

# Responses to assisted suicide requests: an interview study with Swiss palliative care physicians

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## ABSTRACT

**Objectives** Assisted suicide in Switzerland is mainly performed by right-to-die societies. Medical involvement is limited to the prescription of the drug and certification of eligibility. Palliative care has traditionally been perceived as generally opposed to assisted suicide, but little is known about palliative care physicians' involvement in assisted suicide practices. This paper aims to describe their perspectives and involvement in assisted suicide practices.

**Methods** A qualitative interview study was conducted with 23 palliative care physicians across Switzerland. Thematic analysis was used to interpret data.

**Results** Swiss palliative care physicians regularly receive assisted suicide requests while none reported having received specific training in managing these requests. Participants reported being involved in assisted suicide decision making most were not willing to prescribe the lethal drug. After advising patients of the limits on their involvement in assisted suicide, the majority explored the origins of the patient's request and offered alternatives. Many participants struggled to reconcile their understanding of palliative care principles with patients' wishes to exercise their autonomy. The majority of participants had no direct contact with right-to-die societies, many desired better collaboration. A desire was voiced for a more structured debate on assisted suicide availability in hospitals and clearer legal and institutional frameworks.

**Conclusions** The Swiss model of assisted suicide gives palliative care physicians opportunities to develop roles which are compatible with each practitioner's values, but may not correspond to patients' expectations. Specific education for all palliative care professionals and more structured ways to manage communication about assisted suicide are warranted.

## INTRODUCTION

The European Association for Palliative Care (EAPC) edited a White Paper on euthanasia and physician-assisted suicide—explicitly affirming that

*'Individuals requesting euthanasia or physician assisted suicide should have access to palliative care expertise.'*<sup>1</sup>

It also affirms that

*'It is the responsibility of palliative care professionals to hear and explore the implicit or explicit requests for euthanasia and address the suffering underlying these requests.'*<sup>1</sup>

Even where a palliative care consultation is not legally required in countries where assisted dying is permitted, many international bodies suggested that such a consultation should occur.<sup>2–8</sup> The terminology describing assisted dying is controversial; for present purposes, the definitions in [table 1](#) are used.<sup>1</sup> In this paper, we use the value-neutral term 'assisted dying' to encompass all forms of assisted suicide and euthanasia.<sup>9</sup>

Where assisted dying is legal, palliative care physicians are involved in up to 90% of cases from decision making to drug delivery.<sup>10–12</sup> The majority of patients who have died under the Death with Dignity Acts in Oregon and Washington were enrolled in hospice programmes, and in Belgium and The Netherlands, euthanasia and assisted suicide are practised commonly in inpatient hospices.<sup>11 12</sup> Historically palliative care and assisted dying have been considered incompatible by various palliative care bodies.<sup>13–15</sup> Whereas most of the 21 EAPC White Paper statements achieved high consensus in the Delphi process,<sup>1</sup> the authors acknowledged that

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**Table 1** Terminology describing practices that involve assisted dying<sup>1</sup>

Term	Definition
Euthanasia	A physician (or other person) intentionally killing a person by the administration of drugs, at that person's voluntary and competent request
Assisted suicide	A person intentionally helping another person to terminate his or her life, at that person's voluntary and competent request
Physician-assisted suicide	A physician intentionally helping another person to terminate his or her life, by providing drugs for self-administration, at that person's voluntary and competent request

*'complete consensus on these topics seems to be unachievable due to incompatible normative frameworks that clash.'*<sup>1</sup>

The statement concerning the exclusion of assisted dying from palliative care practice did not reach consensus, with the Benelux countries in firm disagreement.<sup>16</sup>

European professional palliative care associations hold varying views about assisted dying,<sup>1 2 17–19</sup> with four positions proposed:

