

Accepted version

*'How is it possible that at times we can be physicians and at times assistants in suicide?'* Attitudes and experiences of palliative care physicians in respect of the current legal situation of suicide assistance in Switzerland

Martyna Tomczyk, Roberto Andorno, Ralf J. Jox

### Abstract

**Introduction:** Switzerland lacks specific legal regulation of assistance in suicide. The practice has, however, developed since the 1980s as a consequence of a liberal Swiss Criminal Code and is performed by private right-to-die organizations. Traditionally, assistance in suicide is considered contrary to the philosophy of palliative care. Yet, Swiss palliative care physicians regularly receive patient requests for suicide assistance. Their attitudes towards the legal regulations of this practice and their experience in this context remain unclear.

**Objectives:** Our study aimed to explore and describe the attitudes and experiences of Swiss palliative care physicians concerning the legal situation of suicide assistance.

**Methods:** In 2019, we performed an exploratory interview study with 12 Swiss palliative care physicians on palliative sedation as an alternative to assisted suicide. In this paper, we present the results that emerged from a thematic sub-analysis of the data.

**Results:** Participants stated that assistance in suicide and palliative care are based on opposing philosophies, but they admitted a shift in paradigm over the last years in the sense that one practice does not necessarily exclude the other. They reported various roles in suicide assistance and considered that the current activities of Swiss right-to-die organizations were problematic and needed to be regulated by law.

**Discussion and conclusion:** These results could enrich national and international reflection on suicide assistance in the context of palliative care by reducing confusion between the two practices and strengthening the confidence of patients and their relatives.

**Keywords:** palliative care, suicide assistance, physicians, Switzerland, qualitative study.

## INTRODUCTION

Over the past few decades, the legal and ethical issues around medical decisions taken to intentionally shorten the life of patients suffering from incurable and/or terminal diseases, either through euthanasia or physician-assisted suicide (PAS), have been discussed intensively in many countries around the world.

In Switzerland, the concepts of euthanasia and PAS are not explicitly recognized at the legal level. Homicide at the request of the victim (i.e., euthanasia) is considered a crime under the Criminal Code, although it is treated as a lesser offence than murder [1]. Contrary to what is generally believed, Switzerland does not have any specific law regulating PAS and the current situation has resulted from a liberal Criminal Code that was adopted in 1937. More specifically, article 115 of the Code is the only federal provision that directly relates to the practice of suicide assistance. Article 115, titled ‘Inciting and assisting suicide’, provides that ‘[a]ny person who for selfish motives incites or assists another to commit or attempt to commit suicide is, if that other person thereafter commits or attempts to commit suicide, liable to a custodial sentence not exceeding five years or to a monetary penalty’ [2]. Therefore, in the absence of any ‘selfish motives’, the assisting person is not criminally liable.

In 1937, the lawmakers did not have any intention of ‘legalizing’ assisted suicide as we know it today, but they had in mind the scenario of an individual who assists a desperate person wanting to end his or her life for sentimental reasons [20]. Taking advantage of this unintentional loophole in the Criminal Code, the first two non-profit organizations aiming to promote assisted suicide were created in 1982, but independently of each other: *EXIT Deutsche Schweiz*, for the German-speaking part of Switzerland, with headquarters in Zurich, and *EXIT ADMD Suisse Romande*, for the French-speaking part of the country and headquartered in Geneva. Given their non-profit nature, such organizations do not, in principle, have selfish motivations and, therefore, their activities are not considered illegal [3].

One of a few particularities of the model of suicide assistance in Switzerland, when compared with that of other countries authorizing this practice, is that it is not performed by physicians, but by persons working for private right-to-die organizations. This is why the practice cannot be labelled PAS, the term by which it is generally known in other countries [4, 5]. In Switzerland, the role of physicians is limited to prescribing a lethal dose of the drug sodium-pentobarbital and assessing the individual’s decisional capacity; they do not need to be present during the procedure. Anyone can be an “end-of-life attendant” for a right-to-die organization – laypersons but also physicians [5-9]. However, in those circumstances, a physician would act as ‘private citizen’, not as ‘physician’.

On the regional level, three cantons (i.e. regions or states) of Switzerland have legal provisions with regard to assisted suicide. In 2012, the Canton of Vaud, with the capital of Lausanne, was the first to introduce a new provision to its Law on Public Health stipulating that public health care institutions cannot refuse suicide assistance in their premises, if they are requested by competent patients suffering from serious and irreversible diseases or conditions (Article 27, d). Geneva and Neuchâtel have followed with similar laws since.

Traditionally, assistance in suicide has been regarded as contrary to the philosophy of palliative care. According to the definition by the World Health Organization, palliative care affirms life and regards dying as a normal process, intending neither to hasten nor postpone death [10]. Consequently, the European Association for Palliative Care (EAPC) states that the provision of assisted dying, such as PAS, ‘should not be included into the practice of palliative care’ [11]. The International Association for Hospice and Palliative Care (IAHPC) supports the EAPC, adding that ‘in countries where euthanasia and/or PAS are legal, IAHPC agrees that palliative care units should not be responsible for overseeing or administering these practices’ [12]. The American Medical Association also considers that ‘physician-assisted suicide is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks’ [13]. Similarly, the World Medical Association notes that ‘physician assisted suicide [...] is unethical and must be condemned by the medical profession’ [14].

Some studies and our personal experience indicate that Swiss palliative care physicians regularly receive assisted suicide requests from their patients [15-17]. Although guidelines have been developed by the Swiss Academy of Medical Sciences (SAMS) [18], they are rather general, and it is not known which concrete steps physicians should take and which they should absolutely not perform in this situation. Lacking clear guidance on this issue, palliative care physicians manage each patient’s request in line with their own professional and personal values. They may, however, prefer clear legal regulation in order to know precisely what actions are required when a patient requests assistance with suicide [16]. Nevertheless, little is known in what way Swiss palliative care physicians want the current law to change. Moreover, it is not known whether palliative care physicians already act as volunteers for private right-to-die organizations or provide assistance in suicide in other roles.

