Engl J Med 2007;357(18):1834-40.
Stewart C, Peisah C, Draper B. A test for mental capacity to request assisted suicide. J Med Ethics 2011;37(1):34-9.

Comment 3:
Line 160-169. I wonder whether the increase here provides substance for any meaningful interpretation, given that the overall number of cases remains so low. An increase from 2 to 4 would also have constituted a doubling of cases etc etc.
Reply 3*: It is correct that this increase in the proportion of persons with mental disorders is difficult to interpret without further information about the details of the cases. We therefore just report the figures and abstain from an interpretation. But we have added the following sentence: "This per se is not a proof for a slippery slope, but special caution and scrutiny seems to be warranted to ensure that the required legitimacy criteria are met in these cases."*

Comment 4:
The discussion of eligibility thresholds is excellent.
I'd add a subheading at line 217 to enhance readability of the text.
Reply 4: *Thanks, we have added the subheading "Ethical challenges in requests for assisted suicide by patients with mental disorders" which makes the structure of the paper more accessible.*

Comment 5*:*
Line 218-220 Isn't it also possible that a wish is causally related to mental disorder and an expression of autonomous choice. Is it necessarily an either/or type situation? Couldn't a depressed person be caused by the suffering resulting from their depression to ask for an assisted death and that decision the result of a substantially autonomous choice. A number of authors have argued this case. - I see you address this under Challenge 1.
Reply 5: *Correct, we have devoted a full paragraph (Challenge 1) to distinguish these cases. And we explicitly state, patients' suffering from severe depression can have sufficient capacity to make a free ("autonomous") request for assisted suicide.*

Comment 6:
Your analysis of Challenge 4 could be linked back to the point you're making in response to Challenge 3. If unbearable suffering isn't an access threshold (it shouldn't for the reasons you outline persuasively) it's not unreasonable to build in waiting periods triggering further review of capacity (and consistency of the wish to die, over time). It's difficult to demand this if unbearable suffering is the standard. People who suffer unbearably shouldn't be subjected to lengthy waiting periods.
Reply 6: *Thank you for this valuable comment, which addresses an important problem. Even if unbearable suffering is not an access threshold, it may subjectively occur, and may be a motivational factor in psychiatric patients seeking suicide assistance. Hence, it is particularly important to offer intensified support in between repeated assessments to those patients. We have included a sentence in the respective recommendation (last bullet point in the concluding section) that explicitly addresses this point: "In determining the appropriate time period, the intensity of subjectively experienced suffering should be taken into account. The person should be provided intensified support between the assessments."*

Comment 7:
Line 391 'full decision-making capacity' takes us back to the 'free choice' issue. The standard should be the locally applicable legal standard of decision-making capacity'.
Reply 7*: See our reply to comment 2 above where we clarify the standard for decision-making capacity. We added the reference of Stewart et al.2011 for clarification.*

Reviewer B

Comment 8:
The author observes that "many countries around the world have introduced legal frameworks to enable suicide assistance". He adds that legal frameworks look to support the right to self determination whilst protecting vulnerable people through ensuring the decisions is "freely made".

He defines "freely made" as

- Well informed
- Having full decision making capacity
- Without undue external influences

(It may be assumed in this review that when reference is made to decision making capacity that this specifically means the capacity to consent to assisted suicide, acknowledging that capacity is specific to the decision at hand and mindful of the general principle that the rigor of the assessment of capacity is related to the outcomes of the decision).

The first two conditions introduce the counter argument of "paternalism" in which an external perspective requires satisfaction that the decision maker has the qualities of an autonomous individual (most notably of adequate age, cognitive capacity and mental health), commonly legally defined as the capacity to consent to a specific action.

Reply 8*: Yes, when we refer to decision-making capacity, we refer to the capacity required to make a request for assisted suicide. To further clarify this point, we have included two more references, Appelbaum 2007 and Stewart et al. 2011 (cf. our reply to comment 2 above).*

Comment 9:
He notes that most countries have restricted the support of suicide assistance to those with intolerable suffering and terminal illness, apparent restrictions to the fullest expression of autonomy around the decision to end one's life (assuming information, decision making capacity, freedom from coercion). He expresses the opinion the underlying ethical reason for these restrictions are as protection from "inappropriate use of suicide assistance". This view is not well explained.

