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«Assisted Suicide»

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Summary

Assisted suicide is a socially, legally and ethically complex issue. This report describes the current legal position with particular reference to Article 115 of the Swiss Penal Code (StGB) and its interpretation in practice. This position is critically discussed from an ethical viewpoint. In addition, a set of specific recommendations is proposed for legislators and practitioners. The questions are first explored in a variety of contexts – historical, medical, sociological, political and ethical – that are of relevance for an assessment of the current situation and for the formulation of recommendations.

The NEK-CNE detects a deep-seated ambivalence in assisted suicide, leading to conflicting goals, especially for health care professionals. The ethical dilemmas that arise in practice are correspondingly acute. The Commission takes the view that these ethical dilemmas cannot be resolved at a general theoretical level, but only within the complex circumstances of the individual case. Accordingly, someone who is asked to provide assistance with suicide must make a personal decision, as dictated by his or her conscience. Assisted suicide should not become a matter of routine. There is no general rule that could be readily applied in practice to justify assisted suicide. For this personal aspect of the ethics of assisted suicide and also for measures at the legal and institutional level, two fundamental values, representing as it were twin poles, are crucial: provision of care for a suffering fellow human bereft of hope, and respect for individual autonomy. Rather than giving priority to one of these poles, recommendations and regulations must take both of them, and the tensions between them, into account.

In ethical terms, assisting a suicide should be distinguished from terminating life on request, even though these acts may be similar in practice. The Commission supports, on ethical grounds, the existing liberal approach enshrined in Art. 115 StGB, under which assisted suicide is legal as long as the act is not prompted by self-seeking motives. It does not recommend any change to the provisions of criminal law in this respect, but identifies a need for action in other areas of the law. The Commission takes the view that, in order to address the problems that have arisen as a result of the emergence of right-to-die organizations, such bodies need to be subjected to state supervision. This would ensure that decisions on assisted suicide are arrived at in compliance with quality criteria.

The Commission also considers a number of specific problems, such as the question of whether people with mental disorders should be eligible for assisted suicide. On this question, it adopts a cautious stance, calling for priority to be given to psychiatric and psychotherapeutic care. Assistance with suicide is not to be provided in cases where suicidality is a manifestation or symptom of a mental disorder. This means that the mentally ill are generally, although not completely, excluded from assisted suicide. Other topics examined include the problem of young people who, although legally still minors, are mentally competent; assisted suicide in hospitals and care homes; the implications for health care professionals; and so-called death tourism. The Commission emphasizes the ethical risks for society associated with the spread of assisted suicide. Facilities and services, particularly for people who are in need of care and support, must be provided in such a way, and palliative medicine must be so readily available, that the desire for suicide is not promoted. Suicide should not offer a cheap way out of spiralling health care costs. With regard to the suicide issue, society has a responsibility to take preventive action not only by setting legal boundaries but also by providing support for carers.

Note on the status of the recommendations and other text:

The recommendations given in Chapter IV have been adopted by the Commission, sentence by sentence, in the current wording and are a formal expression of the Commission's position. In contrast, the text in Chapters I–III was not adopted on a sentence-by-sentence basis; instead, numerous versions were discussed in detail, repeatedly amended and checked by the Commission, and additional considerations were added so that the text would appropriately reflect the broad spectrum of experience and views found among Commission members, pointing the way to the position expressed in Chapter IV.

I. Introduction

I.1 Legal position

Under Swiss law, inciting and assisting suicide are not punishable, unless these acts proceed from self-seeking motives:

Art. 115 StGB: Inciting and assisting someone to commit suicide

A person who, for selfish reasons, incites someone to commit suicide or who assists that person in doing so shall, if the suicide was carried out or attempted, be sentenced to a term of imprisonment (Zuchthaus) of up to 5 years or a term of imprisonment (Gefängnis).

This article of the Penal Code conclusively regulates criminal involvement in a freely chosen suicide. It makes involvement in suicide for selfish reasons ("*selbst-süchtigen Beweggründen*", "*mobiles égoïstes*", "*motivi egoistici*") a punishable offence and thus by the same token makes involvement in suicide non-punishable if it does not proceed from such motives. This provision is currently of great practical relevance, as it defines the boundary between legal and illegal assisted suicide with regard to the activities of right-to-die organizations (e.g. Exit, Dignitas).¹

Involvement is taken to mean incitement and assistance ("*Verleitung und Beihilfe*", "*incitation et assistance*", "*istigazione e aiuto*"):

According to criminal law doctrine, the term *incitement* applies to cases where a *decision to commit suicide was provoked* in some other person. For such an act to constitute incitement, it must also be the case that this other person committing suicide (1) exercised control over the act and (2) acted independently. The objective requirements for this offence are the same as for instigation ("*Anstiftung*") under Art. 24 StGB.

An objective requirement for *assistance* is that the person in question should make a causal *contribution* to the attempted or accomplished suicide. Suicide itself is (1) an act of selfkilling committed by the person wishing to die, with this person (2) exercising control over the act and (3) acting independently. The causal contribution may consist of providing lethal means. Assistance may, however, like abetment ("*Gehilfenschaft*") under Art. 25 StGB, also take the form of psychological support.

With regard to subjective requirements, the person providing assistance must, firstly, act with *premeditation*. More precisely, there must be premeditation involving an awareness and acceptance of the possible consequences ("*Eventualvorsatz*") with regard to the self-killing carried out by the person who, exercising control over the act and acting independently, commits suicide; the same kind of premeditation is required in relation to the incitement or abetment. Secondly, the person committing the offence must have acted for "selfish reasons". According to the prevailing doctrine, indifference on the part of the person involved in the suicide is sufficient to rule out any such motivation. The reasons are deemed to be selfish if the offender is *pursuing personal advantage*. Such gains may be of a material nature (e.g. securing an inheritance or saving on maintenance), but also non-material or emotional (e.g. gratification of hatred, a desire for revenge, or spite). The qualification concerning the subjective reasons for the act means that involvement in suicide is partially prohibited, with punishability being the exception rather than the rule. In general, assisted suicide as practised by right-to-die organizations is not punishable, as selfish reasons are lacking.

¹ On the following points cf. Christian Schwarzenegger: Art. 111–117 (Tötung) in: Marcel Alexander Niggli / Hans Wiprächtiger (ed.): Basler Kommentar. Strafgesetzbuch II. Art. 111–401 StGB. Basel 2003, pp. 64–69 (further references therein).

However, the provisions concerning incitement and assistance relate to all persons, irrespective of their profession, training or institutional affiliation. They make no reference to specific contexts or situations in which people express a wish for support in committing suicide but are applicable in a general manner. The provisions essentially allow anyone to offer services relating to the execution of a suicide, as long as the motives for the offer are not self-interested. From a criminal law perspective, considerable latitude exists.

An external framework for the applicability of Art. 115 StGB is, however, provided by the term "self-deliverance". Suicide in the criminal law sense (which in this respect is narrower than colloquial usage) implies self-determination. If a suicidal act lacks self-determination, it cannot be regarded as self-deliverance even if it constitutes self-killing in purely physical terms. Self-determination implies mental capacity and freedom of choice. As a result, the provisions of Art. 115 StGB are not applicable to cases where, for example, people who are mentally confused, intoxicated or incapacitated by an acute mental disorder seek the help of others in killing themselves.

From 1960 to 1998, there were only 8 recorded convictions for inciting and assisting suicide, including 5 that occurred between 1991 and 1993.² In terms of sentencing statistics, Art. 115 StGB is of minor importance. Its practical relevance lies rather in its delineation of the boundaries of legal assisted suicide.

1.2 Background to the preparation of the Opinion

The NEK-CNE was prompted to elaborate the present Opinion by a series of developments.

Perceived abuses in the practice of assisted suicide: It was demonstrated that a considerable proportion of the suicides facilitated by right-to-die organizations did not involve a medically hopeless condition. According to a recent study of 748 cases of suicide assisted by "Exit Deutsche Schweiz" between 1990 and 2000, 21% of these cases involved people whose condition can scarcely be regarded as hopeless (polyarthritis, osteoporosis, arthritis, chronic pain, blindness, general infirmity and also 9 cases of mental disorders, mostly depression).³ In some cases, these practices were construed as abuses, and efforts were initiated to revise the provisions of Art. 115 StGB. A parliamentary initiative was submitted on 14 March 2001 (by National Councillor Dorle Vallender, no. 01.407), calling for incitement to be criminalized in all cases and for tighter restrictions to be placed on assisted suicide (exclusion of physicians and nursing staff, outlawing of assisted suicide outside the individual's immediate circle, mandatory authorization for right-to-die organizations, state supervision, etc.); however, this was rejected by a relatively clear margin in the National Council debate held on 11 December 2001.⁴ The question of when assisted suicide should be considered an abuse remained unresolved from an ethical perspective.

Revision efforts and legislative project on euthanasia and palliative medicine: Since 1994, when a motion calling for a "new Article 115bis" was submitted by National Councillor Victor Ruffy, the regulation of assisted suicide has been discussed in the context of the broader, contentious debate on euthanasia. In March 1999, a report by the Euthanasia Working Group (chaired by State Councillor Josi J. Meier) was presented to the Federal Department of Justice and Police (FDJP). This report called for termination of life on request to be legalized in certain circumstances, while the provisions of Art. 115 StGB concerning assisted suicide were to be left unchanged. This proposal was rejected by the Federal Council on 5 July 2000.

² Ibid., p. 64.

³ G. Bosshard / E. Ulrich / W. Bär: 748 cases of suicide assisted by a Swiss right-to-die organization, in: Swiss Medical Weekly 133 (2003) 310–317

⁴ Amtliches Bulletin. National Council, 2001, 1835.

Following a series of parliamentary initiatives (Cavalli, Vallender, Zäch, etc.), Federal Councillor Ruth Metzler (in a letter of 4 July 2003) requested the NEK-CNE to consider the ethical and legal aspects of the "entire euthanasia issue", including assisted suicide, and to develop proposals for legal regulations. Under the Federal Council's new plans for the legislative period from 2004, however, this project to overhaul existing regulations in this area was shelved, and the request to the Commission was withdrawn by the new Head of the FDJP, Federal Councillor Christoph Blocher. But it is to be presumed that the needs underlying the various initiatives have remained unchanged.

Requests by mentally ill patients for assisted suicide: As shown by internal statistics compiled by the right-to-die organization Exit, the presence of depression in addition to somatic disease was confirmed on 24 of 132 checklists completed for the individual cases.⁵ In 1998, it emerged that a physician working for Exit had prescribed a lethal dose of sodium pentobarbitone for a mentally ill 29-year-old woman in Basel, without a thorough diagnosis. In this case, suicide was prevented through the intervention of the Cantonal Medical Officer and involuntary psychiatric committal.⁶ Exit subsequently announced a moratorium on suicide assistance for the mentally ill and initiated discussions on the precautions that would need to be taken before the moratorium could be lifted.

Death tourism: In the canton of Zurich and recently also in the canton of Aargau, the right-to-die organization Dignitas has increasingly been offering suicide assistance for people who have come from abroad. According to Zurich City Police figures, the total number of cases was 3 in 2000, 37 in 2001, 55 in 2002 and 91 in 2003.⁷

Increase in organizations' assisted suicides: The number of deaths assisted by Exit trebled, from 110 in the 1990–1993 period to 389 in the 1997–2000 period.⁸

Assisted suicide in hospitals and old people's homes: With effect from 1 January 2001, the city of Zurich introduced regulations allowing assisted suicide to be carried out in public hospitals and old people's homes. A new recommendation issued by the Ethics Committee of the Association of Medical/Social Institutions of Canton Vaud (AVDEMS) supports the option of assisted suicides being carried out in hospitals and old people's homes, if the individuals concerned no longer have their own home.⁹

Influence of modern medicine on dying: Medical science has at its disposal ever more means of prolonging life and delaying death. As a result, the nature of the diseases from which people now die has changed; dying itself is not eliminated. In the case of certain progressive diseases, the quality of life may be so severely impaired – even with optimum medical care – that the patients concerned feel that their life is devoid of dignity. Within society, more and more people are expressing the desire to have a say in their own end-of-life care. This gives rise to specific requests for active and passive euthanasia, or for the types of suicide assistance offered by right-to-die organizations. However, it also creates a need for renewed debate and for changes to the institutional and legal framework, so as to permit greater self-determination in dying.

Role of physicians and carers: In 2004, following a consultation procedure, the Swiss Academy of Medical Sciences (SAMS) published revised "medical-ethical guidelines for the care of patients at the end of life"; these allow physicians in certain cases to provide individual patients with assistance in suicide on the basis of a "personal decision of conscience".¹⁰

⁵ E. A. Ulrich: "Exit": Beihilfe zum Suizid zwischen 1990 und 2000 (Diss. Med. Uni). Zürich 2002, p. 24. Cf. G. Bosshard / M. Kiesewetter / K.P. Rippe / Ch. Schwarzenegger: Suizidbeihilfe bei Menschen mit psychischen Störungen – unter besonderer Berücksichtigung der Urteilsfähigkeit: Expertenbericht zu Händen von EXIT-Deutsche Schweiz. Zürich 2004, p. 5.

⁶ Schwarzenegger: Art. 111–117 (see Note 1), p. 69 (including references).

⁷ NZZ am Sonntag, 22 February 2004.

⁸ Bosshard / Ulrich / Bär: 748 cases of suicide (cf. Note 3)

⁹ A. Jotti-Arnold et. al.: Assistance au suicide en EMS: recommandations éthiques et pratiques de la Chambre de l'éthique de l'AVDEMS, in: Revue Médicale Suisse No. 1, 5 January 2005.

¹⁰ Medical-ethical Guidelines of the SAMS: Care of patients in the end of life; http://www.samw.ch/content/Richtlinien/e_RL_Lebensende.pdf

Frustration and uncertainty when a patient wishing to die has to be discharged from institutional care: Individual case reports from institutions clearly indicate how adversely staff are affected when care provision is discontinued because a patient has to leave a hospital or home in order to proceed with assisted suicide. Relations with the medical and nursing team are broken off; support can no longer be provided by carers at the very time that it would be most needed by the patient concerned.

Blurring of the distinction between assisted suicide and direct active euthanasia: In recent practice, the acts involved in assisted suicide may closely resemble acts that would be regarded as constituting active euthanasia (termination of life on request). In cases where a straw is used to administer a lethal drug to a quadriplegic, so that he or she only has to suck and swallow, or where the final act leading to the death of an extremely infirm patient merely consists of opening a valve or pressing a switch, it is often difficult from a physician's viewpoint to see what distinguishes these acts so sharply in the eyes of the criminal law from directly bringing about death at the patient's request.

These (and other) developments, which will be examined more closely below, indicated to the Commission the need for an ethical study of assisted suicide, covering both fundamental aspects and the particular situation in Switzerland.

1.3 Definition of the subject matter of the Opinion

From an ethical perspective, the first question that arises is whether the boundary dividing unacceptable circumstances of assisted suicide from acceptable circumstances was *correctly drawn* in Art. 115 StGB. Are the provisions of Art. 115 StGB to be supported in this politically liberal form? The second question is whether the *application* of these provisions gives rise to problems that would make it necessary (or advisable) for the law to be supplemented, possibly also in other areas outside criminal law. Thirdly, uncertainties and conflicts arising in *medical practice* demand ethical analysis, without legislative action being required as a result. In the following discussion, the Commission addresses questions at all three levels.

Firstly, however, it should be noted that the liberal formulation of Art. 115 StGB only regulates the question of what constitutes a criminal offence. This does not preclude the introduction – in areas other than criminal law – of further regulations to govern practice. It is conceivable, for example, that rules could be introduced in health law to regulate how requests for assisted suicide are dealt with in hospitals and homes. Or right-to-die organizations could be required to obtain authorization for their activities, which would be subject to certain conditions.

Nor do the criminal-law provisions of Art. 115 StGB mean that altruistic motives are sufficient to make assisted suicide ethically acceptable. Restrictions may be imposed by professional rules and ethical guidelines. For example, Art. 115 StGB does not indicate that a wish for suicide needs to be considered or consistent, or that it should not arise from a temporary or resolvable crisis. Finally, the decision whether or not to provide a specific person with assistance in suicide remains a

matter of conscience and is not preordained by legislation. Even if it can be said that Art. 115 StGB makes it possible to assist a suicide without being liable to punishment, this does not entail an *obligation* to do so in a specific case. Whether someone feels morally bound to help another person carry out a suicide is a question that requires personal ethical deliberation, guided by conscience. Nobody can oblige other people to assist a suicide by invoking Art. 115 StGB.

The provisions of Art. 115 StGB – at least as they are currently applied – embody an unmistakably *liberal political outlook*. State interference in the citizen's personal affairs is to be restricted. Through Article 115 StGB, the state seeks to prohibit only such acts as endanger people or threaten the freedom of third parties. Attempted suicide is considered not to be an offence because the person performing the act only directly harms him/herself. It is an exercise of freedom which does not fundamentally endanger other people. After a suicide attempt, the person concerned requires help, respect and support rather than punishment. Thus, for good reasons, suicide is not deemed to be a criminal offence. If the help of others is enlisted to carry out a suicide, the provision of such help cannot be criminalized since involvement in a legal act cannot be an offence. (Criminal law doctrine speaks of *derivative liability*.) If two people take part in the execution of a suicide by mutual agreement, there is no need to protect third parties.

A liberal view of the ethics of assisted suicide claims that, as moral agents, we should have the right or freedom to control the course of our lives and to decide how we wish to live, provided only that we do not curtail other people's right to do likewise. This is what is meant by personal autonomy or self-determination on the liberal view. Thus conceived, the right to moral autonomy implies the right to exercise the greatest possible control over the length of one's own life and the way in which one dies. This in turn implies that other people should also be allowed to participate in the exercise of this freedom.¹¹

However, Switzerland's criminal law did not go so far as to declare that involvement in suicide never constitutes a criminal offence. The legislators identified an exception in cases where the person providing assistance is not motivated by solidarity, but pursuing personal advantage. There is then a risk that the suicidal inclinations of the person concerned will merely be exploited by the assistant to gain such advantage. In this case, the person inclined towards suicide is rendered vulnerable by the offer of assistance and requires protection.

The legislators thus implicitly acknowledged *two* ethical concerns: firstly *respect* for the autonomy of people committing suicide and those who assist them, but secondly also *responsibility* for people who require special protection on account of their suicidal inclinations. To this extent, the question whether the liberal view can accommodate all the dimensions of the ethics of assisted suicide, or needs to be supplemented by notions of care, is already addressed in the law itself.

Definition of scope: According to the relevant legislation,¹² the Commission is responsible for considering ethical and legal matters in all areas of medicine. However, the application of Art. 115 StGB doubtless extends beyond this sphere. For this reason, the NEK-CNE decided to address the issue of assisted suicide in

¹¹ For a typical expression of the liberal position, see: M. Charlesworth: *Leben und sterben lassen: Bioethik in der liberalen Gesellschaft*. Hamburg 1997, pp. 47f.

¹² Reproductive Medicine Act (FmedG), Art. 28, and the Ordinance of 4 Decembre 2000 concerning the Swiss National Advisory Commission on Biomedical Ethics (VEK).

the context of medical practice and to confine itself to this specific area. The field of "medicine" is, however, defined relatively broadly: if a medical act such as issuing a prescription is involved, if the assistants include medical staff, or if a medical institution is concerned, assisted suicide is considered to fall within the province of medicine for the purposes of this Opinion. The report does not cover situations in which assisted suicide takes place between two individuals outside a medicalized setting.

The Commission's legal mandate – to serve the Federal Council, Parliament and the cantonal authorities in an advisory capacity – accounts for its particular perspective: the Commission is required to undertake a critical and constructive examination of the legal and institutional framework from an ethical viewpoint, but it is not to assess the ethical legitimacy of personal decisions to commit or assist a suicide as such. This perspective limits the range of questions to be addressed in the Opinion and leaves other aspects of ethical matters to other partners within society and to the individuals themselves.

I.4 Conflicting values in medicine

It is an inescapable fact that all members of health care professions are also free citizens. In considering the question of assisted suicide, therefore, it should always be borne in mind that members of health care professions, like their patients, are not only defined by their role or function. They share their existence as human beings. In establishing the values that are at stake, it may prove useful to draw a distinction between, on the one hand, the strictly professional role of physicians and nursing staff and, on the other, the common humanity they share with their patients.

The main argument against assisted suicide advanced by certain groups – particularly physicians' and nurses' professional associations – invokes the code of ethics to which the health care professions are subject, according to which their activities are focused on the preservation of life. However, this same code also calls for the alleviation of patients' suffering. These two imperatives are not always mutually compatible, as there are some – albeit a small number of – patients who cannot be helped by palliative care. In the case of patients in this condition, it is thus impossible to comply with both imperatives at the same time.

Given the impossibility of fully complying with mutually exclusive imperatives, a patient's request for help is ultimately an appeal to the moral conscience of the physician, both as a treatment provider and as a human being. This is precisely the tenor of the new SAMS guidelines on end-of-life care. It is self-evident that freedom of conscience makes it illegitimate to compel physicians or nursing staff to take part in a patient's suicide; moreover, this is in accordance with the Code of Ethics of the Swiss Medical Association, which in Art. 3 states that: "Physicians are not to perform any medical acts or make any statements that they cannot reconcile with their conscience."

Another important point in the current debate in Switzerland concerns the setting in which a suicide is planned or carried out. An agreement concluded in private between two people cannot be prevented by the state. The act of suicide is possible if the plan is carried out in the home of the person concerned or at a private

location. The situation is, however, quite different in a medicalized context. Accordingly, one of the central questions raised in the current debate concerns the moral conflict that may be posed by suicide in a medicalized setting (nursing/old people's home or acute care hospital). How is the therapeutic function of such an institution to be reconciled with the intention of a patient or resident to commit suicide? At present, for most institutions in Switzerland, the therapeutic function precludes the practice of suicide and assisted suicide on the premises. As far as possible, these institutions seek to persuade patients who are determined to commit suicide to carry out the planned act in their own home. Exceptions to this general attitude are rare; they occur in cases where people reside, of necessity, at an institution, i.e. almost exclusively in old peoples' or nursing homes. Restrictions have been eased by the cities of Zurich and Lugano, where assisted suicide is officially permitted in facilities of this kind.

