Early experiences with a hospital policy for assisted suicide

A physician's view

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January 29, 2015 – Basel

“If I ever end up dancing like that, please buy me a one way ticket to Switzerland.”

Hospital policy on Assisted Suicide - Physician's view

Outline

- Swiss legislation and practice
- First in-hospital AS clinical case
- Vaud law regarding in-hospital AS

Swiss Legislation and Practice

- Article 15 Swiss penal code stipulates:

  « Anyone with a **selfish motive** who incitates a person to commit suicide or who helps that person to commit suicide, if the suicide is consummated or attempted, will be punished by a maximum of 5 years reclusion or imprisonment »

Swiss Legislation and Practice

Swiss Legislation and practice

- Right-To-Die-Societies (RTDS) initially limited their practice to patient’s home
- RTDS lobby and pressure for AS in nursing homes (AS in parking lot)
- Some nursing homes allowed AS since 2001
- AS policy in acute-care university Hospital in 2006

Swiss Legislation and Practice

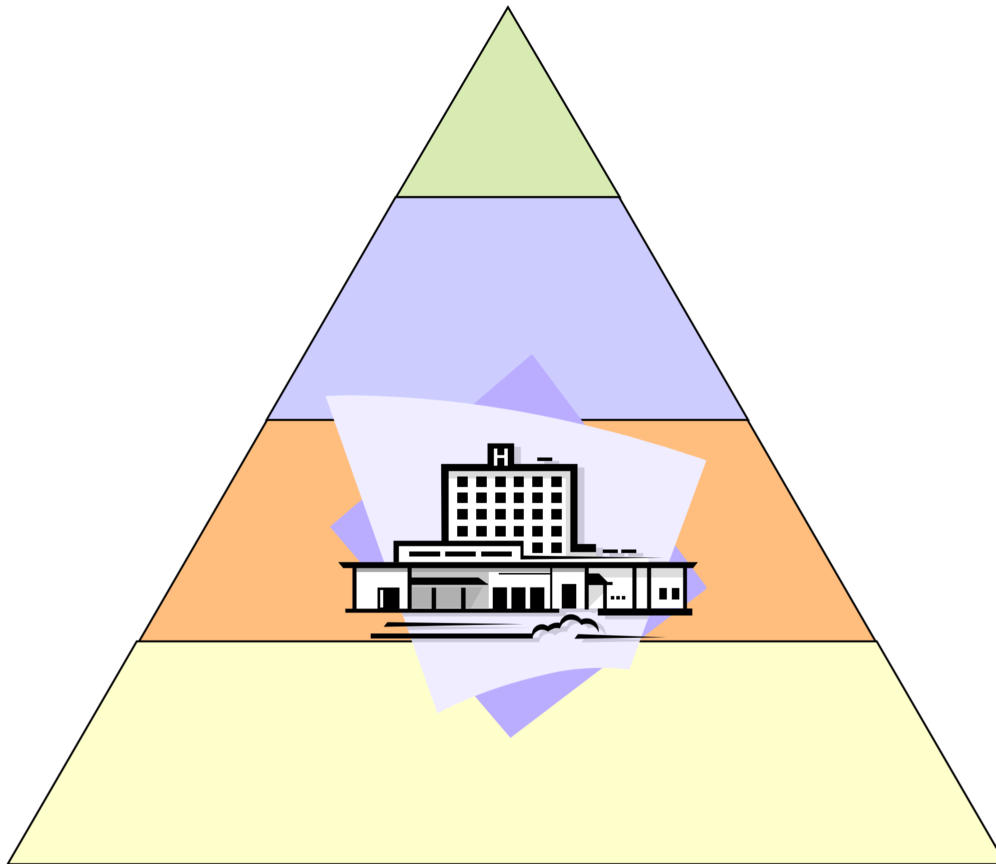
- Swiss National Advisory Commission on Biomedical Ethics 2005: Every acute care hospital should determine if AS is accepted within its walls

- January 2006: Institutional policy on AS in Lausanne University Hospital. « Patients condemned to stay at the hospital for the rest of their lives should have the same rights that other citizens »