The best understanding as to the common use of these limitations (intolerable suffering and terminal illness) is that historically the group around which the argument for assisted

suicide was first made, in the face of the moral counter argument, was these with intolerable suffering in terminal illness. The lived experience of these patients and their families drove the emergence of a paradigm at odds with western (Christian) and medical traditions. The arguments to extent assisted suicide beyond the initial intended group has been more broadly driven by principles of autonomy and fairness.

The author then notes that the German constitutional court, in applying the principles of autonomy and non-discrimination has countermanded these limitations. This position opens the scope of assisted suicide to all people with 'decision making capacity', including those without terminal or somatic illnesses. From the position of the German constitutional court, people are legally allowed to aid someone's wish to die, having received a request for assistance in someone with capacity. (In practice, this is done within some sort of procedural framework, usually an Act with affiliated governing bodies, principles and guidelines).

The author, in keeping with the German constitutional court states

"From the perspective of self-determination, patients suffering from a chronic mental disorder have the same right to request suicide assistance as patients with an incurable somatic illness"

His paper expands as to how aspects of how the necessary framework to allow this to occur might be developed, addressing potential challenges.

Hence a critique of his work made relate both to the arguments in support of lessening the current limitations and whether his proposed framework actively address the challenges identified.

Reply 9: *Thank you very much for pointing this out! We were not sufficiently clear regarding the additional criteria of unbearable suffering and terminal illness which cannot be justified by reference to respecting the persons' autonomy. We have completely rewritten this paragraph to make it clearer what role these additional criteria shall play in the assessment of a person's request for assisted suicide.*

Argument for assisted suicide for mental illness

Comment 10:
Discrimination in the restriction to somatic illness as a prime cause of intolerable, irredeemable suffering.

As noted, the author applies an equal rights and self-determination argument. What is not acknowledged is that although connected physical health and mental health, body and mind, somatic and psychic are not the same. Mental illness is still largely a metaphor derived from the notion of physical illness in which the complex, visible underlying pathology is well understood. Mental illness is still "explained" by a range of models and

hypotheses. Many of these models apply psychological and social understandings derived from metaphysical constructs outside the certainty of empirical science. Constellation of symptoms and dysfunction are categorised according to common features, but one persons depression is not the same as another.

Furthermore, at the core of "mental disorder" are difficulties with 'loving, living and playing' such that existential questions, including those of being alive inevitably arise. The answer is inevitably individual, often (as noted) ambivalent and variable, but (in my experience) invariably interpersonal. Whether someone chooses to live or not invariably relates to how they believe others think and feel. Suicide always involves others in some way, a counterpoint to notion of the rights of individual autonomy.

Reply 10*: Actually, we do not claim that intolerable, irredeemable suffering is restricted to physical illness. Instead, we argue that suffering always remains a subjective experience, which from the outside sometimes can be more easily empathized or understood if it is based on a physical illness rather than on a psychiatric disorder. Anyhow, we argue that assessment of persons seeking suicide assistance should concentrate on decision-making capacity in both, somatic illnesses and psychiatric disorders. We also agree that interpersonal relationships play an important role in suicidality. We now explicitly mention the importance of the social dimension of suicidality in our recommendations and added a reference for this point.*

Comment 11:
The requirement for terminal illness
The author states "the requirement of terminal illness can hardly be justified". What needs to be added here, (in fairness this is an assumption throughout the paper) is "from the perspective of a legal framework which looks to support the right to self determination…". As already indicated, the historical origins of legislation was case based, iterative and responding to a well articulated needs. Legislation was not simply a rational development of rights based legal practice and still remains in tension with a range of other frameworks (Moral, non nocere, impact of the societal value of the individual etc).

The requirement for terminal illness is also a tied to the notion of irredeemable. By definition, terminal illness is without curative treatment. Symptom relief cannot be achieved through cure, and not always be adequately achieved through palliative care (a view opposed by many palliative care physicians) which formed the basis of the argument for the original legislation.

Reply 11*: Thank you again for pointing this out. We now can build upon the more detailed ethical analysis above (cf. reply 9) and argue explicitly why the requirement of terminal illness cannot be justified.*

Challenges to implementation

Comment 12:

Challenge 1: Causal relationship between mental disorder and wish for suicide

The author states that

"in chronic depression, it may be more difficult to decide whether the wish to die is a symptom of the illness or an expression of a rational, autonomous choice".