As a complement to the paper by Gamondi et al. mentioned above [16], the objective of our study was to explore and describe the attitudes and experiences of palliative care physicians with regard to the current legal situation on assistance in suicide in Switzerland. The term ‘attitudes’ was used in a general sense, in accordance with the definition by Cambridge Dictionary, as a “[feeling](#) or [opinion](#) about something or a way of [behaving](#) that is [caused](#) by this [ ]”.

**Kommentiert [RJ1]:** Please include a reference here!

## METHODS

### Study design

An exploratory multicentre qualitative study based on face-to-face interviews with physicians working (or who have worked) in palliative care units in the French-speaking part of Switzerland was conducted between February and November 2019. The overall study focused [on continuous deep sedation until death as an alternative to assisted suicide in Switzerland \(a detailed methodology and initial results have been published elsewhere \[17\]\)](#). In this paper, we present a sub-analysis of the data. In this section, we present a brief summary of the methods. All methodological detail are reported according to the COREQ checklist (COnsolidated criteria for REporting Qualitative research) [19], in Supplementary File 1 and in our paper related to the main study [17]

**Kommentiert [RA2]:** Pourquoi le rouge?

### Inclusion criteria

We included physicians who were currently working or had previously worked in a specialized palliative care unit in the French-speaking part of Switzerland. No restrictions regarding gender, age, experience, diploma, current role, and position in palliative care, or native language were set. Physicians were recruited via the heads of palliative care units.

## Data collection

Data was collected by MT, who had no prior relation to the participants; in all cases, the research was the first contact. Physicians were interviewed face to face at their workplace. At the beginning of each interview, the researcher explained that the study aimed to explore experiences on a palliative care unit in general and not necessarily related to the current workplace. An interview guide based on a preliminary literature review and containing very general themes was piloted and then used. Questions were also initiated by the interviewee's answers. All interviews were conducted in French and audio-recorded. Interview recordings were manually transcribed, and the audio-recording was deleted afterwards.

**Kommentiert [RJ3]:** Can you just add a few words where/how it was piloted, e.g. "piloted among a few palliative care physicians, modified accordingly, and used for the interview study." - ?

## Data analysis

To explore our material in depth, a thematic analysis with continuous theming (not using a framework) was performed<sup>1</sup>. Thus, themes were not identified in advance and were inductively derived from the data. The data was analyzed by MT in two steps: vertical (interview by interview) and transversal (all interviews) analyses. Variations in theme by age, gender, experience, and qualifications were not examined. The whole analysis was carried out on the original versions in French and only the results and quotations were translated into English. The quotations illustrate majority and minority experiences. To reinforce the anonymity of the participants, the number assigned to each interview during the analysis is not indicated here. RA and RJJ contributed to the process of interpretation for this paper.

**Kommentiert [RJ4]:** Change footnote into reference in literature list.

---

<sup>1</sup> Braun V, Clarke V. (2019) Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health* 2019;11(4):589-597, DOI: [10.1080/2159676X.2019.1628806](https://doi.org/10.1080/2159676X.2019.1628806)

## RESULTS

### Sample size and characteristics

Nine palliative care units in the French-speaking part of Switzerland were contacted, all of which replied. Six agreed to participate in the study, and four were eventually included. These were geographically dispersed across French-speaking Switzerland, in both urban and rural areas. Twelve physicians from the four palliative care units were interviewed, but only 10 interviews were transcribed and included in the analysis. Two interviews were excluded from the study: one of them was a bit too short ( $\approx 3$  min.) and the other was not well recorded (inaudible recording). The characteristics of the participants are presented in Table 1 (see below). The included interviews lasted between 13 and 46 minutes.

**Kommentiert [RJ5]:** This sounds indeed strange. Was ist stopped by the interviewee or did the interviewee have other obligations and had to stop it? Maybe specify?

Table 1: Characteristics of the participants	
Number of participants	n = 10
Gender	Female: n = 5 Male: n = 5
Age	Median age: 49 years (range 38-61)
Principal medical speciality <small>(Palliative care is not a specialty in Switzerland but only a subspecialty)</small>	Internal medicine: n = 8 Anaesthesiology: n = 1 Without a medical speciality: n = 1
Training in palliative care <small>(e.g., subspecialization in palliative medicine, Certificate of Advanced Studies (CAS), Diploma of Advanced Studies (DAS), and Master.</small>	Yes: n = 7 No: n = 3
Experience in palliative care <small>(until 2019)</small>	More than 10 years: n = 7 Less than 10 years: n = 3
Current workplace	Palliative care unit: n = 7 Other (mobile palliative care team, ambulatory consultations): n = 3*  <small>* Various configurations, depending on the percentage of the work</small>

**Kommentiert [RJ6]:** These complements in small font are usually added to the legend of a table, not put directly in the table.

### Findings

Three main themes emerged from the data: 1) General reflections about palliative care and assistance in suicide; 2) The role of palliative care physicians regarding assistance in suicide; and 3) The Swiss legal situation of assistance in suicide.

#### 1) Palliative care and assistance in suicide: change of paradigm

The quotations pertaining to this section (1-12) can be seen in Table 2 (see below).

All participants stated that palliative care and assisted suicide, such as offered by Swiss right-to-die organizations, are two diametrically opposite approaches. They considered that the purpose of palliative care consists, as its name indicates, in caring for individuals with serious health-related suffering, but without causing death. This is why they regarded palliative care as contrary to the activities of right-to-die organizations, which aim to cause death. According to the participants, these two approaches are based on different philosophies (*see quotation 1*).

However, most of the study participants pointed out that they were currently observing a change of paradigm in Switzerland. In the past, palliative care physicians and right-to-die organizations were in very strong opposition and mutually exclusive. Now, although right-to-die organizations continue to base their work on a philosophy contrary to that of palliative care and not as integral part of medical practice, some study participants considered it a potential complementary approach to palliative care (*see quotations 2 and 3*).

The participants explain this shift in paradigm by a change in the attitudes of physicians who have realized that palliative care, even of the best quality, has its limits and that it is not always possible to relieve all human distress to a sufficient degree (*see quotations 4-6*). One participant pointed out that because of the progress in medicine, some lives are full of suffering, and this would no longer make sense (*see quotation 7*).