- ▶ 'Integral palliative care,' which views assisted dying as an integral part of palliative care<sup>11</sup>;
- ▶ 'Euthanasia accompaniment,' which recommends assisted dying as part of good general care and provides it within palliative care consistent with the 'non-abandonment principle'<sup>11</sup>;
- ▶ 'Studied neutrality,' defined as 'the careful or premeditated practice of being neutral in the dispute about euthanasia,' which embodies the principles of equality, individual autonomy and tolerance as core values of palliative care<sup>20</sup>;
- ▶ A rejection of any integration between palliative care and assisted dying procedures.<sup>1 21</sup>

In Switzerland, assisted suicide is depenalised and socially accepted, although euthanasia remains illegal.<sup>22 23</sup> According to Article 115 of the Swiss Criminal Code, those involved in assisted suicide are not prosecuted provided they are without self-serving motives.<sup>22 23</sup> Assisted suicide represents approximately 1% of annual Swiss deaths, with a consistent increase over the last few years.<sup>24</sup> In most cases of assisted suicide, involvement of Swiss physicians consists predominantly of providing the patient with a prescription for a lethal dose of pentobarbital, which the persons must take by themselves and with full mental capacity.<sup>25 26</sup>

In 2012, the Swiss Academy of Medical Sciences (SAMS)—an institution bridging biomedical ethics, medical practice and society—developed guidelines largely opposing the involvement of the medical profession in assisted suicide.<sup>27</sup> The guidelines state that, if the physician is present at time of self-ingestion, this must be as a private citizen.<sup>27</sup> As a result, requests for assisted suicide are generally processed by right-to-die societies and assistance is provided by

volunteers who may be physicians, other health practitioners or laypersons. The right-to-die associations assess the patient's medical documentation for eligibility, determine their mental capacity, refer to a physician to obtain a prescription for the lethal drug and offer the support of a volunteer to assist the patient during this process. The assigned volunteer evaluates the patient's mental capacity prior to ingestion and assists during self-ingestion of the drug.<sup>28</sup> Thus, the involvement of Swiss physicians is mostly confined to the decision-making phase; medical certification of diagnosis and mental capacity.<sup>28</sup> Self-administration usually occurs in the patient's home, as few health-care facilities allow it.<sup>28</sup> However, two French Swiss cantons (Vaud and Neuchâtel) recently enacted laws to regulate assisted suicide in public hospitals and nursing homes (see online supplementary appendix 1).<sup>29</sup> A survey conducted with a small sample of Swiss physicians confirmed that most were willing to evaluate eligibility, but only a small minority would consider performing assisted suicide as a medical responsibility.<sup>30</sup> A 2002 survey of interdisciplinary members of *palliative ch* (Swiss society of palliative care) found that all palliative care professionals demonstrated wide variation in their positions concerning assisted dying.<sup>31</sup> A significant minority endorsed the legalisation on assisted suicide and euthanasia, and about 10% reported personal experiences with assisted dying.<sup>32</sup>

In this paper, we focus on assisted dying among mentally competent people; we are not addressing separate issues such as suicide and its prevention in the mental health field. No studies have comprehensively investigated palliative care physicians' experiences of assisted suicide. This paper aims to describe their perspectives and involvement in assisted suicide practices.

## METHODS

This cross-sectional interview study used a stratified purposive sample of Swiss palliative care physicians to capture the experiences of physicians working in specialised palliative care settings when dealing with assisted suicide requests. A qualitative methodology was chosen to enable diverse and culturally salient viewpoints to be elicited in a largely unexplored field. All 336 physician members of *palliative ch* were invited by email to register online their interest in participating in an interview. The inclusion criteria were: (A) working more than 0.7 Full Time Equivalent (FTE) in palliative care, for at least 3 years, and (B) working in an accredited facility and/or home care setting. Of the 64 doctors who registered (19% of those invited), 15 did not meet inclusion criteria such as working less than 0.7 FTE in palliative care. Of the remainder, 23 were purposively selected to represent a range of variables including gender, age, extent of experience and type of role and position, type of institution, and language group (approximately proportional to the distribution