He suggests that a psychiatrist may be able to tell the difference. It would be a commonly held view in psychiatry that mood disorders by their very nature, colour the individual's view of the world and their perception of their future. In other words, their decision making is impacted by their mood. This does not mean that they do not have decision making capacity as defined by the common criteria, but non the less their decision making is impacted by their mood. Hence a distinction between symptom of illness and impact on rational autonomous choice cannot easily be made (if at all). The judgement then becomes a kind of mind game in which the question is addressed to the "rational autonomous" aspect of the individual separate from the psychic elements seen to constitute their illness. To address this dilemma some authors have introduced the notion of 'capacity as an agent' (Radoilska L. Depression, Decisional Capacity and Personal Autonomy. In: Fulford KWM, Davis M, Graham G, Sadler J, Stanghellini G, Thornton T, editors. The Oxford Handbook of Philosophy and Psychiatry. Oxford: Oxford: Oxford University Press; 2013.) Agency is the human characteristic whereby we exercise control over our own thought processes, motivations and actions (Mendz GL, Kissane DW. Agency, Autonomy and Euthanasia. J Law Med Ethics. 2020;48(3):555-64.) Where an individual's agency is impaired, as in a depressed state of mind, even when the criteria for decision making capacity are met and a patient acts thinking they have sufficient reason, the choice may be seen as 'non-autonomous'. Alternatively, one can adopt the position that those judgment is impacted by mental illness have the right to end their lives (suicide is not a crime) – which is currently the case with the exception of "imminent risk of self harm" under many mental health acts. Notably (as discussed later) this is autonomous but not assisted.

Reply 12*: In response to reviewer A, we have made a clearer reference to the question of assessing decision-making capacity (cf. reply 2). We refer to established standards of decision-making capacity for consent to treatment (e.g. Appelbaum 2007), which have been specified for the request for assisted suicide (Stewart et a. 2011). We consider this acceptable, as there are many requirements for "autonomous" decisions about committing assisted suicide that are analogous to the question of consent to medical treatment: understand the current situation, understand and appreciate the benefits and risks of the available options, referring these options to the values of the person and finally choose an option that is consistent with the well-founded values and preferences of the person.*

Comment 13:
Challenge 2: Possible impairment of decision-making capacity due to mental Disorders

The author states that no mental disorder, by itself renders the patient incompetent. It is presumed that the author is not arguing that the presence of mental disorder alone cannot lead to incapacity, but that the presence of a mental disorder does not necessarily lead to incapacity all the time. He suggests that, in times when those with mental disorder have capacity and request help in ending their lives, assistance should be provided.

The author rightly makes the point that decision making capacity can be seen to be present in someone with a diagnosed mental illness. This has been described in the literature from Oregon where a proportion of individuals receiving assistance to die (with terminal somatic illness) have a concurrent diagnoses of major depression. The issue then becomes that as discussed previously, namely is the fulfilling of the criteria for capacity an adequate paternalistic safeguard against the impact mood has on judgement or should other principles (capacity as an agent, the views of significant others) be applied.

Reply 13*: We have changed the wording according to your suggestion and make reference to the established criteria of decision-making capacity for informed consent (Appelbaum 2017).*

Comment 14:
Challenge 3: Difficulties to determine unbearable suffering in patients with mental disorders

The author rightly points out the difficulty with assessing the criteria of intolerable suffering, its subjectivity. How are we to question the experience of other, or at least what they say they experience? Should an external authority be able to say, that the suffering of another is tolerable? Much of the contemporary literature suggests not and provisional data from jurisdictions requiring "intolerable suffering" indicate that the absence of this criteria is seldom or ever used to preclude access to assisted suicide.