The physicians' attitude has had a positive impact on the patient-physician relationship: participants felt that decisions were now clearer and more honest, in the patient's



best interests, and in accordance with the patient's values. At present, when a patient requests assistance in suicide, the palliative care physician respects this decision and does not judge or try to change it (see quotations 8 and 9). Some of the physicians pointed to the freedom of choice and stated explicitly that they were happy that the possibility of assisted suicide existed in Switzerland (see quotations 10 and 11). Finally, some physicians stated that this change in paradigm has permitted a reduction of tension in healthcare teams (see quotation 12).

Table 2. Palliative care and assistance in suicide: change of paradigm. Quotations 1-12.	
1	Here [in this palliative care unit], we aim to 'be together in suffering and [to] support'. One of the messages is: 'Life is worth living'. A human being has the right to his/her dignity, which has an unalterable value and is inalienable and not modified by disease. In contrast, the organizations for suicide assistance would like to tell us: 'There is no more meaning to living like that, so you have to put an end to it, you have to stop it. Life becomes absurd'. [In this palliative care unit], we think that life retains its value until the end. Thus, we always favour a natural end of life, an end of life that occurs spontaneously.
2	[At present], we have better interactions with the EXIT organizations. They think highly of our work in this palliative care unit. They visit our patients, and they say: 'I hope that the patient is not going to do it'. [...] But, in the beginning, it was different: we were in a religious war. We insulted each other, from a distance, even face to face. Now, we are accepting, tolerant, even if we do not do the same job.
3	At the beginning of my work in palliative care, I felt that society or my colleagues or people in general contrasted palliative care with EXIT. It was a real battle. There was one who was right and the other who was wrong. Sometimes, it created crises in the team, because of these oppositions. Later, when I worked with patients every day, I understood that sometimes palliative care does not have the answers to everything. [...] Now, we are working in complementarity.
4	Palliative care aims to try to relieve human suffering. If this suffering leads to the desire for death, if we manage to identify this suffering, if we manage to help the patient's suffering, later... this patient doesn't want to die... This is a success. [...] The goal of palliative care is to relieve suffering and not to fight the desire for death. [...] We regularly see situations, and these are special, from my point of view, situations of existential or spiritual distress, even psychological sometimes, where we are extremely ineffective, despite an entire interdisciplinary team, all these beautiful things, etc. This is where the desire to die often persists. It is still extremely rare (this is my personal experience) that this is linked to a physical problem. The desire to die because of a physical problem does not persist after palliative care. When it comes to physical problems, we are quite efficient (again, not 100%, we should not be too proud either but, in general, we are efficient).
5	Despite our efforts, treatments, sedation, midazolam, some cases are particular and exceedingly complicated... Or we cannot meet a patient's expectations... or we don't manage to relieve suffering, despite everything. It happens, and it is not a failure.
6	It's very personal. [...] fundamentally, I am not very comfortable with assisted suicide. I am not comfortable [...] I am not for it and... I struggle to be totally against it. I have experienced and seen situations where... I must admit that assisted suicide was the least bad solution. [...] It would be unfortunate if that [assisted suicide] were not possible.

7	I think that assisted suicide is acceptable, because the concept of life at all costs is a concept that comes from the Middle Ages, from the Church of the Middle Ages, from the time where 50% of children would die before age five and life expectancy was 45 to 50 years. So, in this context, with a very high mortality, life at all costs has a meaning (life – a sacred gift, it must be protected and made so that it is as long as possible). Now, we have created so many tools to assist and support nature and life that we have created life with very little meaning and very little value. [...] I think that currently life is allowed to evolve in states of life that can be considered worse than the state of death.
8	[...] if the patient wants to die by assisted suicide, this is his choice. We will respect it. We will not try to dissuade him; we will welcome this choice.
9	When we stopped opposing palliative care to EXIT[...], we also stopped (perhaps in an unconscious way) absolutely wanting to change the patient's opinion, by saying 'But all the same, you are not going to bring in EXIT, you are in palliative care. We can offer you something else'. [...] We put the cards on the table, and we say: 'There are many options in life. Our option is to offer this to you. But it can be understood that this does not suit you. But if that does not suit you and you choose assisted suicide, we will help you as far as we can, make sure that you go home as comfortably as possible and that it is anticipated, we will try to discuss it with your relatives, but the choice is yours'. We don't try to make them feel guilty. I remember a few patients who were almost ashamed or afraid to tell us that palliative care was fine for a while and finally they made their decision. So, I have stopped opposing [palliative care and assisted suicide] and I try to work in collaboration with EXIT when there are cases that go through to the end.
10	[...] contrary to the countries where it [assisted suicide] doesn't exist, here you can say, 'That is enough, my life. It's horrible', and you no longer want to live some experiences again or the like. It is good that this freedom exists and that it is accompanied, and that the person does not go into the forest to shoot themselves, jump under a train, etc. That, I think, is really horrible. Here, I am relieved. [...] Here, when life no longer makes sense for the person, we are not in 'Life at all costs'.
11	[...] I think that it is necessary to leave a field of freedom... The prohibitions, apart from the basic prohibitions that allow us to live together (for example, homicide, rape, all of those things). Otherwise, there is a ban that restricts a plurality of opinions, so that others think like me because I think it's just...that is not fine and that doesn't help much.
12	I think it also reduced the tensions in the healthcare team. We can say: 'We are all together as a team, with the patient we try to make sure as much as possible that everything has been done for comfort... but if the decision is made, we are not going to judge it'.

## 2) Role of palliative care physicians regarding assistance in suicide: heterogeneity

The quotations presented in this section (13-20) are shown in Table 3 (see below). Most participants maintained that palliative care physicians should never proactively suggest assisted suicide to patients (*see quotation 13*). In contrast, when a patient requests suicide assistance, the palliative care physician is involved and has a specific role. During the interviews, participants insisted on explaining the activities they perform in this context. The procedure they mentioned most frequently was establishing a medical certificate that confirms the required eligibility criteria (e.g., regarding decisional capacity and the free, unambiguous and well-reflected nature of the patient's decision) (*see quotation 14*).

Other elements mentioned by the participants were more heterogeneous. For instance, one participant reported two supplementary activities followed in the palliative care unit in which he was currently working. First, when a patient is discharged home for assisted suicide, his or her hospital bed remains available until the family or the right-to-die organization confirms that the patient has died. This gives patients the opportunity to change their mind right up until the last minute. Second, families are invited to return to the unit after the patient's death, in order to ask physicians any questions they might have (*see quotation 15*).