Clinical Case

- 53 y/o male patient
- PMH of reactive depression (6 years ago)
- Diagnosis of myelofibrosis 2 years ago
- Diagnosis of acute leukaemia 1 year ago
- Non response to chemotherapy
- Bone metastases
- Hospitalized for pain treatment
- Persistent symptomatology (NSAID, fentanyl, hydromorphone, corticoesteroids, quetiapine)
- Patient request AS during hospital stay

Hospital discussion – Structure



Special Committees

Medical Director

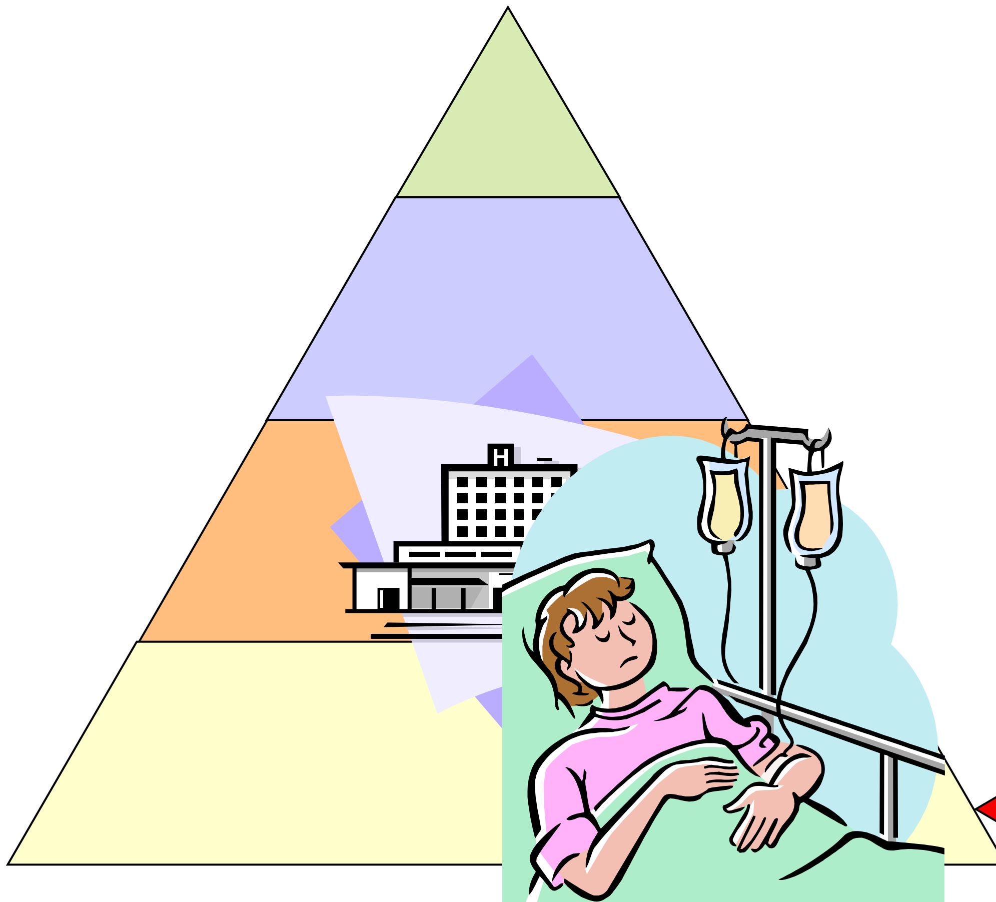
Chief of Service

Attending physician

Chief Residents

Residents

Hospital discussion – Structure



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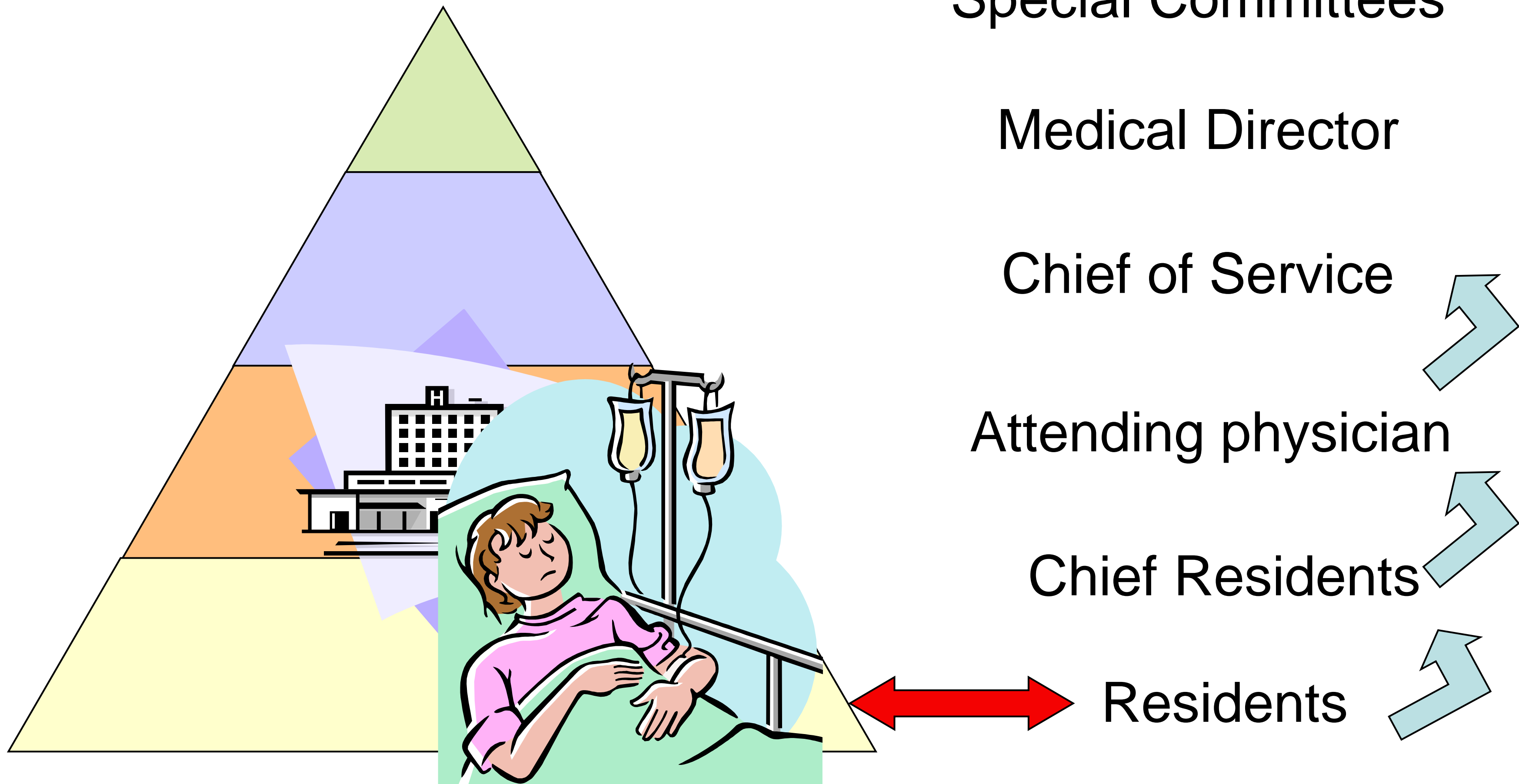
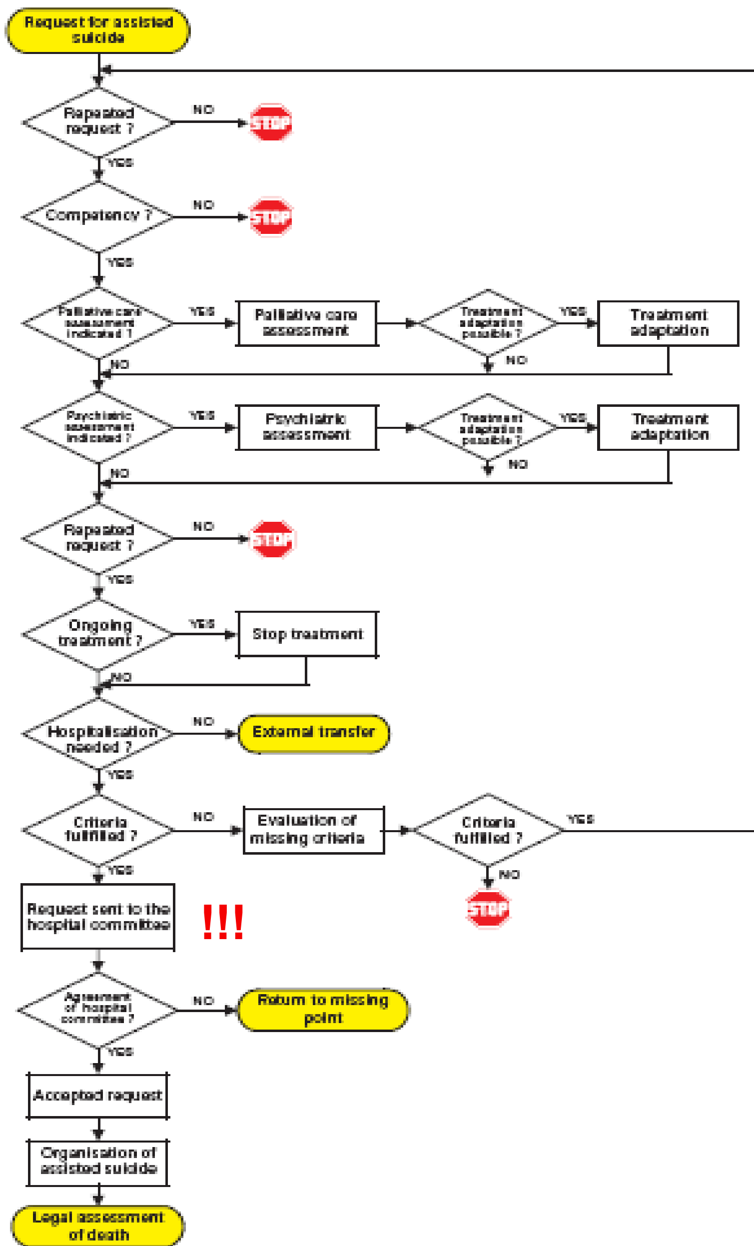