Is that the end of the matter? As always it depends on the perspective applied. From a positivist perspective, if we do cannot demonstrate independent reliable evidence to override the individual's description of their state of mind, then we are bound to take what they say on face value. It is only through adopting alternative perspectives, (outside the approach of this paper), that different analysis of the experience of intolerable suffering can occur. These include the intersubjective lens (that our selves are constituted in relation to others) or the view that self is not necessarily cohesive, consistent, fully known or fully developed (psychodynamic). Here suffering has a relational element (potentially shared and subject to change) and an intrapsychic element (potentially amenable to mostly unavailable therapies)

Reply 14*: Thank you very much for your thoughtful comment! We completely agree that suffering also has relational elements and shared experiences and mutual support play an important role in suffering. However, not suffering has to be determined, but unbearable suffering. We would argue that it cannot be determined from an external perspective whether the – socially mediated – suffering is unbearable to the person herself. This can*

only be determined by the person herself. In our concluding recommendations we explicitly state that one should "consider thoroughly the mentally ill person's social circumstances".

Comment 15:
Challenge 4: The wish to die may be variable over time in persons with mental Disorders
The author addressed the issue of variability with the important notion of longitudinal assessment.
Reply 15*: Thank you very much for pointing this out.*

Comment 16*:*
Challenge 5: Prognostic uncertainty and treatment resistance in mental disorders

The author addressed the difficulty in ensuring that suffering in mental disorder is irredeemable. He acknowledges the possibility that change is possible in even the most severe and enduring of cases, albeit with a very low likelihood. He further argues that, the absence of absence of a certainty of death or regarding enduring suffering should not preclude allowing assisted suicide for mental disorders if judged by independent experts very unlikely to improve. The point is well made.

Reply 16*: Thank you very much for the feedback!*

Other issues

Comment 17*:*
Increasing uptake – cultural momentum.
The author notes the disproportionate uptake of assisted suicide in the Netherlands in people with dementia and mental disorders (most commonly depression and personality disorders). This increased uptake invites concerns regards the "slippery slope" in assisted suicide which is often at the forefront of arguments against legislation. Notions as to how the weak and infirm are cared for in society are central narratives. Irrespective of the actual intent of intent of assisted suicide legislation, Acts commonly becomes mastheads of alternative community beliefs regarding the authenticity of the caring state which it is feared looks to end the lives of the infirm.
Reply 17*: Another important point, thank you! See our reply to comment 3 above. We have added a sentence that the increasing numbers are no proof far a slippery slope but require special caution and scrutiny.*

Comment 18:
Why do people need or want assistance to commit suicide?
Currently people commit suicide at their own hand. It may be argued that mechanisms are

unreliable and may lead to morbidity rather than mortality. Currently many jurisdictions make it a crime to provide information that might be used to end life, although in information is widely available on the internal. Hence one argument is that assistance is more humane.

From an intersubjective perspective this is a central question. Why does my death require the hand of another? What is being enacted? What impact does those have on the other (both the individual and society)? A comprehensive understanding of the interpersonal nature of suicide remains elusive, but common notions are self hate, self destruction, isolation, failure and worthlessness. It is possible that the wish for assistance signifies the presence of a belief that an other (mother, father, society, the law etc) owns some responsibility for their intolerable pain, lead to the wish that an other be present, participate in their death or even be responsible for killing them.
From this perspective, those providing the assistance may be left carrying an unwanted psychological burden. Hence the legislation may allow for enactment of self destruction with potentially negative impact in those providing assistance. Notably one of the key principles of liberty is freedom to the extent that it does not harm others, which on face values is contravened in this scenario.
Reply 19*: This is another important point to consider regarding assisted suicide. However, it is not specific to assisted suicide for patients with mental disorders. We therefore decided not to go into more details on this issue in our article that already is scratching the maximum word limit.*

Comment 20:
Concluding Comments

The author makes the argument that "from the perspective of self-determination, patients suffering from a chronic mental disorder have the same right to request suicide assistance as patients with an incurable somatic illness". He adequately identifies and addresses the challenges and makes recommendations as to how they may be addressed (presumably in Germany).

My main concern as a reviewer is not with the quality of the analysis or argument. Rather it is that such fundamental shifts in norms, such as expansion of assisted suicide to those with mental disorder, in my view, requires appraisal from a range of paradigms (not just self determination /legal/rights based). To this end, I am not sure the author best edit his submission (if at all). Perhaps (I make this suggestion more to illustrate a point rather than as a literal request) if the title were something like

"An argument for assisted suicide in persons with mental disorders within a self determination framework: clinical and ethical considerations"

acknowledged the importance of other perspectives and/or invited counter arguments, the nature of his "encultured lens" would be more apparent.