Approximately one third of the participants also insisted on commenting upon the steps they do *not* take in this context. In general, the participants refrain from creating barriers to assisted suicide, but they do not facilitate the procedures either (*see quotations 16 and 17*). For example, they do not themselves establish the first contact with a right-to-die organization on behalf of a patient. Some participants reported giving patients the telephone number of a right-to-die organization, but not calling on their behalf. In addition, some participants reported that they will not go to the patient's home to assist in suicide there and will not remain at the patient's bedside during an assisted suicide until death (*see quotation 18*).

Finally, one physician reported that some of their colleagues – palliative care physicians – have even become EXIT volunteers, which he/she considered highly inappropriate, however (*see quotation 19*). Another participant – the head of a palliative care unit – even reported prohibiting physicians working in his/her unit from volunteering with EXIT and assisting in suicide (*see quotation 20*).

**Table 3. Role of palliative care physicians regarding assistance in suicide: heterogeneity. Quotations 13-20.**

13	As a physician, I will not suggest it [assistance in suicide]. Never! This choice is up to the patient. I do not consider it an act of care and nobody here [in this palliative care unit] considers it an act of care. So, it will never be offered as a therapeutic approach, because a therapeutic approach is part of life and not of causing death.
14	[...] my duty is to make sure that the patients have the decisional capacity, that it is a clear and considered decision, and that there is no one who pushed to do that. When I have reasonably, in good conscience, ensured that, I put my cards on the table, I say: 'It is your choice. I will not judge it [...]'.
15	[...] we offer the possibility of keeping the patient's bed open until we hear from the family or relatives or from EXIT that the patient has died. This gives the patient the opportunity to change his decision until the last moment. We also offer to families the opportunity to come back, to ask questions, either the same day or a few days later, as needed.
16	[...] formally, I think that if the patient wishes to die by assisted suicide, it is his choice, we will respect him. We will not try to dissuade him, we will welcome this choice. On the other hand, we are not going to do anything to facilitate if there are steps to be taken, it is he who will do it. We are not going to stop it.
17	If the patient wants to do assisted suicide, we are not going to object, but we are not going to help either. He organizes it or his relatives do it. We take him home and he can do it there, not inside the hospital.
18	[...] I do not go to their home. Some patients ask me to go but I say: 'No, my palliative care work stops there. I will not accompany you until death. I will not telephone for you. If you want the phone number, that's OK, I can do it, but I will not do all this work for you'.
19	[...] for me, as a physician ... it is very disturbing to see palliative care physicians (or working in another medical speciality) being EXIT volunteers. [...] Finally, in hospitals, as we go along, we hear: 'She is an EXIT volunteer. She is going to see this patient'. OK... This is always disturbing for me. When you are a retired or non-active physician, and an EXIT volunteer, that is OK. But when you are an active physician and an EXIT volunteer... (doing both at the same time) ..., that is very problematic for me. [...] In their work as a physician, it is not clear where their volunteering begins and where it ends. That is complicated.
20	Here [the canton of X], the law provides a good framework for suicide assistance in hospitals; a physician cannot practise or be involved in it. This is good because this shows that it is not an act of care. So, that is not confusing for physicians. In this palliative care unit, we have even prohibited physicians from assisting (because we could assist, not as a physician, but as a civil person). We said: 'How is it possible that at times we can be physicians and at times assistants in suicide?' I think that it is difficult to be both of them. We need to protect physicians.

### 3) Swiss legal situation of assistance in suicide

The quotations relating to this section (21-37) are presented in Table 4 (see below). Most participants accepted assistance in suicide and saw the current Swiss federal law as sufficient. In any case, it would not need to be fundamentally changed in the sense of prohibiting this assistance (*see quotations 21-23*). However, one participant explicitly pointed to a lack of legal transparency with regard to where assisted suicide may be performed (e.g., the patient's home, palliative care unit, other) (*see quotation 24*).

In contrast, all participants maintained that the activities of right-to-die organizations would have to be regulated. They regarded the activity of these organizations as not being sufficiently controlled, or even as uncontrolled (*see quotations 25 and 26*). One participant specified that it is currently only the police who checks patients' documents after death by assisted suicide (*see quotation 27*). Another participant suggested that the law permitting assistance in suicide was not fully respected; in particular, the prohibition on acting out of selfish motives (*see quotation 28*).

Participants explicitly reported several instances of a lack of transparency by right-to-die organizations with regard to the following: information of professional caregivers (*see quotation 29*), indications (*see quotations 30 and 31*), the period of reflection (*see quotation 32*), statistics (*see quotations 33 and 34*), financial aspects (*see quotation 28*), and the language used (*see quotation 35*).

Two of the participants also pointed to the lack of legal regulation regarding the advertisement of suicide assistance. Presenting assisted suicide as a trivial act could have a significant and negative influence on patients, who would not always realize that what is being referred to is suicide (*see quotations 36 and 37*).

<b>Table 4. Swiss legal situation of assistance in suicide. Quotations 21-37.</b>	
21	I have an extremely simple and rural opinion on this topic: Swiss law suits me very well. Article 114 [this is an error on the part of the participant; it is actually article 115] of the Penal Code suits me very well. [...] I don't see the need to make a new and specific law.
22	I wouldn't want the law to be changed. I think it's hard to express it... My personal reflection is that the legal vacuum or the law is not problematic.
23	[...] Is it necessary to legislate more or less? OK... hm... I think that's enough for me. Honestly, as it is today, that's enough for me.
24	I think one of the problems is when someone asks (or even requires) that EXIT be done here [in this palliative care unit]. One of the contentious points is to demand precisely that the patient leave the institution, if he says: 'I do not want to go back' or 'I cannot go home'. The law is not very clear as to who is entitled to decide in this context.
25	What does not suit me is the lack of legal framework for the organizations that practises this [right-to-die organizations]. That troubles me [...] Currently, they only have the constraints related to associations, so exactly the same as a football club or a singing choir in a village. [...] the law should better regulate these organizations by imposing a minimum framework[...]. I think that is necessary, but it is another legislative level.