II. General points – historical, legal, regional, political and ethical aspects

II.1 Suicide in the history of ethics

Over the ages, a wide variety of views on suicide have been advanced in theological and philosophical ethics. Overall, suicide has been subject to disparate interpretations, resisting reduction to a uniform or at least consistent logical framework. All that can be attempted here is a survey of some of the ethical assessments of suicidal behaviour that are to be found in the history of Western thought.¹³

a) Suicide as a “sin”

In European history, Christian thought has influenced social attitudes to suicide in many different ways. One of the central figures in the development of Christian theology was *St Augustine*. His categorical rejection of suicide is due to his interpretation of the fifth commandment – “Thou shalt not kill” – in absolute terms. This uncompromising stance, set out in the *City of God*, contrasts with the more nuanced positions adopted by *St Ambrose* or *St Jerome*. These authors allowed for certain exceptional cases where suicide was “excusable”, for example if this act enabled martyrs to avoid violation. Augustine’s line of argument is primarily based on a deontological view of the divine commandment. On his interpretation, it does not admit of any exceptions and is to be followed to the letter. Suicide cannot be justified even to avert an evil such as the violation of a woman: “It is not without significance, that in no passage of the holy canonical books there can be found either divine precept or permission to take away our own life, whether for the sake of entering on the enjoyment of immortality, or of shunning, or ridding ourselves of anything whatever. Nay, the law, rightly interpreted, even prohibits suicide, where it says, ‘Thou shalt not kill.’”¹⁴

Augustine’s rigorism had a profound influence on European mentalities, which extended beyond the medieval period. The question of suicide was also discussed by *St Thomas Aquinas*, whose views have shaped official Catholic doctrine down to the present day. Aquinas’s opposition to any form of suicide contrasts with his general philosophy of the *conditio humana*. His reflections on suicide are less concerned with ideas of man’s nature and moral freedom than with a particular conception of God’s sovereignty over man. To explain his thinking, Aquinas uses an analogy referring to the relationship between master and slave under Roman law. According to this interpretation, any act of suicide represents an infringement of the rights belonging to God alone, who is regarded as an omnipotent lord, the owner of his creation, man: “... because life is God’s gift to man, and is subject to His power, Who kills and makes to live. Hence whoever takes his own life, sins against God, even as he who kills another’s slave, sins against that slave’s master, and as he who usurps to himself judgement of a matter not entrusted to him. For it belongs to God alone to pronounce sentence of death and life [...].”¹⁵ This passage from the *Summa theologiae* shows how the argument combines elements from the Bible and the Roman system of private law. The concept of God emerging from this text strongly resembles that of the Roman *pater familias*, who had power over the life and death not only of his slaves but also of his children and spouse. This notion of God’s dominion in determining the duration of human life is not confined to medieval theology; it still survives in parts of both Catholic and Protestant theology.

¹³On the history of ethical assessments of suicide, see J.-P. Wils, “Anmerkungen zur Geschichte des Sterbens”, in A. Holderegger (Ed.), *Das medizinisch assistierte Sterben*, Academic Press, Fribourg/Herder, Freiburg, 2nd ed., 2000, pp. 23–38; *idem*, *Sterben: zur Ethik der Euthanasie*, Schönigh, Paderborn, 1999, Chapter 4; M. Zimmermann-Acklin, *Euthanasie: eine theologisch-ethische Untersuchung*, Academic Press, Fribourg/Herder, Freiburg, 2nd ed., 2002, Chapter 1.

¹⁴St Augustine, *De Civitate Dei*, Book I, Chapter 20.

¹⁵St Thomas Aquinas, *Summa theologiae*, IIa-IIæ, q. 64, art. 5 c: *Tertio, quia vita est quoddam donum divinitus homini attributum, et eius potestati subjectum qui occidit et vivere facit. Et ideo qui se ipsum vita privat in Deum peccat; sicut qui alienum servum interficit peccat in dominum cuius est servus; et sicut peccat ille qui usurpat sibi iudicium de re sibi non commissa. Ad solum enim Deum pertinet iudicium mortis et vitae [...].*

The question remains whether this kind of interpretation of the relationship between God's sovereignty and man's freedom before God actually corresponds to the *biblical view*. This question cannot be explored in depth here. However, it may be pointed out that no *explicit doctrine* on suicide is to be found either in the Old or in the New Testament; in scriptural accounts, suicide is mentioned almost incidentally, without any attempt being made to provide a detailed ethical justification or condemnation of the practice.

b) Suicide as a "crime" in classical pre-Christian antiquity¹⁶

In the dialogue *Phaedo*, Plato argues that suicide cannot be approved of as it represents a rejection of the protection afforded by the gods to each individual human life. He ascribes these views to his master *Socrates*, although the latter also claims that in certain cases it is better for some people to be dead than to carry on living. However, as we are not our own masters, suicide cannot be lawful.¹⁷ In the *Laws*, Plato appears to signal a somewhat greater understanding of painful situations that could lead to suicide. But since such an act could never be legitimate, those who commit suicide should be buried in an unmarked grave in a remote area.¹⁸ While these views had a major influence on later, especially Christian, eras, there is no evidence to prove that they were actually embraced by the Greek societies (Athenian or Spartan) of that period.

Aristotle also addressed this question, although the arguments he employed were of a legal rather than a fundamental nature. For Aristotle, suicide is primarily an offence against the state, as in his view it is not possible to act unjustly towards oneself. In addition, he takes the view that everything which is not explicitly prescribed by the law is prohibited.¹⁹ It is apparent that suicide was already essentially disapproved of in pre-Christian cultures, although the opposition was less radical than in subsequent centuries. In Roman law, provision was made for a special kind of sanction, namely confiscation of the goods of a defendant who has committed suicide in order to escape prosecution. Although this was a highly specific and thus rare type of case, it influenced the customs and attitudes of later Christian periods.²⁰

c) First criticisms of the prohibition of suicide

With the advent of humanism, positions that had been "indisputable" in medieval times began to be questioned and, during the Enlightenment, subjected to increasingly radical criticism.

The Humanists were at liberty to take philosophers of pre-Christian antiquity as their guide. The *Stoics* in particular had already sought to give suicide a certain respectability. Put simply, the doctrine of the Stoics was that everyone must live in harmony with the *logos* – the rational divine force underlying the cosmos. In other words, one must live in accordance with the laws of nature. In addition, one should not be ruled either by instincts or by emotions, but solely by reason; one may thus attain the state of *apatheia*, or complete absence of passions. Human decisions are of different kinds, concerning that which is good or evil, or matters of indifference (known as *adiaphora*).²¹ A well-considered decision in favour of suicide, which is then not carried out for lack of courage, is classified as a matter of indifference, whose positive or negative value depends on the context. Reflections of this kind can be found in several places in the writings of *Seneca*, which were not entirely rejected by the Christian tradition.²²

¹⁶ For an account of suicide in the history of philosophy, see G. Minois, *Geschichte des Selbstmords*, Artemis & Winkler, Düsseldorf/Zürich, 1996. See also A. Holderegger, *Suizid – Leben und Tod im Widerstreit*, Paulusverlag, Fribourg, 2000.

¹⁷ Plato, *Phaedo*, 62 a–d.

¹⁸ *Idem*, *Laws*, IX, 873 c–d.

¹⁹ Aristotle, *Nicomachean Ethics*, V 11, 1138a.

²⁰ For an analysis of Roman law, see R. Marra, *Suicidio, diritto e anomia: immagini della morte volontaria nella civiltà occidentale*. Edizioni Scientifiche Italiane, Naples, 1987.

²¹ H. von Arnim (Ed.), *Stoicorum Veterum Fragmenta*, Vol. 3, Teubner, Stuttgart, 1978, p. 54.

²² Seneca, *Moral Letters to Lucilius* (especially Epistles 12, 26, 61, 70, 77).

People are free to depart from this life should they be stricken by adversity or mental derangement. In his famous 70th epistle, Seneca writes: "You can find men who have gone so far as to profess wisdom and yet maintain that one should not offer violence to one's own life, and hold it accursed for a man to be the means of his own destruction; we should wait, say they, for the end decreed by nature. But one who says this does not see that he is shutting off the path to freedom. The best thing which eternal law ever ordained was that it allowed to us one entrance into life, but many exits."²³ The Stoics thus not only argued against the outlawing of suicide on moral grounds but actually presented a philosophical case in its support. *Epictetus*, for his part, wrote, "Friends, wait for God; when He shall give the signal and release you from this service, then go to Him; but for the present endure to dwell in this place where He has put you."²⁴ Until the late Roman period, suicide prompted by old age or physical decay and intolerable pain was not unusual, as attested by relatively frequent accounts. In some cases, physicians were also involved.²⁵

In the Renaissance period, this idea re-emerged, adapted to the contemporary historical context. *Michel de Montaigne*, the best-known humanist exponent of this line of thought, presents a comprehensive view of life in his *Essais*; here, under certain specific conditions, suicide may be positively appraised. Suicide can only be seen in a positive light if death is placed in perspective. Rather than signifying the end of our life, death merely marks a boundary. It should therefore not be accorded too great importance; instead, what is important is to "frequent" and "get used to" death. For Montaigne, if death is a reasonable choice, then it should be contemplated fearlessly. It is therefore essential not to be swayed by the claim that life does not belong to us: "Just as I break no laws ... against arson if I burn my own woods, so too I am not bound to the laws against murder if I take my own life."²⁶ If Montaigne's position is to be correctly appreciated in the context of humanism, we need to see him primarily as a courageous advocate of man's autonomy vis-à-vis external – human or divine – forces, ultimately expressing a desire to decriminalize suicide. Montaigne thus finally breaks away from the tradition founded by Augustine.

With the Enlightenment philosophy of the 18th century, the arguments calling the Christian tradition into question became increasingly radical. However, this radicalization is the only common denominator for the philosophers of this movement. Their positions diverge on crucial points, thus representing the first experience of a *public debate* on this issue in an *open society*. Among the influential figures adopting an unequivocal position were *David Hume* and *Immanuel Kant*, who respectively approved of and condemned suicide. In David Hume's essay "Of Suicide", published posthumously in 1777, the criminalization of suicide, still common at that time, is described as a matter of "superstition and false religion". Hume seeks to show that suicide should not be opposed on either moral or legal grounds. His "deconstruction" involves three different levels: suicide is not "a transgression of our duty, either to God, our neighbour, or ourselves".²⁷ As regards the first level, Hume argues that God has established material laws and animal powers to govern the universe. The interplay of these forces creates a harmony that confirms God's existence. Not even the suicide of an individual "can encroach upon the plan of his providence, or disorder the universe". Rather than wishing to justify suicide in all cases, Hume argues that this act should not be regarded as a crime against God's will – a contravention that in any case cannot be proven, any more than the contrary. Instead, we should be grateful that we have been granted a free choice, and that providence does not intervene directly to prevent suicide.

²³ *Ibid.*, Epistle 70 ("On the proper time to slip the cable").

²⁴ Epictetus, *Discourses*, Book I, Chapter 9.

²⁵ A. J. L. van Hooff, *From Autothanasia to Suicide: Self-Killing in Classical Antiquity*, Routledge, London/New York, 1990; cf. Zimmermann-Acklin, *op. cit.*, p. 23.

²⁶ Michel de Montaigne, *The Complete Essays* (English translation by M. A. Screech), Penguin, Harmondsworth, 1991, Book II:3.

²⁷ David Hume, *Of Suicide*.

Regarding the second level, Hume also seeks to counter the objection that suicide is a crime against our neighbour and society. He replies that the obligations of individuals and society are reciprocal. Therefore, someone who, without seeking permission, withdraws from society through suicide is released from any obligations: although he no longer gives society anything, neither does he demand anything in return. Therefore, suicide is not inequitable. The third level concerns our duty to ourselves. In Hume's view, this duty is not violated by suicide since our instinct for self-preservation protects us from acting thoughtlessly against our own interests. If an individual has the strength to commit suicide, it may be assumed that he is convinced that this is in his best interests: therefore, it is not an act of self-mutilation. To these reflections, Hume adds a theological observation: while it is clear from a careful reading of the Bible that the killing of others is strongly condemned, scripture contains no explicit strictures against suicide. Augustine's interpretation of the fifth commandment – likening suicide to murder – is thus rendered untenable.

Kant's approach to the subject of suicide is quite different,²⁸ focusing on human beings' duties to themselves. What is the basis of such duties? Here, it should be recalled that, for Kant, there are two aspects to man's nature. The first is that of *animality*. People seek to preserve themselves and therefore not to destroy themselves. But if someone does intend to kill himself, he must not merely consider his animality, but rather the fact that he is also a *moral being*. For Kant, this means that he also has duties to himself. If someone respects the moral being within himself, he also respects humanity as a whole in his own person; but if he treats it with contempt or destroys it, he degrades humanity itself. For this reason, Kant considers suicide to be not merely a moral evil, but a crime: "To annihilate the subject of morality in one's own person is to root out the existence of morality itself from the world [...]."²⁹

Among his contemporaries, Kant's rigorism found both supporters and critics. The latter included Arthur Schopenhauer, who commented ironically and at length on the notion of "duties to oneself". These and other arguments from the history of ethics are also encountered in the current ethical controversy concerning assisted suicide. The main positions in this debate are to be outlined below.

II.2 The churches' stance on assisted suicide

A distinction needs to be drawn between the official positions adopted by the two main denominations on assisted suicide and the individual attitudes of many of their members. For both churches, it may be assumed that the individual attitudes of a considerable number of members differ from the official stance of the governing bodies. Accordingly, the official church positions described below cannot be regarded as fully representative of the congregations' views.

The position of the Council of the Federation of Swiss Protestant Churches (SEK) is clearly articulated in its submission to the consultation procedure concerning the "medical-ethical guidelines for the care of patients at the end of life" issued by the Swiss Academy of Medical Sciences (SAMS). The comments are prefaced by a paragraph on "guiding principles and fundamental values", in which it is noted that, in view of man's inalienable dignity, "the attitude of each individual to his or her own death is to be respected".

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This also applies to the "well-thought-out and nuanced position of the SAMS on the question of assisted suicide", and in particular the observation that assisted suicide does not form part of a physician's duties. This position is justified primarily in terms of the need to maintain the relationship of trust between physician and patient. It is underlined that the physician's role does not authorize him or her to offer the patient assistance in suicide. However, the SEK Council agrees with the SAMS that "it must be possible for the physician under certain clearly defined conditions to comply with a request for assistance in suicide". The physician must, however, also have the right to refuse to assist in a patient's suicide. In addition, the Council proposes that the minimum requirements for assisted suicide specified by the SAMS (the patient is approaching the end of life, alternative forms of assistance have been exhausted, and the patient's decision is voluntary and well-considered) should be supplemented, with two additional conditions being met: the patient's disease must involve intolerable mental or physical suffering, and the patient must be capable of expressing his or her wishes and have clearly expressed the desire to die. Society's responsibilities are also underlined, together with the need to monitor assisted suicide through legislation and social institutions.

A different stance on assisted suicide is taken by the Catholic church. This is set out in a Pastoral Letter from the Swiss bishops on the subject of assisted dying and terminal care, entitled "The dignity of the dying". The letter begins with reflections on the "gravity of human dying", explaining the religious significance of dying and the "three dimensions" of human dying –biographical, social and religious. This section includes a discussion of various efforts to come to terms with dying – through scientific investigation of the process of dying, the suppression and trivialization of dying, self-determined dying in the form of suicide, and the religious approach to dying. The Pastoral Letter then considers in detail the "Christian dignity of dying" and the "dignity of the dying person". Here, the relationship between autonomy and dependence is discussed in particular. Autonomy, it is argued, only exists on the basis of and within the limits of the fundamental dependencies of human life. "The function of any end-of-life assistance must be to ease the passage into the final and inescapable heteronomy of dying"; this is facilitated by a religious conviction that, even in dying, one is "in God's hands".

In the section on assisted suicide, it is noted that this procedure differs only minimally from active euthanasia, since all the preparations are made by the assisting party, and the patient only has to carry out the final action leading to death: "It is difficult to see in this small difference more than a legal nicety."

²⁸ For an introduction, see H. Wittwer, "Über Kants Verbot der Selbsttötung", in *KantStudien* 92/2 (2001), pp. 180–209.

²⁹ Immanuel Kant, *The Metaphysics of Morals* (English translation by Mary Gregor), CUP, Cambridge, 1996, p. 177 (The Doctrine of Virtue, §6).

Of much greater significance, it is argued, is another difference, namely that “whereas killing on request is only contemplated as an *ultima ratio* in an intolerable situation of terminal suffering, the option of assisted suicide is often chosen long before a terminal process”. The bishops’ opposition to assisted suicide is based partly on “internal” grounds, such as the fact that, in many cases, the decision to take this course of action is not truly voluntary. Decisions to commit suicide are often attributable to severe suffering. But “external” grounds are also cited, in the form of the possible *consequences* of widespread suicide practices in terms of *social ethics*. Reference is made to the imitation effect and to the trivialization of death associated with an “erroneous ideology of human self-determination” that seeks to evade life’s trials and tribulations by ending life itself. The Pastoral Letter also draws attention to possible effects relating to the severely disabled, who are confronted with the question of whether they should have their lives terminated rather than receiving costly and elaborate care.

The bishops conclude: “Because it comes close to killing on request, we ... categorically reject assisted suicide.” They call for the existing gap in Swiss criminal law to be remedied as a matter of urgency, particularly with regard to the provision of assisted suicide for the mentally ill, or on a commercial basis.

II.3 Sociology of suicide

In the 19th century, the topic of suicide was also studied by social scientists. Such studies are not primarily concerned with the question of whether it is permissible for people to take their own lives or not. Instead, they address in particular the *causes* of and *reasons* for suicidal acts arising from society itself.

Émile Durkheim, the most important representative of this new branch of research, demands consideration in any discussion of this issue. His analysis of suicide (*Le suicide*), first published in 1897, has remained influential down to the present day. Anyone approaching this work today may expect to find a sober and clinical view of the phenomenon. But the opposite is the case: while Durkheim sets out his convictions quite clearly, he does not content himself with the simplistic claim that the act of suicide is harmful in any type of society.³⁰ He offers a complex explanation for the fact that “primitive” societies are more permissive than medieval or modern societies in their assessment of and efforts to control suicide. According to Durkheim, this change in attitudes was due to the fact that modern societies were conscious of the *sanctity of the human being* and had developed an attitude of respect precluding any kind of destruction. This attitude could also be maintained if the religious convictions of people in industrial societies became increasingly removed from the doctrines of the Judaeo-Christian tradition. For society, the suicide of one of its members was a rupture, damaging the social network, and it felt vulnerable as a result. Modern societies therefore had to react for their own protection, expressing their moral and social disapproval of the act of suicide, but without reintroducing the penalties imposed on suicides by archaic societies. To ensure that individuals acted in accordance with rules and did not succumb to *anomie*, society had to strive for a balance between collective and individual tendencies; in this way, the conditions would be created to prevent the individual from contemplating suicide as a last resort in the event of a conflict.³¹

³⁰ Émile Durkheim, *Suicide: A Study in Sociology* (English translation by George Simpson and John A. Spaulding), Free Press, New York, 1951.

³¹ *Ibid.*

In the 20th century, the sociology of suicide was initially informed primarily by psychological and psychiatric discourse, with less emphasis on moral debate; this debate is now once again attracting greater attention, essentially as a result of the issues arising from the disease and pain associated with the final stages of human life.

Sociological research has confirmed that people exposed to diseases, stress, traumatic life events, abuse or other serious personal problems are at an increased risk for suicidal behaviour. However, only a minority of those belonging to the various risk groups actually attempt or commit suicide. The individual risk factors are therefore not sufficient to explain why a relatively large or small number of the members of these groups kill themselves. The incidence of suicide must, as Durkheim assumed, be determined by the moral or psychological climate within a given society. Prevalent norms and values, behaviour patterns and problem-solving approaches that are generated and communicated within a society need to be adduced as explanatory factors. Durkheim’s general rule that the frequency of suicide varies with the degree to which individuals are integrated into the community has been amended by the addition of various other social factors.

As I. H. Mäkinen has argued, the social climate primarily consists in a cultural-normative system, which includes laws, cultural attitudes and also religion. Citing Talcott Parsons’ theory of society, Mäkinen contends that cultural “systems of symbols” give rise to a “need-disposition” in the individual, which “narrows the range of conceivable alternatives for action, influencing both the motivation of problem-solutions and their practical form”. Menno Boldt points out that individual behaviour may be influenced by socio-cultural conceptualizations of suicide as, for example, “an unforgivable sin, a psychotic act, a human right, a ritual obligation, an unthinkable act, and so on”.³²

Within the framework of a social motivation theory that not only compares frequencies but considers the development of motives in qualitative terms, Christa Lindner-Braun³³ has proposed four explanatory approaches for suicide research.

1. The outcomes approach, investigating when suicidal acts result in death and when attempters survive.
2. The acts approach, studying when and why suicidal acts are carried out.
3. The instrumentality approach, exploring how the readiness to attempt or commit suicide arises.
4. The motivation approach, examining how a sense of hopelessness develops.

Lindner-Braun insists that suicides and suicide attempts need to be regarded as a social phenomenon and not simply as psychopathological events. This is particularly apparent in the fourth explanatory approach: the factors producing a sense of hopelessness may lie outside the individual’s sphere of influence.