Discussion - Patient

- Patient demand AS based on:
  - Lack of response to treatment
  - Progression of symptoms
  - Reflected decision
  - Autonomy
  - Supported by the law
  - Supported by Institutional policy
  - Low probability of discharge
  - Already member of RTDS

Discussion – Health-care team

- First intuition to deny demand because:
  - Against usual practice
  - « Psychiatric » comorbidity
  - Against Hippocratic Oath
  - AS is not a «medical activity »
  - Too « young » to made this decision, so decision belongs to a « chief »
- Physician follow institutional checklist



Repeated request?

Competency?

Palliative Care?

Psychiatric evaluation?

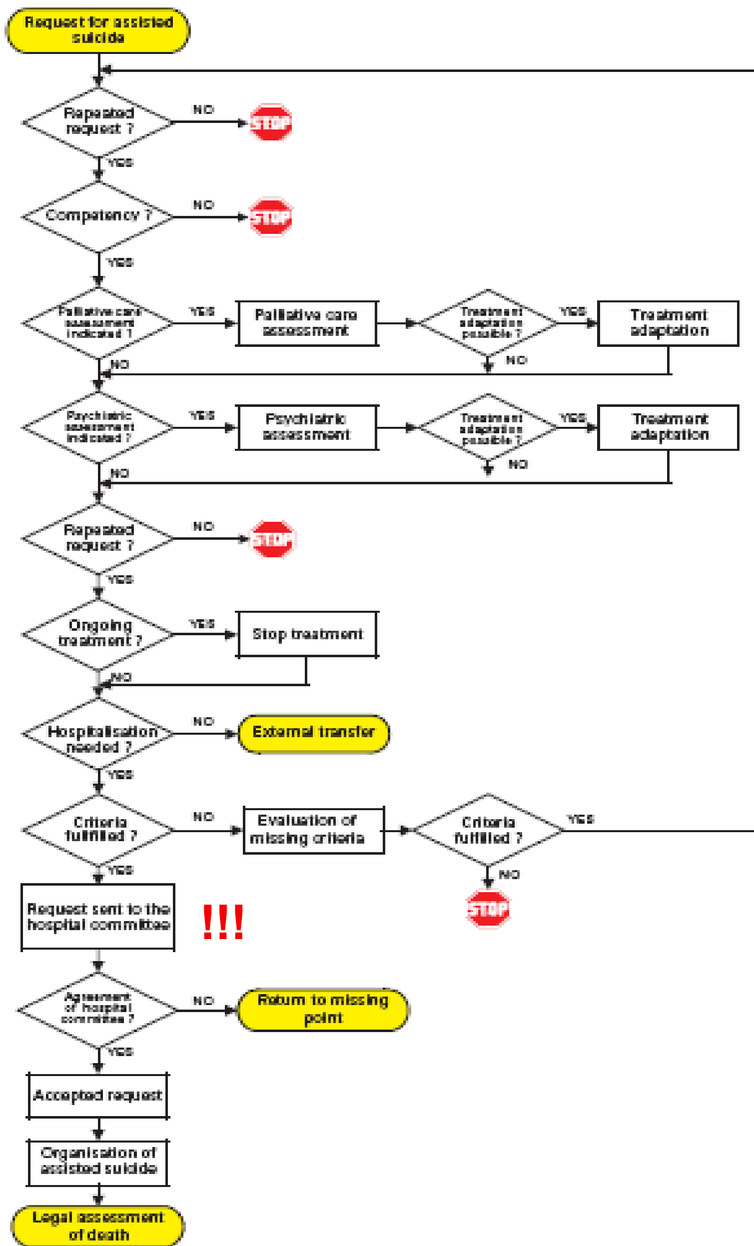
Repeated request?