in the general Swiss population, ie, 65% German, 30% French and 5% Italian speaking). Participants were asked to describe their likely responses to a typical assisted suicide request scenario<sup>31</sup>; their actual experiences of responding to assisted suicide requests; their perspectives towards assisted suicide and the activities of the right-to-die societies; and the main influences on their views. Additional questions explored participants' philosophies of palliative care, their perception of their role as a palliative care physician, their training on responding to assisted suicide requests and their views on the relationship between assisted suicide and palliative care practices. Between January and March 2015, twenty-three semistructured interviews were conducted face-to-face at each participant's workplace (three by Skype). The interview questions were pilot tested with three participants and as no substantive changes were made, these were included in the data set. Interviews were conducted in English, with participants' agreement, to minimise translation bias. Their transcribed interview was provided to each participant for comment and to ensure accuracy. To enhance reliability and trustworthiness, the research team included a gender balance, various professions and researchers from four countries. Using thematic analysis,<sup>33</sup> categories were developed through an iterative process, then data were analysed to identify key emergent themes and variations in responses by age, gender and experience.<sup>34</sup> Verbatim quotes were selected to illustrate majority and minority viewpoints ('majority' refers to approximately 50%–75% of the sample and 'minority' less than 30%) (see [figure 1](#)). Approval for the study was obtained from the Local Ethical Committee (CE 2740) and Lancaster University Ethical Committee.

## RESULTS

The characteristics of the 23 participants are shown in [table 2](#).

Swiss palliative care physicians received assisted suicide requests regularly and tended to follow a common pattern in responding to them which involved (see [figure 2](#)):

- ▶ setting and communicating early on boundaries on their level of willingness to support a patient's assisted suicide request;
- ▶ playing an active role in the decision-making process by presuming a responsibility for exploring patients' reasons, offering alternatives and discussing assisted suicide risks, often iteratively over an extended period;
- ▶ engaging with families on the topic, without always explicitly obtaining the patient's consent.

The amount and focus of each participant's engagement appeared to be mostly determined by the individual's personal philosophies of assisted suicide. The majority of participants were not willing to prescribe a lethal drug and/or attend the death. A majority also wanted clearer and stronger state regulation of assisted suicide.

## Experiences of responding to assisted suicide requests

Participants reported receiving annually between 3 and 20 requests and estimated that only 5%–10% of them resulted in an assisted suicide. Most participants, especially those over 50 years, interpreted assisted suicide approaches as requests for information, rather than for help with obtaining assisted suicide (see [quotes 6 and 7](#)). Three participants acknowledged that their opposition/ambivalence about assisted suicide was probably a barrier to them recognising requests for help. More than half of the participants stated that they would not initiate a conversation about assisted suicide or discuss it unless the patient first raised the topic. However, several participants identified ethical dilemmas in determining what their role should be in assisted suicide, when their personal stance conflicted with explicit or implicit institutional policy (see [quotes 1 and 3](#)). Most participants required the patient to engage in extended, repeated discussions about the reasons for their request. The most frequently reported topics of discussion with these patients were: the reasons for requesting assisted suicide; offer of alternatives; consultation with families; provision of the required eligibility certificate; interaction with the right-to-die societies; and physician's unwillingness to prescribe the lethal drug (see [box](#)).

Alternatives to assisted suicide were presented as 'natural' deaths (see [quotes 15, 11, 13](#)). These protracted discussions, sometimes over several weeks, and generally initiated by participants, meant that some patients died before assisted suicide could be arranged. Physicians also commonly reported engaging families in extended discussions, on the principle of including them in the care plan.

Most participants set boundaries early on with patients, clarifying that they would not participate in assisted suicide (such as prescribing or interacting with the right-to-die association), but would not interfere with the patient's choice (see [quotes 2, 4, 8](#)). Although participants saw it as their responsibility to write the medical certificates, if requested, four of them reported an organisational policy of sending the certificate to the general practitioner (GP). In general, participants did not liaise with GPs or other professionals outside of the patient's care team about assisted suicide requests.