At the individual level, “suicidal transmission” is observable within families or smaller groups: suicidal behaviour is evidently learned as a special kind of communication and means of problem solving. Several studies have shown that if a person has experienced suicidal behaviour in his/her family, this increases the risk of the person eventually committing or attempting suicide him/herself. At the macro level, people’s attitudes are significantly influenced by the media, with suicidal ideation being communicated through a “contagious effect”.³⁴

³² For an overview, see U. Bille-Brahe, “Sociology and Suicidal Behaviour”, in K. Hawton, K. van Heeringen (Eds), *The International Handbook of Suicide and Attempted Suicide*, Wiley, Chichester, 2000, pp. 193–207.

³³ Ch. Lindner-Braun, *Soziologie des Selbstmords*, Westdeutscher Verlag, Opladen, 1990.

³⁴ U. Bille-Brahe, *loc. cit.*

Among the most impressive evidence for the influence of the media is the proven effect of preventive measures, adopted in 1987, which changed the way in which suicides on Vienna's subway were reported in the press. Suicides had occurred on the subway since the system opened in 1978. The frequency of such events was initially low, but rose rapidly from 1984 onwards – a phenomenon that could not be attributed to expansion of the network. Media coverage of suicides, however, tended to be sensationalist. In 1987, following the introduction of media guidelines, reports of suicides, if they appeared at all, were given little space or prominence. The frequency of suicides on the subway system dropped to about a third of the previous level in the course of the year and remained at this low rate in subsequent years.³⁵

Also familiar, although controversial in empirical research, is the so-called Werther effect. Convincing evidence for the existence of such an imitation effect came from Germany, where a drama series about the railway suicide of a 19-year-old student (*Tod eines Schülers*) was broadcast on national television in 1981 and 1982. In the periods immediately after these transmissions, suicide rates among 15- to 29-year-old males showed a significant increase, although the effect was less marked following the repeat transmissions.

The link between the change in the nature of press coverage and changes in suicide rates supports the hypothesis that reporting and the portrayal of real and fictional suicidal behaviour can trigger additional suicides and promote the imitation of suicide methods.³⁶ Accordingly, changes in the manner of presentation can also have preventive effects. To date, no studies have been made of how the motivation for suicidal behaviour could potentially be affected by increased social acceptance or the specific symbols associated with assisted suicide in right-to-die organizations and in medical contexts.

II.4 Epidemiology of suicide³⁷

Relatively precise statistics are available on the incidence of suicide: about 1–2% of all deaths in Switzerland are recorded as "suicide".³⁸ In EU countries, there are around 58,000 deaths from suicide or self-inflicted injury per year, i.e. more fatalities than are caused by road accidents (50,700) or homicide (5,350).³⁹ Knowledge of suicide attempts, however, is less precise. Attempted suicide is a relatively frequent phenomenon. It is to be assumed that during their lifetime about 10% of all people in Switzerland will attempt suicide on one or more occasions.

a) Suicides

In 2000, the incidence of suicide in Switzerland was 19.1 per 100,000 inhabitants; i.e. 1,378 people (979 men, 399 women) committed suicide. The SFSO cause-of-death statistics show that there were more deaths from suicide in 2000 than from Aids, drug use and road accidents combined (see Table). Among 15- to 44-year-old men, suicide is currently the leading cause of death. As a cause of premature death, suicide is only surpassed by cancer, particularly among women.

³⁵ A. Schmidtke, S. Schaller: "The Role of Mass Media in Suicide Prevention", in K. Hawton, K. van Heeringen (Eds): *The International Handbook of Suicide and Attempted Suicide*, Wiley, Chichester, 2000, pp. 675–697.

³⁶ *Ibid.*

³⁷ See also the Swiss Federal Office of Public Health (SFOPH) report *Suizid und Suizidprävention in der Schweiz, Bericht in Erfüllung des Postulates Widmer (02.3251)*, Bern 2005; available online in French, German and Italian: <http://www.bag.admin.ch/gespol/suizidpraevention/d/index.htm>

³⁸ Swiss Federal Statistical Office (BFS), *Todesursachenstatistik* [Cause-of-death statistics; German/French/Italian publication], Neuchâtel, 2004.

³⁹ WHO, European health for all database (HFA-DB), June 2004, <http://www.euro.who.int/hfad>

Table: Cause-of-death statistics for 2000⁴⁰
(Source: SFSO cause-of-death statistics)

Cause of death	Total		Men		Women	
	Number	Percentage of all deaths	Number	Percentage of all deaths	Number	Percentage of all deaths
Suicide	1,378	2.2%	979	3.2%	399	1.2%
Aids	127	0.2%	83	0.3%	44	0.1%
Drug use	222	0.3%	177	0.6%	45	0.1%
Road accidents	578	0.9%	419	1.4%	159	0.5%
Alcohol-related deaths*	approx. 2,200	approx. 3.5%	approx. 1,300	approx. 4.3%	approx. 900	approx. 2.8%
Tobacco-related deaths*	approx. 8,800	approx. 14.7%	approx. 6,500	approx. 21.4%	approx. 2,300	approx. 7.2%
Total	62,545	100%	30,411	100%	32,134	100%

*Estimates from the Swiss Institute for the Prevention of Alcohol and other Drug-related Problems (SFA) for 2001 (alcohol) and 1999 (tobacco)

In 2000, according to WHO estimates, around 815,000 people died from suicide worldwide. This is equivalent to 14.5 suicides per 100,000 population. In other words, a case of suicide occurs somewhere in the world every 40 seconds.⁴¹ At 19.1, the corresponding suicide rate in Switzerland is markedly higher and clearly exceeds the European average, for both men and women. While it is lower than in Russia, Hungary, Slovenia, Finland, Croatia, Austria and Belgium, it is higher than in France, Denmark and Germany, and markedly higher than in the US, Spain, Italy, Portugal and Greece.⁴²

Cantonal variation: Over the past 30 years, the differences between individual cantons as regards suicide rates have become appreciably less pronounced. In the period 1990–1999, annual suicide rates were between approx. 25/100,000 (Appenzell, Basel, Bern) and 15/100,000 (Ticino and Central Switzerland). This sequence reflects the proportion of the population living in urban areas: the more urbanized the canton, the higher the suicide rate, with the only exception being the rural cantons Appenzell Innerrhoden and Aargau, whose position at the top end of the range has yet to be explained.

Sociodemographic characteristics

Sex: The incidence of suicide in men is around three times as high as in women. Between 1995 and 2000, the average suicide rate was 26.7 per 100,000 for men and 9.3 per 100,000 for women. Substantial sex-related differences are also observed in suicide methods (see below).

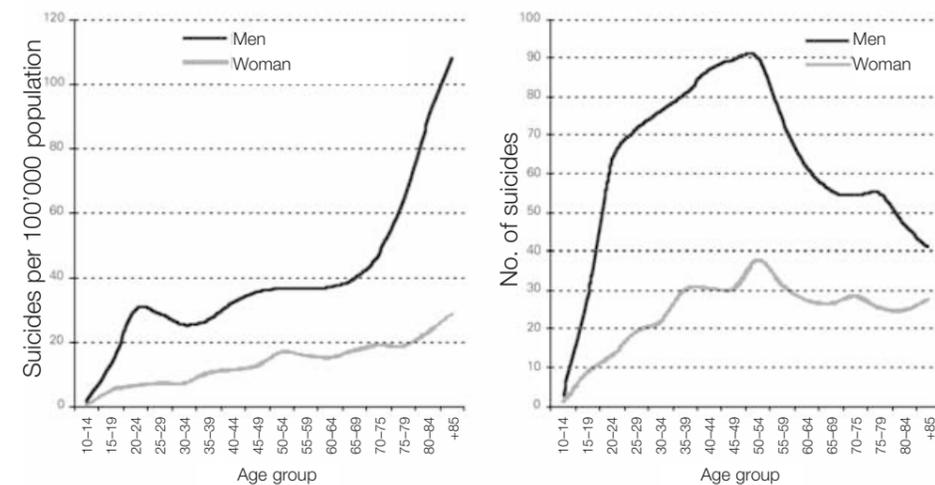
Age: Sex-related differences in suicide rates are particularly marked among young people aged between 15 and 24, and among those aged over 75. In these age groups, suicide is 3.5–4 times more common in men than in women. However, the patterns of age-specific suicide rates differ for men and women (cf. Figure below). Among the elderly, suicide rates have risen over the past 15 years. In view of demographic trends, i.e. the ageing of society, the absolute number of suicides is expected to increase among those aged over 65 in the coming decades.

⁴⁰ SFOPH, *op. cit.*, p. 8.

⁴¹ E.G. Krug et al. (Eds), *World report on violence and health*, World Health Organization, Geneva, 2002.

⁴² *Ibid.*

Figures: Incidence and absolute number of suicides by age and sex⁴³
(Mean values 1996-2000; source: SFSO cause-of-death statistics)



Other factors influencing suicide risk: Among men in particular, the risk of suicide is strongly influenced by marital status. Widows and widowers, divorcees and the unmarried are at a 1.5- to 2-fold higher risk for suicide than people who are married. Education, income and occupation have a lesser influence on the suicide risk. According to the 1993 Swiss health report, the suicide risk was slightly elevated among skilled workers and people lacking vocational training.⁴⁴

Suicide methods

The SFSO cause-of-death statistics also cover suicide methods for the period 1969–2000. They indicate that men most frequently employ “hard” suicide methods (firearms 32.2%, hanging 28.1%). In contrast, the leading suicide method for women is poisoning (24.5%), followed by hanging (19.2%), drowning (17.7%) and jumping from a height (16.9%).

b) Suicide attempts

Attempted suicide is more difficult to capture statistically than completed suicide. However, a fairly reliable picture can be obtained from studies of medically treated suicide attempters. The WHO/Euro Multicentre Study on Parasuicide⁴⁵ sought, with the aid of a uniform definition,⁴⁶ to document all cases of attempted suicide in selected regions of various European countries. In Switzerland, data were collected in the greater Bern area for 1989–1995 and, from 2003, in the canton of Basel-Stadt. If these data are extrapolated, it must be assumed that more than 10,000 parasuicides receive medical treatment in Switzerland per year (approx. 4,000 men and 6,000 women). Allowing for multiple attempts, this means that each year some 9,000 people are treated following attempted suicide. Put differently, at some point during their lifetime, just under 10% of the Swiss population will undertake a suicide attempt. The total number of cases of attempted suicide can be assumed to be markedly higher than the figure of 10,000 treatments cited above. As it is extremely difficult to quantify the unreported cases, estimates vary widely. Conservative estimates put the annual total at 20,000–25,000 cases of attempted suicide in Switzerland. This figure does not include habitual self-harm or self-inflicted damage due to excessive alcohol consumption, smoking, massive obesity or dangerous driving.

Sociodemographic characteristics:

In contrast to completed suicide, attempted suicide is more common in women than in men. Thus, the mean attempted suicide rate in the greater Bern area from 1989 to 1995 was 100 per 100,000 for men and 160 per 100,000 for women. The sex-related difference is highly pronounced among young people in particular. In Switzerland, the rate of attempted suicide is 4 times higher than that of completed suicide among men, and 16 times higher among women. Like the risk of suicide, the risk of attempted suicide is also influenced by marital status: for people living alone and single parents the attempted suicide risk is twice as high as for those in two-parent households. The rate of attempted suicide is above average among those who lack higher education, the unemployed and the foreign resident population. Only minor differences are observed between the various religious denominations.

Attempted suicide methods:

In contrast to completed suicides, medicines and drugs are used in at least two thirds of all attempted suicides. Psychoactive substances account for more than three quarters of the agents used.⁴⁷ In attempted suicide, “hard” methods (slashing, hanging or leaping from heights) are more frequently used by men than by women. In a quarter of all cases, more than one method is employed.

c) Factors influencing suicidality: psychological and psychiatric aspects

In the 20th century, suicide research yielded broad-based findings concerning conditions for the development of suicidality and precipitating factors, including epidemiological data, neurobiochemical results and clinical-phenomenological and depth psychological-psychodynamic accounts. Suicidality can now be understood as a complex type of behaviour, usually determined by a number of different circumstances, to which everyone may essentially be susceptible. Although suicidality is not itself a disease, it tends to be associated with a mental disorder or with a stressful situation engendered by disease. Suicidal behaviour can be an expression of a desire for autonomy, but usually, from a psychiatric viewpoint, freedom of decision is only present to a limited extent in suicidality. Often, the theoretically available option of self-determination is restricted by feelings of dejection or despair, unrealistic or exaggerated fears, and misjudgements involving illusions or even delusions. Suicidality frequently fluctuates in intensity. Suicidal acts are often preceded by ambivalent deliberations. Failed suicide attempts are only immediately repeated in a minority of cases. The desire for death is usually mixed with unfulfilled but sustained expectations of life. Suicide research has consistently shown hopelessness to be one of the main motives for suicide. Other motives may be desperation, restriction of experience, a sense of being threatened, isolation, shame or narcissistic rage. Some suicidal acts can be understood as an attempt to salvage threatened self-esteem through an autonomous act, or to avoid an anticipated ignominious downfall by taking resolute action. Mental disorders are the main risk factor for suicide. Ninety per cent of all people who commit suicide have a history of depression or another diagnosable mental or substance use disorder.⁴⁸ In psychological autopsy studies, the deceased was found retrospectively to have exhibited a marked depressive mood at the time of suicide in 40–50% of all cases. At the same time, a substance use disorder was diagnosed in around 40%, with alcohol dependence being implicated in about a fifth of all suicides. Schizophrenia is diagnosed in 10% of suicides.⁴⁹

⁴³ SFOPH, *op. cit.*

⁴⁴ T. Spuhler, K. Michel, “Suizid”, in W. Weiss (Ed.), *Gesundheit in der Schweiz*, Seismo, Zurich, 1993.

⁴⁵ U. Bille-Brahe (Ed.), *WHO/EURO Multicentre Study on Parasuicide. Facts and Figures*. World Health Organization Regional Office for Europe, Copenhagen, 1999.

⁴⁶ “An act with nonfatal outcome, in which an individual deliberately initiates a nonhabitual behaviour that, without intervention from others, will cause self-harm, or ingests a substance in excess of the prescribed or generally recognized therapeutic dosage, and which is aimed at realizing changes which he/she desired via the actual or expected physical consequences” [WHO, Working Group on Preventive Practices in Suicide and Attempted Suicide: Summary Report (ICP/PSF 017 (s) 6526 V). Copenhagen: WHO Regional Office for Europe, 1986].

⁴⁷ K. Michel, C. Knecht, I. Kohler, M. Sturzenegger, “Suizidversuche in der Agglomeration Bern”, *Schweizerische Medizinische Wochenschrift* 1991; 121:1133–1139.

⁴⁸ A. L. Beautrais, *Risk factors for suicide and attempted suicide among young people. A report prepared for the National Health and Medical Research Council 1998*, National Health and Medical Research Council, Canberra, 2000.

⁴⁹ T. Bronisch, *Der Suizid. Ursachen, Warnsignale, Prävention*, Beck, Munich, 1999.

In contrast to completed suicides, where a history of mental illness is found in up to 90% of cases, an association with mental disorders is less evident in *attempted suicide*. Especially in the case of single suicide attempts, the precipitating factor is often a (temporary) crisis and more rarely a mental disorder requiring long-term treatment.⁵⁰ Serious physical illness is, however, present in 25–50% of all cases of attempted suicide (particularly in the elderly), frequently involving chronic pain and physical disability.⁵¹ First and foremost, people in a suicidal crisis require understanding and empathy. They need good listeners, who understand that there is no set explanation for a suicidal act. They are dependent on a personal approach, which cannot however be forced. Many people can also be helped by psychiatric or psychotherapeutic treatment of the underlying mental disorder. A marked decline in the suicide rate among the general population can also be achieved through specific prevention efforts – for example, by training general practitioners to recognize and treat depression.⁵²

II.5 Suicide prevention

Suicide can be considered a cause of death that is, at least in some cases, preventable. In view of Switzerland's high suicide rates, there is a major need for prevention. However, the difficulty of detecting people at risk for suicide poses a particular challenge for the healthcare system. Suicide and attempted suicide are thus not merely an individual problem, but a public health issue confronting society as a whole, which needs to be addressed through appropriate measures. In Switzerland, assisted suicide accounted for 0.4% of all deaths in 2001/2002. Nationwide, the frequency of assisted suicide at the beginning of the 1990s was about 20 cases per year, and since 1996 it has levelled out at about 100 cases per year: in 2002, according to data from right-to-die organizations, suicide was assisted in a total of 137 cases (Exit in German-speaking Switzerland 100, Dignitas 17, Exit in French-speaking Switzerland 20). This is equivalent to 10% of all suicides or 0.2% of all deaths. In addition, Dignitas assisted the suicide of 59 people who had come from abroad in 2002 and 91 non-Swiss residents in 2003.⁵³

Assisted suicide is only to be classified as an act of euthanasia if it involves people who are terminally ill and dying. In Switzerland, however, assisted suicide is also provided by right-to-die organizations for people who are neither close to death nor suffering from a fatal illness. According to an analysis of Exit cases in the Basel region from 1992 to 1997, no severely disabling or terminal illness was present in 11 of the 43 cases studied.⁵⁴

Suicide prevention comprises, from a chronological perspective, efforts on the following levels:

1. *Primary suicide prevention* seeks to combat the risk of suicidal acts among the general population through preventive measures within society. This involves, for example, educational or other measures designed to reduce the incidence of serious mental disorders (such as depression or alcohol abuse) in society.

2. In cases where the suicide risk is already elevated as a result of stressful life events or existing mental disorders, *secondary suicide prevention* seeks to reduce the risk through appropriate treatment and care.
3. *Tertiary suicide prevention* seeks to improve the prognosis for people who have already attempted suicide, through appropriate precautionary, counselling, treatment and care measures.

In Switzerland, primary prevention is mainly carried out within families, schools, churches and other social institutions. In recent years, progress has been made in the area of education on the issue of suicide, both in the classroom and in higher education establishments. The success of primary prevention also depends on social conditions.

As a social measure, restriction of access to the means of suicide (e.g. domestic gas detoxification, stricter controls on handguns, regulated dispensing and use of less toxic medicines, etc.) has preventive effects at the primary and secondary level. Samaritan services also operate between these two levels of prevention: as well as seeking to prevent suicidal crises by providing helplines, they also offer support for people already affected by crises of this kind.

The most widely used and best studied secondary prevention measure is pharmacological and/or psychotherapeutic management of mental disorders that involve an increased risk of suicide. Critical situations can be alleviated – and the pressure to act relieved – with the aid of appropriate medication. Specific pharmacotherapy can be used to treat depressive episodes and anxiety or psychotic disorders, and to control associated suicidality. In addition to drug treatments, however, dialogue with suicidal patients and a supportive relationship is important and valuable in prevention.

Care and rehabilitation programmes specifically designed for so-called at-risk groups such as elderly and socially isolated people, dependent drug users or psychiatric inpatients also contribute to tertiary prevention. At this level, prevention is mainly concerned with facilitating the reintegration of people who have survived suicide attempts. This includes long-term psycho- and pharmacotherapeutic measures.

The effects of the various specific preventive measures have yet to be adequately documented. However, there is no doubt that the majority of people who receive appropriate help after a serious suicide attempt do not subsequently kill themselves. In modern suicide prevention, social, medical/psychiatric and worldview-related factors need to be taken into consideration.

Trends in suicide rates in various European countries (cf. Bopp and Gutzwiller 2003) indicate that suicide incidence is not immutable. Partly as a result of preventive efforts, a marked reduction was achieved between 1955 and 1999 by countries with traditionally high suicide rates such as Germany and Denmark. In the future, deficiencies need to be addressed in three areas – detection of suicidality, professional care of suicidal individuals and research on prevention.

While this does not imply an absolute duty to prevent any possible suicide, there is at least a duty to prevent such cases as are clearly associated with a mental disorder, e.g. severe depression. Equally, the duty of prevention does not mean that every possible means must be used to prevent a suicide. In the current debate, a degree of consensus is emerging: the *principle of proportionality* is to be respected in all cases. Coercive measures such as protective custody are only justifiable in the case of psychiatric patients whose judgement is impaired.

⁵⁰ I. Sakinofsky, "Repetition of Suicidal Behaviour", in K. Haston, K. van Heeringen (Eds), *The International Handbook of Suicide and Attempted Suicide*, Wiley, Chichester, 2000, pp. 385–404.

⁵¹ E. Nylev Stenager, E. Stenager, "Physical Illness and Suicidal Behaviour", in K. Haston, K. van Heeringen (Eds), *op. cit.*, pp. 405–420.

⁵² See the following: W. Rutz, L. von Knorring, J. Walinder, "Frequency of suicide on Gotland after systematic postgraduate education of general practitioners", *Acta Psychiatrica Scandinavica* 1989; 80:151–4.

G. E. Murphy, "The Physician's Responsibility for Suicide. II. Errors of Omission", *Annals of Internal Medicine* 1975, 82:305–309. K. Michel, "Suizide und Suizidversuche: Könnte der Arzt mehr tun?" *Schweizerische medizinische Wochenschrift* 1986; 116:770–774. K. Michel, "Der Arzt und der suizidale Patient, Teil 1: Grundsätzliche Aspekte", *Schweiz. Med. Forum* 2002; 29/30:704–707; "Teil 2: Praktische Aspekte", *Schweiz. Med. Forum* 2002; 31:30–34.

⁵³ See the following: K. Faisst, S. Fischer, U. Zellweger, G. Bosshard, W. Bär, F. Gutzwiller, "Medizinische Entscheidungen am Lebensende in sechs europäischen Ländern: Erste Ergebnisse. EU-Projekt 'Medical End-of-Life Decisions: Attitudes and Practices in 6 European Countries'", *Schweizerische Ärztezeitung* 2003; 84:1676–1678. G. Bosshard, E. Ulrich, W. Bär, "748 cases of suicide assisted by a Swiss right-to-die organisation", *Swiss Medical Weekly* 2003; 133:310–317.

⁵⁴ A. Frei, T. A. Schenker, A. Finzen, K. Krauchi, V. Dittmann, U. Hoffmann-Richter, "Assisted suicide as conducted by a 'right-to-die' society in Switzerland: a descriptive analysis of 43 consecutive cases", *Swiss Medical Weekly* 2001; 131:375–380.

