



ASSISTED SUICIDE IN SWITZERLAND: CLARIFYING LIBERTIES AND CLAIMS

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ABSTRACT

Assisting suicide is legal in Switzerland if it is offered without selfish motive to a person with decision-making capacity. Although the ‘Swiss model’ for suicide assistance has been extensively described in the literature, the formally and informally protected liberties and claims of assistors and recipients of suicide assistance in Switzerland are incompletely captured in the literature. In this article, we describe the package of rights involved in the ‘Swiss model’ using the framework of Hohfeldian rights as modified by Wenar. After outlining this framework, we dissect the rights involved in suicide assistance in Switzerland, and compare it with the situation in England and Germany. Based on this approach, we conclude that in Switzerland, claim rights exist for those requesting suicide assistance, and for those who are considering providing such assistance, even though no entitlements exist toward suicide assistance. We then describe the implementation of the ‘Swiss model’ and difficulties arising within it. Clarifying these issues is important to understand the Swiss situation, to evaluate what features of it may or may not be worth correcting or emulating, and to understand how it can impact requests for suicide assistance in other countries due to ‘suicide tourism’. It is also important to understand exactly what sets Switzerland apart from other countries with different legislations regarding suicide assistance.

INTRODUCTION

Assisting suicide is legal in Switzerland if it is offered without selfish motive to a person with decision-making capacity. There are no direct legal rules about physician involvement and most assisted suicides are provided by lay right-to-die associations. Although some countries permit both euthanasia and assisted suicide (Belgium, Netherlands, and Luxembourg) and other jurisdictions allow physician-assisted suicide (among them four US states), the Swiss situation of legal and non-medicalized assisted suicide is unique. The normative context of this practice is largely made of ethical guidelines drawn up by healthcare professionals and various regulations resulting in no small part from the policies of the right-to-die associations themselves.

The Swiss practice is of general interest for several reasons. For one, the normative claims implicit in the Swiss treatment of assisted suicide have traction beyond Swiss borders, as illustrated concretely by the significant number of foreign residents who come to Switzerland for the purpose of receiving suicide assistance. A recent study of this ‘suicide tourism’ identified 611 cases in the Canton of Zurich, where most cases take place, for the years 2008 to 2012.¹ Furthermore, ‘suicide tourism’ towards Switzerland affects the context in which suicide assistance requests are made in other countries, as well as the legal and political debates taking place there. Finally, these claims impinge on the professional duties of

¹ S. Gauthier, J. Mausbach, T. Reisch & C. Bartsch. Suicide tourism: a pilot study on the Swiss phenomenon. *J Med Ethics* 2014; doi:10.1136/medethics-2014-102091.

physicians whose patients wish to travel to Switzerland and they are obviously relevant for health professionals in countries where physician assisted suicide is legal.

The Swiss situation as regards assisted suicide has been extensively described in terms of practice,² legal background,³ demographics,⁴ motivation,⁵ psychological and socioeconomic and cultural determinants,⁶ medical role,⁷ and ethics.⁸ Nevertheless, the formally and informally protected liberties and claims of assistors and recipients of suicide assistance in Switzerland are incompletely captured by these descriptions. The fuzziness of the Swiss legal situation was highlighted and criticized in the recent sentence of the European Court of Human Rights in the case of *Gross v. Switzerland*.⁹ To clarify and evaluate the 'Swiss model', and to assess what features of it may or may not be worth emulating,¹⁰ the importance and content of extra-legal norms in Switzerland must be understood. This article describes the package of rights involved in the 'Swiss model', using the framework of rights developed by Hohfeld and modified by Wenar.¹¹

² Ibid; G. Bosshard, E. Ulrich & W. Bar. 748 cases of suicide assisted by a Swiss right-to-die organisation. *Swiss Medical Weekly*. 2003; 133(21–22): 310–317; S.A. Hurst & A. Mauron. Assisted suicide and euthanasia in Switzerland: allowing a role for non-physicians. *BMJ* 2003; 326(7383): 271–3.

³ O. Guillod & A. Schmidt. Assisted suicide under Swiss Law. *Eur J Health Law* 2005; 12(1): 25–38.

⁴ S. Fischer et al. Suicide assisted by two Swiss right-to-die organisations. *J Med Ethics* 2008 Nov; 34(11): 810–814.

⁵ S. Fischer et al. Reasons why people in Switzerland seek assisted suicide: the view of patients and physicians. *Swiss Medical Weekly* 2009 Jun; 139(23–24): 333–338.

⁶ A. Spoerri et al. Swiss National Cohort S. Religion and assisted and non-assisted suicide in Switzerland: National Cohort Study. *Int J Epidemiol* 2010; 39(6): 1486–94; N. Steck et al. Suicide assisted by right-to-die associations: a population based cohort study. *Int J Epidemiol* 2014; 43(2): 614–522.