26	It is the EXIT organizations which practise assisted suicide that pose a problem, because they have different practices, they do not have visibility everywhere, they do not have the same communication culture that we [palliative care physicians] do and they are not controlled. It is a private association.
27	At present, there is only one control. Once the patient is dead, they call the police. They do not hide that it is an assisted suicide from the police, they say 'It is an assisted suicide'. 'Here, you have the advance directives signed by the person. Here, you have the letter from the person'. That is why they make the person sign a lot of papers. There is also a letter from the doctor attesting that the person had full capacity to kill himself, that he had an incurable disease. [...] It is a bit light.
28	[...] I recently heard on the radio that EXIT is the recipient of 20 million Swiss francs, so I don't know whether the motives are really devoid of selfishness. We may also wonder what the psychological motivations of the people in EXIT are, the volunteers who engage in such a process. That... I do not know [...] What happens to the fees? Maybe it is something to ask?
29	I have experienced several situations in which EXIT volunteers ask the patients not to tell, to hide the project from their doctor. I think that this is not beneficial for the person who is in distress and who wants to commit suicide, and that leaves some doubt as to their [the EXIT volunteers'] motives. This is problematic for me. [...] For example, they say to the patient: 'Don't tell your doctor that you are going to do it, or the EXIT physicians ask the nurses to put in an infusion for hydration, while they will use it to inject the product. Why do they do this? Obviously, this allows us to think that there are things to hide, it must give them something. I don't understand why it is not completely transparent.
30	[...] people who assist in suicide... In fact, they judge indications for assisted suicide and perform it. Sometimes, they intervene in psychological situations... I think that it is a serious drift because suicidal urges are a symptom of depression... But it may be temporary, lasting a few months ... And they suppress life when the problem is maybe reversible.
31	[... in the palliative care unit], we had a patient [... who] had been a member of EXIT for about 10 years, and then he was in a terminal oncological situation. Yet, his autonomy capacity was good. This patient returned home. He went home to call EXIT. Despite the absence of clear symptoms of discomfort, psychologically, he was afraid of death in a state of disability (which he did not have). So, there was a prevention approach for him. It was really a preventive aspect of appealing to suicide so as not to see yourself [...], getting worse, and see yourself losing your autonomy [...] It was really suicide in a situation where we thought that the patient could still benefit from those around him.
32	[...] monitor how much time elapsed between the request and the assisted suicide. These are things that we do not know. [...] I do not know if patients can arrive and hear: 'Hello, tomorrow we are available. We are going'. I'm going to put that a bit in parallel with aesthetic surgery. The aesthetic surgeon is supposed to see the patient again, there is a minimum delay. For assisted suicide, there is nothing in the law.
33	I don't know whether they are required to report: How many assisted suicides did they have? What were the situations?
34	I think that there should be minimum legal requirements to do this, especially in terms of providing statistics [...] Usually, they do, but we are not very sure of them because when we compare [them] to official statistics, there are differences... It is problematic for me.
35	I think you have looked a bit at the vocabulary they [EXIT] use: 'potion', 'departure'. And that, I think that is [...] dangerous, this kind of softening death and making it more pleasant. It's also... I think it is necessary to stop the hypocrisies and to give people the freedom of position on it. If they do offer death, they must say that they offer death, not 'we offer you a trip'. This is not an airline company!
36	[...] the law says not only that assisted suicide is not criminal, but the fact of promoting [it] is not criminal under these conditions. It is true; there is a lot of promotion going on...
37	[...] we hear a lot of publicity around, in the media, generalities, but also generalizations of assisted suicide which becomes a little... In fact, there is a trivialization of the act. Consequently, the patients (that's what worries me a little) often forget that EXIT is suicide. And they don't see it as suicide. Rather, they see it as a way to end their suffering but forget the word 'suicide'. When we tell them, 'Are you going to commit suicide?', that shocks them [...] Sometimes, they forget that EXIT is ultimately suicide, even people who are religious (and therefore normally suicide would not be taken into consideration). I think it comes from media trivialization.

Kommentiert [RJ7]: Owner??

## DISCUSSION

Our exploratory study on attitudes and experiences of palliative care physicians from the French-speaking part of Switzerland with regard to the current legal situation of assisting suicide in this country is the first on this topic.

The main finding of this qualitative study leads us to the hypothesis that we are currently witnessing an emerging paradigm shift in the relation between palliative care and assistance in suicide in Switzerland. From the beginning of modern palliative care in the late 1960s [21], which has developed enormously since then across the world [22, 23], this holistic approach was strongly opposed to assistance in dying [24]. In Switzerland, the interest in palliative care has grown steadily among healthcare professionals since the 1980s, when the first palliative care unit opened [25]. It is interesting to note that the first Swiss right-to-die organizations were founded in the same time period as palliative care emerged in this country, probably explaining their initial identities as mutually exclusive alternatives or even competitors. It remains to be investigated by historians which of these developments causally promoted or impeded the other one. It may well be plausible that both were independent responses to the increasingly biological and technical medicine since the 1950s that focused on acute rescue of life and organ functions, this being more and more perceived as depersonalizing.

The paradigm shift in the relation between palliative care and suicide assistance as practiced by right-to-die associations is also confirmed by a recent survey among more than

**Kommentiert [RJ8]:** Maybe you could reference here: <https://www.amazon.com/Being-Mortal-Medicine-What-Matters-ebook/dp/B001CW0BCY>  
Or this: <https://link.springer.com/book/10.1007/978-3-319-54178-5>

**Kommentiert [H9]:** Ralf, pourrais-tu développer un peu ce fragment ? Je suis à court d'idée ☹️ Si tu pouvais ajouter 1-2 références, ce serait vraiment super.

**Kommentiert [RA10]:** Maybe "organ transplantation" is better.

5000 health care professionals in two large Swiss teaching hospitals and by the fact that the Swiss Palliative Care Society has just launched, for the first time, the development of a guideline on how to deal with wishes for suicide assistance. As our results indicate, the reasons for this paradigm shift probably lie in both palliative care and right-to-die associations opening up to each other in a context of increasing societal acceptance and normalization of assisted suicide in Switzerland as well as in Western Europe in general.