What is required, therefore, is appropriate suicide prevention, respecting the autonomy of mentally competent individuals and not compelling people to go on living at any price. Appropriate prevention is a long-term enterprise, which needs to be initiated during childhood or adolescence, rather than following a first suicidal crisis in adulthood.

Suicide is not amenable to a general theoretical account – a conclusion dictated by the wide variety of interpretative frameworks and the plurality of ethical discourses concerning this issue. There is also a tragic aspect that is difficult to comprehend; this is reflected by the fragmented nature of the law's response to this question and its efforts, if not to regulate, then at least to formalize suicide.

II.6 Origins, interpretation and context of the provisions of Art. 115 of the Swiss Penal Code (StGB)

a) Historical background

The 18th century saw a fundamental change in the way in which the question of suicide was assessed from the perspective of criminal law in continental Europe. As indicated above, the medieval (religious and secular) dogma to the effect that suicide is a crime was gradually abandoned in the Enlightenment age. With the emergence of modern criminal law, penal sanctions against suicide began to be removed – a process reflected in a variety of laws.⁵⁵ The assessment of suicide in Switzerland mirrored these changes in the legal environment. Thus, in a treatise on criminal law published in 1893, Carl Stooss – the “father” of the Swiss Penal Code⁵⁶ – wrote: “Swiss laws rightly make no provision for the punishment of a suicide whose attempt has failed; in most cases the act stems from a mental disturbance, and in all cases from a state that calls for sympathy rather than punishment.”⁵⁷ To this extent, the principle that suicide or attempted suicide is not punishable was uncontroversial.⁵⁸

A different view was taken of involvement in suicide. At the end of the 19th century, the predominant opinion – in Switzerland, as in numerous other countries – was that the participation of third parties in a suicide was to be punished. In accordance with the spirit of the times, Viktor Wellauer noted in a monograph which appeared in 1896: “*Incitement to and assistance in suicide is, however, an act of such an immoral nature and the actions of the parties concerned involve such a breach of the legal order that the imposition of a specific penalty is advisable.*”⁵⁹ A similar argument was presented by Carl Stooss in 1894: “But anyone who induces the unfortunate [suicide] to commit the act or assists him therein deserves punishment; for the reasons that exclude punishment of the suicide do not apply to the participant.”⁶⁰

These fundamental arguments provided the basis for the establishment of a specific offence of inciting and assisting in suicide. Even before the Swiss Penal Code came into effect (1 January 1941), criminal laws specifying penalties for involvement in suicide were in force at the cantonal level.⁶¹

In his preliminary draft of a Swiss Penal Code published in 1894, Stooss was guid-

ed by these “models”; his proposed article on suicide read as follows: “Whosoever deliberately induces someone to commit suicide or assists him therein shall be liable to a penalty of imprisonment from three months to a year.”⁶²

The principle that participation in suicide is punishable was confirmed by the expert committees appointed to elaborate a preliminary draft. There was a consensus that the legal dilemma – while suicide itself was not punishable, participation merited punishment – should be resolved by establishing a specific offence. In the words of Professor Alfred Gautier of Geneva: “Car s’il n’en était pas fait mention expresse, ces actes échapperaient à toute peine, le suicide n’étant pas un délit, de sorte que l’assistance et l’incitation au suicide ne sauraient être, à défaut d’une disposition expresse, envisagées comme des actes de complicité dans un délit.”⁶³

Fundamental disagreements arose, however, over the question of what elements were required to constitute the offence of participation in suicide, and specifically whether the act had to proceed “from self-interested motives”. This qualification was opposed by Professor Philipp Thormann of Bern.⁶⁴ Ultimately, however, the view prevailing within the expert committee was that this qualification was necessary to prevent the “overextension” of the criminal offence: “Si elle [la restriction] est biffée, l’article pourra devenir une application plus fréquente, mais alors il frappera surtout des personnes qui ont agi par des mobiles loyaux et honorables, les hommes, par exemple qui auront par amitié facilité le suicide d’un camarade perdu d’honneur.”⁶⁵

Mention should also be made here of the position adopted by the prominent professor of criminal law Ernst Hafter. He argued that participation in suicide fundamentally merited punishment: someone involved in another person’s suicide created “conditions for the destruction of a human life”, essentially giving rise to a need for penalties.⁶⁶ In Hafter’s view, however, only acts prompted by “self-interested motives” should be punishable, while altruistic assisted suicide should not be considered a criminal act: “It offends the finer human sensibilities to punish someone who procures the means of suicide for a friend who, as a result of a crime, has lost his honour and destroyed his existence, regardless of whether a specific case involves incitement or assistance. It is contrary to justice to punish the helper who strengthens the resolve of an incurably ill man who has decided to take his own life, and provides him with the means to do so.”⁶⁷

These arguments were taken into account in the draft Penal Code formulated by the Federal Council in 1918. Article 102 read: “Whosoever, from self-interested motives, incites someone to commit suicide or assists him therein shall be punished, if the suicide was carried out or attempted, by confinement in a penitentiary for up to 5 years or by imprisonment.” The Federal Council’s comments on these provisions were as follows: “[...] because persuading someone to commit suicide and providing assistance may be an act of friendship, penalties are here only threatened for self-interested incitement and assistance, e.g. persuading a person to commit suicide whom the perpetrator has to support or whose estate he hopes to inherit [...]”⁶⁸

The specific offence of inciting and assisting in suicide, as drafted by the Federal

⁵⁵ For the relevant legal history, see K. Schüttauf, “Suizid im Recht”, in G. Bruder Müller, W. Marx, K. Schüttauf (Eds), *Suizid und Sterbehilfe*, Königshausen & Neumann, Würzburg, 2003, pp. 82–91. Cf. also A. Bondolfi, “Ethische Wertungen des Suizids im Laufe der Geschichte: Übertretungen des Tötungsverbots, Pathologie ...?”, in H.-B. Peter, P. Mösli (Eds), *Suizid...? Aus dem Schatten eines Tabus*, TVZ, Zurich, 2003, pp. 37–48.

⁵⁶ Swiss Penal Code, 21 December 1937, SR 311.0.

⁵⁷ C. Stooss, *Die Grundzüge des Schweizerischen Strafrechts*, Basel/Geneva, 1893, p. 15.

⁵⁸ See, for example, the statement by E. Hafter, a renowned Professor of Criminal Law in Zurich, in his *Lehrbuch des schweizerischen Strafrechts. Besonderer Teil. Erste Hälfte: Delikte gegen Leib und Leben, gegen die Freiheit, gegen das Geschlechtsleben, gegen die Ehre, gegen das Vermögen*, Berlin, 1937, p. 26: “Criminal law does not concern itself with suicide [...]”. An equally unequivocal comment is to be found in P. Logoz’ *Commentaire du Code pénal suisse. Partie spéciale*, Vol. 1, Neuchâtel/Paris, 1955: “For a person who commits suicide only makes an attempt on his own life. His act falls within the province of religion, not criminal law.”

⁵⁹ V. Wellauer, *Der Selbstmord: insbesondere Anstiftung und Beihilfe zum Selbstmord (Diss. jur. Fak.)*, Bern, 1896, p. 94 (original italics).

⁶⁰ C. Stooss, *Schweizerisches Strafgesetzbuch: Vorentwurf mit Motiven*, Basel, 1894, p. 26.

⁶¹ Provision was made for penalties relating to involvement in suicide in the cantons of Schaffhausen, Ticino, Bern, Fribourg and Neuchâtel.

⁶² Art. 52.

⁶³ “For if they were not expressly mentioned, these acts would not be liable to any penalty; since suicide is not an offence, assistance in and incitement to suicide could not, in the absence of explicit provisions, be deemed to constitute complicity in an offence” (*Schweizerisches Strafgesetzbuch. Protokoll der zweiten Expertenkommission*, Vol. 2, Lugano, 1912, p. 170). For the historical background, see also A. Pedrazzini, *L’omicidio del consenziente ed il suicidio nel diritto penale contemporaneo: con particolare riguardo al Codice penale svizzero (Diss. Bern)*, Locarno, 1949.

⁶⁴ On grounds including the following: “that in many cases it is likely to be extremely difficult to establish the motives of the person inciting suicide” (*Protokoll der zweiten Expertenkommission, op. cit.*, p. 171).

⁶⁵ “If it [the qualification] is deleted, the article will be applied more frequently, but it will then affect in particular people with honourable motives acting from loyalty – for example, men who out of friendship facilitated the suicide of a dishonoured comrade” (a comment made by the Neuchâtel Councillor Albert Calame; cf. *Protokoll der zweiten Expertenkommission, op. cit.*, p. 172).

⁶⁶ E. Hafter, *op. cit.*, p. 26.

⁶⁷ *Idem*, “Zum Tatbestand: Anstiftung und Beihilfe zum Selbstmord”, *Monatsschrift für Kriminalpsychologie und Strafrechtsreform* 8 (1912), pp. 398–399.

⁶⁸ Report submitted by the Federal Council to the Federal Assembly on the draft Swiss Penal Code, 23 July 1918, BBl 1918 IV, p. 32.

Council, was finally adopted in the Swiss Penal Code as Art. 115 StGB. This offence proved uncontroversial in the parliamentary debates, while other issues (such as abortion) were keenly disputed.⁶⁹

b) Concept and interpretation

Article 115 StGB steers a middle course between two “extremes” – absolute freedom from punishment and undifferentiated punishability. This represents a compromise solution: while it was recognized that assisting in suicide essentially merits punishment, punishability was restricted to acts committed from self-interested motives, which amounts to a qualification of the general provisions concerning involvement (Art. 26 StGB).

As mentioned in Section I.1, the following constituent elements of the offence can be distinguished in detail:⁷⁰

Physical elements: The first and most important element is a genuine act of suicide. The victim alone deliberately causes his own death (exercising control over the act). If another person is responsible for the killing (e.g. if someone is driven to suicide through severe maltreatment, or if a third party gives the willing victim a lethal injection), this is not a case of suicide but of deliberate killing (punishable under Art. 111–114 StGB). The acts of “incitement” (= instigation according to Art. 24 StGB) or “assistance” (= abetment according to Art. 25 StGB) are only punishable in cases where suicide is completed or at least attempted.

Mental elements: An intention is required on the part of the perpetrator to bring about a decision to commit suicide, or to support the execution thereof. In contrast, according to prevalent doctrine, negligent participation is not punishable.⁷¹ In addition, the perpetrator must have acted from “self-interested motives”.

Complex issues of interpretation arise in connection with the following points in particular:

Mental capacity: For Art. 115 StGB to be applicable, the person wishing to commit suicide must be able to appreciate the significance of his proposed course of action and to act in accordance with this insight.⁷² If this is not the case, the parties involved may be liable to punishment for a crime of killing under Articles 111 ff. StGB. The possibility of a voluntary and considered act of suicide appears to be questionable, for example, in the case of evident mental crises and disorders. Article 115 StGB may, however, be applicable despite the presence of mental illness if the person wishing to commit suicide is deemed to be of sound mind in a lucid interval.⁷³ As a general rule, children are not assumed to be capable of voluntary decision-making; this approach should also be applied in the case of adolescents.⁷⁴ In specific cases, the circumstances of the suicide or attempted suicide are to be investigated. In this process, the act of suicide is not in itself to be considered a sufficient reason to exclude mental capacity.⁷⁵

Failure to prevent suicide: The question arising here is whether a guarantor (e.g.

⁶⁹ Cf. *Stenographisches Bulletin*, Nationalrat 39, 1929, pp. 1–22; *Stenographisches Bulletin*, Ständerat 41, 1931, pp. 481–484.

⁷⁰ See in particular M. Schubarth, *Kommentar zum schweizerischen Strafrecht: Schweizerisches Strafgesetzbuch. Besonderer Teil*, Vol. 1., Bern, 1982, N 12–41 on Art. 115; J. Rehberg, N. Schmid, A. Donatsch, *Strafrecht III, Delikte gegen den Einzelnen*, Schulthess, 8th ed., Zurich, 2003, pp. 14–16; M. Steinmann, “Art. 115 StGB als schweizerische Besonderheit”, in J.B. Ackermann (Ed.), *Strafrecht als Herausforderung: zur Emeritierung von Professor Niklaus Schmid*, Schulthess, Zurich, 1999, pp. 339–343; G. Stratenwerth, G. Jenny, *Schweizerisches Strafrecht. Besonderer Teil I: Straftaten gegen Individualinteressen*, 6th ed., Bern, 2003, pp. 38–42.

⁷¹ Cf. G. Stratenwerth, G. Jenny, *op. cit.*, p. 41.

⁷² On this question, see F. Riklin, “Die strafrechtliche Regelung der Sterbehilfe: zum Stand der Reformdiskussion in der Schweiz”, in A. Holderegger (Ed.), *Das medizinisch assistierte Sterben*, pp. 322–344, especially pp. 333–334.

⁷³ G. Stratenwerth, G. Jenny, *op. cit.*, p. 40.

⁷⁴ M. Schubarth, *op. cit.*, p. 112.

⁷⁵ F. Riklin, *op. cit.*, p. 334.

husband or physician) is liable to punishment for failing to save the life of the person committing suicide. The point at issue is whether a duty to save life exists at least from the point at which the suicide loses the power to act (e.g. as a result of unconsciousness). On this question, the prevailing view is that failure to act is only punishable if it springs from self-interested motives (Art. 115 StGB). A plausible justification is provided by G. Stratenwerth and G. Jenny: “Otherwise, the husband would be permitted under Art. 115 to procure the means of suicide for his severely suffering wife, provided that he is not acting selfishly, but would be obliged – on account of his conjugal duty as a guarantor – to prevent her from making use of them!”⁷⁶

Motive: An act is not only held to spring from “self-interested motives” if the party concerned is pursuing a material advantage. Instead, the concept is to be understood in a broad sense; this is underlined by the wording of the law – the term “intent on gain” (which occurs elsewhere) is not used. In this context, the term “self-interested motives” also encompasses the gratification of emotional needs (e.g. hatred, revenge, spite). The presence of a *single* self-interested motive is sufficient. To this extent, the French version of the law (“*Celui qui, poussé par un mobile égoïste [...]*”) is more precise than the German and Italian versions (“*Wer aus selbstsüchtigen Beweggründen [...]*”, “*Chiunque per motivi egoistici [...]*”).⁷⁷ An attitude of complete indifference is not liable to punishment under Art. 115 StGB. The doctrine that impunity depended on acting “from pure, honourable motives”⁷⁸ is now outdated.

c) Involvement in suicide in a medical setting

One striking point about the origins of Art. 115 StGB is that the debate did not include consideration of the medical aspects of assisted suicide. The legal discussions of the suicide issue focused largely on the complex relationship between the non-criminal nature of suicide and the (limited) punishability of inciting and assisting in suicide. It is apparent from an examination of the legal materials (minutes of the expert committees, parliamentary deliberations, Federal Council’s report) that specific questions associated with medically assisted suicide were not addressed.⁷⁹

The fact that the offence was not considered in medical terms was by no means symptomatic of the legal debate as a whole. For example, medical aspects were discussed in connection with the offence of killing on request (Art. 114 StGB). Thus, Carl Stooss had already referred to the medical background to these provisions. As an example of a “respectable motive”, he cited the case of pain relief in medicine: “A physician gives a dying patient at his request a powerful dose of morphine to release him from his pain [...]”⁸⁰

Rather than being concerned with medical realities, the legal debate on Art. 115

⁷⁶ G. Stratenwerth, G. Jenny, *op. cit.*, p. 40.

⁷⁷ Cf. M. Steinmann, *op. cit.*, pp. 341 f.

⁷⁸ E. Hafter, *op. cit.*, p. 27. Cf. also François Clerc, *Cours élémentaires sur le code pénal suisse. Partie spéciale*, Vol. 1, Art. 11–186, Lausanne, 1943, p. 29.

⁷⁹ This confirms the thesis presented by S. A. Hurst and A. Mauron in “Assisted suicide and euthanasia in Switzerland: allowing a role for non-physicians”, *British Medical Journal* 2003; 326:271–273.

⁸⁰ C. Stooss, *op. cit.*, p. 26.

StGB reflects a mentality characteristic of the 19th century, with its recourse to romantic imagery and conceptions from a “different age”. Thus, in its report issued in 1918, the Federal Council refers to the “classic” case of unhappy lovers in its discussion of the suicide issue.⁸¹ There is, however, no evidence that the legal debate on involvement in suicide was influenced by the notions of eugenics and “racial hygiene” that had become established in certain medical and psychiatric circles at the end of the 19th century. As already mentioned, these discussions were not guided by biomedical paradigms – in contrast to the situation in other areas of criminal law, which were not immune to the pseudoscientific aberrations of eugenics and racial hygiene.⁸²

The possibilities of modern medicine raise new issues with regard to suicide and euthanasia. The framework for legal assessments of medically assisted suicide is set by the underlying purpose of the legal regulations. The criminal law debate has focused on the following aspects and demarcation problems.⁸³

Active euthanasia: The deliberate killing of a patient (direct active euthanasia) – even with the victim’s consent – is punishable as an unlawful killing under Articles 111 ff. StGB. If the physician kills a person “at the latter’s earnest and insistent request”, the punishment is less severe, provided that the physician acts from “respectable motives” (Art. 114 StGB). If, in order to relieve the suffering of a terminally ill patient, a physician administers agents that may also have life-shortening effects (indirect active euthanasia), this act, according to the prevailing view, is not punishable, provided that the patient’s consent has been given. Since such cases essentially involve an act of killing undertaken with an awareness and acceptance of the possible consequences, there is a need to justify the non-punishability; for this purpose, legal doctrine invokes, for example, the permissible risk, the physician’s professional duty (Art. 32 StGB), or a state of necessity (or conflicting duties) as an exonerating factor. If the physician merely procures lethal means for a patient wishing to commit suicide who acts independently, he is not liable to punishment unless this action is prompted by self-interested motives (Art. 115 StGB).

Passive euthanasia: Here, the physician withholds or withdraws life-prolonging measures (e.g. resuscitation, antibiotics, nutrition). Under certain conditions, passive euthanasia is considered to be permissible – on the grounds that the physician cannot be expected to “prolong fading life to the outermost limits of what is technically possible in the face of overwhelming contrary interests, particularly those of the patient concerned”.⁸⁴ If medical treatment is discontinued in accordance with the patient’s express wishes, there will be no question of punishability provided that the patient’s decision has been reached autonomously and without any external pressure. If the patient is no longer capable of expressing his wishes, e.g. as a result of unconsciousness or a progressive neurological disease, declarations (e.g. advance directives) made previously by the patient (while still mentally competent) should be decisive. In the absence of such declarations, the medical duty to treat or not to treat is determined by the dying patient’s presumed wishes; in such cases, it is advisable to consult people close to the patient and the nursing staff.

Prevention of suicide: Prevailing legal doctrine takes the view that the guarantor

⁸¹ Report submitted by the Federal Council to the Federal Assembly on the draft Swiss Penal Code, 23 July 1918, BBl 1918 IV, p. 32.

⁸² By way of example, the following comment on abortion may be cited from a report issued by the Basel-Stadt Health Office (quoted in E. Zürcher, *Bibliographie und kritische Materialien zu den Entwürfen eines schweizerischen Strafgesetzbuches. Vierte Fortsetzung 1912–1923*, Bern 1924, p. 66): “Artificial abortion indicated on grounds of racial hygiene [is] not to be punishable in particular cases if, according to the findings of an official committee, it must be expected with a high degree of likelihood from the outset, given the nature of the progenitors (idiots, carriers of hereditary diseases), that the offspring will be inferior [...]”.

⁸³ For a detailed discussion, see e.g. A. Donatsch, “Die strafrechtlichen Grenzen der Sterbehilfe”, in M. Mettner (Ed.), *Wie menschenwürdig sterben? Zur Debatte um die Sterbehilfe und zur Praxis der Sterbebegleitung*, NZN, Zurich, 2000, pp. 126–131; F. Riklin, *op. cit.*, pp. 322–335; K. Seelmann, “Sterbehilfe: Die Rechtslage in der Schweiz”, in G. Bruder Müller, W. Marx, K. Schüttauf (Eds.), *Suizid und Sterbehilfe*, Königshausen & Neumann, Würzburg, 2003, pp. 135–146.

⁸⁴ G. Stratenwerth, G. Jenny, *op. cit.*, p. 24.

(physician or other carer) should respect the voluntary decision of a patient wishing to commit suicide. Accordingly, there is a duty to prevent suicide in cases where the patient’s free will is at least questionable. In individual cases, account should be taken of the specific circumstances (personal situation, age, state of health, social relations, future prospects, etc.).⁸⁵

II.7 The contemporary (1970–2004) debate on Art. 115 StGB

The debate on the issue of assisted dying (assisted suicide) is linked to discussions concerning advance directives and the rise of intensive care, but also to the debate on the concept of preserving life at any price (*acharnement thérapeutique*).⁸⁶

The rise of intensive care, which began in the 1960s, represented an important step in the history of medicine, raising a series of interrelated questions. Over the years, thanks to intensive-care units (also known as “resuscitation centres”), patients whose days or hours would formerly have been numbered have been able to survive for ever-longer periods. The question of the limits of medical treatment has therefore become increasingly important. The aim of life-sustaining measures is to stabilize patients who are in a critical condition, so as to permit treatment to be continued with a view to curing the patient. But at what point do these efforts become the preservation of life at any price? Unfortunately, in many cases, patients are not able to express their wishes, particularly with regard to the continuation or withdrawal of an increasingly futile treatment. The significance of the advance directive lies in the fact that it allows patients, as a precaution, to formulate their wishes in case they are subsequently no longer able to do so.

The 1970s saw a growing awareness of this issue among healthcare professionals and the public at large. During that period, highly specialized intensive-care units were established at most hospitals in Switzerland. While patients are admitted to these units in medical emergencies, their condition may not always be life-threatening. The wide variety of admissions gave rise to situations that were difficult to manage, and the medical profession saw a need for the definition of criteria to provide guidance.