⁷ G. Bosshard et al. A role for doctors in assisted dying? An analysis of legal regulations and medical professional positions in six European countries. *J Med Ethics* 2008 Jan; 34(1): 28–32; S.A. Hurst. 2013. Doctors and suicide assistance – International questions and the Swiss context. in *Suizidhilfe in der Schweiz – zur Kontroverse um eine angemessene ärztliche Rolle*. S.A. Hurst, F. Mathwig, & C. Kind, eds. Folia Bioethica. Swiss Society for Biomedical Ethics: 35–64.

⁸ A.K. Martin, A. Mauron, & S.A. Hurst. Assisted Suicide is Compatible with Medical Ethos. *Am J Bioethics* 2011; 11(6): 55–57; R. Andorno. Nonphysician-Assisted Suicide in Switzerland. *Camb Q Healthc Ethic*. 2013 Jul; 22(3): 246–253.

⁹ *Gross v. Switzerland*, 2013. The sentence was overturned on appeal for circumstantial reasons but the general argument remains relevant. See also I. Black. Existential Suffering and the Extent of the Right to Physician-Assisted Suicide in Switzerland *Gross V Switzerland* [2013] *Echr* 67810/10. *Med Law Rev* 2014; 22(1): 109–118.

¹⁰ S.J. Ziegler. Collaborated Death: An Exploration of the Swiss Model of Assisted Suicide for Its Potential to Enhance Oversight and Demedicalize the Dying Process. *J Law Med Ethics*. 2009; 37(2): 318–30; S. Ost. The De-Medicalisation of Assisted Dying: Is a Less Medicalised Model the Way Forward? *Med Law Rev*. 2010 Win; 18(4): 497–540.

¹¹ L. Wenar. The nature of rights. *Philos Public Aff*. 2005; 33(3): 223–52.

THE FOUR HOFELDIAN RIGHTS

This framework is appropriate for examining rights of conduct in general, no matter whether they are based on law, custom, or morality. This is particularly useful in the case of Switzerland, where the practice of organized assisted suicide is based largely on informal arrangements that generate rightful expectations, not grounded in positive law. In Wenar's reworking, the Hohfeldian framework is descriptive, aimed at 'explicating the meanings of rights assertions' independently from a normative assessment of the (legal, moral or customary) validity of such assertions and without commitment to any global theory of the nature of rights and their functions in normative systems.¹² In this framework, the four 'Hohfeldian incidents', i.e. *privileges*, *claims*, *powers*, and *immunities* are considered the 'atoms' of which the 'molecules' of most concrete, existing rights are composed (albeit 'atomic' rights, expressed by a single Hohfeldian term, can also exist by themselves). The four 'Hohfeldian' atomic rights, rights according Hohfeld's typology of rights, represent for rights what the periodic table of elements is for chemistry: a list of all the 'atoms' from which all kinds of 'molecular' rights are composed.

Privileges

The first is the *privilege*, which is the core concept behind the notion loosely referred to as liberty-right. A rights assertion involves a privilege if the following implication holds:

- (1) 'A has a right to f' implies 'A has no duty not to f.'

Where the right in question can be legal, moral, or 'customary, and f is an active verb.¹³ f stands for any kind of action on things or persons that an agent A may consider performing as of right. The sort of privilege relevant to our context is what Wenar calls a 'paired privilege', i.e. a molecular assembly of two connected privileges of the form: 'A has no duty not to f' and 'A has no duty to f'. Paired privileges are *rights of discretion*, i.e. they express the fact that a subject has a discretionary right to perform some action, or not to perform it. Many rights assertions resulting from personal freedoms in a liberal polity can be expressed as paired privileges. For instance, I enjoy a right to free expression (on one possible reading of this right) if I am both free to express myself in the public sphere – i.e. I have no duty to shut up – and I am also free to shut up, i.e. I have no duty to express myself, as I choose.

¹² Ibid: 227.

¹³ Ibid: 225.

Table 1. Hohfeldian incidents

	'A has a right to f'	'A has a right that B f'
First-order rights : rights over persons and things	PRIVILEGE	CLAIM
Second-order rights : rights over first-order rights	POWER	IMMUNITY
	Privileges and powers are exerted by A.	Claims and immunities are enjoyed by A, in connection with an obligation that falls on B.

Adapted from Wenar, *op. cit.* note 11, Figure 4

Claims

The second Hohfeldian right considered here is the *claim*. When asserting this kind of right, a subject is not affirming a liberty to do or abstain from an action that she may consider doing, but rather asserting the existence of someone else's duty to perform some action. The following implication is true if the right thus asserted is a claim:

- (2) 'A has a right that B f' implies 'B has a duty to A to f'.¹⁴

The basic difference between a privilege and a claim is that the latter establishes a connection between three elements: the action under consideration, the bearer of the claim-right, and the subject who has a duty to the right bearer as regards the action. A is the passive enjoyer of a claim-right against B, who is moved to be an active performer of f.

In contrast, In the case of a privilege, A is an active bearer of this privilege, active in the sense that the privilege empowers A to act, i.e. to perform f.