***Reply 20**: This comment is slow well-taken. We now more explicitly make reference to obligations of beneficence in addition to the right of self-determination in the thoroughly revised section on the ethical foundations. Furthermore, we explicitly address the protection of the vulnerable group of patients in the final recommendations, as it is mandated by the ethical obligations of beneficence. We added a sentence that in the 7th recommendation which explicitly mentions how the beneficence-based obligations come into play in the communicative process with the requesting person. Overall, we therefore consider it appropriate to keep the title as it is.*

Reviewer C

***Comment 21**:*
In the paragraph entitled "Assisted suicides in patients with mental disorders", numbers are used which can be found in the annual report for 2021 of the Dutch regional euthanasia review committees. However, the annual report for 2022 has been published a few months ago. The numbers referred to are the cases reported as prescribed by the Dutch law on euthanasia. They are not the actual numbers. It is also proper to speak of physician-assisted suicide and termination of life by a physician on request, since the reported cases are cases physician-assisted suicide and termination of life by a physician on request.
***Reply 21**: Thanks, we have updated the figures according to the 2022 annual report and corrected the terminology.*

Reviewer D

***Comment 22**:*
This paper is well-written, on an important and timely topic. However, a wealth of literature in the field has already made similar arguments. My main recommendation is that the authors clarify what gap in the literature this paper aims to fill, situate their paper in the broader debate and engages with papers that have made similar normative arguments.
***Reply 22**: First of all it is important to note that we have been asked by the editors of the special series "Ethics and psychiatry meet palliative medicine" (Manuel Trachsel and Jan Gärtner) to write a "scoping review" on assisted dying for persons with severe and persistent mental illness, providing an overview of the arguments pro and con. With our paper, however, we have taken a rather novel approach that systematically links ethical considerations to the relevant clinical features of mental disorders. We have added a sentence towards the end of the introduction which explains this approach: "It thereby tries to take a somewhat novel approach in starting with the fundamental right to self-determination, elaborating systematically the challenges in realizing this right based on the specific features of mental disorders and developing recommendations how these*

challenges can be met in order to develop a clinically and ethically justified practice of assisted suicide in persons with mental disorders."
Following your recommendation to situate the paper in the broader debate, we included 7 further references. We explicitly make references to the two main papers who have made similar arguments in favor of offering assisted suicide to persons with mental disorders by Schuklenk and van de Vathorst 2015 and Steinbock 2017.

***Comment 23**:*
The authors say that they are assuming that it is a given that assisted suicide in mental disorders is ethically justified, as a starting point. Then they proceed to describe the various ethical challenges related to this issue. However, the two are not disconnected: these ethical challenges are directly related to whether the practice is morally permissible or justified. As the literature shows, the practice is far from being universally considered ethically justified, within the academic community and beyond.
Reply 23: Our starting point is not that assisted suicide is ethically justified in persons with mental disorders. Rather, we assume that assisted suicide is ethically justified in general (cf. last sentence of the introduction). From this starting point we explore one by one whether the specific challenges of assisted suicide in persons with mental disorders would constitute ethical reasons to exclude patients with mental disorders from assisted suicide.

I recommend a revision reflecting the authors' efforts to situate their publication in the broader debate and clarify their paper's specific contribution to the literature.
See Reply 22 to comment 22

Reviewer E

The manuscript raises several valid points regarding the challenges associated with assisted suicide in patients with mental disorders. However, there are some aspects that require further examination and clarification.

***Comment 24**:*
Lack of Clear Definition: The manuscript does not provide a clear definition of "self-determination" and how it applies to patients with mental disorders. It is important to establish a precise understanding of this concept to avoid ambiguity.
Reply 24: We elaborate in the paragraph on the ethical foundations that self-determination in the context of this paper refers to the right not only to determine the termination of life-sustaining treatment but also to seeking assistance in actively terminating one's life via suicide. We then elaborate the standards of a self-determined, "autonomous" decision. In response to comment 2, we now further explain how we would suggest to approach the important question of decision-making capacity. We refer to established standards of decision-making capacity for consent to treatment (e.g. Appelbaum 2007), which have been specified for the request for assisted suicide (Stewart et a. 2011). We consider this acceptable, as there are many requirements for

"autonomous" decisions about committing assisted suicide that are analogous to the question of consent to medical treatment: understand the current situation, understand and appreciate the benefits and risks of the available options, referring these options to the values of the person and finally choose an option that is consistent with the well-founded values and preferences of the person.

