

Medical-ethical guidelines: Coercive measures in medicine

Swiss Academy of Medical Sciences

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I. Preamble

Patients should be able to give and justify their consent to medical measures in an autonomous manner – i.e. on the basis of reliable information, following careful assessment and in accordance with their personal values. Autonomy is thus a central concept in medical ethics. Any use of force runs counter to the principle of respect for autonomy, and yet there are certain medical situations in which coercive measures are unavoidable. This may be the case, in particular, where it is not otherwise possible to comply with the principles of beneficence and non-maleficence.

The present guidelines provide a framework for addressing questions arising in this thorny area. They take into account the provisions of the child and adult protection law which came into effect on 1 January 2013. These regulations not only specify essential procedural requirements with regard to coercive medical measures, broadly understood, but also – as part of the Swiss Civil Code (SCC) – help to harmonise at the national level the legal position which was previously characterised by substantial differences from one canton to another. In particular, the new legislation also regulates the representation of persons lacking capacity in relation to medical measures.

The guidelines are designed to promote and maintain awareness of the fact that coercive measures of any kind – even if they comply with all the relevant procedural requirements – represent a serious infringement of fundamental personal rights and thus require ethical justification in each case. Among the professional groups concerned, the appreciation of this key point must not be weakened by the fact that rules and procedures are defined for coercive measures. Compliance with procedural requirements does not in itself provide a justification for the application of such measures. In all cases, careful ethical reflection is just as indispensable as rigorous compliance with legal provisions and applicable guidelines.

These guidelines¹ are addressed to the members of medical² teams providing care in institutions, to independent physicians and to the domiciliary care sector. The focus is on the following questions:

- What can be done to help avoid the use of coercive measures (prevention, alternatives)?

- What ethical and legal conditions have to be met for coercive measures to be considered indispensable and justifiable?
- In the decision-making process for the application of a coercive measure, what needs to be taken into consideration within the team? When a coercive measure is planned or has been implemented, what type of communication is required with the patient, the trusted person, the authorised representative or the relatives?
- What precautions are to be taken to ensure that, if coercive measures are deemed essential, they are implemented as gently as possible and any traumatic effects are kept to a minimum?
- How is (possibly long-term) follow-up care to be planned and provided for persons undergoing coercive measures?
- How is the procedure adopted to be documented and evaluated?

II. Guidelines

1. Scope of the guidelines

The present guidelines are addressed to physicians, nurses and other healthcare professionals responsible for carrying out or ordering coercive measures. They cover the entire range of coercive measures employed in patients for medical purposes (i.e. prevention, diagnosis, therapy or rehabilitation). Not covered are coercive measures carried out for non-medical purposes. For care professionals in the areas of social work and special-needs education, specific guidelines are to be complied with.

2. Basic concepts and legal framework

Coercion (the use of force) means carrying out a measure in spite of the fact that the person concerned either indicates or has previously indicated – through an expression of wishes or opposition – that he or she does not consent to it. In medical practice, force can take a wide variety of forms, whose ethical and legal acceptability varies across a continuum extending from imperative to completely unacceptable (cf. Annex A). The broad conception of coercion adopted here encompasses not only physical but also

less obvious types of force – in particular, the application of overt or covert force by psychological means, either directly, in contact with a patient, or indirectly, with the involvement of relatives or other relevant persons. In this area, there is an increased risk that force may not be perceived as such by the professional groups concerned, but as a «normal» and unavoidable component of the treatment and care process.

Within the meaning of these guidelines, measures applied in a medical context are *coercive* if they are carried out against the patient's self-determined wishes or in spite of his/her opposition.³ In determining whether or not a measure is coercive, it is irrelevant whether the wishes are evident – i.e. articulated by a patient with capacity – or have to be ascertained in the form of previously stated or presumed wishes because the patient (temporarily) lacks capacity. Also immaterial is the question whether opposition is merely expressed through verbal or non-verbal refusal or also takes the form of active resistance.