The action f in question can be defined in the negative. For instance, I have a right to bodily integrity if others have a duty not to inflict bodily harm on me. The relevance of claims thus includes, but goes beyond entitlements as usually understood, i.e. as claims to provision of a concrete good or service. Claims can also refer to duties of abstention or protection, or duties to perform some specific action, for instance as a result of legal or contractual obligations.

Powers and immunities

The 'second order' Hohfeldian rights are *powers* and *immunities*. These are in effect meta-rights, having first-order rights as their object. Powers confer *authority* to modify first-order privileges and claims whereas immunities provide the opposite function of *protecting* specific first-order rights against infringement or annulment. For

instance, a criminal court has a *power* to abrogate the privilege of free movement of a citizen by sentencing him to a prison term. On the other hand, citizens enjoy *immunity* against being detained without a judicial order beyond the deadline of police custody, i.e. immunity against the abrogation of the privilege of coming and going as one sees fit.

Note that there is a homology between the conceptual couples of privileges/claims and powers/immunities (Table 1). Privileges and powers are active rights that empower their bearer to accomplish some action; they can both be expressed by the assertion that 'A has a right to f'. Claims and immunities are passive rights enjoyed by whoever may rightfully expect that another accomplish some action or refrain from some action; they can both be expressed by the assertion that 'A has a right that B f'. The difference between the rights assertion of privileges/claims and of powers/immunities is that for privileges/claims, f represents an action on some aspect of the real world, whereas in the case of powers/immunities, f is an action bearing on first-order rights. Often the same state of affairs can be interpreted in terms of either privileges/claims or of powers/immunities, depending on whether or not some first-order rights are considered to be part of the picture.

RIGHTS REGARDING SUICIDE AND ASSISTING SUICIDE

Regarding suicide, a total prohibition prevailed throughout Europe before the Enlightenment. This prohibition was abolished in continental Europe during the 19th century but survived much longer in common-law countries, as recently as 1961 in England. Once suicide is removed from the criminal code, there is no longer a (legal) duty to abstain from suicide and one can conclude that a Hohfeldian privilege of suicide exists. This right abolishes any penalties for suicide. However, at first sight, this privilege of suicide would seem to be moot since duties to abstain from *assisting* suicide and indeed duties to

¹⁴ Ibid: 229.

prevent suicide may still prevail.¹⁵ Such duties may be incumbent upon healthcare professionals or upon every citizen.

Once this privilege of suicide exists, could there be claim-rights that consolidate the actual exercise of this privilege? For instance, is there a claim-right to control one's time and manner of death? In effect, the *Pretty* doctrine of the European Court of Human Rights recognized something very like this, although the ruling gave greater weight to other considerations in the end. Such a claim would seem to entail an obligation to refrain from preventing suicide in certain cases, and would give some weight to the decriminalization of suicide assistance in specific instances. Does this imply a right to assist suicide or obtain assistance? The answer is of course controversial. If one answers positively, as in the Swiss situation, the right to provide suicide assistance has to be seen as a privilege. This step in turn leads to the need to specify additional rights that this privilege would imply. These could be *claims*, for instance the right to have one's request for suicide assistance evaluated according to specific criteria. They would also involve *powers*, such as the *power* of physicians to prescribe a lethal drug, a right best defined as a power since it modifies the normative landscape as regards the right of patients to obtain these drugs. Finally, it would also entail *immunities*, for instance the right not to be forced to provide suicide assistance against the dictates of one's conscience.

The Swiss model of legal suicide assistance

With the Hohfeldian toolkit in hand, we turn to the Swiss situation. Here, an essential distinction must be made between legal rights on the one hand and customary rights arising from accepted practice on the other. Much of the Swiss specificity hinges on the latter rather than the former.¹⁶ In Switzerland as in other continental European countries, the logic behind decriminalizing suicide assistance is that it follows from the lack of incrimination of suicide itself. The Swiss penal code does include a crime of aiding and abetting suicide,¹⁷ but makes a selfish motive of the assistor a defining characteristic of the crime. The principle of *nulla poena sine lege*, requires that one cannot be punished for doing something that is not prohibited by law. Since suicide assistance is only a crime if a selfish motive exists,

¹⁵ Nevertheless, the existence of a Hohfeldian privilege of suicide is far from trivial. Abolishing the crime of suicide cannot be interpreted as the mere acknowledgment that penalties for (successful) suicide are impossible, since such penalties have been meted out in actuality for many centuries. Rather it recognizes that suicide is not transgressive of the social order: it is no longer thought to merit blame but to be a matter of a compassionate and a possibly paternalistic protective response.

¹⁶ C. Rehmann-Sutter & L. Hagger. Organised assistance to suicide in England? *Health Care Anal.* 2013 Jun; 21(2): 85–104.

¹⁷ Art.115, Swiss penal code.

unselfish suicide assistance is not. It is, therefore, legal. Case law has persistently confirmed that altruistic suicide assistance offered to a person with decision-making capacity and a well-considered wish to die cannot be prosecuted under art.115. Therefore, there is a privilege of assisting suicide for the ordinary citizen. This privilege is not unique to Switzerland, but here it is not counter-vailed by Good Samaritan legislation¹⁸. This privilege of assisting suicide is therefore applied in practice in Switzerland.