In 1976, the Central Ethics Committee of the Swiss Academy of Medical Sciences (SAMS) issued its first set of guidelines on end-of-life care (i.e. *Sterbehilfe*, understood at that time merely as measures designed to ease the process of dying). In these guidelines (revised in 1981), the subject of advance directives was explicitly addressed for the first time.

Initially, advance directives were coolly received by the medical profession – not merely on moral grounds. The physicians’ opposition or reservations had to do with the fact that the principle of patient autonomy referred to in the guidelines appeared to restrict their freedom in making clinical assessments of specific situations. However, the profession soon developed a more nuanced response and began to accept the duty-of-care criteria specified in the guidelines. The possibility of advance directives is indirectly recognized in the Code of Ethics of the Swiss Medical Association, which make reference to the SAMS guidelines (“Medical-ethical guidelines for the medical care of dying persons and severely brain-damaged patients”, point 3.4).⁸⁷

Publications of similar scope were issued by other social or church organizations,

⁸⁵ On the conflict between the state’s criminal-law policy interests and the guaranteeing of autonomy, see A. Bondolfi, “Beihilfe zum Suizid: grundsätzliche Überlegungen, rechtliche Regulierung und Detailprobleme”, *Ethik in der Medizin* 12/4 (2000), pp. 262–268. Cf. also M. Bahro, J. Strnad, “Beihilfe zum Suizid bei psychisch Kranken – eine Form aktiver Sterbehilfe: eine bedrückend aktuelle Diskussion in der Psychiatrie”, *ibid.*, pp. 257–261.

⁸⁶ Cf. R. Baumann-Hölzle et al. (Eds.), *Leben um jeden Preis? Entscheidungsfindung in der Intensivmedizin*, Peter Lang, Bern, 2004.

⁸⁷ Cf. Article 17 of the Code of Ethics of the Swiss Medical Association (revised version, 30 April 2003), www.fmh.ch

such as Caritas Schweiz. A list of these documents was prepared by the Institute for Social Ethics of the Federation of Swiss Protestant Churches (SEK) in 1992.⁸⁸

After the lapse of time, it is now conceded that the initial reaction of the medical profession and terminal care organizations was partly triggered by a legal recommendation on the status of advance directives, which had been commissioned by the right-to-die organization Exit. The conclusion of the author, Max Keller, was that such directives were to be deemed directly applicable for the attending physician. In response to this recommendation, the SAMS commissioned a counter-opinion from two other legal experts, Professors Guinand and Guillod. Their conclusions, which were not entirely at odds with those of Exit, served to reveal the legitimate claims inherent in advance directives. The Academy subsequently sought to take account of these claims, proposing a more open interpretation of the significance of advance directives, although the Director of the Federal Office of Justice had hitherto denied that such documents had any legal significance.⁸⁹

In 1995, the SAMS guidelines were once again revised, and the section on advance directives was redrafted. The Academy clarified its position: on the one hand, it attached greater importance to these documents in relation to the actions of the physician; on the other hand, it limited their force, specifying the conditions under which they are applicable. Directives requiring the physician to provide active assistance in suicide or to kill with the patient's consent were declared to be inadmissible: "If an advance directive is available to the physician which has previously been written by the patient while mentally competent, it shall be binding; however, requests are not to be respected if they call for illegal conduct on the part of the physician or demand the withdrawal of life-sustaining measures even though general experience suggests that the patient's condition warrants the expectation of a return of interpersonal communication and a renewed strengthening of the will to live."⁹⁰

In recent years, the debate on advance directives has intensified as the issues of assisted dying and legal regulations in this area have attracted growing public attention. In 1999, an expert committee appointed by the Federal Department of Justice and Police (EJPD) came to the following conclusions: "If treatment is withheld or withdrawn on the express wishes of the patient, the physician cannot be liable to punishment for this conduct, for the simple reason that – according to a generally recognized legal principle – any medical measure requires the patient's (express or presumed) consent. If this is lacking or has been expressly denied, the medical intervention is to be deemed unauthorized and hence impermissible. This applies even to life-prolonging treatment measures."⁹¹

In 1994, National Councillor Victor Ruffy submitted the following motion: "Despite all the means of prolonging life that are currently available, there still remain incurable diseases whose progression severely impairs human dignity. In view of this fact, growing numbers of people in our society wish to be able to participate in decisions concerning the end of their own life and to die in dignity. I therefore request the Federal Council to present a draft for a new Article 115^{bis} of the Swiss Penal Code (StGB)."⁹² The Federal Council, in contrast to previous occasions, did not respond by

stating that a motion of this kind is not compatible with the right to life. Instead, it proposed that the motion be converted into a postulate (i.e. given a less binding form). In 1996, this proposal was approved by the National Council.

In 1997, the EJPD established a Working Group to analyse the situation and develop proposals. In March 1999, the Working Group issued its report, entitled "Sterbehilfe/Assistance au décès".⁹³

Within the Working Group, there was a consensus on the following points: the modalities of palliative medicine were to be not merely promoted, but fully exploited. In this context, the right to withhold or withdraw life-sustaining measures was to be guaranteed. Passive euthanasia and indirect active euthanasia were not merely to be considered permissible, but the relevant practices were to be explicitly regulated in a formal law (although the Working Group did not present a specific draft). Under no circumstances were the costs of medical care to motivate or to serve as an argument legitimizing euthanasia. The majority of the Working Group supported the addition of a new paragraph to Art. 114 StGB (mercy killing on request) specifying an exemption: "If the offender has killed a person who is incurably and terminally ill, in order to release that person from intolerable and intractable suffering, the competent authorities shall not institute criminal proceedings, refer the matter to the court or impose penalties."⁹⁴ A minority of the Working Group rejected this proposal, arguing that it would be redundant in all cases where palliative care was appropriately administered. This minority invoked the "slippery slope" argument and pointed to the risks associated with the relaxation of moral and criminal-law prohibitions.

Discussions of the report in the media and within political parties further stimulated the public debate that had already been under way for some years. For its part, the Federal Council reviewed the report and submitted its response in July 2000. While rejecting the Working Group's majority proposal, it expressed its support – given the alternative of the status quo – for efforts to fully exploit the methods of palliative medicine. On the question of passive and indirect active euthanasia, the Federal Council took the view that legal regulations were required. However, it categorically excluded the possibility of providing for an exemption to the offence of killing on request: "Even an exemption from punishability for direct active euthanasia formulated in a highly restrictive manner, as proposed by the majority of the Working Group on Euthanasia, would be tantamount to a relaxation of the prohibition on killing other people, thereby breaking a taboo that is deeply rooted in our Christian culture."⁹⁵ In the media, opinions differed; in Parliament, the debate was pursued, with two parliamentary initiatives playing an important role. The first of these, submitted by Franco Cavalli (an oncologist, member of the Social Democratic Party and President of the Swiss Cancer League), sought to have the proposals of the majority of the Working Group adopted and incorporated into a procedure that would grant the privilege of immunity from prosecution only to those physicians who had been explicitly mandated by a patient to terminate his or her life.⁹⁶ The second initiative, submitted by Appenzell Liberal Dorle Vallender, called for a revision of Art. 115 StGB, under which assisted suicide is

⁸⁸ See *Patientenverfügungen: eine Materialsammlung*, Institute for Social Ethics, Bern, 1992 (ISE-Texte 1/92).
⁷⁷ *Neue Zürcher Zeitung*, 31 December 1987, p. 18.

⁸⁹ Swiss Academy of Medical Sciences, "Ethisch-medizinische Richtlinien für die ärztliche Betreuung sterbender und zerebral schwerst geschädigter Patienten", *Schweizerische Ärztezeitung* 1995; 76:1226.

⁹⁰ Report of the Working Group on Euthanasia to the Federal Department of Justice and Police, March 1999, p. 14; available online in French/German at <http://www.ofj.admin.ch/bj/de/home/themen/gesellschaft/gesetzgebung/sterbehilfe.html>

⁹¹ "Sterbehilfe. Ergänzung des Strafgesetzbuches" (N 14.3.96), *Amtliches Bulletin. Nationalrat*, 1996, p. 362.

⁹² Working Group on Euthanasia, *op. cit.*

⁹³ *Ibid.*, p. 35.

⁹⁴ Report of the Federal Council on the Ruffy postulate, "Sterbehilfe. Ergänzung des Strafgesetzbuches" (July 2000), p. 15.

⁹⁵ Parliamentary initiative ("Strafbarkeit der aktiven Sterbehilfe. Neuregelung") submitted to the National Council on 27 September 2000 (00.441).

⁹⁶ Parliamentary initiative ("Verleitung und Beihilfe zur Selbsttötung. Neufassung von Artikel 115 StGB") submitted to the National Council on 14 March 2001 (01.407).

legal in the absence of self-interested motives. In particular, there was a need to clarify its application in critical areas such as psychiatry.⁹⁷

The majority of the Committee for Legal Affairs of the National Council supported the Cavalli initiative and rejected the Vallender initiative. However, the National Council itself came to a different conclusion, rejecting both initiatives, albeit on the basis of different considerations and arguments.⁹⁸

The parliamentary debate was resumed in June 2003, when the Council of States approved a motion on euthanasia and palliative medicine submitted by the Committee for Legal Affairs of the Council of States (RK-SR).⁹⁹ The motion requested the Federal Council to submit proposals for the legal regulation of indirect active and passive euthanasia, and to take measures to promote palliative medicine.

On 4 July 2003, the EJPD requested the Swiss National Advisory Commission on Biomedical Ethics (NEK) to examine the ethical and legal aspects of the entire euthanasia issue and to prepare a report and develop proposals for legal regulations by the spring of 2004. The Commission, which had already (independently) started considering the questions of euthanasia and end-of-life decisions in 2002, continued this work, according priority to assisted suicide. But, as mentioned in Section I.2, this mandate was cancelled by the newly constituted Federal Council at the end of 2003.

However, on 10 March 2004, the RK-SR motion on euthanasia and palliative medicine was approved by the National Council.¹⁰⁰ The Federal Council will therefore have to consider the issues raised by the motion – the regulation of passive and indirect active euthanasia, measures to promote palliative medicine, and the problem of “suicide tourism”.

Recently, Exit and other right-to-die organizations such as Dignitas have sought to extend their activities in two new directions: firstly, they wish to make euthanasia available as a possible option in homes for the elderly and, secondly, it is also to be offered to people who, although not strictly terminally ill, are undergoing severe mental suffering as a result of their situation. These developments have sparked controversy. The authorities in Zurich, who had previously prohibited members of Exit and comparable organizations from offering assisted suicide in municipal old people’s and nursing homes, recently granted permission for this practice, although stringent conditions were imposed.¹⁰¹ Similar regulations are currently being elaborated by other cantons, particularly in French-speaking Switzerland: while assisted suicide is to be permitted in old people’s homes, promotional activities are not to be allowed and it is to be ensured that the other residents are not unsettled. The debate is now under way, and it is difficult to estimate what impact it will have in the coming years.

II.8 The legal situation in various other countries

In most European countries, including Austria, Italy, England/Wales, Spain, Portugal and Poland, assisting suicide is a criminal offence. In other countries, such as Belgium, Scotland, Sweden and France, while assisted suicide is not explicitly covered by criminal-law provisions, existing laws are interpreted to the same effect. Only a few European countries – including Switzerland and the

Netherlands – provide for exemptions, through legal regulations or court practice, permitting assisted suicide under certain conditions. Outside Europe, assisted suicide is only permitted in the US state of Oregon.¹⁰²

Germany

No specific offence of involvement in suicide exists in German criminal law. Therefore, participation in an independent act of self-killing by a third party is essentially non-punishable, provided that it is limited to acts of assistance. No provisions equivalent to Art. 115 StGB are to be found in German law.¹⁰³ If a person wishing to commit suicide is not acting autonomously, even allowing a suicidal act to occur may possibly be punishable. A physician, for example, may be held criminally liable for manslaughter by omission if he fails to initiate life-saving measures for an unconscious suicidal patient. But even in cases of autonomous attempted suicide, the Federal Court of Justice has consistently held that there is a duty to take necessary and reasonable measures to avert harm and risk. According to this practice, a physician is obliged to render medical assistance as soon as the patient is “no longer in control of events” (e.g. following an overdose of hypnotics). Under German law, direct active euthanasia is always punishable, as this essentially constitutes the criminal offence of termination of life on request (§ 216 of the German Penal Code).

The Netherlands

Under Article 294 of the Dutch Penal Code, deliberate incitement to or assistance in suicide, or procurement of the necessary means, is punishable by imprisonment for up to three years. Physician-assisted suicide is thus, in principle, considered to be an illegal act, subject to punishment. In recent decades, however, courts’ and prosecutors’ practices have developed in such a way that physician-assisted suicide may be exempt from punishment (“defence of necessity”) if certain due care criteria are fulfilled.¹⁰⁴

This practice was enshrined in the Termination of Life on Request and Assisted Suicide (Review Procedures) Act – Europe’s first euthanasia law – which came into force on 1 April 2002. Under these regulations, while active euthanasia and assisted suicide remain punishable offences, they are “decriminalized” under certain conditions. To this end, special exemption provisions were added to Articles 293 (termination of life on request) and 294 (incitement to and assistance in suicide) of the Dutch Penal Code.

A physician is only immune from punishment for euthanasia or assisted suicide in cases where the relevant due care criteria have been complied with. According to Section 2 of the Act, the attending physician must:

- a. be satisfied that the patient has made a voluntary and carefully considered request
- b. be satisfied that the patient’s suffering was unbearable, and that there was no prospect of improvement
- c. have informed the patient about his situation and his prospects
- d. have come to the conclusion, together with the patient, that there is no reasonable alternative in the light of the patient’s situation;
- e. have consulted at least one other, independent physician [...]; and

¹⁰² On the legal situation in Germany, see K. Ulsenheimer, “Ärztliche Sterbehilfe”, in A. Laufs/W. Uhlenbruck/H. Genzel/B.-R. Kern/D. Krauskopf/G. H. Schlund/K. Ulsenheimer (Eds), *Handbuch des Arztrechts*, Beck, Munich, 2nd ed., 1999, pp. 1226–1231. See also the report issued by the Federal Ministry of Justice: *Die Rechtslage in Deutschland zur Sterbehilfe* (July 2002).

¹⁰³ On the legal situation in the Netherlands, see J. W. Fokkens, “Sterbehilfe im niederländischen Recht”, in G. Bruder Müller, W. Marx, K. Schüttauf (Eds), *Suizid und Sterbehilfe*, Königshausen & Neumann, Würzburg, 2003, pp. 147–167. See also M. Conradi, *Der Arzt an den Grenzen seines Behandlungsauftrags: eine Untersuchung zu Fragen der Sterbehilfe im Zeitalter der Intensivmedizin*, Peter Lang, Frankfurt, 2002, pp. 307–320.

¹⁰⁴ H. Nys, “Country Report Belgium”, in J. Taupitz (Ed.), *Zivilrechtliche Regelungen zur Absicherung der Patientenautonomie am Ende des Lebens/Regulations of Civil Law to Safeguard the Autonomy of Patients at the End of Their Life*, Springer, Berlin, 2000, pp. 135–161, especially pp. 148 f.

⁹⁷ *Amtliches Bulletin. Nationalrat*, 2001, p. 1835.

⁹⁸ Motion (“Sterbehilfe und Palliativmedizin”) submitted by the RK-SR to the Council of States on 11 April 2003 (03.3180); *Amtliches Bulletin. Ständerat*, 2003, p. 618.

⁹⁹ *Amtliches Bulletin. Nationalrat*, 2004, p. 266.

¹⁰⁰ Further information is available online at <http://www.stzh.ch> (keyword “Sterbehilfe”).

¹⁰¹ An overview of the situation in Europe is provided by a survey conducted by the Steering Committee on Bioethics of the Council of Europe. See “Replies to the questionnaire for member states relating to euthanasia” (20 January 2003) at:

http://www.coe.int/T/E/Legal_Affairs/Legal_co-operation/Bioethics/Activities/Euthanasia/Replies_questionnaire_intro.asp
For a global overview, see L. Spinney, “Last Rights”, *New Scientist*, 23 April 2005, pp. 46–49.

- f. have terminated the patient's life or provided assistance with suicide with due medical care and attention.

Five regional review committees are responsible for assessing all reported cases of euthanasia or assisted suicide. If the review committee concludes that the attending physician has complied with the due care criteria, and thus acted in accordance with the law, criminal proceedings are not normally instituted.

Belgium

No specific offence of assisting suicide exists in Belgian criminal law. The view generally taken in jurisprudence is that assisted suicide involves a failure to render aid in an emergency (Art. 422bis of the Belgian Penal Code). However, no relevant examples are to be found in court practice.¹⁰⁵ Recently, assisted suicide has been legally permitted and regulated in Belgium by the Euthanasia Act (28 May 2002). This law, which came into force on 20 September 2002, establishes the legal conditions for the "decriminalization" of euthanasia carried out by a physician in accordance with certain due care criteria. It should be noted that the 2002 Act is only applicable to euthanasia (defined as terminating life at the patient's request). Theoretically, therefore, assisted suicide remains punishable, even in cases where the legal provisions applicable to euthanasia are complied with. Termination of life at the patient's request is not punishable if:

at the time of making the request, the patient has attained the age of majority and is mentally competent, the request is voluntary, well-considered and repeatedly expressed and the patient's medical condition is beyond hope of improvement, involving constant, intolerable physical or mental suffering. These fundamental principles are supplemented by further conditions and procedural requirements (duty to inform the patient and consult another physician, time frame, notification, etc.).

Denmark

Under Danish law, assisting suicide is a criminal offence, carrying a fine or a term of imprisonment (Art. 240 of the Danish Penal Code).¹⁰⁶ Danish courts have consistently held that there is a duty to render aid to a person who is unconscious following a suicide attempt. This duty also exists when the person attempting suicide has expressed a wish to die and asked for it to be respected. However, if a mentally competent person remains conscious after a suicide attempt and refuses any aid, this wish is generally to be respected. The criminal-law regulations are supplemented by a large number of laws and ordinances relating to the issue of medically assisted dying. Of particular interest is the Patients' Rights Act, which came into effect on 1 October 1998. The aim of this law is to protect the patient's dignity, integrity and autonomy, with prime importance being attached to the concept of self-determination. The Patients' Rights Act provides for the establishment of a central register for advance directives (living wills). If a physician intends to institute life-prolonging treatment in a terminally ill patient unable to exercise the right of self-determination, he must ascertain whether a living will expressing a wish for discontinuation of treatment has been registered.

¹⁰⁵H. Nys, "Country Report Belgium", in J. Taupitz (Ed.), *Zivilrechtliche Regelungen zur Absicherung der Patientenautonomie am Ende des Lebens/Regulations of Civil Law to Safeguard the Autonomy of Patients at the End of Their Life*, Springer, Berlin, 2000, pp. 135–161, especially pp. 148 f.

¹⁰⁶On the legal situation in Denmark, see U. Hybel, "Country Report Denmark", in J. Taupitz (Ed.), *op. cit.*, pp. 491–528, especially p. 495; J. Vestergaard, "Denmark: the right to self-determination", in Council of Europe (Ed.), *Ethical eye: Euthanasia, Vol. 2, National and European perspectives*, Strasbourg, 2004.

United States

In the US, involvement in suicide is punishable in every state except Oregon. In most states, the offence of assisting suicide is defined either in specific legislation or in an explicit passage of the criminal-law regulations on manslaughter. In other states, the legal basis for punishment is provided by common law.¹⁰⁷ In several states (California, Washington, Michigan, Maine, Hawaii and Vermont), there have been efforts by right-to-die groups to secure a relaxation of the regulations, but these have been unsuccessful. Prosecutions for assisted suicide are rare. In two decisions handed down in July 1997, the US Supreme Court ruled that there is no constitutional right to assisted suicide.¹⁰⁸ According to the Supreme Court, states are entitled under the Constitution to legalize assisted suicide or not. The regulations in force in Oregon since 1997 call for the involvement of two physicians and prohibit the injection of lethal drugs (i.e. requiring self-administration of oral medication).

United Kingdom

The most recent attempt to legalize assisted dying was made in 1994. At that time, the Bill was rejected. A new proposal has now been submitted by Lord Joffe: the Assisted Dying for the Terminally Ill Bill, originally introduced in 2003, would permit active euthanasia and assisted suicide in terminally ill patients. This Bill has been more favourably received. Following detailed investigations and hearings in the Netherlands, Oregon and Switzerland,¹⁰⁹ a House of Lords Select Committee recommended in April 2005 that an amended version of the Bill should be further discussed in Parliament.¹¹⁰

II.9 The ethical arguments in the debate¹¹¹

a) Pro

To justify physician-assisted suicide, three ethical notions are frequently invoked – self-determination, the "right to die" and beneficence.

Principle of self-determination

Certain proponents of "liberal bioethics", invoking the principle of autonomy and self-determination, accord patients the right to determine the means and timing of their death themselves. On this view, the right to make decisions concerning one's own death may provide a justification for physician-assisted suicide in certain circumstances. One of the arguments advanced by those who seek to "liberalize" suicide is as follows. The patient's right to refuse medical treatment is now generally recognized. Accordingly, the provision of assistance for a patient who is determined to commit suicide cannot automatically be considered impermissible.¹¹² As the individual's claim to autonomy is the central consideration, physician-assisted suicide can only be morally acceptable if this act is a faithful final expression of the patient's wishes. From this perspective, the patient retains "the right to change his or her mind until the point at which the lethal process becomes irreversible".¹¹³

¹⁰⁷ On the legal situation in the US, see A. Nussbaum, *The right to die: die rechtliche Problematik der Sterbehilfe in den USA und ihre Bedeutung für die Reformdiskussion in Deutschland*, Duncker & Humblot, Berlin, 2000, pp. 85–94; L. Snyder, "United States: Euthanasia, assisted suicide and the 'right to die'", in Council of Europe (Ed.), *Ethical eye: Euthanasia, Vol. 2, National and European perspectives*, Strasbourg, 2004.