Our study shows that palliative care physicians are still unsure about their role in the event of a patient's request for assistance in suicide. While they conduct some activities that legally count as assistance in suicide (e.g., establishing medical certificates confirming the eligibility criteria), they are reluctant to engage in others (e.g., contacting EXIT). This result is fully in line with those in the study conducted by Gamondi et al. [16] that outlined the ambiguous role of the Swiss palliative care physician in the event of a patient's request for assistance in suicide.

The slow paradigm shift is also visible with regard to the attitude of the medical profession with regard to assisted suicide. In 2004, the Central Ethics Commission of the SAMS still expressed serious reservations about the direct involvement of physicians in the practice of assisted suicide, claiming that 'the task of doctors is to alleviate symptoms and to support the patient [and not] to directly offer assistance in suicide' [26]. However, physicians may provide assistance in suicide if they would be able to reconcile this with their personal conscience. Since 2006 this guideline has been part of the Professional Code of the Swiss Medical Association (FMH) obligatory for all physicians [27]. In 2018, the SAMS adopted a new guideline that provided more details about the stance towards assisted suicide [28, 29] and adopted a more liberal approach, which is why it was initially not incorporated into the Professional Code [30]. After years of negotiations, the SAMS and the FMH have agreed on an amended guideline, incorporated into the professional code [35]. It now explicitly states

**Kommentiert [RJ11]:** <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0274597>

**Kommentiert [RJ12]:** Maybe not necessary to reference this website: <https://www.palliative.ch/de/was-wir-tun/arbeitsgruppen/bigorio-best-practice>

**Kommentiert [RJ13]:** Referece <https://pubmed.ncbi.nlm.nih.gov/26927307/>

**Kommentiert [RJ14]:** Reference: <https://pubmed.ncbi.nlm.nih.gov/23558505/>



that suicide assistance *is not a medical act* to which patients could claim to be entitled, but that physicians are *free* to decide whether or not to consider this option, provided they respect certain due process criteria specified in the guideline [35].

Two of the participants in our study also mentioned physicians who work in palliative care while also volunteering for a right-to-die organization, and considered this double role inappropriate. From a legal point of view, this is not prohibited as long as his/her volunteering activity is driven by non-selfish motives. From an ethical perspective, this double role may create conflicts of interest and give rise to confusion about the aim of the palliative care profession, not only among patients and their relatives, but also for the health care professionals themselves. The large majority of patients who do not want to hasten their death may feel societal pressure or lose trust in palliative **care**. On the other hand, a well-integrated practice that offers palliative care and suicide assistance as complementary options that may also be used in conjunction would be more in line with patient autonomy and societal **pluralism**. This aspect should be more deeply studied both from an empirical and normative angle. In particular, it would be interesting to perform an interview study with Swiss palliative care physicians who have become volunteers of right-to-die societies in order to explore and describe their normative and practical framework, as well as the personal and moral values that led them to become volunteers in suicide assistance.

Interestingly, the lack of a clearly defined, detailed legal framework for responding to a patient's request for assistance in suicide does not generally seem to be a problem for the physicians participating in our study. On the contrary, most of them explicitly stated that the legal liberty suits them and that they have no desire to change this legal situation in any fundamental way. However, all participants felt that the activities of right-to-die organizations still needed to be legally regulated. One of the reasons for this, although only mentioned by one participant, seems particularly important. Assistance in suicide is not free of charge in

**Kommentiert [RJ15]:** Reference  
<https://pubmed.ncbi.nlm.nih.gov/33522860/>

**Kommentiert [RJ16]:** Reference  
<https://pubmed.ncbi.nlm.nih.gov/33945324/>

Switzerland and private right-to-die organizations are not sufficiently transparent concerning the financial aspects of the practice [36]. As already mentioned, article 115 of the Swiss Criminal Code [2] explicitly states that assisting suicide is a crime if (and only if) it is driven by selfish motivations. The absence of financial transparency in the private organizations would put into doubt the non-selfish nature of their assistance in suicide and, consequently, the legality of this practice.

During the past decade, Swiss authorities, politicians and citizens have tried to develop specific legal rules relating to assistance in suicide, but every such initiative generated considerable controversy and was eventually unsuccessful. For instance, in September 2010, the government considered amending article 115 of the Swiss Criminal Code, but, after reflection, finally concluded that the current legal situation is satisfactory and specific rules on suicide assistance, including the legitimization of right-to-die organizations, would not improve the practice and could cause supplementary problems. Consequently, no specific legal regulation on suicide assistance has been adopted. In contrast, some measures to prevent suicide and to promote palliative care have been adopted [7].

#### Methodological limitations

When interpreting our study, two main methodological limitations should be taken into account.

First, as previously mentioned, our principal study was focused on continuous deep sedation until death as an alternative to assisted suicide in Switzerland [17] and the present study emerged from a secondary analysis of the data. For the main study [17], the progressive inclusion of participants (i.e., inclusion until data saturation was reached) was performed. Data saturation was defined as the point at which no new themes emerged from the analysis of the interviews. The Comparative Method for Themes Saturation (CoMeTS) was used in order to

Kommentiert [RA17]: Pourquoi cache sous le rouge?

achieve rigorous data saturation. Moreover, data saturation was in line with theoretical saturation. For the present study, data saturation was not sought because this was the sub-analysis of the data; it was only at the time of the analyses that we discovered interesting elements that were not directly related to the objective of our main study and we decided to present it in a separate paper. At that time, it was not possible to conduct supplementary interviews for practical reasons and it was not methodologically appropriate. Theoretical saturation was not sought either because there was no literature that would allow us to establish the theoretical saturation point. However, the data were sufficient to explore the complex and largely ignored reality of assistance suicide from the point of view of palliative care physicians. Nevertheless, some more specific questions, such as the motivations that may lead palliative care physicians to volunteer for right-to-die organizations, would deserve to be explored in more detail. Further studies are needed.

Second, as mentioned in the Introduction section, [at the cantonal level, some cantons, including the Canton of Vaud, have legal norms dealing with assisted suicide](#). As this topic was not the main objective of our principal study, the question regarding cantonal law was not directly asked during the interviews. Interestingly, [the participants did not spontaneously address this aspect either, except for one participant](#). This important issue merits to be explored in depth in a separate study.