Does this privilege also apply to physicians or is it overridden by specific duties of health professionals? The Federation of Swiss Physicians and the Swiss Academy of Medical Sciences (SAMS) provide a code of professional conduct and medical-ethical guidelines for physicians, respectively. The latter includes some guidance to physicians confronted with a request for suicide assistance and defines conditions for its acceptability, but they are not legally binding by themselves. The legal norms currently applicable to the medical participation in assisted suicide have been shaped by case law and can be summarized as follows.¹⁹ Firstly, the privilege of assisting suicide does extend to physicians. For all assistors, whatever their profession, the legality of assisted suicide hinges on the altruistic motivation of the helper as well as the fact that the person is capable of decision-making and freely self-administers the lethal drug. Secondly, although 'assisted suicide is not part of medical activity', an individual physician is basically free to choose to provide it, within specific legal safeguards. In essence, the prescription of a fast-acting barbiturate by a physician licensed for private practice must conform to the legal requirement of following 'recognized rules of medical science'. According to a decision of the Federal Tribunal in 2006, this entails a diagnosis, an indication, a thorough discussion with the patient, and a painstaking determination of decisional capacity as regards the patient's decision to end her life. Unlike the ethical guidelines of the SAMS, the Federal Tribunal does not make a terminal disease a precondition for lawful assisted suicide by a physician.

The physician's privilege of assisted suicide is solidly established in Switzerland, in part because the relevant professional guidelines are relatively liberal, but also because the courts have consistently defended a liberal stance on assisted suicide, whether or not it involves a physician's participation. Physicians do have additional duties as compared to lay assistors, but these duties are those entailed by the competent and diligent practice of medicine in this particular situation. The physician's prescription privileges apply to prescribing a lethal

¹⁸ Which exists in Switzerland (art. 128 Swiss penal code) but is not invoked to oppose suicide assistance.

¹⁹ Swiss Academy of Medical Sciences. 2012. *Bases juridiques pour le quotidien du médecin*. Swiss Medical Association.

substance, in other words, the *power* vested in the physician to write a prescription for a controlled substance extends to cases where voluntary death is the intended use of that substance. Provided ordinary rules of professional conduct are adhered to, the terms of the choice of providing or not providing assisted suicide are not substantially different for physicians than for other citizens.

Recognizing claim-rights without entitlements

The legal framework of assisted suicide in Switzerland is 'lean'. It does not delve into the specifics of what a medical indication for assisted suicide may look like, nor does it deal explicitly with the existence of assisted suicide organizations. It allows an open and relatively undisturbed practice of AS, where the normative framework is a matter of informal custom rather than positive law. For instance, there is an implicit agreement that assisted suicide is not to be actively prevented by authorities or medical personnel, unless there is a presumption of an egregious violation of legal or regulatory norms, or of the informal norms set by right-to-die associations. In several localities, collaboration exists between authorities and right-to-die societies to ensure that post-mortem inquiries will be conducted in a discreet and sensitive manner. This open and pacified social practice is predicated on a set of expectations on the part of assistees, assistors and concurring physicians and family members. These expectations are considered to be rightful and can consequently be formulated in the language of claim-rights. After Gross, one of these claims may even be a legal claim and not just customary or moral one, namely the claim-right to obtain a fair hearing for one's request for assisted suicide.

Legal discussions have so far focused on entitlements and have not examined claim-rights as such. For example, in the Haas case the Federal Tribunal and the ECHR merely exclude any 'right to assisted suicide' and specifically deny any right to obtain the lethal drug sodium pentobarbital without a physician's prescription. This legal doctrine, however, only rules out an entitlement-right to obtain assisted suicide from the State and specifically to obtain a lethal substance without medical oversight. Yet claim-rights cover a much broader scope than entitlement-rights. The sorts of claim-rights that are plausibly excluded are of the following sort:

- (3) 'A has a right that B provide A with assisted suicide'

where B is an individual physician or other individual potential assistor. This is obvious, since such a claim-right would abolish the physician's (or other potential assistors') right to conscientious objection. It would in effect transform the discretionary privilege-right of assisting suicide into an obligation to provide it.

Furthermore, Haas explicitly invalidates a claim-right such as the following:

- (4) 'A has a right that B provide A with a lethal drug for the purpose of assisted suicide',

where B is some public authority which would be in a position to provide the lethal without a physicians' oversight and discretionary right to provide the prescription (or to refrain from providing it).

There are other examples, however, where case law as well as the implicit rules and expectations that frame the Swiss practice of assisted suicide can be understood as grounding a set of *claim-rights*, distinct from *entitlement rights* in terms of which this debate is too often framed. We are now in a position to list the rights relevant to assisted suicide (Table 2), after which we will outline which claim rights may require more explicit consolidation.