¹⁰⁸ *Vacco v. Quill*, 117 S. Ct. 2293, 1997; *Washington v. Glucksberg*, 117 S. Ct. 2258, 1997.

¹⁰⁹ The report is available online at: www.publications.parliament.uk/pa/ld/dasdy.htm

¹¹⁰ Cf. L. Spinney, *op. cit.*

¹¹¹ A large body of literature is available on this subject. See, for example, N. Aumonier, "Evaluation of the arguments", in Council of Europe (Ed.), *Ethical eye: Euthanasia, Vol. 1, Ethical and human aspects*, Strasbourg, 2003; H. Doucet, *Les promesses du crépuscule. Réflexions sur l'euthanasie et l'aide médicale au suicide*, Labor et Fides, Geneva, 1998; A. Holderegger, "Zur Euthanasie-Diskussion in den USA. Erster Teil", in *idem* (Ed.), *Das medizinisch assistierte Sterben*, Academic Press, Fribourg/Herder, Freiburg, 2nd ed., 2000, pp. 121–135; M. Reichlin, *L'etica della buona morte*, Ed. di Comunità, Turin, 2000.

¹¹² On this point, see A. Holderegger, *Suizid – Leben und Tod im Widerstreit*, Paulusverlag, Fribourg, 2000, pp. 135–136.

¹¹³ D.W. Brock, "Voluntary active euthanasia", in *idem*, *Life and death: philosophical essays in biomedical ethics*, CUP, Cambridge, 1993, p. 204.

According to the liberal approach, the patient has a right to request assistance with suicide, but there is no corresponding "duty to cooperate" on the part of the physician. On the contrary, in an individualistic and pluralistic system, the physician's freedom of choice must be assured, which implies the recognition of a "right of conscientious objection".

Recognizing the moral right to a self-determined death sets in train a process of legalization that logically culminates in the decriminalization of physician-assisted suicide.

The "right to die"

The idea of a "right to die" is closely linked to the principle of autonomy and self-determination. In (post-)modern biomedical discourse, the concept itself is symptomatic of a process of subjectification: the modern subject, enjoying fundamental freedom of personal choice, claims dominion over its own life and death. To this extent, assisted dying and assisted suicide are understood (euphemistically) as an affirmation of human freedom and as an expression of the human right to one's own body.

In this context, mention should be made of Margaret Battin's notion of a "right to suicide". For Battin, suicide is a fundamental right, constitutive of human dignity. However, she distinguishes between "nonviolent" suicide, based on "a self-ideal: a conception of one's own value and worth, beneath which one is not willing to slip", and all other forms of suicide, which she describes as "irrational": only in the former case does a fundamental right exist which justifies assisted suicide.¹¹⁴

The principle of beneficence

A third argument in favour of physician-assisted suicide is based on the physician's duty to do no harm, and to prevent or alleviate pain and suffering for the benefit of the patient. The question thus arises, if the art of medicine is no longer able to improve the condition of a patient whose life consists solely of suffering, is physician-assisted suicide not then justified by the Hippocratic principle of non-maleficence (*primum non nocere*)?

In the view of utilitarian philosophers such as Peter Singer, Helga Kuhse or James Rachels, moral decisions concerning life and death are inevitably based on the criterion of "quality of life". For Singer, in contrast to the traditional sanctity of life ethic, the "new ethic" can only be based on an acceptable level of well-being; in the absence of this, life no longer appears to be worth living.¹¹⁵ This type of "quality of life ethic" focuses on human beings taking control of their own lives. Someone who is ill is not required to tolerate his miserable existence; if his own life appears to him to be no longer worth living, his wish to die is to be respected.

From this moral perspective, dying can be "well" managed even in cases where the patient is unable to express his or her own preferences. Here, the quality of life criterion is applicable, and the question to be answered is whether life-prolonging measures are "objectively beneficial" for the patient. If this is not the case, the utilitarian line of thought considers medically assisted dying to be essentially acceptable.¹¹⁶

¹¹³ M. Battin, "Suicide: a fundamental human right?", in *idem*, *The least worst death*, OUP, Oxford, 1994, pp. 277–288.

¹¹⁴ P. Singer, *Rethinking Life and Death: The Collapse of Our Traditional Ethics*, St. Martin's Press, New York, 1994.

¹¹⁵ Cf. H. Doucet, *op. cit.*, pp. 126–129.

b) Contra

Opponents have argued that autonomy, understood as a right to refuse medical treatment, does not provide a sufficient basis for a right to *assistance* in suicide. The three main arguments advanced against physician-assisted suicide invoke the sanctity of life, professional integrity and the risk of a slippery slope.

The sanctity of life

In the current debate on euthanasia and physician-assisted suicide, arguments of a theological nature play a prominent role. One such argument appeals to the sanctity of life – a principle that is interpreted theologically in various ways. One interpretation, inspired by Judaism, emphasizes the infinite value of every moment of human existence; accordingly, physicians have a responsibility to sustain life for as long as possible. A second interpretation was advocated by Pope John Paul II, for whom the prohibition on killing was to be understood in absolute terms. A third and final interpretation takes the sanctity of life to consist, not in inviolability, but in its relationship to God. Whether this last interpretation implies a prohibition on assisted dying is, however, a matter of controversy among theologians.¹¹⁷

Recently, the sanctity of life principle has been taken up once again by a number of authors and applied in a secularized context. One of these authors is Leon R. Kass, a physician and professor of humanities at the University of Chicago. For Kass, the sanctity of human life is based on human dignity. In his view, euthanasia or assisted suicide with the patient's consent cannot be justified, as it is an intrinsically bad act.¹¹⁸ The Anglo-American legal theorist and philosopher Ronald Dworkin also invokes the sanctity of life, but takes the view – on the basis of a liberal approach – that euthanasia is justifiable under certain conditions.¹¹⁹

Professional integrity

The objection is raised that neither euthanasia nor assisted suicide is compatible with the nature of the physician's role. Assisted suicide is considered to conflict with the social, moral and professional responsibilities of the physician, whose function is to heal. From this perspective, "Desire for death [...] cannot take precedence over provision of care, and provision of care cannot be turned into ending of life."¹²⁰

This argument has been developed by the philosopher Hans Jonas. In his view, it is ethically unacceptable for a physician to bring about death through euthanasia or assisted suicide.¹²¹ He argues that the prohibition on any form of euthanasia or assisted suicide not only protects the physician from a conflict of interests (killing versus curing) but also preserves the patient's confidence in the physician.

Reflections on the physician's role and the concept of professional integrity are to be found in works by philosophers such as Edmund D. Pellegrino, as well as Leon R. Kass.¹²² In their view, medicine is not an exclusively technical and neutral activity, based on "external values", but rather a moral profession, defined by its own "internal values". The intrinsic value giving meaning to medical activity consists in healing. Medicine is founded not on patients' wishes or rights, but on their therapeutic needs. A physician who practises euthanasia or assisted suicide thus violates the profession's fundamental values.

¹¹⁷ *Ibid.*, pp. 85–90.

¹¹⁸ L. R. Kass, "Death with dignity and the sanctity of life", in J. D. Moreno (Ed.), *Arguing Euthanasia*, Touchstone, New York, 1995, pp. 211–236.

¹¹⁹ R. Dworkin, *Life's Dominion*, Vintage, New York, 1994, pp. 179–217.

¹²⁰ N. Aumonier, *op. cit.*, p. 65.

¹²¹ H. Jonas, "The right to die", *Hastings Center Report* VIII (1978), pp. 31–36.

¹²² L. R. Kass, *Toward a More Natural Science*, Free Press, New York, 1985; E. D. Pellegrino, *Humanism and the physician*, University of Tennessee Press, Knoxville, 1979.

The "slippery slope" argument

A third argument deployed against physician-assisted suicide emphasizes the risk of a "slippery slope" leading (perhaps inevitably) to increasingly unacceptable practices.¹²³ This argument involves both logical/conceptual and sociological/empirical elements. Thus, it is claimed (the first element) that if assisted suicide is legalized, one will be compelled, for reasons of consistency, also to make concessions in related areas, such as that of active euthanasia. Another consequence of legalizing assisted suicide (the second element) would be a risk of abuses and specifically a descent towards involuntary euthanasia. The emphasis here is on an alleged psychosocial disposition that would lead people increasingly to accept practices exhibiting a growing lack of respect for human life.¹²⁴ It is feared that, with assisted suicide, individuals would be exposed to increasing social pressure to die when their own life became burdensome to others. Liberalization of assisted dying could lead society to use this option to save on the costs of providing an appropriate level of care.

¹²³ M. Reichlin, *op. cit.*, pp. 164–177.

¹²⁴ H. Doucet, *op. cit.*, p. 69.

III. Arguments considered by the NEK-CNE on physician-assisted suicide

Against the backdrop described in Chapters I and II, the NEK-CNE considered from an ethical perspective the significance, implications and limits of the provisions of Art. 115 StGB regulating assisted suicide. The points receiving particular attention are presented below, including some that were of crucial importance in the development of the recommendations given in Chapter IV.

III.1 Article 115 StGB: an area of freedom

There is no doubt that one of the key questions is what precisely Art. 115 StGB grants the individual: is it a "right to assist in suicide", a "moral entitlement to assistance in suicide", or merely a "restricted liability to punishment", not providing the basis for any corresponding right? The Commission found a moderate interpretation to be the most persuasive. Article 115 StGB grants a certain personal freedom to decide in favour of non-punishable assistance in suicide. The article does not, however, provide a sufficient foundation for an ethical "right to (perform or receive) assisted suicide".

The ethical question then arises of whether it is *right* that this freedom should exist. As stated below in Recommendation 3 (the wording of which was unanimously adopted), the NEK-CNE takes the view that this freedom is to be welcomed and should be preserved. Given the existing ethical guidelines for healthcare professionals, there is no pressing need for Art. 115 StGB to be clarified in relation to *medically* assisted suicide; the article appears to be appropriate in its current form.

This position is adopted for reasons of different kinds, reflecting the individual backgrounds of the Commission's members. Great importance was attached to considerations of respect. Even if one sets a high value on the duty of beneficence and admits that people have a responsibility to ensure that the quality of life is such that a desire for suicide does not arise (or persist), there may still be situations in which people make a voluntary, considered decision to end their life and are dependent on the help of others in accomplishing suicide. These situations can only be assessed on an individual basis, and however tragic and regrettable such a decision may be, it deserves understanding and respect. This applies both to the well-considered decision to commit suicide and to the carefully weighed decision to provide assistance.

In issuing its Opinion, however, the Commission assumes that it is not required to express a fundamental view on the ethical legitimacy either of suicide itself or of assisting suicide in particular cases: judgements of the legitimacy of suicide remain a matter for the individual.

In supporting the freedom granted by Art. 115 in its present form, the Commission does not intend to promote assisted suicide and naturally takes the view that efforts to prevent suicide are also essential.

In addition, the Commission is aware that these legal provisions involve a risk of abuse and perversion. It therefore believes that it is necessary, outside of the criminal law, to formulate a number of restrictions so as to ensure that decisions are well-considered and that assessments are carried out with due care; these restrictions concern medical practice, the relevant institutions and the practices of right-to-die organizations.

III.2 The ethical ambivalence of assisted suicide

Assisted suicide gives rise to a serious conflict of moral demands. This cannot be straightforwardly resolved by focusing exclusively on the personal freedom of the individual committing suicide. Conflicts repeatedly arise between the need to respect the self-determination of people considering suicide and the duty to provide care for those who wish to take their own lives. Personal autonomy in the form of self-determination is regarded as central to personal fulfilment, and restrictions are perceived by those concerned as detrimental to their well-being and a breach of respect. Accordingly, self-determination also needs to be protected and supported in relation to end-of-life decisions. At the same time, self-determination is not to be conceived of in isolation from relations with other people, or social and biological conditions. Indeed, personal freedom and autonomy only makes sense in this broader context. One element of human relationships is the fact that we are not indifferent to the death of other people. This ethical dilemma cannot be resolved on a theoretical level.

This explains why assisted suicide is not a moral question that can be addressed in a general way; rather, efforts to reconcile conflicting personal freedoms are always particular. For this reason, assisted suicide must never become a matter of routine or the application of a rule based on formal conditions. It cannot be formalistically regulated or administratively organized.

Dilemmas also arise at the institutional level: on the one hand, facilitation of suicide, if it is not carefully handled, can tragically turn into an act of unlawful killing; on the other hand, certain suicides cannot be carried out merely because of opposition on the part of institutions. While this does not fundamentally call Art. 115 StGB into question, it demonstrates that the conditions for the application of these provisions should be more precisely specified.

Individual decisions arise in the context of an individual life, but are also to be seen in a social context. The individual decision both influences and is influenced by this broader context. It is therefore necessary to consider to what extent the conditions in which a specific wish for suicide arises permit freedom of choice. For example, have palliative care options been exhausted? Is the individual protected from social pressures, such as the feeling that one must not be a burden on society or the family?

A variety of tensions may thus arise between the social and individual ethical perspectives. This is also reflected in Swiss law, where under Art. 115 StGB individual freedom is defended, and at the same time under Art. 10 of the Federal Constitution the state has a responsibility to protect people's physical and mental integrity. To what extent individual freedom of choice concerning assisted suicide should be allowed to influence the social climate and thus also other people's decisions is a matter for individual judgement. While the members of the Commission agree in principle that individuals should have the freedom to commit suicide without their actions being morally condemned by the secular state, and therefore approve of Art. 115, their opinions vary widely as to the appropriate individual and social framework. Accordingly, their assessments of the wisdom of liberalizing assisted suicide differ, and different conclusions are drawn concerning the relevant regulations.

The desire for assisted suicide can give rise to ethical dilemmas of three different kinds:

- *in individual ethics*, the entitlement to freedom of the individual considering suicide versus that of the person who is to assist the suicide;
- *in social ethics*, the state's duty to protect its citizens' physical and mental integrity versus the granting of individual freedom for people considering suicide;
- *in social ethics*, the state's duty to protect its citizens from social constraints and adverse conditions versus the recognition of the individual entitlement to freedom of people considering suicide.

III.3 Art. 115 StGB in the deontological context of medicine and care

Clearly, Art. 115 StGB did not arise in a medical environment. Nonetheless, the application of these provisions in a medicalized context gives rise to a series of specific problems of an ethical and deontological nature. The Commission sees at least two reasons for the medicalization of assisted suicide. Firstly, a physician's responsibility is involved insofar as the lethal medication can only be obtained in a pharmacy with a prescription; secondly, death in our society increasingly occurs in a more or less medicalized setting.

For physicians (but not only for members of this profession), these two factors create serious deontological conflicts. Physicians who issue prescriptions designed to enable a patient to commit suicide must inevitably adopt a position on the Hippocratic duty not to administer poison to – or otherwise harm – patients. The conflict becomes more radical in cases where the physician is requested not "merely" to write a prescription but personally to participate in assisted suicide.

The direct involvement of healthcare professionals raises three problems. *Firstly*, medical and nursing ethics are concerned if professional medical or nursing skills are employed. *Secondly*, deaths occur relatively often, if not always, in a specialized setting, such as a hospital or old people's/nursing home. Situations in which no healthcare professionals are involved in the patient's plans (suicide at home) cannot be ruled out. Frequently, however, suicide is most likely to be contemplated in a "healthcare setting" (hospital) or in a medically supervised "residential setting" (old people's/nursing home). *Thirdly*, special problems arise in connection with assisted suicide in a healthcare setting, i.e. when institutions whose traditional function has been to preserve life are assigned the opposite task of assisting dying. In a setting of this kind, assisted suicide could be unsettling for patients and staff, and indeed for society as a whole.

For these reasons, the Commission is convinced that there is a need for a debate on the professional ethics of physicians and nurses with regard to assisted suicide. In many cases, healthcare professionals are likely to be involved as partners – in some way, directly or indirectly – or at least to be asked to provide support. While a physician who is approached for a prescription of a lethal drug already faces a moral dilemma, the dilemma is even more acute for a nurse asked to assist in the preparation of lethal medication. The moral issue is further complicated by the tragic circumstances – the voluntary death of someone with whom the nurse will generally have established a relationship.

Problems are also raised by the intervention of right-to-die organizations in hospitals or old people's/nursing homes. Organizations of this kind are associated with values or even a certain militancy that may conflict with the carers' primary responsibilities and the values espoused within these institutions.

III.4 Self-determination and provision of care

The question of whether a wish to die is well-considered, not based on an error, and not disproportionate to the patient's objective situation is assessed in the light of the duty to provide care. To this extent, a conflict may arise between the self-determination of a patient who wishes to die and the caring responsibilities of those who are to authorize the patient's death.

The tensions frequently perceived between self-determination and the provision of care are partly attributable to historical factors. The demand that the patient's autonomy is to be respected was formulated in recent medical ethics in opposition to the unduly "paternalistic" care provided by physicians who failed to take (sufficient) account of patients' wishes. It can easily be overlooked, however, that patient autonomy is actually dependent on the availability of care options – possible medical treatments and measures – with regard to which patients can exercise their freedom of choice. Caring also includes a responsibility to help patients see how possible medical options relate to their own life plans and explore future prospects. "Self"-determination requires patients to integrate possible options into their self-conception. Finally, true self-determination is only possible if the patient's decisions are not constrained by fear, panic or despair. Here, too, self-determination may be dependent on the provision of care.

There is a broad social consensus concerning the duty to provide care for people at risk for suicide. This includes a duty, when confronted with a mentally competent person wishing to commit suicide, to discuss this desire and to point out alternative options, i.e. medical support that could be provided throughout the remaining lifespan, taking into account the patient's own perception and understanding of the situation. Self-determination involves establishing what one wishes to do in the light of the available options. To this extent, an assessment of this kind is not paternalistic interference, but an aid to self-determination. This extends far beyond a mere evaluation of mental capacity. The desire for suicide need not, but may, disappear following discussions with the physician or nursing staff. Experience, e.g. in geriatric clinics, shows that this is generally the case. One of the key concerns regarding so-called suicide tourism is based precisely on this finding. Ethically, it is difficult to justify denying assisted suicide to non-residents if it is held to be acceptable for one's own fellow citizens. The problem, however, lies in the fact that the duty to provide care is not adequately fulfilled if barely 24 hours elapse between a non-resident's arrival and assisted suicide.

In summary, the relationship between the provision of care and self-determination is not only characterized by tensions (as suggested by the "paternalism versus autonomy" formulation) – the provision of care is one of the prerequisites of genuine self-determination. Suicide and assisted suicide are no exception to this rule.

III.5 Possible ethical criteria

a) Why is there a need for criteria?

In the current Swiss context, the provisions of Art. 115 StGB are fairly far-reaching, given that their applicability is not limited by any provisos – apart from the absence of self-interested motives. In addition, what is involved is not a positive entitlement to something, but rather a liberty right. Because clear and explicit criteria for the applicability of Art. 115 StGB are lacking, the law – whether liberally or restrictively interpreted – is currently applied in a relatively arbitrary and inconsistent manner in Switzerland. On the one hand, private organizations operating in this area require patients to meet certain criteria (e.g. mental capacity, earnest and repeated requests, incurable disease, bleak diagnosis, intolerable suffering); on the other hand, certain institutions refuse to even consider requests from patients or residents in old people's/nursing homes. The discrepancy between these two extreme positions demands clarification.

The current situation is marked by arbitrariness in two respects. Firstly, the way in which requests are dealt with depends on whether someone considering suicide approaches an institution or a private organization. Secondly, arbitrariness results from the lack of a democratic debate on the introduction of restrictive criteria, as employed by various organizations. Moreover, an assessment of these criteria reveals a lack of consistency and stability: they may vary from one organization to another and change over time within a given organization. Finally, whether a request is accepted generally depends on the decision of a single person, who thus has complete discretion in a matter of vital importance. In contrast to those countries where the question is legally regulated, Switzerland also lacks procedural controls, which further expands the area of discretion.

In practice, people who request assisted suicide in Switzerland today often have only limited options. Those who live in an institution are subject to the discretion of the head of the department or the management of the institution. Those who do not live in an institution will turn to a private organization. In the former case, those making a request have to hope that it will be handled by someone sympathetic to their wishes. In the latter case, applicants have to meet the criteria specified by the organization concerned.

Finally, the risks associated with the modus operandi of certain right-to-die organizations should not be underestimated. In some cases, their self-imposed restrictions may be breached. This risk arises in particular because these organizations are not subject to external controls.

Current developments are not wholly conducive to respect for patients or citizens in general. For this reason, the Commission calls for more precise regulation of the conditions under which assisted suicide is performed.

In practice, care institutions pursue different policies in this area. In the Commission's view, greater transparency on the part of the institutions and organizations concerned would be desirable.

At the same time, the social ethical perspective should be borne in mind: the development of a social climate hostile to the weak and the disabled, with the attendant pressures, is insidious and not readily perceptible. Of particular concern is the fact that reflections on assisted suicide may all too easily be associated with financial considerations.¹²⁵ A principle of fundamental importance is that human beings have an existential claim to dignity and autonomy, irrespective of their actual capacity for autonomy. This gives rise to a moral duty to treat and care for people in accordance with this claim to dignity and autonomy. This involves promoting their capacity for autonomy and – if this is, irreversibly, no longer possible – acting in accordance with their presumed wishes.¹²⁶

b) Are ethical or legal criteria required?

The formulation of ethical recommendations offers the advantage that reference can be made to them in legal regulations (for example, a number of cantonal health laws refer to the medical ethical guidelines of the SAMS); in addition, recommendations are more adaptable and flexible than binding laws. For the professionals concerned, ethical recommendations provide guidance of an essentially non-binding character: it is conceivable that exceptions may be justifiable in certain cases.

