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## Assisted suicide and euthanasia in Switzerland: allowing a role for non-physicians

Samia A Hurst, Alex Mauron

Switzerland has an unusual position on assisted suicide: it is legally condoned and can be performed by non-physicians. Euthanasia is illegal, but there is a debate about decriminalisation that also discusses participation by non-physicians

The involvement of a physician is usually considered a necessary safeguard in assisted suicide and euthanasia. Legislation in Holland, Belgium, and the US state of Oregon all require it, as did the legalisation of euthanasia in Australia's Northern Territories.<sup>1-4</sup> Physicians are trusted not to misuse these practices; along with pharmacists they are in control of prescription drugs. Physicians are believed to know how to ensure a painless death, and they are in a position to offer palliative care knowledgeably.

Switzerland seems to be the only country in which the law limits the circumstances in which assisted suicide is a crime, thereby decriminalising it in other cases, without requiring the involvement of a physician. Consequently, non-physicians have participated in assisted suicide. The law has explicitly separated the issue of whether or not assisting death should be allowed in some circumstances, from that of whether physicians should do it. This separation has not resulted in moral desensitisation of assisted suicide and euthanasia.

### Methods

We describe the history of the Swiss law for assisted suicide, the current debate, and the existing data on euthanasia and assisted suicide in Switzerland. This review is based on the relevant literature and on the experience of participants in these debates.

### History of the Swiss law

In 1918, a comment by the Swiss federal government on the first federal penal code stated: "In modern penal law, suicide is not a crime ... Aiding and abetting suicide can themselves be inspired by altruistic motives. This is why the project incriminates them only if the author has been moved by selfish reasons."<sup>5</sup> At the time, the attitudes of the Swiss public were shaped by suicides motivated by honour and romance, which were considered to be valid motives. Motives related to health were not an important concern, and the involvement of a physician was not needed. Euthanasia for terminally ill patients, although intensely discussed in the United States and the United Kingdom in the

### Summary points

Most legislation condoning assisted suicide or euthanasia stipulates that a physician must be involved

The acceptability of voluntary death is not entirely contained within the framework of medicine

Assisted suicide is not a criminal act under Swiss law if it is motivated by altruistic considerations

Sharp controversy surrounds assisted suicide in Switzerland, but the few data that exist suggest that the public supports it

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1900s, seems not to have been debated in 1918 in Switzerland.<sup>6</sup>

### Assisted suicide

Article 115 of the Swiss penal code considers assisting suicide a crime if and only if the motive is selfish. It condones assisting suicide for altruistic reasons.<sup>7</sup> In most cases the permissibility of altruistic assisted suicide cannot be overridden by a duty to save life.<sup>8</sup> Article 115 does not require the involvement of a physician nor that the patient be terminally ill. It only requires that the motive be unselfish. This reliance on a base motive rather than on the intent to kill to define a crime is foreign to Anglo-Saxon jurisprudence, but it can be pivotal in continental Europe.<sup>9</sup>

Swiss law does not consider suicide a crime or assisting suicide as complicity in a crime. It views suicide as possibly rational. Also, it does not give physicians a special status in assisting it. When an assisted suicide is declared, a police inquiry is started, as in all cases of "unnatural death." Since no crime has been committed in the absence of a selfish motive, these are mostly open and shut cases. Prosecution happens if doubts are raised on the patient's competence to make an autonomous choice. This is rare.

## Euthanasia

Swiss law does not recognise the concept of euthanasia. "Murder upon request by the victim" (article 114 of the Swiss penal code) is considered less severely than murder without the victim's request, but it remains illegal. Following a proposal to the Swiss parliament to decriminalise euthanasia, in 1997 the federal government commissioned a working group which included specialists in law, medicine, and ethics to examine the issue. This group recommended that euthanasia remain illegal. Most of the group, however, proposed decriminalising cases in which a judge was satisfied that euthanasia followed the insistent request of a competent, incurable, and terminally ill patient in unbearable and intractable suffering. This explicitly included euthanasia performed by non-physicians, as they would not be committing a greater transgression than physicians. It was considered dangerous to create legal circumstances where a non-physician helper would have to be prosecuted whereas the physician would not. Some members of the group opposed decriminalising euthanasia.<sup>10</sup> Despite this report, parliament voted not to go ahead with the proposed legislation, and a change is unlikely in the near future. The Swiss National Advisory Commission on Bio-medical Ethics is debating these issues. Its position cannot be predicted.

## The physician's role

The Swiss Academy of Medical Sciences states in its ethical recommendations that assisted suicide is "not a part of a physician's activity."<sup>11</sup> This statement is ambiguous. It has usually been understood to mean that physicians should not assist suicide and was paraphrased in 2002 in a joint statement by the Swiss Medical Association and the Swiss Nurses Association.<sup>12</sup> But the statement from the Swiss Academy of Medical Sciences has also been understood to place assisted suicide outside the purview of professional oversight, and to refer physicians, as citizens, to the law. This allows them, like other citizens, to altruistically assist suicide.<sup>13</sup> In fact, even if it is understood to discourage physicians from assisting suicide, legally it leaves physicians with the same discretion as any citizen to altruistically assist suicide.