A SET OF RIGHTS REGARDING ASSISTED SUICIDE IN SWITZERLAND

Ending one's own life

Art 115 of the Swiss Penal Code recognizes a general discretionary right to end one's own life, confirmed in the Haas decision. This right is broad, imprecise, and strictly a privilege – otherwise described as a liberty-right. As outlined above, however, recognized norms regarding suicide assistance in Switzerland are also to be found in professional codes and other norms. Examining these norms shows that the Swiss legal situation and the role of doctors when receiving requests for suicide assistance do imply a number of claims (Table 2).

Claims to protection

A person making a request for assisted suicide arising from an 'irrational' motive, one that is not a self-determined choice but the result of decision processes perturbed by mental illness or other such factors, has a right to be protected from suicide, again by the state and by professionals. Swiss law requires that the dying person be capable of decision-making, a capacity that Swiss law does not define specifically for medical decision-making. Rather, this capacity is the general ability to make reasoned choices that is required for any binding decision, such as making a purchase, consenting to a medical intervention, marrying, or writing a will. It is presumed in adults and older adolescents. Evaluation of decision-making capacity is not, then, technically required prior to suicide assistance. The controversy that surrounds this practice, however, makes it prudent for helpers to obtain evaluation of decision-making capacity before suicide assistance. Formal evaluation serves to document capacity and is considered a requirement in practice.

Table 2. Rights recognized by case law in connection with the Swiss practice of AS

	<i>Privileges</i>	<i>Claims</i>	<i>Powers</i>	<i>Immunities</i>	<i>Against</i>	<i>Justification</i>
General						
Discretionary right to end one's life	Privilege: Choosing the time and manner of one's death					Haas §51
Assistor						
Discretionary right to provide AS (or not)		Privilege : Providing AS				SCC 115
Protection against unreasonable obstacles to providing AS		Claim: That there be no prevention of AS if criteria are fulfilled			Authority, institution or individual able to prevent AS	SCC 115 Implied by the claims of the requestor
Right to prescribe a lethal drug		Power: Giving patients the right to obtain these drugs				
Protection against being compelled to assist suicide		Immunity: from being forced to provide suicide assistance against the dictates of one's conscience				
Requestor						
Protection against self-interested exploitation of a suicide request		Claim: That there be no inducement or exploitation of a suicide request for selfish motives			Authority, institution or individual able to prevent AS	SCC 115
Protection against unreasonable obstacles to receiving AS		Claim: That there be no prevention of AS if criteria are fulfilled			Authority, institution or individual able to prevent AS	Haas §51
General duty of protection		Claim: To be protected against irrational suicide			The state	Haas §54–8
Professional duty of protection		Claim: To be protected against irrational suicide			Doctors	Professional implementation of state obligation. Standard of care rules.

NB: note that case law has confirmed that there are no rights to obtain AS, or to obtain a lethal drug, without a medical prescription

When someone requests suicide assistance, a second reason to evaluate her capacity will be to alleviate doubts regarding pathological suicide requests. This gives doctors a role in assessing whether this criterion is fulfilled.

The Haas doctrine (§54 and 54) provides additional grounds for assessment of decision-making capacity.²⁰ The court recognized that the state has an obligation to protect vulnerable persons against dangers even if these are caused by the persons themselves. From this, it derives a duty to verify that suicide assistance only follows a decision based on the 'free will of the individual concerned', and allows that requiring a medical prescription after psychiatric evaluation would be one way of fulfilling this duty. The more liberal a state is in allowing individuals to choose the manner of their own death, the more prudent it must be in verifying that such decisions are indeed free. It is not a feature of the assisted suicide law to protect persons who are capable of decision-making and acting freely from nevertheless making irrational decisions. This factor can, of course, colour decisions regarding whether or not to assist suicide on the part of potential helpers. This would be a problematic

feature of the Swiss context if a right to access assisted suicide were recognized. However, this is precisely what Swiss law does not recognize.

Although this evaluation is usually within the remit of doctors, the SAMS guidelines 'Medical care of dying persons' allows the verification of decision-making capacity to be conducted by a lay person: *The patient is capable of making the decision, his wish has been well thought out, without external pressure, and he persists in this wish. This has been checked by a third person, who is not necessarily a physician.* Since decision-making capacity is a legal requirement, patients have a claim to some verification even when they are not being assisted by doctors. This implies that non-doctors who assist suicide should be familiar with the most important aspects of capacity and either systematically request medical evaluation or acquire the ability to detect situations where capacity is doubtful.

Claims to beneficence

Those making requests for suicide assistance have the right to a certain level of beneficence, from the state and from professionals. Patients who request suicide assistance because they are suffering have a claim to medical care for their suffering. The corresponding duty of

²⁰ Haas v. Switzerland, 31322/07, 2011.

beneficence on the part of medical professionals is clear in the case of requests for medically assisted suicide. The exploration of alternatives is not only, perhaps not even primarily, a way to prevent suicides, it is a response to human distress.²¹ Fulfilling this duty is not straightforward: it requires knowledge and multiple skills. Controversies and emotions surrounding this topic can make these discussions difficult, and remaining non-judgmental is important to patient management.²² If the patient has decision-making capacity, a structured discussion about advance care planning should take place.²³ Suffering should be assessed using a holistic ‘total suffering’ palliative care approach.²⁴ Depression should be screened for and treated if and only if present. Where relevant and available, specialized palliative care expertise should be offered.