In patients lacking capacity, coercive measures may become unavoidable if, in spite of vigorous efforts, an imminent risk to welfare cannot be averted with the agreement of the person concerned. In patients who have capacity, coercive medical measures are generally not permissible and may only be applied in connection with an involuntary committal, in the execution of penal measures, under the Epidemics Act, or possibly on the basis of cantonal regulations.⁴ It is, however, never permissible for persons with capacity to be subjected to medical measures which violate their physical integrity – in particular, treatment administered forcibly.

Switzerland's adult protection law regulates the use of coercive measures in specific areas, i.e. in connection with an involuntary committal or the detention of patients admitted voluntarily, or during stays in residential or nursing institutions; in particular, it includes provisions designed to strengthen legal protection for the persons concerned.

In practice, a distinction can be made between compulsory drug *treatment* (compulsory treatment in the narrow sense) and the forcible administration of sedative agents in cases of danger to third parties.⁵ In addition, there are numerous other forms of restriction of liberty which do not involve the use of medication.

2.1. Measures restricting liberty

The term *restriction of liberty* covers the restriction of freedom of movement and the curtailment of other fundamental rights. Measures restricting liberty are used primarily in cases where a risk of harm to the patient cannot otherwise be averted; less frequently, they may also be used to avert a risk to third parties, or to prevent serious disruption to community life. A restriction of liberty which is undertaken at the request of the person concerned or is discussed in advance and accepted as an incidental effect of treatment is not considered a coercive measure within the meaning of these guidelines. Restrictions of liberty which are passively accepted or even not perceived as such by the person concerned may constitute a coercive measure if they are contrary to the person's presumed wishes.

2.1.1. Restriction of freedom of movement

The term *measure restricting freedom of movement* covers any restriction imposed on personal mobility. This may involve mechanical restraints, medication, or the use of psychological means.⁶

2.1.2. Other measures restricting liberty

As well as restrictions on freedom of movement, *measures restricting personal liberty* may take other forms – in particular, restriction of privacy, e.g. permanent (electronic) monitoring, and individual restrictions on the use of substances considered harmful (such as alcohol, tobacco or confectionery) or on freedom to communicate (e.g. in relation to visits, telephone calls, etc.).

2.2. Compulsory treatment⁷

Compulsory treatment refers to any coercive medical measures designed to maintain or restore health.

In patients with capacity, compulsory treatment is not generally permissible. Treatment which is necessary for the common good may, however, be carried out in a few exceptional situations where a specific legal basis exists. This will be the case if a patient who is obliged to choose between two undesired alternatives prefers the option of accepting treatment to a restriction of liberty which would otherwise be ordered (e.g. treatment of tuberculosis rather than isolation, or court-ordered treatment rather than deprivation of liberty).

In patients lacking capacity, compulsory treatment may be carried out in spite of opposition if no previous expression of wishes to the contrary can be discovered and consent has been given by an authorised representative.⁸ In cases where a serious risk cannot otherwise be averted, compulsory treatment can also be initiated before consent is obtained. In the case of patients with mental disorders who lack capacity⁹ and are subject to involuntary committal,¹⁰ compulsory treatment is, however, possible under certain conditions – under Art. 434 or Art. 435 SCC – without the consent of an authorised representative (cf. Section 4.2.).

In cases where, for reasons of urgency (cf. Section 2.5.), information on the patient's wishes cannot be obtained, medically indicated measures which are undertaken in the patient's best interests and in the absence of verbal or non-verbal opposition are not considered to be compulsory treatment within the meaning of these guidelines.

2.3. Involuntary committal/Detention of persons admitted voluntarily

In *involuntary committal*, a person is involuntarily admitted to an appropriate institution for treatment and care.

A prerequisite for the ordering of involuntary committal is the existence of a debilitating condition (mental disorder or disability, or severe neglect) necessitating treatment or care which cannot be provided other than through involuntary committal to an appropriate institution (individual need for protection). An unreasonable burden placed on relatives or other third parties may be an additional important criterion, but it cannot in itself justify the ordering of involuntary committal. Under Art. 426 ff. SCC, incapacity is *not* a requirement for the ordering of involuntary committal.