All participants saw it as their responsibility to not create barriers to right-to-die societies visiting the patient, but most physicians regarded establishing contact with right-to-die societies as the patient's responsibility. While many physicians acknowledged that they might suggest that patients contact the right-to-die societies, only five had actively advised patients to do so (see [quotes 9, 10](#)). Four doctors reported having met with the right-to-die societies' personnel together with the patient; a further six would do this if asked by the patient, while two would recommend such a meeting to the patient. The four participants who had had direct personal contact with these societies'



<p>1: This guy from The Netherlands said..."If you are not ready to talk about assisted suicide, nobody will ask you about it". And that's the thing. I'm not allowed to provide assisted suicide. But there were families who told me afterwards, ... who would have liked to ask me [for assisted dying], and they didn't. Just to... uhm... not to bring me into difficulties. (Lucy, 50-65 years old)</p>
<p>2: I would give him the phone number of the association that is considered to be in charge of that. I would not prescribe it [lethal medication] myself in my doctor's position, okay? That is in line with the recommendations of our academy of medical sciences and the FMH, that's our professional association. ... And this is something that goes back in medical history to the <i>primum non nocere</i> - first, do no harm. So I would not do harm to anyone. (George, 50-65 years old)</p>
<p>3: ... an ugly situation I shared with a patient... So, the patient was not member of EXIT and requesting for medically assisted suicide for weeks. And because there is no law, people [health professionals] were just chit-chatting about the fact but not listening to the patient, I felt so uncomfortable ... this situation where the patient was begging me at least to act as an advocate definitely impacted on my daily practice. (Brad, 40-50 years old)</p>
<p>4: We try to explain the situation to show him the other possibilities but if he wants to...ah, if he desires the assisted suicide, it's...at the end, it's his decision. But we will not help him to organise this way or the assisted suicide. It's not our wish to help him. And first he has to do it alone. And the second is it's not possible here or in the...in a hospital. He has to search another place. (Paul, 40-50 years old)</p>
<p>5: I'm sure that there are some very big common questions about values of society, about living styles, ...about expectations in society and in each individual about end of life, and about having control. It raises big issues. So I think this debate [between palliative care and right-to-die-societies] can be very fruitful for the whole development of society in regard of integrating end of life in everyday. (Frank, 50-60 years old)</p>
<p>6: As a request, I think...I don't get requests from patients. Patient talk about, 'I'm fed up. I don't want to live anymore. I'm tired. I don't want to live.' But I've never had the question, 'Please doctor give me medication.' Maybe these people know that for that they have to go to EXIT - I don't know. (Caroline, 40-55 years old)</p>
<p>7: Uhm well patients sometimes say, "Give me a drug to die." But I don't think that it's really what they want. It's perhaps a possibility or to talk about dying. And I never heard this wish directly for active suicide. No, never. (Paul, 40-50 years old)</p>
<p>8: So, okay, then I will ask him [person requesting assisted dying], do you suffer physically or psychologically from anything? Can I help you with this? And he then answers, no I'm fine. I've no pain. I have no dyspnoea. I have no ... anything ... Then I said okay. But I can't offer you assisted suicide. (Kristine, 50-65 years old)</p>
<p>9: And for me, it was special to call EXIT. They said, "Oh, it's rare that a doctor calls us, you know?" Because I thought the best is to call them and to ask for information, because that is what they do. ... they were very happy that somebody was interested to know. (Lucy, 50-65 years old)</p>
<p>10: I even suggest to patients to talk [with EXIT] so they know what it is all about. ... I say, "Well, then it's better you talk to them and you get information." ... so for them, it's also important to have this door open ... that's what they always tell me, you know, Exit means security. (Lucas, 50-65 years old)</p>
<p>11: I think it might not be necessary to have this tool if you start early in reflecting and also stopping, withdrawal of treatment. And also, voluntary stopping of eating and drinking, for instance, might be really another way to address or to take into consideration. (Jim, 50-65 years old)</p>
<p>12: I'm not one of the palliative care specialists who like to put them one against the other, the assisted suicide versus palliative care. I think both have their place in life and in dying. (Ernest, 40-55 years old)</p>
<p>13: So, I don't think that we should offer this (assisted suicide) to the patient. No. There's no place for it in palliative care. Because palliative sedation is a good possibility ...yeah. To help the patient don't have their symptoms. But we shouldn't raise the dose of the drugs. (Paul, 40-50 years old)</p>
<p>14: I see my role is in giving him (the patient) best supportive care, and to do everything to reduce his suffering when I can. And when I have done this, I have to accept his decision, but I would tell him that I'm not...it's not my role to give him assisted suicide. (Francine, 40-50 years old)</p>
<p>15: And then I say [to patients], "With antibiotics you can prolong your disease, but it's also a chance to have a natural way to go". And to die with an infection is not the worst thing to do." (Sandra, 50-65 years old)</p>
<p>16: And I have to confess that I am supported here...at least in Neuchâtel state and the Vaud state – by the fact we have a legislation. To be honest, it's very helpful ... I might have a personal opinion with regards to assisted suicide, but as a health professional, I hopefully have rules and I can follow the rules ... At least for the physician, for the health professional, it's a step-by-step attitude. And maybe it's decreasing... or it lowers the pressure on our shoulder. I have to be honest, I feel far more comfortable in state of Vaud than in state of Geneva, where a patient 10 years ago were already requesting for assisted suicide and there is no bill in Geneva. And at that time, we were more or less all expressing our value system rather than listening to the patient value system. So I have to confess that with this bill or this guidance, definitely, it lowers the pressure on our shoulder because it's a step-by-step recipe. (Brad, 40-50 years old)</p>
<p>17: ... the problem is ... uhm, actually it's not regulated. There's no rule [about whether] people could go with assisted suicide in the hospital or not. Nowhere it's written yes or no. Actually, I would like to clarify that [rule], so I know what I can tell the patients if they ask". (Brad, 40-50 years old)</p>