This claim to a response to human distress is particularly clear when a request for suicide assistance is made because a person is suffering as a result of a serious disease. This derives both from a general duty to assist others in distress, and from the commitments of medicine to respond to human disease. Rather than eliminating doctors from the process entirely, the ‘Swiss model’ gives individual doctors the option of remaining at the margins of the process rather than taking a central, piloting role. At these margins, however, there are roles of doctors to which patients can be said to have a real claim.²⁵ Since some derive from more general non role-specific duties, they also imply more general claims from non-doctors.

When a request is motivated by other kinds of suffering, the person making that request arguably also has a claim to some response to her suffering. In this case, however, the right person to respond may not be a physician. In such cases, do non-physicians have a corresponding duty of beneficence? A claim to assistance from non-physicians is less evident, because it is not associated with a role-specific duty. To the degree that we recognize general duties of beneficence towards those in distress, however, such claims do exist.

BALANCING CLAIMS: PROTECTION AGAINST UNREASONABLE OBSTACLES

Those receiving requests for suicide assistance have a discretionary right to provide or not provide such

assistance, and to be protected against unreasonable obstacles in implementing their choice. Similarly, those making requests for suicide assistance also have a right to be protected against unwarranted obstruction of *their* choice. This does not imply that no controls may exist. In an overwhelming majority of cases, for example, suicide assistance involves the ingestion of barbiturates. To protect the public against abusive use, these substances are only available with a medical prescription. In practice, doctors currently have the de facto ability to veto suicide assistance. Assisting suicide is a privilege, not a medical duty. This means that patients have no right to access such assistance, and doctors who refuse can simply refuse, without even invoking conscientious objection. Doctors thus do not have to provide any justification for their refusal. In the Haas case, a patient who was refused suicide assistance sued for the right to obtain barbiturates over the counter, without a medical prescription.²⁶ The court found against him, concluding that he had no valid claim against the state to obtain barbiturates.

In requiring a medical prescription, the state exercises a power to limit individuals’ privilege to acquire barbiturates. Case law has held that the requirement to protect others trumps the possible wrong incurred by legitimate suicide assistance candidates to whom the lethal drugs would be denied. However, if this wrong was found to be avoidable by some regulatory arrangement that would make the protection of others compatible with a claim to access for legitimate suicide assistance candidates, then such a claim should stand.

Similarly, although the law does not require any particular kind of suffering or even a medical diagnosis, current Swiss practices and guidelines require a terminal or otherwise incurable disease. This entails that access to a *diagnosis* must also exist. This requirement is not directly grounded in the fact that the condition to be confirmed is medical. Rather, if any limit is set to the practice of suicide assistance then the possibility of verifying the relevant criterion should be available. If one such limit is the presence of suffering due to a medical condition, candidates to suicide assistance must be in a position to have this criterion verified, lest they be deprived in practice of a claim-right to suicide assistance that is theirs in theory. This claim to a correct assessment of a medical condition also belongs to persons who do not fulfil it but in their case it is a claim to protection: it should be verified that they do not meet the condition because in that case they should not have access to suicide assistance. Whatever condition is prescribed for suicide assistance, the possibility of verification – including the possibility for a second opinion in case of disagreement – should exist.

²⁶ Haas v. Switzerland, 31322/07, 2011.

²¹ A. Hurst & A. Mauron. The ethics of palliative care and euthanasia: exploring common values. *Palliat Med.* 2006 Mar; 20(2): 107–12.

²² A. Mauron & S.A. Hurst. 2011. Physician aid in dying and euthanasia. In *Clinical Ethics in Anesthesiology*. G. Van Norman et al., editors. Cambridge: Cambridge University Press.

²³ J.A. Tulsky JA. Beyond advance directives: importance of communication skills at the end of life. *JAMA.* 2005 Jul 20; 294(3): 359–65.

²⁴ See for example B. O’Neill & M. Fallon. ABC of palliative care. Principles of palliative care and pain control. *BMJ.* 1997; 315(7111): 801–4.

²⁵ Hurst, *op. cit.* note 7.

COMPARISON WITH OTHER EUROPEAN COUNTRIES

We are now in a position to specify more precisely what sets Switzerland apart from other countries. We will consider England and Germany, because there is significant awareness of the Swiss practice in these countries, due in part to the fact that these countries provide much of the 'suicide tourism' towards Switzerland. They evince distinctive normative landscapes as regards suicide and suicide assistance, which we explore by specifying the Hohfeldian rights that are present or absent.