While involuntary committal is always a coercive measure, it does not in itself mean that the person concerned may be subjected to compulsory drug treatment. Compulsory treatment may only be undertaken in cases where the patient lacks capacity, no less intrusive alternative measures are available, and treatment has been ordered in writing by the chief physician (Art. 434 SCC) or is required in an emergency (cf. Section 2.5.).

In *detention* (Art. 427 SCC), a person with a mental disorder who has entered an institution voluntarily is detained involuntarily because of a serious risk of harm to the patient or third parties. The patient can be detained by the institution's medical management for a maximum period of three days.¹¹

The institution to which a patient is involuntarily committed must be appropriate (Art. 426 SCC); i.e., it must be capable of developing and implementing a care and treatment plan. The goal of treatment may also be to influence the patient's state of health at least to such an extent that less restrictive measures become possible (e.g. outpatient treatment).

Involuntary committal does not necessarily involve a secure psychiatric ward; the patient may also be admitted to an open ward, a non-psychiatric acute hospital, or a residential and nursing institution. The choice of institution depends on the purpose of the involuntary committal.

2.4. Capacity

Capacity is a central legal concept and, as such, is also of great importance from a medical and ethical viewpoint. The core element is the ability to comprehend a given situation and make a reasonable decision in accordance with one's own values. Misunderstandings frequently arise from the fact that, in terms of presence or absence, capacity is *absolute*: in relation to a treatment decision, a person either has or does not have capacity, with no gradation between the two extremes. In contrast, with regard to the questions concerned, capacity is *relative*: thus, a person with a mild cognitive impairment may lack capacity in relation to a complex decision but at the same time have capacity to consent to a readily comprehensible medical intervention.

In individual cases, it may be very difficult to determine whether or not a person has capacity. Capacity is generally presumed to be present; this means that what requires justification is the opposite – incapacity. Crucial importance attaches to the psychopathological findings identified by the attending physician, if necessary in consultation with an expert. Of particular relevance is information regarding capacity provided by people closely associated with the patient.

Decision-making can be facilitated by the use of standardised diagnostic procedures (questionnaires) tailored to this context. On no account is incapacity to be presumed merely on the basis of a diagnosis such as schizophrenia or Alzheimer's disease, or a congenital cognitive impairment. Likewise, incapacity must not be automatically inferred from failure to consent to a proposed procedure which is medically indicated.

2.5. Urgent situation

A situation is considered *urgent* if immediate medical action is required to save life or prevent serious harm. In such situations, the physician is entitled to carry out the necessary medical measures without first obtaining the consent of a patient lacking capacity or the authorised representative (Art. 379 SCC¹²). This applies not only for emergencies in the strict sense of the term, but also for situations where, although it is not clear who the authorised representative is, delaying treatment would pose a serious risk to the patient's health. The authorised representative must, however, be informed as rapidly as possible and the patient's presumed wishes must be determined.

In deciding whether measures must be taken or can be deferred, account is to be taken of the extent to which delayed treatment would be detrimental to the patient's health. According to Art. 379 SCC, treatment must be guided by the patient's presumed wishes and interests. This means that, given the various options available, the treatment team should choose that which is most likely to be in accordance with the patient's presumed wishes.

2.6. Serious disruption to community life

Under Art. 383 SCC, if less severe measures are patently inadequate or prove to be so, a residential or nursing institution may apply measures restricting the freedom of movement of persons lacking capacity in order to remedy serious disruption to community life. Under Art. 438 SCC, measures restricting freedom of movement in the event of serious disruption to community life can also be applied in the context of involuntary committal¹³. Judging when a disruption is sufficiently serious to warrant such measures is not easy in individual cases; it must, however, always be an exceptional situation. The disruption to community life must be so intense that the effects for those concerned are intolerable. Institutions are responsible for specifying in internal guidelines who is authorised to order such measures.

2.7. Severe neglect

Under Art. 426 SCC, involuntary committal may be ordered on the grounds of severe neglect, as well as mental disorder or disability, if the requisite treatment or care cannot otherwise be provided. Severe neglect is usually the result of a mental or physical illness. Neglect is not a technical term in medicine, and there is no generally accepted definition. Consequently, practices may vary among the persons responsible for ordering involuntary committal. It is, however, extremely rare for involuntary committal to be ordered solely on the grounds of severe neglect, i.e. in the absence of a mental disorder.

