



Nationale Ethikkommission im Bereich Humanmedizin
Commission nationale d'éthique pour la médecine humaine
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Duty-of-care criteria for the management of assisted suicide

Opinion no. 13/2006

1. Introduction

Among the recommendations made to the legislative authorities by the NEK-CNE in its Opinion no. 9/2005 was that organizations which offer and render assistance with suicide in Switzerland under the protection of Art. 115 of the Penal Code (StGB) should be subjected to state supervision. Legal regulations should ensure that in the application of Art. 115 StGB consideration is given not only to respect for autonomy but also, in equal measure, to the provision of care for people who are at risk for suicide, in the sense of protecting their life.

Specifically, the Commission takes the view that a set of minimal duty-of-care criteria should be defined for the practice of organized assisted suicide. In Opinion no. 9/2005, however, the question of precisely what criteria should be specified in a supervisory regime was left open – apart from a number of general indications. With the present paper, the Commission is seeking to fill this gap. The recommendations presented here are also addressed to practitioners.

The requirements formulated below are not to be understood as criteria that, if met, can lead to recognition by the state or society of right-to-die organizations or of their practices in individual cases. Rather, the criteria are conceived as necessary minimal standards, which do not relieve the organizations of any responsibilities. In the view of the Commission, the extensive freedom granted by Swiss law through the applicable Art. 115 StGB to offer assisted suicide on an organized basis also entails a responsibility for society to protect the individuals concerned. The present recommendations arise from this concern to provide protection.

The recommendations make no claim to definitiveness. Rather, it should be possible for them to be discussed and if necessary revised in the light of practical experience.

These recommendations were discussed and formulated within the Commission following hearings involving representatives of three right-to-die organizations, medical jurisprudence, a cantonal medical department and a cantonal prosecutor's office. They also have their origins in the broad debate that preceded the publication of Opinion no. 9/2005, and which was reflected in the book entitled *Beihilfe zum Suizid in der Schweiz. Beiträge aus Ethik, Recht und Medizin* (edited by Rehmann-Sutter/Bondolfi/Fischer/Leuthold; Peter Lang, Bern, 2006).

The 12 recommendations included in Opinion no. 9/2005 "Assisted suicide" form an integral part of the present recommendations.

2. Aim and background

The **aim** of these recommendations is to outline the protection required by people wishing to die vis-à-vis organized assisted suicide services. This also applies to non-residents contemplating suicide.

The **background** is provided by the criminal-law regulations (Art. 115 StGB) that permit assistance in suicide as long as it is not prompted by "self-seeking motives". No more exacting legal requirements currently exist in Switzerland to ensure, for example, that assisted suicide is preceded by a sufficiently careful assessment, including consideration of other options.

From an ethical perspective, assisted suicide hovers between two “poles”: on the one hand, the requirement to provide care for people at risk for suicide and, on the other, respect for the autonomy of the person contemplating suicide. Both of these poles merit equal consideration. On ethical grounds, the Commission supports the freedom that exists in Switzerland to provide assistance in suicide. However, Recommendation 5 (in Opinion no. 9/2005) identified a need for additional regulations regarding the activities of right-to-die organizations. Although a number of key points were noted by the Commission as to the substance of these requirements, no list of criteria was elaborated. The Commission now wishes to fill this gap and at the same time to draw attention to risks of abuse.

The liberal legal situation makes it possible for right-to-die groups to organize themselves freely within the legal framework, to specify their own guidelines and to carry out their activities. There is, however, an essential difference between the provision of aid within a family relationship or friendship and organized services facilitating a certain and painless death. The availability of organized services changes the situation for people who wish to commit suicide. There is a risk that these organizations will focus one-sidedly on the principle of individual autonomy, paying insufficient attention to the protection of life and the requirement to provide care as a matter of responsibility towards people who are at risk for suicide.

Regarding the involvement of physicians in assisted suicides in the context of end-of-life care for patients, new guidelines were issued by the Swiss Academy of Medical Sciences (SAMS) in 2004¹. In its decision of 31 May 2006, the Federal Council declined to establish state supervision for right-to-die organizations. It did, however, acknowledge the potential for abuses, especially in the case of vulnerable groups such as the young, people with mental disorders, and the terminally ill². The authorities have a legal duty to detect and investigate abuses. These efforts can be supported by ethical guidelines which clarify aspects that are crucial in specific cases from the viewpoint of protecting life – the mental competence and capacity to act of the person contemplating suicide, the duty to assess the individual circumstances, and legal proxy relationships.

3. Definition of organized assisted suicide

In these recommendations, “organized assisted suicide” or “assisted suicide organization” is to be taken to refer to activities that involve offering or providing assistance with suicide for persons not previously known.

Such activities may be performed by associations or similarly organized entities, or by individuals (if they regularly provide assistance with suicide and/or make these services available to people they do not know). These recommendations are not, however, primarily concerned with assistance provided within a single, close personal or family relationship, or with a single and unique act of assistance performed within the framework of a comprehensive physician-patient relationship, nor with the act of suicide as such.

¹ Medical-ethical guidelines for the care of patients at the end of life, SAMS, 25 November 2004.

² Report of the Federal Department of Justice and Police: “Euthanasia and palliative care – Does the Confederation need to act?”, p. 3.

4. Recommendations concerning assessment of people contemplating suicide

For assisted suicide to be permissible from an ethical perspective, the following minimum requirements need to be reviewed, fulfilled and documented.