Ongoing treatment?

Hospitalisation needed?

Criteria fullfiled?

Request to the Hospital Committee



Attending physician:
Personally against but all institutional criteria fulfilled

Chief of Service:
Despite institutional policy, AS will never be performed in MY Service

Hospital Committee:
Criteria fulfilled but…

Discussion – Hospital Committee

- Agree that policy criteria fulfilled BUT
- Mostly against demand:
  - No previous cases
  - Hospital as a place of cure
  - Society perception
  - Media reaction
  - Why being the first Hospital???
  - Psychiatric comorbidity
  - **Advice HCT to make patient change his mind**

Discussion – Health-care team

- HCT waiting for hospital committe advice
- Many members of the HCT changed advice and support patient's demand (mostly based in patients symptoms)
- Other HCT request to don't treat patient
- Perception that authorities were waiting *for disease evolution and avoiding the decision*

Physician on charge perception

- Institution was not ready for AS
- Multiple « patients » in charge (patient, family, residents, nurses)
- Contradictory opinions among hospital authorities
- Perception that authorities were *waiting for disease evolution*
- *Feeling of loneliness*

Patient died three weeks after his request due to disease progression

First-case conclusions / proposals

- Gap between theory and practice
- Great distance between HCT and Hospital authorities
- Gap between clinicians expectations and ethicist / ethical committee work
- Loneliness of HCT members (and patient?)
- Clear procedure on AS could help decision-making and patient-care

First-case conclusions / proposals

- AS policy should be discussed with HCT to avoid contradictory messages
- Institutions that accept AS within its walls should asume their responsibility
- Ethicist's work should be also done in the « field » and not only « behind a desk »
- Support to HCT should be guaranteed

Assisted Suicide in Health Care Institutions in Switzerland

Swiss Legislation and practice

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- **VD law – 2012-2013**

Assisted Suicide in Health Care Institutions in Switzerland

Vaud 2012-2013 Legislation

- Until 2012: few institutional policies and AS in some nursing homes

- EXIT practice AS at patient's home. As nursing home constitutes the only domicile for some patients, and law should be equal to every citizen, nursing homes do not have the right to prohibit assisted suicide within its walls

EXIT A.D.M.D. Suisse romande

Association pour le Droit de Mourir dans la Dignité

http://www.exit-geneve.ch

Membres au 26 janvier 2015: 20’617

EXIT ADMD n'aide que ses membres domiciliés en Suisse romande, s'ils ont leur discernement, s'ils sont atteints d'une maladie incurable avec un pronostic fatal ou des douleurs intolérables ou invalidité importante. L'assistance au une suicide est totalement gratuite !

L'assistance au suicide est totalement gratuite pour les membres de l'association !