The disadvantage of ethical guidelines, however, is the lack of formal sanctions for those who fail to comply with them. From this perspective, legally binding regulations would offer the advantage of immediate, irrevocable sanctions in the event of infringements. The purpose of subsequent normative provisions accompanying Art. 115 StGB would be to prevent abuses and to obtain reliable data on this subject. A combination of the two different levels is also conceivable – a legal obligation (overseen by the state) to comply with due care criteria, which are themselves formulated in ethical guidelines.

c) Criteria to be considered

Mental capacity

Assisted suicide is based on the decision of an autonomous subject: in the law, decisional autonomy is covered by the concept of mental capacity. For this reason, if a request for assisted suicide is to be granted, mental capacity is of crucial importance.

In the spirit of Art. 16 of the Swiss Civil Code (ZGB), mental capacity is not a characteristic that is permanently acquired at a given point in time. Under the law, every adult essentially has mental capacity; claims to the contrary have to be proved (the grounds specified in the law range from mental deficiency to inebriation). Unlike legal majority – which is reached in principle at the age of 18 and confers legal capacity – mental capacity is to be understood as a variable faculty, exercised with regard to specific decisions. To eliminate any doubts as to a person's mental capacity, it is essential that two conditions should be met: the cognitive component (ability to comprehend the consequences of one's own decisions) and the volitional component (no pressure of any kind exerted by a third party).

¹²⁵ Cf. F. Th. Petermann, "Entwurf eines Gesetzes zur Suizid-Prävention" [Draft of a law on suicide prevention], *Aktuelle juristische Praxis (AJP/PJA)* 09/2004, pp. 1111–1136: "In view of the fact that ... – at a conservative estimate – the costs arising from the consequences of failed suicide attempts amount to CHF 2.37 billion, the suicide issue is a cost factor within our social and health policy which has evidently not been recognized to date."

¹²⁶ Cf. R. Baumann-Hölzle, "Ethische Entscheidungsfindung in der Intensivmedizin", in *idem et al. (Eds), Leben um jeden Preis? Entscheidungsfindung in der Intensivmedizin*, Peter Lang, Bern, 2004, p. 117–147.

Suffering

If suffering is invoked to justify a request for assisted suicide, it is an important criterion for assessment. Everything possible must be done to promote the person's physical and emotional well-being (medical treatment and attention). Under these circumstances in particular, palliative care is to be supported, while bearing in mind that suffering cannot always be combated with the medical means available to this discipline. It is equally important to distinguish between pain and suffering: while pain is a physical phenomenon, suffering encompasses moral, mental, psychosocial and even spiritual dimensions.

The point of drawing this distinction is not to discriminate against either pain or suffering, but merely to point out that while pain is more amenable to control by scientific means, suffering lies within an intimate, personal realm. The individual remains the sole and final arbiter of the tolerability of suffering. Healthcare professionals can do no more than provide means for its alleviation. Here, the situation could be perceived as paradoxical, insofar as suffering appears to be a prerequisite for granting a request for assisted suicide. It must be conceded, firstly, that in a medicalized setting it is scarcely possible to grant such a request in the absence of a burden of suffering; secondly, it is difficult to see how and by whom such a wish could be called into question, since the patient is the sole judge of the tolerability of his or her suffering. In the context of this argument, it should be mentioned that anyone who considers suicide to be the only possible solution is probably suffering sufficiently to request assisted suicide.

Diagnosis of a terminal or severely disabling illness

These are generally cases in which all possible treatment options have been exhausted and there is no longer any prospect of a medical solution. A number of diseases (e.g. neurodegenerative conditions) can be managed by pharmacotherapy, while the impending loss of mobility makes suicide appear to be possible only within a limited period. Mention should also be made of patients who are severely disabled but autonomous. It is conceivable that a number of these patients, out of despair, may ask for their lives to be terminated.

These situations give rise to various difficulties – notably, the uncertainty associated with the prognosis, but also the fact that the patient's perceptions of the disease are influenced by the fears of relatives and carers.

Nonetheless, the subject remains the sole judge of the tolerability of awaiting the fatal outcome. Likewise, the subject is free to take into account or disregard any statistical data presented by medical staff.

Place of residence

Problems are also raised by the place of residence. The situation may differ depending on whether the person considering suicide is in an old people's/nursing home or in an acute-care hospital. Clients of an old people's/nursing home are generally resident in the institution concerned; this is where they live and receive care. In contrast, acute-care inpatients almost always retain their personal residence.

For this reason, old people's/nursing home residents are generally unable to carry out their suicide plans in their familiar surroundings. The highly unsatisfactory alternatives include renting a hotel room or – as has occurred in a canton in French-speaking Switzerland – retreating to a caravan. At first glance, the situation seems to be easier for acute-care inpatients, as – in principle – they can return home to commit suicide. However, as will be discussed below, this situation creates moral and psychological problems of a different kind.

It is obvious that assisted suicide is generally unwelcome in an institution. As well as damaging the institution's image, the procedure could create anxieties among the other residents or hospital patients. This represents one of the key challenges arising from the debate. In addition, it has not been demonstrated that, in cases where patients officially have a personal residence, their own home provides the requisite environment for carrying out their plans.

If the decision on whether a request for assisted suicide is to be approved or not were to be based solely on the trivial reason that the applicant has a personal residence, this solution would be difficult to justify morally. Quite apart from the evident injustice, it would mean that, in cases where patients have their own home, the institution would automatically be relieved of the burden of their requests. But this is essentially the current situation in Switzerland – which is precisely one of the concerns expressed by healthcare professionals. Their sense of justice is offended, or they feel that they are abandoning the patients in their care at a critical moment in these patients' lives. These inconsistencies may give rise to moral conflicts, with healthcare professionals being torn between their duties and their empathy. In such cases, institutions could be tempted to instruct professionals who wish to care for their patients in the final moments of life to do so outside working hours and away from the institution. In the Commission's eyes, these entirely real situations are morally incoherent.

Finally, ethical and psychological tensions may also arise in an acute-care setting in cases where a terminally ill patient is sent home, having requested assisted suicide because palliative care has failed to provide (sufficient) relief. In such cases, patients may feel abandoned by the physicians treating them, with whom they have established a close relationship. Carers, for their part, may feel that they have deserted their patients at a crucial moment.

In the Commission's view, the question of a suitable location is one of the most difficult issues. There is a need for a nuanced approach, involving the following key points:

1. The Commission takes the view that the issues differ for long-term care institutions and acute-care hospitals.

Long-term care institutions: residents who desire assisted suicide and have no other place of residence outside the institution should be able to carry out the act on the premises. An exception to this would be the case of an institution that specifically and explicitly only admits residents who, at the time of admission, explicitly accept that assisted suicide is not tolerated within the institution. The institution's regulations must disclose its values, including whether assisted suicide on the premises is explicitly permitted or prohibited. Staff at long-term care institutions cannot, however, be forced to participate in assisted suicide (right of conscientious objection). Finally, institutions that permit assisted suicide must make arrangements to ensure that the freedom of conscience of all parties concerned (applicant, staff, assistant) is respected, and that privacy (indeed confidentiality) is guaranteed for those determined to commit suicide.

Acute-care hospitals: Every institution should decide whether it intends to permit the option of assisted suicide for its patients or not. This decision should also be made transparent. If this practice is to be allowed, the institution will naturally also have to establish the necessary framework to enable the act to be carried out in the best possible conditions. But here, too, the right of conscientious objection is to be respected for all staff concerned. If the institution does not accept requests of this kind, patients should have the option of being transferred to a different healthcare facility where these wishes can be complied with. A conflict may arise in the case of public hospitals that have a mandate to treat patients with standard health insurance, who are not entitled to a free choice of hospital.

2. In both cases, the Commission stresses the importance of the transparency and explicitness of an institution's policy on assisted suicide, whether it is permitted or not, and the institution's duty to review the quality of the specified procedures. This would also apply to any psychological aftercare provided for professionals involved in these acts and the support offered to people whose request for suicide cannot be granted.

Interval between request and act, and second opinion

These requirements – that a certain interval should elapse between request and act, and that a second medical opinion should be obtained – are precautions to ensure that the expressed wish for suicide is genuine. It is conceivable that a request made on one occasion may be attributable to circumstances that could change. It is more difficult to cast doubt on a desire that is persistent, repeatedly expressed and well-founded. The aim is by no means to call into question the truth or validity of a request, but rather to ensure as far as possible that it was not merely the product of temporary despondency. It would appear to be difficult, however, to specify an interval in absolute terms, since this would be excessively arbitrary: a given interval may be justified in one case but not in another, depending not only on the type and severity of the illness, but also on the patient's temperament and emotional state.

Psychiatric assessment

A psychiatric assessment can help to identify or exclude a mental disorder as the cause of the desire for death. According to epidemiological studies, the great majority of suicide attempts and suicides are associated with mental illness. Follow-up studies indicate that if patients with a mental disorder who have a history of suicidal behaviour receive appropriate psychiatric and/or psychotherapeutic care, the great majority will subsequently die from natural causes, rather than suicide.

A psychiatric assessment carried out by a specialist or an appropriately trained physician is to be recommended in all cases where a mental disorder is suspected in a suicidal individual. From an ethical perspective, assisted suicide should never be performed if suicidality is a symptom or manifestation of a mental illness. More difficult to assess are the relatively rare situations in which remission of a mental disorder does not lead to the disappearance of a desire for suicide. In such cases, the question to be asked is whether the stigmatization of the mentally ill in our society contributes to the persistence of the wish for suicide, or whether it is maintained as a result of some other social (e.g. financial) pressures.

If factors of this kind are decisive in the desire for suicide, there is a need primarily to alleviate these individuals' situation or to help them come to terms with the socially problematic role of a mentally ill patient. In any event, social discrimination against the mentally ill must not lead to the cynical advocacy of equality of treatment in the area of assisted suicide as a solution to social disadvantage.

At the same time, suicide should not be prevented by forceful means in the case of patients with mental disorders whose desire for suicide – for example, during a symptom-free interval – is not a direct manifestation of their illness. People who are mentally ill should be able to avail themselves of the right to care and treatment, and also, if they have mental capacity, exercise the right to make decisions concerning the end of their life. First and foremost, however, efforts should be made to ensure that they enjoy the same status as patients with physical disorders in everyday life and in insurance law, and that social discrimination does not lead them to choose death in preference to the "shame" of mental illness.

In addition, the desired psychiatric/psychotherapeutic interview with suicidal individuals should not consist solely of a psychopathological assessment. The aim must also be to understand the situation of those concerned and through this understanding to help provide relief. Some suicidal individuals feel isolated with their desire for death and long for attentive and unprejudiced listeners. The psychiatric/psychotherapeutic interview is thus not designed to "pathologize" the desire for suicide, but to provide an insight into the situation of those concerned. Preconceived ideas are of little value in open encounters of this kind. Abstract rules (such as the imperatives of autonomy or beneficence) are likewise of limited use in individual cases. More fruitful are interviews in which suicidal people can describe their difficulties and desires, or express feelings such as shame, despair, anger, sadness or resignation.

Deep and long-standing familiarity

Particularly in the case of the elderly, the length of a relationship with a (family) physician is not a reliable indicator of its quality. Although it seems desirable that such a relationship should be "long-standing", this can scarcely be specified as a general requirement. People suffering from a serious illness with a fatal course are likely to consult a number of specialists that they have scarcely ever met before the onset of the disease. For this reason, a long-standing relationship between patient and physician could not conceivably be a requirement. On the other hand, early contacts between the specialist and the attending physician would be highly desirable, in order to establish the confidence that is essential to any therapeutic relationship.

In addition, the length of a therapeutic relationship appears to be at best a necessary but not automatically a sufficient condition, since the depth of the therapeutic relationship is equally indispensable. It may be that a relatively short-lived relationship between patient and therapist is of such quality that, with a knowledge of the situation, a decision on assisted suicide can be made.

Psychological support and pharmacological training

Psychological support for suicide assistants and technical/pharmacological training are supplementary elements. At present, virtually no conclusions can be drawn as to whether right-to-die organizations have adequate support (debriefing or external supervision) or appropriate pharmacological training. Moreover, no provision for the latter is made in the core medical curriculum. If existing gaps are to be filled, significant efforts will be required at the level of basic training for health-care professionals.

For care facilities intending to permit assisted suicide on their premises, the practicalities involved cannot be a matter of indifference. Without assuming responsibility for assisted suicide, they would be required to protect people wishing to commit suicide and staff from practices incompatible with human dignity. Institutions that permit assisted suicide are also required to settle the legal questions relating to the responsibilities of the parties concerned.

Age

With the exception of children, who are deemed to lack mental capacity in the relevant legal sense, age in itself cannot be considered a restrictive criterion for the application of Art. 115 StGB. At most, it can be regarded as providing reinforcement, e.g. in the event of repeated requests or a confirmed diagnosis of an incurable disease with a fatal course. The exercise of strictly personal rights depends not on the age, but on the mental capacity of the individual concerned. There is therefore no fundamental reason why age should be a decisive factor. The question of legal minors is discussed in greater detail below.

III.6 Special cases

a) Assisted suicide among the mentally ill

In the case of patients with severe mental disorders, assisted suicide raises a specific question to which different answers are given within the psychiatric community. The issue was considered above, in the discussion of criteria. Most psychiatrists take the view that assisted suicide is not permissible, arguing that the desire for death in these patients is precisely a manifestation of their mental disorder. Other psychiatrists believe that in certain patients mental illness can produce irremediable suffering which makes it justifiable to grant their request.

Only a few empirical studies have addressed this topic, although the debate is of considerable interest to healthcare professionals – judging by the numerous editorials, comments and correspondence on this subject. While the question should be of relevance for all mental health professionals, old age and liaison psychiatrists appear in practice to be those most commonly confronted with this issue.¹²⁷ In Switzerland, a study¹²⁸ of the activities of Exit showed that, between 1990 and 2000, 3% of assisted suicides were directly connected with a mental disorder, while up to 18% of cases within this organization concerned patients with a somatic disease and a concurrent mental disorder.

¹²⁷ B. Kelly et al., "Euthanasia, assisted suicide and psychiatry: a Pandora's box", *British Journal of Psychiatry* 181 (2002), p. 278.

¹²⁸ G. Bosshard, E. Ulrich, W. Bär, "748 cases of suicide assisted by a Swiss right-to-die organisation", *Swiss Medical Weekly* 2003; 133, p. 310.

The issue of assisted suicide concerns three different categories of mentally ill patients:

1. patients not suffering from a serious somatic illness who request assisted suicide on account of a severe mental disorder;
2. patients with a severe mental disorder who request assisted suicide on account of a serious somatic disease;
3. elderly (psychogeriatric) patients.

In patients with dementia, the capacity for autonomy may have almost entirely disappeared. It should, however, be emphasized that this does not affect their claim to dignity and autonomy, and that their universal human rights remain intact. From a legal perspective, they lack mental capacity, and assisted suicide cannot be considered in such cases.

1. Patients not suffering from a serious somatic illness who request assisted suicide on account of a severe mental disorder

In 1994, the Dutch Supreme Court ruled that assisted suicide could be permissible in cases of intolerable suffering of a mental rather than physical nature. In the Netherlands, unlike in Switzerland, assisted suicide is only permissible in cases where a request has been accepted by an ad hoc committee. This body will only grant such a request if the applicant – specifically in the context of a depressive disorder – has failed to respond to treatment of recognized efficacy. In the Netherlands, the justification offered for the policy of permitting assisted suicide for patients with mental disorders is that failure to do so would further stigmatize a group that is already socially disadvantaged in many ways. In fact, however, only 2% of all requests for assisted suicide based on mental suffering are granted, compared with an approval rate of 37% for requests based on physical suffering.¹²⁹ In contrast to Switzerland, where assisted suicide is permitted in non-medical settings, only physician-assisted suicide is countenanced in the Netherlands. Half of the Dutch physicians surveyed considered this practice acceptable, and a minority had already participated in an assisted suicide.¹³⁰ However, according to an analysis of published data on the very small number of cases in which assisted suicide was motivated by mental suffering, practically all the patients had serious somatic illness in addition to a mental disorder. If the motives for requesting assisted suicide are studied in depressive patients, the depth of their motivation is striking, but at the same time one is compelled to ask whether everything possible has been done to alleviate these patients' suffering. Finally, empirical data indicate that depressive patients' attitude towards assisted suicide is less stable over time than that of patients considering assisted suicide for purely somatic reasons.¹³¹

In general, it is not recommended that requests for assisted suicide motivated by mental disorders should be granted, for the following reasons:

- a. reliable prognosis for mental disorders is difficult to establish, despite the considerable progress that has been made recently in describing these conditions and perhaps even identifying biological substrates. In patients with depressive or psychotic disorders, for example, it is extremely difficult to predict the response to – pharmacological or psychotherapeutic – interventions in specific cases.¹³² Moreover, these patients' attitudes to assisted suicide fluctuate markedly.¹³³ It may be mentioned that this rule does not necessarily apply to neurodegenerative disorders such as Alzheimer's disease or Huntington's chorea, where the neuropsychiatric course is known to follow a relatively regular pattern, with a slow but inexorable mental decline.

¹²⁹ J. Groenewoud et al., "Physician-assisted death in psychiatric practice in the Netherlands", *New England Journal of Medicine*, 336 (1997), p. 1795.

¹³⁰ *Ibid.*

¹³¹ E. Emanuel et al., "Attitudes and desires related to euthanasia and physician-assisted suicide among terminally ill patients and their caregivers", *JAMA*, 284 (2000), p. 2460.

¹³² R. Schoevers et al., "Physician-assisted suicide in psychiatry: developments in the Netherlands", *Psychiatric Services* 49 (1998), p. 1475.

¹³³ E. Emanuel et al., *loc. cit.*

- b. Mentally ill patients carry a heavy burden of suffering. They struggle against their disease under difficult conditions, and highly motivated carers provide support, sometimes without being able to detect significant improvements. A broad liberalization of assisted suicide could be demotivating for therapists and promote dangerous resignation among patients and carers.¹³⁴
- c. In mentally ill patients, a request for suicide is generally a manifestation or symptom of their disorder. It is difficult to conclude definitively that the condition is incurable.

2. Patients with a severe mental disorder who request assisted suicide on account of a serious somatic disease

Understandably, depression and a desire for death is common in patients with an incurable somatic disease. However, there is a lack of scientific evidence on the psychological effects of somatic diseases.¹³⁵ A depressive state, e.g. in response to bereavement, is frequently "normal" in the given circumstances. Most studies indicate that the dominant factors in patients' despondency are pain and, above all, hopelessness.¹³⁶ In this area, significant progress has been made thanks to advances in psychiatry, biopharmacology and psychotherapeutics. In addition, an extremely important contribution is made by palliative medicine.

But are there cases of somatic disease with concurrent mental illness where assisted suicide is nevertheless permissible? Here, no general recommendations can be given; instead, individual decisions will be required in individual cases.¹³⁷

3. Elderly (psychogeriatric) patients

Among elderly patients, the management of requests for assisted suicide may potentially be influenced by two characteristics of this population: the high incidence of comorbidity and the large number of patients who are resident in old people's/nursing homes.

The Commission's reflections on assisted suicide are significantly influenced by these two factors for the following reasons:

- a. In this patient population, mental capacity may be partial and fluctuate over time.
- b. The risk of economic, frequently unspoken or hidden institutional or family pressures cannot be entirely ruled out. These could engender support for assisted suicide. For relatives, institutions and even society, there could be "self-seeking motives" that would make it appear advantageous to allow patients to die rapidly. Such pressures would be ethically reprehensible. Although this risk also exists in the case of purely somatic illness, the patient is then capable of assessing the situation more realistically – in marked contrast to patients with severe mental disorders. In the case of elderly, mentally confused patients, requests for assisted suicide should be handled with the greatest restraint. Nevertheless, since such patients may have the mental capacity for decisions of a highly personal nature, assisted suicide could be considered or a request granted in rare cases.

¹³⁴ L. Ganzini et al., "Psychiatry and assisted suicide in the United States", *New England Journal of Medicine*, 336 (1997), p. 1824.

¹³⁵ H. M. Chochinov et al., "The euthanasia debate: attitudes, practices and psychiatric considerations", *Can J Psychiatry*, 41 (1996), p. 315.

¹³⁶ B. Rosenfeld, "Assisted suicide, depression and the right to die", *Psychol Public Law*, 6 (2000), p. 467.

Nur Krebserkrankungen haben insbesondere bei den Frauen (43% der durch vorzeitigen Tod verlorenen Lebensjahre) eine grössere Bedeutung.

¹³⁷ B. Kelly et al., *loc. cit.*

From a broader perspective, the Commission was repeatedly concerned with the following question: Should psychiatrists act as gatekeepers in the authorization of assisted suicide? Empirical data indicate that while 64% of British psychiatrists consider it important that requests for assisted suicide should be evaluated by a specialist in this discipline, 65% are not willing to carry out such an evaluation themselves.¹³⁸ The same applies to the Netherlands, where about half of the psychiatrists surveyed did not intend to participate in an assisted suicide involving a psychiatric patient.¹³⁹ The fact that psychiatric specialists do not wish to serve as experts evaluating requests for assisted suicide suggests that this activity raises intractable existential questions.

b) Assisted suicide among minors

In the case of legal minors, requests for assisted suicide are almost always motivated by medical conditions. Evidently, the question has only ever arisen to date with minors suffering from an incurable (usually hematoproliferative) disease, following the failure of highly burdensome treatments. It is not conceivable that a request for assisted suicide could arise from the diagnosis of an incurable mental disorder without this having been preceded by several years of observation, at the end of which the patient would inevitably have attained legal majority.

Minors confront us with special *legal problems*. In principle, consent for a minor to undergo a medical intervention (to which, in this context, assisted suicide can be considered analogous) is granted by the legal representative (parent or guardian). However, parents have no rights over the life of their children. If the decisions of the minor patient's legal representatives have serious consequences, the physician may approach the guardianship authorities. In an emergency, a physician is even entitled to carry out a medical intervention that he or she deems necessary, if failure to do would pose a risk to the minor's life.