## **CONCLUSION**

Switzerland has a uniquely liberal approach concerning assistance in suicide. The results of our study might be helpful to better understand the attitudes and experiences of palliative care physicians in respect of the current legal vacuum relating to this practice. The results may also be used to enrich national and international reflection in this field in order to reduce confusion

between assistance in suicide and palliative care, to facilitate a reflection among palliative care physicians about their role and identity with regard to suicide assistance, and to strengthen the confidence of patients and their relatives.

### **Acknowledgements**

The first author warmly thanks to the heads of the palliative care units for responding to her call and facilitating contact with palliative care physicians, and to all the participants in the study for sharing their knowledge, experience and reflections regarding this topic. She would also like to express her gratitude [REDACTED]

[REDACTED] for his invaluable medical and existential reflections, and to [REDACTED] native English speaker and professional proofreader, for her excellent linguistic suggestions.

Finally, the authors *give our warm and sincere thanks to the Editor and the two reviewers for their expertise and time, which have helped us reflect on this complex topic and greatly increased the quality of the manuscript.*

### **Contributors**

MT contributed to study conception and design, data collection, analysis, and interpretation. She also translated the results, including the quotations, from French into English. RA and RJJ contributed to the interpretation and discussion of the data and the final results. All authors prepared the final version of the results. MT wrote the manuscript with input from both the other co-authors. All the authors read and approved the final version of the manuscript.

### **Funding**

This study was not funded by any grant. [REDACTED]

[REDACTED] The research was independent of any involvement from this structure.

### **Competing interests**

None declared.


### **Patient consent for publication**

Not applicable.

### **Ethics approval**

This study was outside the scope of the Swiss Federal Act on Research involving Human Beings and did not entail any risks. Consequently, the study was deemed exempt from an ethics review by the Swiss Cantonal Ethics Committee. Participation in the study was voluntary and in accordance with ethics and legal rules. Before performing the interviews, participants were informed about all aspects of the study and could ask any questions. Express oral consent to participation and the interviews being audio recorded was systematically sought and obtained from each participant. All interviews were carried out by the first author of this paper (MT), a postdoctoral researcher in the Ethics of Palliative Care with nine years of experience in conducting qualitative research. In order to ensure total confidentiality for the participants, the interviews were transcribed and all the transcripts were anonymized. The transcripts were analyzed by MT, who was the only person who had access to the recordings and integral transcripts. RA and RJJ had access to anonymized quotations selected by MT.

### **Data availability statement**

All data are not available because of information that potentially permits the participants to be identified, particularly as the names of the institutions that participated in this study and the characteristics of the participants are explicitly indicated in our previous paper 

### **Supplemental material**

Supplementary File 1: COREQ checklist  
(Consolidated criteria for REporting Qualitative research)

### **REFERENCES**

- [1] Swiss Criminal Code of 21 December 1937, article 114 ‘Homicide at the request of the victim’. Available from: <https://www.admin.ch/opc/fr/classified-compilation/19370083/index.html#a114> (Accessed 15 April 2022).
- [2] Swiss Criminal Code of 21 December 1937, article 115 ‘Inciting and assisting suicide’. Available from: <https://www.admin.ch/opc/fr/classified-compilation/19370083/index.html#a115> (Accessed 15 April 2022).
- [3] Fischer S, Huber CA, Imhof L, et al. Suicide assisted by two Swiss right-to-die organisations. *J Med Ethics* 2008;34(11):810-4. doi: 10.1136/jme.2007.023887. PMID: 18974416.

- [4] Emanuel EJ, Onwuteaka-Philipsen BD, Urwin JW, et al. Attitudes and practices of euthanasia and physician-assisted suicide in the United States, Canada, and Europe. *JAMA* 2016;316(1):79-90. doi: 10.1001/jama.2016.8499. Erratum in: *JAMA* 2016;316(12):1319. PMID: 27380345.
- [5] Steck N, Egger M, Maessen M, et al. Euthanasia and assisted suicide in selected European countries and US states: systematic literature review. *Med Care* 2013;51(10):938-44. doi: 10.1097/MLR.0b013e3182a0f427. PMID: 23929402.
- [6] Hurst SA, Mauron A. Assisted suicide and euthanasia in Switzerland: allowing a role for non-physicians. *BMJ* 2003;326(7383):271-3. doi: 10.1136/bmj.326.7383.271. PMID: 12560284; PMCID: PMC1125125.
- [7] Andorno R. Nonphysician-assisted suicide in Switzerland. *Camb Q Healthc Ethics* 2013;22(3):246-53. doi: 10.1017/S0963180113000054. Epub 2013 Apr 30. PMID: 23632255.
- [8] Bosshard G, Fischer S, Bär W. Open regulation and practice in assisted dying. *Swiss Med Wkly* 2002;132(37-38):527-34. PMID: 12508137.
- [9] Schmidlin E, Elger BS, McLennan S. Assisted suicide in Switzerland: where do we come from and where are we going? *Eur J Palliat Care* 2014;21:61-5.
- [10] World Health Organization. Definition of Palliative Care. Available from: <https://www.who.int/news-room/fact-sheets/detail/palliative-care> (Accessed 15 April 2022).
- [11] Radbruch L, Leget C, Bahr P, et al. Euthanasia and physician-assisted suicide: A white paper from the European Association for Palliative Care. *Palliat Med* 2016;30(2):104-16. doi: 10.1177/0269216315616524. Epub 2015 Nov 19. PMID: 26586603.

[12] De Lima L, Woodruff R, Pettus K, et al. International Association for Hospice and Palliative Care Position Statement: Euthanasia and Physician-Assisted Suicide. *J Palliat Med* 2017;20(1):8-14. doi:10.1089/jpm.2016.0290.

[13] American Medical Association. Code of Medical Ethics, 2016. Opinion 5.7. Physician assisted suicide. Available from:<https://www.ama-assn.org/delivering-care/ethics/physician-assisted-suicide> (Accessed 15 April 2022).

[14] World Medical Association. Declaration on Euthanasia and Physician-Assisted Suicide, 2019. Available from:<https://www.wma.net/policies-post/declaration-on-euthanasia-and-physician-assisted-suicide/> (Accessed 15 April 2022).

[15] Gaignard ME, Hurst S. A qualitative study on existential suffering and assisted suicide in Switzerland. *BMC Med Ethics* 2019;20(1):34. doi: 10.1186/s12910-019-0367-9. PMID: 31088444; PMCID: PMC6515594.