Figure 1 Selected quotes from the interviews.

**Table 2** Characteristics of the participants

Sex	Male	10
	Female	13
Median age (range)	Median 50 years (35–67)	
Linguistic regions represented	German	10
	French	10
	Italian	3
Country of training	Switzerland	18
	Germany	3
	Italy	1
	France	1
Years of experience in palliative care	Median: 11 years (range 4–35 years)	

personnel were the most likely to regard them positively, view them as ‘professional’ and ethical and be willing to collaborate.

#### ‘Learning by doing’—how physicians deal with assisted suicide requests

No participants had received specific training in how to respond to assisted suicide requests. The majority based their approach on institutional policies, their senior colleagues’ approaches, the SAMS policy guidelines or their personal perception of ‘best practice’ (see quotes 12, 13, 14). Three participants reported having attended an assisted suicide, and two experienced it as valuable learning. Most participants did not want to attend an assisted suicide, seeing it as unethical, voyeuristic or not useful. Nonetheless, all participants

#### Box Identified topics of discussion between patients and palliative care physicians concerning assisted suicide

##### Topics of discussions

- ▶ The interaction with the right-to-die societies
- ▶ Being present at death
- ▶ The certification of medical condition and mental capacity
- ▶ Exploring reasons underpinning the patient’s request for assisted suicide
- ▶ The offer of alternatives to assisted suicide
- ▶ Consultations with families