***Comment 25**:*
Generalization of Vulnerability: While the manuscript states that patients with mental disorders are "especially vulnerable" to inappropriate conduct, it fails to acknowledge that vulnerability is not exclusive to this group. Patients with somatic diseases may also experience vulnerabilities that could influence their decision-making process.
***Reply 25**: Your comment is completely correct, there are other vulnerable groups. However, the starting point of our paper is not vulnerability related to assisted suicide, but rather persons with mental disorders who request assisted suicide. We analyze the specific features of mental disorders relevant to this issue – and arrive to the conclusion that they are a vulnerable group regarding appropriate suicide assistance. We therefore do not discuss other vulnerabilities – which probably would require other approaches to ethical conduct of suicide assistance.*

Comment 26:
Assessment of Decision-Making Competence: The manuscript mentions that decision-making competence may be compromised in patients with mental disorders, but it does not elaborate on how this assessment should be conducted. A more detailed exploration of the methodologies and criteria used to evaluate decision-making capacity would strengthen the argument.
***Reply 26**: Cf. reply 2 and reply 24. We have explained in some more detail in the recommendations what kind of approach to assessing decision-making capacity we would choose, with special consideration of the emotional dimension of suicidality (cf. Mrozynski & Kuhn 2022).*

***Comment 27**:*
Severity of Suffering and Prognostic Uncertainty: The manuscript argues that the severity of suffering and prognostic uncertainty in mental illness make it difficult to determine if the suffering is treatment-resistant. However, it does not provide evidence or references to support this claim. A more rigorous examination of the factors that contribute to suffering in mental illness would enhance the argument's credibility.
***Reply 27**: Actually, we do not argue this way. We clearly separate unbearable suffering (challenge 3) from prognostic uncertainty (challenge 5). In the section of challenge 5 we discuss extensively the problem of prognostic uncertainty, including references to the available empirical evidence. We also explicitly state that it rather unlikely that prognostic uncertainty can be eliminated.*

***Comment 28**:*
Autonomy and Informed Decision-Making: The manuscript correctly highlights the importance of autonomy and informed decision-making in the context of assisted suicide. However, it does not discuss the potential challenges of assessing autonomy in

patients with mental disorders or how to ensure that patients are fully informed about their options.
Reply 28*: We have devoted a paragraph (challenge 2) to the problem of informed decision-making in patients with mental disorders. Following your and the other reviewers comments, we have now elaborated more in detail how the necessary conditions of an autonomous choice can be realized, by assessing appropriately the decision making capacity, providing information on the available options and offering a beneficence-based recommendation regarding the possible options.*

Comment 29*:*
Lack of Counterarguments: The manuscript primarily focuses on highlighting the challenges and vulnerabilities of patients with mental disorders, but it does not adequately address potential counterarguments or alternative perspectives. Acknowledging opposing viewpoints and providing counterarguments would strengthen the overall argument.
Reply 29*: As explained in reply 22, we have deliberately taken a somewhat different approach: We do not collect pro and con arguments, we rather start with the fundamental right to self-determination, identify the challenges which arise from the specific features of mental disorders and then investigate systematically, i.e. one challenge after the other, whether they would constitute an ethically valid argument to exclude patients with mental disorders from assisted suicide. Thereby, we do justice to the main counterarguments in the literature provided against providing assisted suicide to persons with mental disorders.*

Comment 30*:*
Lack of Practical Recommendations: While the manuscript touches upon the evaluation process and the goal of empowering patients to make autonomous choices, it does not provide specific recommendations for addressing the identified challenges. Offering practical suggestions for conducting assessments and implementing safeguards would enhance the usefulness of the discussion.
Reply 30*: We have added some more suggestions to the recommendations, especially regarding the crucial assessment of decision-making capacity. We do also explicitly provide recommendations for those situations in which considerable uncertainties remain.*

Comment 31*:*
In summary, while the manuscript raises important concerns about assisted suicide in patients with mental disorders, it would benefit from further elaboration, inclusion of supporting evidence, consideration of counterarguments, and practical recommendations for addressing the challenges identified.
Reply 31*: Thank you again for you valuable comments which we tried to address in the thorough revisions of our manuscript.*