The second point for clarification concerns minors with mental capacity. According to Olivier Guillod, "In Swiss law, a minor's ability to consent to medical treatment depends on his or her mental capacity. Under Art. 19, Para. 2, of the Swiss Civil Code (ZGB), minors with mental capacity can 'exercise rights enjoyed by virtue of their personality'."¹⁴⁰ Legal doctrine and court practice are in agreement that the ability to consent to (or refuse) a medical intervention is one of these "personality rights".

Mental capacity is defined in Art. 16 ZGB: "Within the meaning of this law, mental capacity is possessed by anyone who does not lack the ability to act rationally on account of minority or as a result of mental illness, mental deficiency, inebriation or similar conditions." It is important to note that mental capacity is always exercised with regard to a given action – in this case, assisted suicide. In addition, physicians are responsible for evaluating an individual's mental capacity. If this capacity is in doubt, an assessment has to be carried out by a specialist (i.e. a physician, generally a psychiatrist).

It should be recalled that in Switzerland, since 1 January 1996, legal majority and marriageability are attained at the age of 18. Under Art. 13 ZGB, every person of legal age with mental capacity has legal capacity.

Consequently, individuals of legal age are able to perform acts giving rise to rights and obligations. Majority thus confers legal capacity; however, the distinction between mental capacity and majority is a peculiarity of the Swiss legal system. While young adults are assumed to have mental capacity, the mental capacity of a person below the age of 18 must be demonstrated. Thus, it is accepted that a legal minor may indeed have mental capacity, but the person concerned is required to prove that this is so. It may be mentioned in passing that under Art. 303, Para. 3, ZGB children who have reached the age of 16 can decide on their religious beliefs independently of their parents.

The mental capacity of "older" minors – the young people in question are generally aged between 15 and 18 – cannot simply be regarded as non-existent or negligible. The crucial question is whether or not, with regard to a life-or-death matter, "older minors" – legally speaking – have mental capacity or – in non-legal terms – are able to exercise decisional autonomy.

The issue of assisted suicide among minors with mental capacity is indeed highly delicate, essentially because young people's maturity with regard to existential questions generally depends, not merely on age, but on a number of different factors. In particular, the attitude of a young person requesting assisted suicide is open to different interpretations. It may be a case of a particularly mature person convinced of the rightness of the arguments presented – all the more so since this individual is the only one truly able to assess the degree of physical or mental suffering involved. In such cases, the decision of a legal minor to request assisted suicide is just as worthy of respect as that reached by an adult with mental capacity in a comparable situation (intolerable pain caused by an incurable disease). Alternatively, it may be a case of a minor or adolescent feeling insecure in the face of a weighty decision or the pressures exerted by parents and others close to him or her – or as a result of the instability of character typical of this stage of development. In such circumstances, no general position applicable to all situations is possible. There is no "medical majority" that would confer mental capacity on a minor reaching a certain age. In addition, pediatric experience shows that the development of children and adolescents varies widely, depending on the individual personality.

The situation of an adolescent minor needs to be considered here. This individual is exposed to a wide variety of more or less intense, positive or negative, influences exerted by the family or other authorities. Adolescents' decision-making may still be far from independent, even though this may not generally be conceded. Thus, in the face of an extremely difficult question of life and death, adolescents' judgement and personality are shaped by external influences. In this particular context, the question arises of how to assess a minor's mental capacity and degree of freedom of choice. This assessment takes time, necessitates careful reflection and often requires the opinions of several people who are experts in this area.

¹³⁸ H. Shah et al., "National survey of UK psychiatrists' attitudes to euthanasia", *Lancet* 352 (1998), p. 1360.

¹³⁹ J. Groenewoud et al., *op. cit.*, p. 1795.

¹⁴⁰ O. Guillod, *Le consentement éclairé du patient*, Editions ides et calendes, Neuchâtel, 1986, pp. 201–257.

c) Organized assisted suicide

Particular ethical issues arise when assisted suicide is offered by specialized organizations, such as those whose existence is possible in this country on the basis of Art. 115 StGB. These organizations (e.g. Exit) may develop significant expertise and accumulate experience that helps to improve the quality of assisted suicide practices. On the other hand, for suicidal individuals, the situation is decisively changed when they know that they need not resort to unreliable methods because an organization of this kind exists which can fulfil their wishes reliably and painlessly. This creates a special human responsibility for the organization's members. They have to deal with previously unknown applicants and are required to assess requests so as to be able to decide whether assisted suicide or some other form of help should be offered in a given case.

Under Swiss law, anyone is entitled to establish private organizations of this kind. Provided that they do not infringe Art. 115 StGB, there is no way of subjecting the organizations' practices to quality requirements. Given the gravity of the life-and-death questions, this scarcely seems appropriate. A crucial step would therefore be to create a legal basis permitting the establishment and enforcement of universal quality requirements. The initial step would be to introduce state supervision of right-to-die organizations. Secondly, there is a need to elaborate the quality criteria to be applied, particularly with regard to the assessment of applicants. In developing these quality criteria, it will be helpful to collaborate with the major right-to-die organizations, so that their experience can be taken into consideration. In principle, this could be achieved through the refinement of federal law or through cantonal legislation. However, given Switzerland's small size and the possibility of evading cantonal regulations by relocating to a neighbouring canton, a solution at the federal level would offer obvious advantages.

d) "Suicide tourism"

As a result of Switzerland's special approach to assisted suicide, non-residents travel to this country to avail themselves legally of assisted suicide offered by an organization, which would be prohibited in their country of origin. This state of affairs is deplored on a variety of grounds. The increasing numbers of cases provide a sufficient reason to give serious consideration to regulations addressing this specific issue.

From an ethical perspective, the precise nature of the problem should first be defined. Is it, firstly, the fact that people are travelling from abroad with the aim of dying in Switzerland that is found offensive? Is it, secondly, the fact that Switzerland is becoming a refuge for suicides? Or is it, thirdly, the fact that the distance travelled and time constraints make it difficult to carry out an adequate assessment of the reasons underlying the non-resident's desire for suicide, which would make it possible to decide responsibly, as a matter of individual conscience, whether or not to provide assistance with dying?

In its deliberations, the Commission clearly favoured the third account. The nationality or domicile of a suicidal person cannot be crucial factors, from an ethical viewpoint, in determining whether or not it is possible to make a responsible decision for or against assisted suicide in an individual case. Considerations of justice would make it scarcely acceptable to choose the simple option of specifying a nationality criterion. The second concern is more of a psychological and political nature than of ethical relevance. However, if the requirements concerning the quality of the assessment are less stringent for non-residents, purely for reasons relating to the distance travelled and the time of arrival, this gives an ethically relevant cause for concern.

On the basis of these considerations, the solution recommended by the Commission is not, therefore, the introduction of residence requirements or the specification of a nationality criterion for people considering suicide, but rather the assurance of a high quality of assessment. The measures recommended by the Commission to address so-called suicide tourism thus coincide with those that it advocates in general for the supervision and quality assurance of right-to-die organizations. Assurance of the quality of assessments preceding decisions on assisted suicide benefits everyone who seeks assistance with dying, irrespective of nationality and domicile. One possible incidental effect of the introduction of quality requirements would be to make assisted suicide for non-residents more time-consuming and probably less common.

IV. Recommendations of the NEK-CNE on the subject of assisted suicide

**Adopted at a meeting of the Commission
held on 27 April 2005**

1 – Twin poles

(unanimously adopted)

The ethical questions raised by the subject of assisted suicide are the product of a conflict between the requirement to provide care for people at risk for suicide, on the one hand, and to respect the autonomy of a person contemplating suicide on the other. Recommendations, guidelines and legal regulations need to take both of these poles, and the tensions between them, into account.

In society, there is a widely held conviction that people at risk for suicide should be helped to live and, in certain cases, should be protected from themselves. Considerable efforts are therefore undertaken to prevent suicide. For example, in order to prevent the desire for suicide arising from inadequate care, the provision of palliative care is to be expanded. Most people are emotionally affected by the suicide of a fellow human being: for the closest relatives, it can have traumatic consequences. After a suicide, many relatives feel guilty and powerless, as they were unable to save the victim. Guidelines and regulations are therefore intended to create and maintain conditions in which, if possible, the desire to commit suicide does not arise and in which the highest value is placed on other peoples' lives.

At the other pole lies respect for another person's autonomy, in particular respect for the wish to die with dignity. This respect reflects a liberal philosophy which has deep roots in Switzerland. It is sorely tested when another person performs acts that we may ourselves regret or believe to be wrong. It also precludes paternalistic intervention based on one's own moral views, as long as the person in question does not do anything that would endanger a third party. Most people probably believe that it is important to be able to determine their own fate in matters of sickness and death.

However, respect for the autonomy of a person determined to commit suicide does not in itself provide a reason to help him or her carry it out. For assisted suicide, an additional motive is required, going beyond mere respect for self-determination. This may be the desire not to abandon the person concerned, and to provide support. Leaving someone alone could involve the risk of that person committing suicide in a terrible way that would also cause suffering for others. This motive may represent an extreme case of providing care: care provided for a person in an extreme situation. Respect for self-determination thus also involves respecting the autonomy of those who support a person determined to commit suicide. All regulations and guidelines arise from the tensions between these two ethical concerns – providing care and respecting autonomy. If only one of these were taken into account, this would amount to a considerable shift in society's moral values.

However, the state's duty to provide care applies not only – in terms of individual ethics – to the individual who wishes to commit suicide, but also – in terms of social ethics – with respect to social developments and the consequences arising for other people: the practice of suicide and assisted suicide must not restrict other peoples' freedom of choice, for example by making people who are disabled or sick feel that they cannot be a burden on society and must opt for suicide or assisted suicide. The entitlement to dignity and autonomy and thus to freedom of choice and human rights applies unconditionally to all people, regardless of their characteristics and abilities.

2 - Assisted suicide and termination of life on request (unanimously adopted)

Assisting a suicide should be distinguished in ethical terms from terminating life on request.

Termination of life on request impinges on the conviction widely held in society that a person's death should not be deliberately brought about by others. In the case of assisted suicide, the person concerned brings about his or her own death. This distinction gives rise to discussions about the whole area of euthanasia, and in particular about direct active euthanasia. For this debate, further reflections are required which do not fall within the scope of this Opinion.

3 - Legality of assisted suicide

(unanimously adopted)

In the view of the NEK-CNE, it is right on ethical grounds that assisted suicide should not be considered a criminal offence unless it is performed for self-seeking reasons. The Commission recommends that no changes be made to the applicable Art. 115 of the Swiss Penal Code (StGB).

The principle that applies here is the liberal one to the effect that the decisions of the person wishing to commit suicide and also of the person lending support are to be respected, and that the state should not interfere. This does not apply to cases where self-seeking motives are involved.

Respect for the decisions of those involved in the suicide is not to be confused with moral evaluation of these decisions. Different views exist within society regarding the morality of suicide and assisted suicide.

However, by tolerating altruistic assisted suicide, the state acknowledges the plurality of moral views within society concerning suicide and assisted suicide.

4 – Decisions based on individual cases

(unanimously adopted)

Decisions on assisted suicide have to be based on the individual situation of the person contemplating suicide, rather than merely being derived from rules.

Criteria can never be more than necessary conditions, specifying when assisted suicide can legitimately be considered at all. However, such criteria are never sufficient to justify assisted suicide in a particular case.

The assistance in question is always assistance for a given individual. Therefore, decisions on assisted suicide always have to be based on the individual situation of the person concerned. This decision is more than merely a case of applying certain criteria and rules. It requires an in-depth knowledge of the person and the situation, the individual background to the desire for suicide, and the consistency of this wish. Furthermore, it requires prior discussion of possible alternative prospects, options, etc.

It would be disastrous if assisted suicide became a routine matter: people who met the criteria might even feel under pressure to justify themselves if they did not wish to avail themselves of this assistance. Carers might also feel under pressure to justify themselves if they were personally opposed to assisted suicide. People who are seriously ill often speak ambivalently and inconsistently about their own death. If assisted suicide became a normal part of care provision, this ambivalence could more readily turn into a wish to die.

Nevertheless – precisely in the interests of such assistance – it is essential to define certain necessary (but not sufficient) conditions and criteria, specifying when assisted suicide can legitimately be considered at all. This is the intention of the three conditions laid down for assisted suicide in the guidelines issued by the Swiss Academy of Medical Sciences (SAMS), and also of the conditions formulated here by the NEK-CNE.

5 – Right-to-die organizations

(unanimously adopted)

Article 115 StGB protects, de facto, the autonomy of people aiding suicide, by exempting them from punishment. This fundamentally liberal attitude should not be called into question. However, in view of the current practice of assisted suicide, additional regulations are required for right-to-die organizations.

Under the applicable law, assisted suicide is not punishable unless it is carried out for selfish reasons. No provisions exist concerning the protection of people at risk for suicide whose wish to die may possibly only be temporary and for whom other options may be available. The existence of right-to-die organizations, which seek to help people to commit suicide effectively and painlessly, creates a new situation for people at risk for suicide. In the case of these organizations, assisted suicide is not carried out by people close to the individual concerned, but offered in a general way to strangers. By their very nature, such organizations may tend to base their activities essentially on the second of the two poles – respect for the autonomy of those wishing to commit suicide – rather than on the first – counselling. There is thus a need for legal regulations, to ensure that sufficient consideration is also given to the first pole. In this respect, the self-prescribed rules of right-to-die organizations are insufficient, since breaches committed by the organizations themselves – which seem in fact to have occurred – are not subject to legal redress or sanctions. Therefore, the obligation to provide care for people at risk for suicide requires the introduction of new regulations making these organizations subject to state supervision.

6 – Mental disorders

(unanimously adopted)

In patients with mental disorders, suicidality is often a manifestation or symptom of their illness. Therefore, people contemplating suicide who are suffering from a mental disorder – alone or in combination with somatic disease – primarily require psychiatric or psychotherapeutic care. If the desire to commit suicide is a manifestation or symptom of a mental illness, assisted suicide should not be carried out.

Suicide research has consistently found that the risk of suicide is substantially increased by mental illness. Suicidal persons who are mentally ill should first and foremost receive help in the form of psychiatric treatment and psychosocial support. Suicidality may be a direct symptom of mental illness. People in a suicidal crisis are in need, first and foremost, of understanding and empathy. They need people who will listen to them and understand that there is no set explanation for suicidal acts. Although mental disorders are associated with a loss of quality of life, they do not mean the end of life. The prognosis of mental disorders is often indeterminate.

Assisted suicide should therefore generally be ruled out. A necessary, but not sufficient, condition for an exception to this rule is the presence of a desire for suicide which is not a manifestation or symptom of the mental disorder and may occur for instance during a symptom-free interval of a hitherto chronic illness. (“Manifestation” of an illness means that there is a direct connection between the suicidal tendencies and the mental disorder, as opposed to suffering occasioned by the patient’s personal situation, which may be partly determined by an illness.)

Since the function of psychiatric institutions is to treat mental disorders and their effects – such as suicidality – assisted suicide should not be carried out in such institutions.

7 – Children and adolescents

Majority view:

In children and adolescents, the legal and ethical rules generally applicable in health care are to be applied. Particular attention should be paid to the considerations expressed in Recommendation no. 4.

In general, a mentally competent minor freely exercises the highly personal right to accept or refuse health care. Mental competence is to be assessed individually. These principles are applicable in the event of a request for assisted suicide. For just as children suffering from an incurable terminal disease may refuse medical treatments, the possibility of a request for assisted suicide also being complied with in a terminal situation cannot be ruled out.

Seriously ill children and adolescents who might express the wish to be assisted in suicide may – depending on the circumstances – be suggestible and susceptible to the opinions of third parties. Often, their conception of themselves is still unstable. People accompanying such patients must be careful to ensure that they are in a position to assess their situation and prognosis fully and accurately.

Minority view:

Children and adolescents should not be assisted in suicide.

In the case of children and adolescents who make a request for assisted suicide, there is still hope that in later life they will lose the wish to die. Children and adolescents are particularly prone to be influenced by external circumstances and other people's opinions. As their conception of themselves is often still fragile, they may be severely perturbed by external stresses or inner conflicts. They are therefore especially at risk for impetuous suicidal acts. Priority must also be accorded to counselling in cases of incurable terminal illness in childhood.

8 – Hospitals and homes

(no dissenting votes)

The function of acute care hospitals and long-term care institutions is to preserve and restore health and quality of life, also at the end of life, and not to bring about death. In such institutions, therefore, suicide gives rise to considerable conflicts.

A – *Long-term care institutions:* If a resident desires assisted suicide and has no other home but the institution, he or she should if possible be allowed to carry out the act there.

A special case is that of a wholly private institution that only accepts residents who have been informed at the time of admission that assisted suicide is not permitted on the premises. However, the staff at long-term care institutions must never be forced to participate in an assisted suicide (right of conscientious objection).

B – *Acute care hospitals:* Every institution should clearly specify whether or not assisted suicide is to be permitted for patients. The institution should be able to explain its decision to patients.

If this practice is allowed, the institution should establish the necessary framework to enable the act to be carried out in the best possible conditions, without other patients being affected. But here, too, the right of conscientious objection is to be respected for all staff concerned.

C – As regards suicide in psychiatric institutions, see Recommendation no. 6.

A well thought-out personal decision to commit suicide should not be frustrated by an institution's regulations, or by the conscientious objection of an individual physician or an individual care team. The option of being referred to another physician or transferred to another institution should be available if desired.

9 – Health care professionals

(adopted unanimously)

For physicians and nursing staff, the medical profession's ethics give rise to a conflict, since medical support means fostering life and not helping to bring it to an end. Therefore, assisted suicide cannot be considered to form part of the duties of health care professionals. In cases where physicians nevertheless assist in suicide, this is a personal decision.

If assisted suicide formed part of medical duties, every physician would be obliged to perform it when requested by a mentally competent patient. The content of medical duties depends on the aims of medical activities. These aims consist of curing or alleviating disease and supporting patients. Even when physicians use their medical skills to assist in a suicide, they are not pursuing these aims and, therefore, not performing a medical duty. This distinction is crucial for an understanding of medical duties and, in the broadest sense, the medical mission.

Having made a decision for or against assisted suicide, as dictated by their conscience, health care professionals should not be subjected to moral disapproval or sanctions by their profession.

Health care professionals are to be appropriately trained to provide end-of-life care. This training should include discussion of the ethical issues and dilemmas posed by suicide and assisted suicide.

10 – Non-residents seeking assisted suicide

(no dissenting votes)

There are no ethical grounds for a general prohibition on people who are not resident in Switzerland seeking assisted suicide in this country. With this group, however, a particular ethical problem is raised by the need to ensure that adequate investigations are performed and the duty of care is observed. For non-residents, just as for Swiss people wishing to commit suicide, it should be ensured that the conditions specified in Recommendation no. 4 are met.

It can be assumed that the reasons why non-residents seek assisted suicide in Switzerland are no different from those that apply for Swiss people. Therefore, if one believes (on ethical grounds) that assisted suicide should be available to the latter, then denying it to the former group cannot be justified ethically, but only perhaps in terms of social policy.

The main ethical problem associated with assisted suicide for Swiss people as well as for non-residents is ensuring that adequate investigations are performed. This requires an in-depth knowledge of the person and the situation, the consistency of the wish for suicide, etc. For this purpose, a single, brief period of contact between the person's arrival in the country and the execution of the assisted suicide is generally not sufficient.

11 – Social trends and risks

(no dissenting votes)

In future, considerable attention should be paid to the prevention of suicide, especially in view of social trends that pose a risk of leading people in extreme situations to accept the organized provision of assisted suicide.

One such trend is the changing demographic structure of our society (age pyramid): as the proportion of elderly people increases, so does the proportion of those in need of care. A second trend is rising health care costs, particularly in the long-term care sector. The combination of these two trends may lead those concerned to feel under pressure from society and/or other family members. Feelings of guilt may arise as a result of placing a burden – financially and in terms of dependence on care – on other people (e.g. the family), which may in turn lead to a desire to commit suicide.

People in need of care are especially vulnerable to this risk. Their freedom and self-determination could be jeopardized by the subjective feeling of pressure, on the one hand, and by the availability of socially accepted assisted suicide on the other – even if the people in need of care meet the criteria of mental competence and the right-to-die organization does not act out of self-seeking motives.

Society has a special responsibility towards people who are in need of care and support. Care facilities and services, particularly in the long-term care sector, must be provided in such a way that the desire for suicide is not promoted. This responsibility for prevention also involves the provision of support for carers, to ensure that their activities do not entail self-sacrifice and are duly recognized by society.

12 - Requirement for legal regulations

Given the current legal situation, there is a need for new regulations to ensure that:

- a) before any decision to proceed with assisted suicide, adequate investigations are carried out for each individual case;**
- b) nobody can be obliged to assist a suicide;**
- c) assisted suicide is not carried out if suicidality is a manifestation or symptom of a mental disorder;**
- d) in the case of Recommendation no. 7, minority view: assisted suicide is not carried out in children and adolescents;**
- e) right-to-die organizations are subjected to state supervision.**

Precisely because a decision concerning assisted suicide has to be based on the individual situation of the person contemplating suicide, investigations need to be carried out with the greatest care. In the course of these investigations, not only is there a need to assess and ensure the individual's mental competence, the absence of social pressure, and the reason for, background to and consistency of the wish to commit suicide, but – in the interests of a concern for life – possible alternative prospects and options also need to be considered and explored with the individual concerned. This is only possible in the context of a non-superficial and longer-term relationship, and not on the basis of a single or brief period of contact with the person wishing to commit suicide.

Nobody can be entitled to receive assistance with suicide from a given person. Conversely, everybody has the right to refuse to assist a suicide, whoever they may be. Assisted suicide can only be carried out on the basis of a highly personal decision. This decision cannot be dictated by anybody – by institutions, by people close to the person wishing to commit suicide, or by this person him/herself. This conscience clause is particularly important for health care professionals and members of staff in health care institutions. Assisted suicide is not one of the services that a patient can claim to be entitled to receive by virtue of the carers' professional skills.