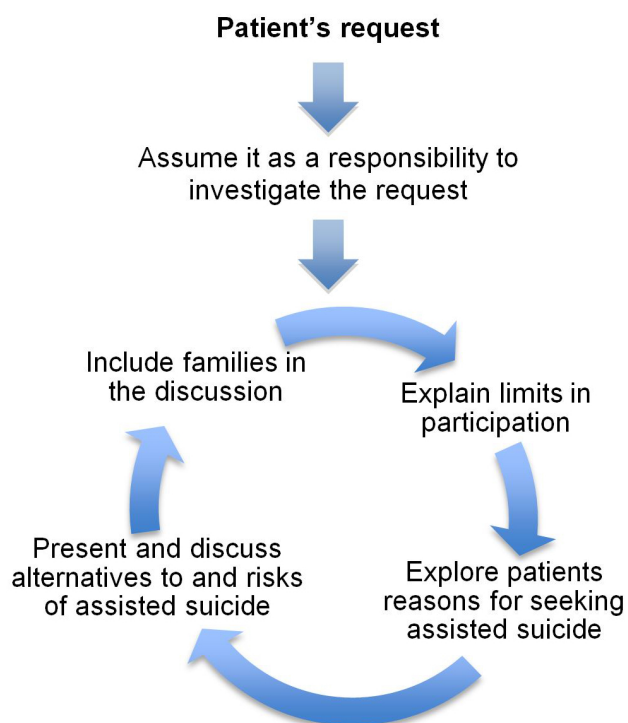
expressed confidence in their ability to describe the assisted suicide process accurately to patients and families. Of those participants who held strong religious beliefs, some said they would never consider assisted suicide for themselves, while many stated they would consider having assisted suicide in particular medical situations.

#### Relationship of assisted suicide to palliative care

Participants’ approaches to managing assisted suicide requests appeared to be aligned with each individual’s conceptualisation of palliative care. Approximately a third of participants considered assisted suicide as actually or potentially a tool in palliative care. Another third were strongly opposed to assisted suicide, seeing it as having ‘no place’ and ‘no common ground’ with the goals of palliative care (see quote 13). The remaining third were ambivalent, seeing AS as having validity, acknowledging its legality and responsiveness to patient autonomy, but expressing concerns about participating in it, due to fears around professional stigma and lack of competence. Many participants described a fear of being stigmatised as physicians, palliative care practitioners or employees of a health institution. A majority of participants believed more collaboration is needed between palliative care physicians and right-to-die societies, being in the patient’s best interests in terms of providing better coordinated information and services (see quote 5). However, individually, most physicians were reluctant to initiate or participate in such collaborations. Contact with right-to-die societies was considered as inappropriate by a minority of mostly older physicians opposing assisted suicide.

#### Improving responsiveness to assisted suicide requests

Around a third of participants wanted to see stronger state regulation of assisted suicide including specific laws like those in two Swiss cantons, to know what actions are required (see quote 16). Half of participants wanted assisted suicide to be available in all Swiss hospitals or wanted to discuss this option, viewing discharging very ill patients seeking this



**Figure 2** Typical pathway of palliative care physicians’ involvement in assisted suicide.

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legally permitted procedure was contrary to palliative care principles (*see quote 17*). Such hospital discharges were perceived as stressful for patients and families, particularly when patients no longer have a home. Participants opposed to assisted suicide in hospitals identified their reasons as fear of hospitals gaining a bad reputation and losing patients' trust, or their belief that assisted suicide is not part of medical practice.

## DISCUSSION

In our study, the role of Swiss palliative care physicians in assisted suicide appeared to be poorly defined, supporting the wider international literature on physicians' role in assisted dying.<sup>35</sup> Medicolegal professional bodies formulating policy and guidelines need to recognise that the desire for assisted dying goes beyond biomedical reasons.<sup>34</sup> Motives may also involve psychoexistential factors and the personal biography of the patient.<sup>36</sup> The Swiss civil model of assisted suicide permits palliative care physicians to develop individualised roles which reflect each practitioner's personal, ethical and professional belief systems. However, individually determined roles can be at odds with patients' expectations.<sup>37 38</sup> Participants reported undertaking extended discussions with patients, to address the underlying reasons for these requests, but not necessarily acting on the patient's request. Moreover, they rarely supported patient access to assisted suicide. They tended to avoid ethically challenging activities, such as prescription of the lethal drug and interactions with right-to-die societies, and focused on alternatives to assisted suicide and their perception of its disadvantages.