3. Principles

3.1. Respect for autonomy

The patient's right to self-determination is a fundamental principle of medical ethics, which is also recognised in international conventions, constitutionally guaranteed and enshrined in civil and criminal law. Whenever coercive measures are applied, the principle of patient autonomy – emphasising the priority of self-determination – is in

tension with the principle of beneficence/non-maleficence, which requires medical professionals to promote the welfare of patients and not to harm them.

While there are exceptional situations in which coercive measures are unavoidable and the right to self-determination is restricted, the use of such measures always demands a particular ethical and legal justification. Respect for autonomy also requires that, even in situations where the use of a coercive measure is justified, physicians, nurses and other therapists should take account of the patient's preferences when choosing the measure and deciding how it is to be applied.

3.2. Subsidiarity and proportionality

When coercive measures are applied, particular attention is to be paid to the principles of subsidiarity and proportionality. This means that such measures must be both necessary and appropriate.¹⁴ If more than one measure would be appropriate, the least burdensome is to be chosen. These requirements must be individually reviewed for each patient. It is to be assessed whether the expected (personal and social) benefits clearly outweigh the potential harms, and whether the consequences of such an intervention are less serious than if a different approach were adopted. The duration must also be adapted to the type of coercive measure and the patient's condition. It should also be taken into consideration that the application of a coercive measure may give rise to adverse somatic and psychological effects. Risks of somatic effects (e.g. injuries, infections) are associated with prolonged immobilisation (e.g. restraint or sedation) or the use of physical force (e.g. contusions, fractures). The risk of psychological trauma is all the greater if coercive measures are perceived as unjustified, humiliating or even as an act of retaliation or deliberate harm.

3.3. Appropriate environment

Where coercive measures are unavoidable, they may only be carried out in an appropriate environment; particular attention is to be paid to the following points.

When coercive measures are applied, the dignity of the patient concerned must be respected. Coercive measures should not be carried out in the presence of other patients, but in a protected space which is suitably equipped. The medical personnel ordering and applying coercive measures must have the requisite skills, including specific training in verbal and non-verbal de-escalation techniques, physical holds, and care and supervision.

For their own safety, patients undergoing compulsory treatment require medical supervision. If immobilisation or restraint is indispensable, the patient is to be supervised in such a way that complications are avoided or can be detected at any time, even if this requires the continuous presence of medical personnel. Economic considerations, staff shortages or work pressures can never justify coercive measures. Staffing levels must be adequate to ensure a safe environment for all patients and care personnel, to enable coercive measures to be avoided, and – if such measures are essential – to permit appropriate supervision of the patient.

3.4. Communication and documentation

Coercive medical measures are often applied in hectic circumstances, under considerable time and decision-making pressures. Usually, a whole team is involved, comprising persons from various professional groups. This makes communication within the care team all the more important – before, during and after the application of a coercive measure. In each case, a balance needs to be struck between two goals: firstly, responding rapidly to an urgent medical situation and, secondly, obtaining and considering the fullest possible information *before* deciding on the coercive measure. While the viewpoints of individual team members need to be taken into account, it may not be possible to reach an immediate consensus on how best to proceed in these difficult situations; this, in turn, may pose risks for the patient concerned. It must therefore be clear at all times who is responsible for assessing the information currently available and making a final decision, which is then to be implemented without delay.

Communication with the patient concerned is of crucial importance before, during and after a coercive measure. This can help to minimise the duration of the measure; ideally, it may even be possible for the measure to be avoided altogether, with less intrusive interventions being adopted instead.

The allocation of roles must be clearly defined in advance, and in particular, which team member is responsible for maintaining contact with the patient.

Finally, appropriate communication with the patient – before and after a coercive measure – often also serves a de-escalating function. Provided that there is no conflict with duties of professional confidentiality, relatives and others close to the patient should also be involved in discussions. Decision-making processes and the implementation of coercive measures are to be documented in detail.¹⁵

4. Areas of application

4.1. Patients with somatic disorders

In patients with somatic disorders, three main types of situation are to be distinguished where coercive measures may be applied in order to avert a risk of harm:

- patients with agitated states who resist treatment and pose a danger to themselves and others;
- patients with clouding or loss of consciousness who cannot express their wishes, including possible opposition to treatment;
- patients who calmly and clearly communicate that they are opposed to a medically indicated treatment, but who possibly lack capacity.