[16] Gamondi C, Borasio GD, Oliver P, et al. Responses to assisted suicide requests: an interview study with Swiss palliative care physicians. *BMJ Support Palliat Care* 2019;9(1):e7. doi: 10.1136/bmjspcare-2016-001291. Epub 2017 Aug 11. PMID: 28801317.

[18] Swiss Academy of Medical Sciences (SAMS). End-of-life care, 2013 (2004, updated 2013). Available from: [https://www.samw.ch/dam/jcr:de64e102-1495-4c48-9fbd-1c7d4d45932f/guidelines\\_sams\\_end\\_of\\_life\\_2012.pdf](https://www.samw.ch/dam/jcr:de64e102-1495-4c48-9fbd-1c7d4d45932f/guidelines_sams_end_of_life_2012.pdf) (Accessed 15 April 2022).

[19] Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care* 2007;19(6):349-57. doi: 10.1093/intqhc/mzm042. Epub 2007 Sep 14. PMID: 17872937.



- [20] Guillod O, Schmidt A. Assisted suicide under Swiss law. *Eur J Health Law* 2005;12(1):25-38. doi: 10.1163/1571809054663140. PMID: 16080369.
- [21] Saunders C. Living with dying. *Man and Medicine* 1976;1:227-42.
- [22] Saunders C. Introduction: history and challenge. In: Saunders C, Sykes N, eds. *The Management of Terminal Malignant Disease*. 3rd ed. London: Edward Arnold; 1993:1-14.
- [23] Clark D. Palliative care history: a ritual process. *Eur J Palliative Care* 2000;7(2):50-5.
- [24] Saunders C. Voluntary euthanasia. *Palliat Med* 1992;6(1):1-5.  
doi:10.1177/026921639200600101
- [25] Spichiger E. Palliative Care in Switzerland. *Journal of Hospice & Palliative Nursing* 2003;5(3):161-7.
- [26] Swiss Academy of Medical Sciences (SAMS). Care of patients in the end of life, 2004. Available from: [https://www.samw.ch/dam/jcr:efba20dd-6b7d-429b-a522-cc3de3092a06/guidelines\\_sams\\_patients\\_in\\_the\\_end\\_of\\_life\\_2004.pdf](https://www.samw.ch/dam/jcr:efba20dd-6b7d-429b-a522-cc3de3092a06/guidelines_sams_patients_in_the_end_of_life_2004.pdf) (Accessed 15 April 2022).
- [27] Schweizerisches Bundesgericht. Entscheide 2A.48/2006 und 2A.66/2006.  
[www.bger.ch/ext/eurospider/live/de/php](http://www.bger.ch/ext/eurospider/live/de/php)
- [28] Swiss Academy of Medical Sciences (SAMS). Management of dying and death, 2018. Available from: [https://www.samw.ch/dam/jcr:25f44f69-a679-45a0-9b34-5926b848924c/guidelines\\_sams\\_dying\\_and\\_death.pdf](https://www.samw.ch/dam/jcr:25f44f69-a679-45a0-9b34-5926b848924c/guidelines_sams_dying_and_death.pdf) (Accessed 15 April 2022).
- [29] Swiss Academy of Medical Sciences. Key messages on the regulation of assisted suicide, 24 October 2018 [Document in French]. Available from: <https://www.samw.ch/dam/jcr:a31367a7-73be-4517-8cf6->

ef35238c1994/directives\_assm\_messages\_cles\_assistance\_suicide.pdf(Accessed 15 April 2022).

[30] Stafford N. Swiss doctors object to new suicide guidance. *BMJ* 2018;361:k2661 doi:10.1136/bmj.k2661

[31] Cherny NI, Radbruch L; Board of the European Association for Palliative Care. European Association for Palliative Care (EAPC) recommended framework for the use of sedation in palliative care. *Palliat Med* 2009 Oct;23(7):581-93. doi: 10.1177/0269216309107024. PMID: 19858355.

[32] Safe Care Victoria, State of Victoria, Australia. Palliative sedation therapy. Statewide guidance for Victoria, 2020. Available from: [https://www.bettersafecare.vic.gov.au/sites/default/files/2020-03/GUIDANCE\\_Palliative%20sedation%20therapy%20FINAL.pdf](https://www.bettersafecare.vic.gov.au/sites/default/files/2020-03/GUIDANCE_Palliative%20sedation%20therapy%20FINAL.pdf) (Accessed 15 April 2022).

[33] Alberta Health Services. Provincial Clinical Knowledge Topic. Palliative Sedation, Adult – All Locations, 2018. Available from: <https://extranet.ahsnet.ca/teams/policydocuments/1/klink/et-klink-ckv-palliative-sedation-adult-all-locations.pdf> (Accessed 15 April 2022).

[34] Expert group of the Swiss Society for Medicine and Palliative Care. Palliative ch. Recommendations ‘Palliative sedation’. Consensus on best practice in palliative care in Switzerland. Bigorio, 2005 [in French]. Available from: [https://www.palliative.ch/fileadmin/user\\_upload/palliative/fachwelt/E\\_Standards/E\\_12\\_4\\_bigorio\\_2005\\_Sedation\\_fr\\_.pdf](https://www.palliative.ch/fileadmin/user_upload/palliative/fachwelt/E_Standards/E_12_4_bigorio_2005_Sedation_fr_.pdf) (Accessed 15 April 2022).

[35] Swiss Academy of Medical Sciences (SAMS). Management of dying and death, 2022. Available from: [https://www.samw.ch/dam/jcr:3154cd58-a2bf-4d2a-b11c-27a46174bbe0/guidelines\\_sams\\_dying\\_and\\_death.pdf](https://www.samw.ch/dam/jcr:3154cd58-a2bf-4d2a-b11c-27a46174bbe0/guidelines_sams_dying_and_death.pdf) (Accessed 15 July 2022).

[36] Dignitas founder accused of profiteering. *Swissinfo.ch*, May 18, 2018. Available from: [https://www.swissinfo.ch/eng/assisted-suicide-\\_dignitas-founder-accused-of-profiteering-/44128646](https://www.swissinfo.ch/eng/assisted-suicide-_dignitas-founder-accused-of-profiteering-/44128646) (Accessed 15 July 2022).