Cotisations annuelles :

CHF 40 pour les membres actifs et CHF 35 pour les membres à l'AVS-AI

EXIT A.D.M.D. Suisse romande

Evolution du nombre d'assistances au suicide effectuées entre 2001 et 2013

En 2001	**17**
En 2002	**35**
En 2003	**48**
En 2004	**42**
En 2005	**54**
En 2006	**65**
En 2007	**66**
En 2008	**75**
En 2009	**69**
En 2010	**91**
En 2011	**111**
En 2012	**144**
En 2013	**155**

160
140
120
100
80
60
40
20
0
1

En 2001
En 2002
En 2003
En 2004
En 2005
En 2006
En 2007
En 2008
En 2009
En 2010
En 2011
En 2012
En 2013

EXIT A.D.M.D. Suisse romande

Nombre d'assistances au suicide effectuées
du 1er janvier au 31 décembre 2013 :

155

A domicile	:	**141**
En EMS	:	**10**
A l'hôpital	:	**4**

Canton de Vaud	:	**69**
Canton de Genève	:	**43**
Canton de Neuchâtel	:	**19**
Canton de Berne	:	**5**
Canton de Fribourg	:	**8**
Canton du Valais	:	**8**
Canton du Jura	:	**3**

Assisted Suicide in Health Care Institutions in Switzerland

Vaud 2012-2013 legislation

- EXIT proposal: **oblige** every **nursing home** receiving public subvention to **ACCEPT** assisted suicide within its walls
- Counter project of the executive: **Any health-care institution has not the right to refuse** AS if this list of conditions is fulfilled

Modification LSP-VD janvier 2013

Art. 27d Assistance au suicide en établissement sanitaire reconnu d'intérêt public [29]

[1] Les établissements sanitaires reconnus d'intérêt public ne peuvent refuser la tenue d'une assistance au suicide en leur sein, demandée par un patient ou un résident, si les conditions suivantes sont remplies :

- a. le médecin responsable du traitement hospitalier ou de l'établissement médico-social (EMS), en concertation avec l'équipe soignante, le médecin traitant et les proches désignés par le patient ou le résident, vérifie que celui-ci :
  1. est capable de discernement pour ce qui est de sa décision de se suicider et persiste dans sa volonté de se suicider ;
  2. souffre d'une maladie ou de séquelles d'accident, graves et incurables ;
- b. des alternatives, en particulier celles liées aux soins palliatifs, ont été discutées avec le patient ou le résident.

[2] Lors de l'examen des conditions prévues à la lettre a) de l'alinéa 1, le médecin responsable peut solliciter l'avis d'un autre médecin autorisé à pratiquer dans le Canton de Vaud ou d'une commission d'évaluation interne à l'établissement.

[3] Le médecin responsable se détermine par écrit sur la demande d'assistance au suicide dans un délai raisonnable. Il en informe les instances de direction de l'établissement.

[4] Si le patient dispose d'un logement extérieur et lorsque l'établissement n'a pas une mission d'hébergement médico-social, le médecin responsable peut refuser que l'assistance au suicide se déroule au sein de l'établissement, à la condition que le retour du patient dans son logement soit raisonnablement exigible.

[5] Le personnel de l'établissement et le médecin responsable ou traitant impliqués ne peuvent participer, à titre professionnel, à la procédure de mise en oeuvre d'une assistance au suicide.

[6] Lorsque la mise en oeuvre de l'assistance au suicide se déroule au sein de l'établissement, le médecin responsable doit s'assurer que le moyen employé est soumis à prescription médicale.

[7] Le département précise les conditions d'application de cet article, après consultation des partenaires concernés.

Conditions d'application AS

- Written demand of the patient to the HC direction
- Demand is then transmitted to «médecin-responsable»
- «Médecin responsable» verifies if the 3 legal conditions are fullfilled: **discernement capacity**, **persistent demand, suffering** of «maladie (ou de séquelles d'accident) *graves et incurables*»
- Palliative care should be discussed with the patient
- The «*médecin responsable*» should give a written response within 4 weeks after patient's demand
- The non-respect of the directive, specially regarding the limit time of 4 weeks, could be punished

Conclusions (questions)

- Importance of institutional policy and discussions
- Can the state oblige an institution to act against their own moral principles?
- Should clinical ethicist be implied in this decision?
- Which role should be play by the CEC?
- Which role for CEC if they refuse to participate?

Thanks for your attention!!!!

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