Participants had received little or no formal training on responding to assisted suicide requests and most preferred to avoid facilitating assisted suicide. Lack of training appeared to contribute to participants' uneasiness in responding to assisted suicide requests, reflecting research with Swiss GPs.<sup>39</sup> Responding to a specific request for assisted dying is complex and must comply with country-specific legislation.<sup>37 40 41</sup> It represents a significant responsibility for physicians and requires specific competencies that are not widely taught.<sup>39 40</sup> For example, Belgian physicians are offered training on end-of-life decisions, assisted dying and communication. They are encouraged to attend biannual 'intervention' groups to evaluate their practice.<sup>42-44</sup> Need for training was also stressed by the British Medical Association.<sup>45</sup> In our study, physicians were confronted with assisted suicide issues beyond certification and prescription. A lack of training and formal guidelines on how to respond to assisted suicide requests within a patient-physician relationship concerns many European countries, not only Switzerland.<sup>46</sup> Further research on how physicians respond to assisted suicide requests in diverse jurisdictions is warranted to understand cultural specificities in Europe and elsewhere.

The absence of clearly defined roles in assisted suicide for Swiss physicians means that their responses seemed to be largely shaped by personal/professional values and their own experiences of assisted suicide. Their typical reaction was to discuss alternatives to assisted suicide, while declining to prescribe the lethal drug. This input pattern, although done with good professional intention, could result in a disparate outcomes. First, extended discussions might create a barrier for deteriorating patients wishing to pursue assisted suicide which may lead to further fragmentation of the roles of professionals. Second, discussion may lead to patients being better informed and reviewing their decision.<sup>47 48</sup>

The physician's ambiguous role, apparently studied neutrality, can result in ethical dilemmas: while they believed in patient autonomy, many participants struggled to reconcile their understanding of palliative care principles with patients' wish for autonomy and assisted suicide. Therefore, patients commonly go directly to the right-to-die societies to obtain assisted suicide, or alternatively they may 'screen' physicians to determine their stance.<sup>49</sup> There is a resonance with physicians' limited role in Oregon and Washington hospices that prohibit staff from engaging in assisted suicide.<sup>50</sup> Our participants' preference for discussing risks and alternatives to assisted suicide may also reflect their need to feel comfortable and competent. However, the impact on patients means that they could remain trapped in a protracted decision making or have to pursue assisted suicide outside of palliative care. Research participants strongly opposed to assisted suicide did not generally refer patients to a non-objecting colleague or a right-to-die society, so that patients' autonomy may not have been respected.<sup>42</sup> The Ontario College of Physicians and Surgeons published guidelines requiring objecting physicians to declare a conflict of interest and refer to another non-objecting physician.<sup>51</sup>

The picture of Swiss-assisted suicide emerging from our study and previous data suggests a patient-initiated process, with diverse stakeholders involved who are typically not working in collaboration.<sup>50 52</sup> Right-to-die societies undertake a dual role, providing the means for patients to achieve assisted suicide and at the same time verifying the patient eligibility, which potentially poses a problem because there is limited external scrutiny.<sup>47</sup> Stakeholders can be unaware of patients and families about reasons for seeking assisted suicide, the nature of the patient's suffering, their plan of care and/or the options available.<sup>50</sup> Our research demonstrated a separate assisted suicide process, with unclear roles and ambiguous legal boundaries, which leaves many palliative care physicians walking a tight-rope between fully respecting the patient's autonomy and upholding their personal and perceived professional ethical code.