Assisted suicide illegal: UK

Once suicide is decriminalized, but without any further rights assertions being accepted, this is a 'naked' privilege of suicide. This is the current legal situation in the UK. Citizens have a right to end their life, i.e. citizens have no duty not to end their life, which is equivalent to saying that they have no duty to go on living.²⁷ What makes the privilege 'naked' is the absence of additional rights of any kind attached to it. The dying person who attempts suicide has no *prima facie* claim against individuals who may be in a position to save her life against her will, unless that will could be established on account of an advance directive or DNAR order. In addition, persons who might be willing to offer suicide assistance have no privilege to do so, not even in the minimal form of agreeing to be present at the suicide of a loved one. In fact, the criminalizing of assisted suicide in England is most severe, since it applies to actions that merely facilitate suicide assistance by another, even if the suicide occurs abroad. Since 2010, and as a result of the *Purdy* case, the policy of the Director of Public Prosecution focuses on actions with malicious intent. Nevertheless, this policy decision does not abolish the legal liability involved in compassionate actions by consenting relatives or by healthcare personnel indirectly facilitating an act of assisted suicide.²⁸ As evidenced by recent discussions in Parliament about the Falconer Bill, nothing short of a formal legalization of assisted suicide in defined circumstances would change that situation.

Assisted suicide legal but only just: Germany

German criminal law does not include any provision making assisted suicide itself a crime. However there are

circumstances in which assisted suicide could in principle be prosecuted as failure to assist a person in peril (paragraph 323, Federal Criminal Code). If the person providing suicide assistance is a close family member or a physician, a guarantor's duty to preserve life could in principle be invoked. According to some reports, the provision of assistance to a suicide plan of a person who is capable of decision-making is unlikely to be prosecuted.²⁹ Moreover, the guarantor's duty to preserve life can be waived by a written declaration of the patient. National professional guidelines stipulate that assisted suicide is not part of the medical role and, since 2011, they also state that physicians should not provide assisted suicide. However, the extent to which a physician would face disciplinary censure seems to vary according to location, as medical boards in several *Länder* have chosen not to incorporate this controversial anti-assisted-suicide policy into their local regulations.³⁰ Since 2015, German criminal law also prohibits commercial assisted suicide, apparently without interfering with private arrangements but without clarifying when assistance by doctors may be considered 'commercial'.³¹

Altogether, these facts confirm the existence in Germany of a privilege-right of assisting suicide, i.e. the absence of a general duty not to provide suicide assistance. This privilege is somewhat restricted – to an extent that is not easy to define precisely – by the possibility of some forms of suicide assistance being prosecuted. In Hohfeldian terms, both the State and regulatory authorities of the medical profession have the *power* to restrict the privilege of assisted suicide, without abolishing it altogether. Furthermore, the *privilege* of assisting suicide does not entail any *claims* for assistors or assistees. It is important to state accurately what those non-existent claim-rights are. Persons seeking assistance to end their life have no claim to obtain such assistance; not from any particular individual³² and not from any person or institution either. In contrast to Switzerland, such persons do not enjoy the weaker claim to have their request for suicide assistance evaluated impartially according to predefined, openly discussed criteria. Finally, neither assistors nor assistees have any claim against third parties thwarting their plan, for instance by treating it as a medical emergency to save a life.

²⁷ Neither do citizens have a duty to end their life (obviously), which is why the privilege of suicide is a paired privilege.

²⁸ Director of Public Prosecutions. UK. Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide. 2010. Available at: https://www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.html (Accessed September 2nd 2016).

²⁹ V. Lipp & A. Simon. Beihilfe zum Suizid: Keine ärztliche Aufgabe. *Dtsch Arztebl.* 2011; 108(5): A2012–16.

³⁰ U. Wiesing. Durfte der Kieler Ärztetag den ärztlich assistierten Suizid verbieten? Nein! *Ethik Med.* 2013; 25(1): 67–71.

³¹ The German term, *geschäftsmässig*, is even broader than the term 'commercial' in English and could include the habitual or associative provision of suicide assistance. The lack of clarity is thus greater than would be the case in English.

³² This results from the privilege of assisting suicide being a paired privilege, entailing the discretionary right to assist or not to assist suicide.

Implementing claim-rights in Switzerland

Two Swiss cantons, Vaud in 2013 and Neuchâtel in 2014, have taken steps towards implementing some of the claim-rights implied within the 'Swiss model' in legislation. Only the case of Vaud will be examined here.³³ This legislation was adopted in 2013 after a vote by the citizens of Vaud and specifies rights and duties regarding requests for assisted suicide made by patients in state-run and state-subsidized health care institutions. This statute includes the following:³⁴

Health-care institutions with public-interest status may not oppose the carrying out within the institution of an assisted suicide requested by a patient or resident, provided that the following conditions have been met:

- a. The physician in charge of hospital treatment or of the residential care facility, in consultation with the care team, the treating physician, and relatives designated by the patient/resident, verifies that:
 1. The patient/resident has decision-making capacity as to his/her decision to end his/her life and persists in the wish to end his/her life;
 2. The patient/resident suffers from a severe and incurable illness or from severe and incurable sequelae of an accident;
- b. alternatives, especially those involving palliative care, have been discussed with the patient/resident.