4.1 Mental capacity exists in relation to the decision to end one's own life with the aid of a third party.

Explanations:

Mental capacity can only be assessed in a series of personal discussions over a relatively extended period. The minimum period should be primarily based on the specific circumstances characterizing the situation of the person wishing to die (individual needs, the complexity of the problems giving rise to the desire for suicide, the course of the disease, etc.). It should not be determined by constraints on the part of those offering assistance (e.g. imposed by their availability or the distance from the place of residence of the person making the request).

Adults in possession of their mental faculties are generally best able to bear witness to and judge their own situation. They can tell whether their suffering is intolerable. It is important that the subjective view of the person desiring suicide should be decisive, rather than an evaluation according to extrinsic criteria.

As long as any doubts remain concerning mental capacity, assistance with suicide may not be provided.

4.2 The desire for suicide has arisen from severe, illness-related suffering.

Explanations:

From the perspective of protecting life, it would appear ethically questionable to provide organized assisted suicide for people who are not satisfied with their life, do not value their life on philosophical grounds, or have a negative attitude towards life. While autonomy is a value of central importance, it is not the only value for organized assisted suicide. The protection of life and social ethical considerations set a boundary in non-illness-related cases. In the absence of a demonstrable reason independent of a declaration of will, the caring aspect (in the sense of protecting life) must take precedence for the organization. Accordingly, requests are only to be considered from people suffering severely on account of illness³.

4.3 Assisted suicide is not to be provided in cases where suicidality is a manifestation or symptom of mental illness.

Explanations:

People with mental disorders often wish to take their own life as a result of suffering which is temporary or treatable. Appropriate psychiatric knowledge is required in order to assess whether mental illness is present. In case of doubt, an expert should be consulted.

³ "Illness" is to be understood in a broad sense; for example, it also includes suffering arising from an accident or severe disability.

4.4 The wish to die is enduring and consistent. It has not arisen impulsively or from a crisis of a temporary nature.

Explanations:

The circumstances giving rise to a wish to die may change over time. In addition, a wish to die can only be definitive if adequate reflection has taken place on the overall situation. This requires a sufficient period of time. However, it is not possible to specify an objective length of time that must elapse if a wish to die is to be regarded as "consistent". The period of time to be allowed should depend firstly on whether, in the view of the person carrying out the assessment, there is any prospect of a significant change in the patient's situation and thus of a weakening of the desire to die. The evaluation of the time required should also take into account whether it has been possible to reflect adequately on the overall situation.

4.5 The desire for suicide has arisen in the absence of external pressure.

Explanations:

External pressure can take various forms, e.g. pressure from relatives, social isolation, "being a burden" on relatives, or financial difficulties that may lead the person concerned to fear that adequate care and attention will not be available. Pressures such as these must not be the crucial factor in the wish to die.

It is important to bear in mind that pressures may also take the form of subjective fears without being objectively detectable; such factors may still play a role.

To assess whether a decision has been reached in the absence of external pressure, it is essential to have individual discussions, excluding relatives or third parties who might have exerted an influence. This rules out joint assessment of two or more people who wish to commit suicide together (e.g. double suicide involving a couple). In such cases, there is a high risk that the initiative does not proceed from the two partners equally and that the decision is not freely reached by one of the two.

4.6 All other options have been explored, considered and reviewed with the person requesting suicide, and exhausted in accordance with the individual's wishes.

Explanations:

The situation must be examined with a view to determining whether an improvement can be achieved in some other way. In deciding to what extent other options (e.g. medical treatment, social assistance, therapy) should be not only assessed but exhausted, consideration must be given to the wishes of the person desiring suicide.

4.7 Repeated personal contacts and intensive discussions are indispensable. An assessment cannot be made on the basis of a single meeting or correspondence.

Explanations:

Even with the most careful assessment, the judgement of mental capacity remains dependent on the investigator's subjective perceptions, values, experience of life and capacity for dialogue. High demands are thus placed on those who conduct assessments.

It is essential that the situation of a person desiring suicide should be ascertained and documented. This includes knowledge of the severe, illness-related suffering and information on the psychosocial context and biography, subject to the individual's right to respect for privacy. To this end, repeated personal meetings and discussions are indispensable. This will ensure that the consistency of the wish to die is reviewed and confirmed over an extended period. At the same time, the careful assessment should not be allowed to prolong the individual's suffering unnecessarily.

4.8 An independent second opinion reaches the same conclusion.

Explanations:

It is important that the situation should not be assessed by only one person, but reviewed in a second – independent – assessment. The second opinion should be provided by a person with the necessary expertise.

5. Comments on the prevention of abuse

In addition to its recommendations, the NEK-CNE wishes to draw attention to other areas which it considers to involve a special risk of abuse. In these particularly sensitive areas, there is a need to take preventive measures so as to limit abuses of non-punishable assisted suicide within the relevant organizations.

- It is not permissible to act for the sake of direct or indirect financial benefits.
- The motives for aiding suicide can be ethically problematic. The following are ethically unacceptable: exploitation of an individual's plight, gratification associated with death (thanatophilia), or ideological motives.
- Assisted suicide can be overtaxing for those involved, e.g. if it is performed too frequently or with inadequate debriefing.
- The risk of abuse can be increased by a lack of transparency in the organization and management (including accounts) of a right-to-die institution, or a lack of controls exercised by internal and external agents, or experts. The risk is particularly high in the case of a non-democratically organized association with a dominant leader, or a group with specific ideological sympathies.