Possible domains that professionals might explore when responding to patients' requests for assisted



## Possible domains to explore when responding to requests for discussion about assisted dying.

- ❖ Be familiar and act in accordance with national and regional laws, professional codes and institutional policies and/or guidelines.
- ❖ Gain an understanding of the patient's unique situation in respect to their personal biography, illness trajectory and family relationships.
- ❖ Explore with the patient their expectations concerning professional input in relation to assisted dying.
- ❖ Recognise when it is appropriate to refer the patient to another physician.
- ❖ Explain national and regional laws to the patient, together with institutional guidelines and/or policies and how they pertain to the patient.
- ❖ Explore and address with patient agreement what 'unbearable suffering' means to the patient, bearing in mind the multidimensional components of suffering.
- ❖ Ensure that the patient has access to all relevant information. Refer where appropriate to external relevant sources (e.g. patient advocacy groups and/or right-to-die organizations).
- ❖ Explain the role palliative care can play including physical and psychosocial symptom management and palliative sedation.
- ❖ Explain death and dying processes, including available options potentially relevant to the patient situation, e.g. advance care planning (ACP), non-treatment decisions (NTDs), and Voluntary Stopping of Eating and Drinking (VSED).
- ❖ Explore with the patient agreement their sources of meaning, hope, dignity and healing.
- ❖ Include families and significant others in the discussion, with patient agreement.
- ❖ Respond to needs of families and significant others as appropriate, in respect of patients autonomy and confidentiality.
- ❖ Use communication skills appropriate to patient needs.

**Figure 3** Possible domains to explore when responding to requests for discussion about assisted dying based on study findings.

dying are proposed in [figure 3](#). These can be relevant to all professionals working in specialist palliative care and address the complexity underlying assisted dying.<sup>53</sup> Future research is needed to test these domains to seek professional consensus on ethical responses to assisted dying requests.

#### Strengths and limitations of the study

All the interviews were held in English with participants' agreement although this was their second language. Where necessary, the participant's meaning was checked during or after the interview.<sup>54</sup> The diversity of physicians' experiences and demographics enhanced the generalisability of the findings across Swiss palliative care physicians. It is unknown what proportion of patients described in the interviews went ahead with assisted suicide; thus the experiences described should be considered as interactions concerning patient requests for information about having assisted suicide, rather than a confirmed, definitive pursuit of assisted suicide. Since physicians were self-reporting data, social desirability may have played a role in their accounts.

#### CONCLUSION

Responding to assisted suicide requests remains a difficult task for Swiss palliative care physicians. To reduce the uncertainty evidenced in our interviews, the physicians' role in assisted suicide should be more clearly defined, based on valid competencies and respecting their ethical principles.<sup>55</sup> In Switzerland, as well as in other countries, patients, families and palliative care physicians can be actually acting in isolation and secrecy when confronted with assisted dying requests, resulting potentially in ethical dilemmas and possible collateral damage.<sup>50</sup> Isolation, lack of networking and lack of education may contribute to miscommunication and misunderstandings in the physician–patient relationship. Concerning palliative care physicians' future role in assisted suicide, questions about the required level of education and any personal objections to assisted suicide must be addressed, especially if assisted suicide becomes more widely available in Swiss healthcare facilities. All efforts should be done to preserve mutual respect, offer open team discussion, assure physician accountability, respect patients' autonomy and ensure appropriate support and counselling across the continuum of care.<sup>56</sup>

## Research

**Contributors** CG conceived the study. PO collected the data. CG and PO analysed the data and prepared the results. CG, GDB, PO, NP and SP participated in the design of the study and the discussion of the results, and CG wrote the manuscript with input from all other coauthors. NP and SP oversaw the research. CG and SP are the study guarantors. The manuscript is an honest, accurate and transparent account of the study being reported; no important aspects of the study have been omitted.

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**Competing interests** None declared.

**Patient consent** Participants of this study were physicians. They all signed the consent form.

**Ethics approval** Canton Ticino Ethical Committee (CE 2740) and Lancaster University Ethical Committee.

**Provenance and peer review** Not commissioned; externally peer reviewed.

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