Although right-to-die associations are not acknowledged as such, it is understood that the assistor will be a person contacted by the patient/resident outside the institution. Also, employees of the institution may not participate in the assisted suicide in their professional capacity. Therefore, the authorization that is defined by this law represents permission for the assisted suicide to go ahead on the premises, not a commitment to provide it. In addition, the procedure for handling requests for assisted suicide specifies rules of due diligence such as the need for a written request, a deadline for answering the request, and the possibility for the patient/resident of appealing the decision.

This legislation was seen as rather restrictive at the time of the vote because it required more stringent safeguards than the alternative that was also on the ballot. It is not expected to greatly change current practice. Nevertheless, it is conceptually significant since for the first time in Switzerland the law defines a duty to abstain from preventing assisted suicide if certain conditions are met. This duty is the correlate of a claim-right that belongs to the persons requesting assisted suicide, namely

the right not to be prevented from receiving suicide assistance if one is a patient in a public hospital or a resident in a long-term care facility. Furthermore, this legislation creates specific duties and rights for *some* physicians: those who are in a position to authorize or prevent assisted suicide from being carried out in the institution that they are responsible for.

Difficulties within the Swiss framework

Some of the claims implicit in the Swiss practice of suicide assistance are uncontroversial, but poorly applied. Implementing requestors' rights against unreasonable obstacles, and their right to be protected against irrational suicide, will both require access to a fair and competent assessment of decision-making capacity. This access can be laborious. Since finding the patient incapable of decision-making effectively constitutes a veto of suicide assistance, some doctors find this evaluation difficult to distinguish from an active participation in assistance itself.

Other claims raise controversy in their application. The object of the duty of beneficence is not clear either. The duty of beneficence in situations of suicide assistance requests has traditionally been understood to imply a duty to prevent suicide at all costs. This, in turn, may lead to unreasonable obstacles to suicide assistance, a transgression of a different claim. The language of suicide assistance as the 'last service to a friend' (*letzter Freundesdienst*), however, also supposes a duty of beneficence to others. In this case, this is beneficence understood as sufficient help for the person to go through with suicide despite attempts to dissuade her or help her in other ways.

Moreover, some persons make rational suicide assistance requests on grounds of loneliness, or not finding meaning in lives that have lost pleasure or usefulness to others. How far does our duty of beneficence extend to a collective duty to provide alternatives to suicide, which the person would find acceptable? This duty could become quite extensive, but this does not invalidate it. We may have to accept that it exists, to the same degree with which we wish to avoid suicide in such circumstances. Simultaneously rejecting a duty of beneficence in such cases, and allowing obstacles to prevent assisted suicide for these persons, amounts to affirming that their suffering is preferable to their death despite their own evaluation to the contrary.

This is currently one of the weak points in the Swiss response to suicide assistance requests. Currently, the exploration of alternatives and the attempt to alleviate social or so-called 'existential' suffering are mostly left to family members. They receive little support, no training, and few opportunities to learn from the experience of others. Unsurprisingly, such suffering tends to receive

³³ Canton de Vaud, Directive et loi sur l'assistance au suicide, 2013. Available at: <http://www.vd.ch/themes/sante/professionnels/assistance-au-suicide/> (Accessed September 2nd 2016).

³⁴ The translation is the authors' and has no official standing.

medical attention – to become medicalized – even when a medical response is clearly inappropriate. The two other main reactions to requests based on non-medical reasons are acceptance based solely on the verification of capacity, and the wish to forbid all suicide assistance in such cases. None of these reactions fulfils all the outlined claims: doing so would require providing non-medical assistance for non-medical suffering.

CONCLUSION

The practice of assisted suicide appears to be uniquely liberal in Switzerland, at least among countries that do not legalize euthanasia as well. Yet there is no unique set of distinctive legal provisions that set Switzerland apart. In fact several other European countries, such as Germany, would seem to be formally more liberal than Switzerland since they lack any statutory prohibition of assisting suicide. To understand these differences, we need a much finer-grained analysis of the normative claims that are formally or informally recognized in Switzerland as compared to elsewhere. We have seen that the privilege of assisting suicide is not specific to Switzerland. However this privilege stands on firmer ground in Switzerland because it is not rendered moot by ‘secondary’ legal constraints that are more compelling in other countries: these include Good Samaritan laws making the saving of life obligatory, more restrictive rules on access to controlled substances, or professional guidelines that can place physicians at risk of losing their licence.

Beyond the privilege of assisting suicide, its open practice relies on a set of claim rights that exist despite the absence of an entitlement to suicide assistance. These include claims for protection against irrational suicide,

but also claims to more general beneficence in distress, and protection against unreasonable obstacles to suicide assistance both for requestors and assistors. The implementation of some of these claims is more fragile in practice. The point at which obstacles to suicide assistance become unreasonable is unclear in practice, as is the extent to which duties of beneficence generate a duty to provide alternatives to suicide when requests are motivated by non-medical grounds. Because physicians effectively have veto power over access to suicide assistance, the protection of requestors against unreasonable obstacles is tenuous. That these claims are implicit in the ‘Swiss model’ rather than explicit in Swiss legislation of suicide assistance makes their protection more difficult to implement, but no less important.

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