Reginald Crew, who had motor neurone disease, travelled from Britain to Switzerland to end his life

In practice, many physicians oppose assisted suicide and euthanasia, and hospitals have barred assisted suicide from their premises. Some physicians, however, do assist suicides and some advocate the decriminalisation of euthanasia. The arguments advanced are the same as in other countries. Opponents argue that killing patients violates physicians' professional integrity and endangers the doctor-patient relationship.<sup>14</sup> Proponents see assisted suicide and euthanasia as part of a caring response to intractable human suffering.<sup>15</sup> In 2001, the Swiss parliament rejected a bill that would have barred physicians from assisting suicide.

The importance of palliative care is acknowledged. Resources for palliative care in Switzerland are not yet available to all terminally ill patients. This remains a strong argument against decriminalising euthanasia.<sup>16</sup> It is also an argument against assisted suicide and an important point in the public controversy.

## Data on attitudes and practices

Assisted suicide is a controversial topic in Switzerland, but data on public attitudes towards assisted suicide and euthanasia are scarce. According to one survey, half of 2411 army conscripts were willing to "shorten the life of a family member who suffered too much and who asked for euthanasia."<sup>17</sup> In a 1999 survey of the Swiss public, 82% of 1000 respondents agreed that "a person suffering from an incurable disease and who is in intolerable physical and psychological suffering has the right to ask for death and to obtain help for this purpose." Of these, 68% considered that physicians should provide this help; 37% considered that the family, 22% that right to die societies, 9% that nurses, and 7% that religious representatives should be able to fulfil such requests. Legislation to allow euthanasia was favoured by 71% of all respondents.<sup>18</sup> No data are available on how well people believe the existing system is working in practice, even though this is one of the key points in the controversy.

In another survey, 73% of 90 physician members of the Swiss Association of Palliative Care opposed the legalisation of euthanasia. However, 19% stated that they would practice it if it became legal.<sup>19</sup> This small support for euthanasia contrasts with the position of the European Association for Palliative Care.<sup>20</sup> No survey has been conducted on the Swiss medical profession as a whole.

No validated statistics exist for assisted suicides in Switzerland. These deaths are not differentiated from unassisted suicides in official records. According to the president of one of the Swiss right to die societies, around 1800 requests for assisted suicides are made each year. Two thirds are rejected after screening. Half of the remaining people die of other causes, leaving about 300 suicides assisted by these societies annually. This constitutes around 0.45% of deaths in Switzerland (J Sobel, personal communication, 2002).<sup>21</sup> Individuals outside these societies may assist additional suicides. In comparison, reported assisted suicide in Oregon represents 0.09% of deaths, and other US data showed a rate of assisted suicide and euthanasia of 0.4% among terminally ill patients.<sup>22-23</sup> The rate of assisted suicide in the Netherlands is 0.3%, lower than the estimate for Switzerland.<sup>24</sup>

## Conclusion

Altruistic assisted suicide by non-physicians is legal in Switzerland. This has led to a unique situation. It has separated issues that are sometimes conflated. Whether assisted voluntary death should ever be allowed has been discussed without being exclusively linked to physicians. Physicians have separately debated their appropriate role at the end of life. They have a part to play in both debates.

Assisted suicide and euthanasia ask questions that cannot be answered from the perspective of medicine alone. An incompatibility between assisting voluntary death and the professional ethos of physicians may mean that physicians should not assist death, but it does not necessarily settle the argument of whether anyone ever should. The controversy has remained intense. Acceptance of assisted suicide seems to be growing, but support for palliative care is growing also, as end of life issues are kept in the public eye. Further empirical analysis of this situation is important. This debate could continue to yield insights into the issues around suffering at the end of life.

Note added in proof—Recently, the practice of one Zurich based right to die society that offers assisted suicide to non-resident foreigners has attracted a great deal of media attention and concern. This could eventually result in increased regulation, but a radical departure from Switzerland's unique stance on this issue seems unlikely.

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## "I think I need a psychiatrist"

A substantial number of patients attending general neurology outpatient clinics have neurologically unexplained symptoms. Psychological and psychiatric factors may be implicated in the genesis and maintenance of many of these symptoms, but the patients are often unwilling either to accept such explanations or to contemplate therapeutic approaches based on them. It is therefore notable to hear a patient open a neurology consultation by stating, "I think I need a psychiatrist."

The man, in his 30s, complained of difficulty controlling his dominant hand. He first noticed this when playing darts: his arrows kept shooting off in unexpected directions and jeopardising the safety of bystanders. Involuntary supination of the hand also became evident when he tried using a knife or scissors and when writing. A diagnosis of focal dystonia was made, and injections of botulinum toxin were offered.

"I think I need a psychiatrist." It might be argued that this opening gambit reflected the patient's diffidence or anxiety,

perhaps intended to forestall a perceived fear of wasting the neurologist's time. However, this was an intelligent person who had clearly thought about his symptoms and, in attempting to find an explanation for them, genuinely thought that a psychiatrist might be the most appropriate source of help. He had already consulted a hypnotist. In this context it is worth noting that until quite recent times neurologists considered dystonic syndromes to be of psychiatric, functional, or non-organic origin.

Just as neurologists are on the lookout for psychiatric illness presenting with somatic symptoms, the lesson I draw from this case is to look hard for neurological illness in those (admittedly rare) patients arriving in the neurology clinic professing a need for a psychiatrist.

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