4.1.1. Decision-making processes

The decision-making process varies according to the type of situation, as the assessment of capacity and efforts to identify previously stated or presumed wishes and to determine whether an authorised representative is available will differ in each case. If it is determined that a patient lacks capacity, efforts must first be made to locate a possibly existing advance directive and an authorised representative; if necessary, the child and adult protection authority must be brought in. Sufficient time should be allowed

for the decision-making process. In particular, relatives or representatives are not to be pressurised into making a rapid decision, as long as there is no medical need for immediate action.

According to the law (Art. 378 para. 3 and Art. 379 SCC), the decision made by the representative and the treatment team must be guided by the patient's presumed wishes and interests. In practice, this requirement can be applied as follows: the various medical options – including possible benefits and risks – are defined by the treatment team. Together with the representative, or with the involvement of other persons close to the patient but not authorised to act as representatives (other relatives, GP, carer), it is then determined which of the possible options is most likely to be in accordance with the patient's presumed wishes. This means that, rather than always carrying out what from a medical perspective is the optimal therapy, that option should be chosen – from the various possibilities compatible with the patient's interests – which most closely reflects the wishes expressed in a state of capacity.

Agitated states

In patients with acute agitated states, marked confusion is often readily apparent and their lack of capacity is manifest. In these patients, the procedure for decision-making with regard to coercive measures is guided by the principles described above. A different approach is required for patients with capacity who are highly agitated and aggressive. If no agreement on how to proceed can be reached with these potentially dangerous patients through discussion and de-escalation measures, then either the internal security service or the police must be called in.

Between these two types of situation, intermediate forms occur where the assessment of capacity may be extremely difficult. If capacity is to be assessed, the situation must, whenever practicable, be defused to such an extent that discussion becomes possible. Often a psychiatrist will need to be involved. Even if doubts remain with regard to capacity, in a situation where no agreement with the patient is possible, a decision must be taken as to whether – on the assumption of disease-related incapacity – coercive medical measures are appropriate and justified or whether, in view of the potential danger, the security service or the police should be called. In the case of persons with capacity, the police have sole responsibility for the use of physical force.

Disturbances of consciousness

In patients who lack capacity as a result of a disturbance of consciousness (agitated or hypoactive delirium¹⁶, stupor, coma), efforts must first be made to locate a possibly existing advance directive and an authorised representative. If a valid advance directive exists, this is binding on the authorised representative and the treatment team. The former should assist the latter in interpreting it. In the absence of an advance directive, consent to treatment must be given by the authorised representative. If no representative can be consulted within an appropriate period (determined by the urgency of treatment), a decision is to be made by the physician on the patient's behalf.¹⁷

If it must be assumed that a measure is contrary to the previously stated wishes of a patient lacking capacity, then it

may only be carried out if it is required to avert a danger to third parties. If the previously formulated refusal of a medically indicated treatment appears to run grossly counter to the patient's interests, it must be carefully assessed whether the advance directive was not already written in a state of disease-related incapacity, and whether it still reflects the patient's presumed wishes. If, on the basis of this assessment, it is comprehensible that the patient would have refused the treatment in question, then it must not be carried out. However, if the physician is convinced that the patient's interests are no longer safeguarded, then the child and adult protection authority should be brought in.

If the treatment is in accordance with the patient's previously stated or presumed wishes and consent has been given by the authorised representative, then it can be carried out. If the patient lacking capacity passively accepts the measure or even cooperates, then it is not considered to be coercive. If, however, the patient exhibits opposition or physical resistance, then the measure is considered coercive, but permissible, as long as it is medically required. If the authorised representative refuses to grant consent for a coercive measure, then the child and adult protection authority is to be brought in.

Lack of insight into the need for treatment

Patients with whom clear communication is possible, but who refuse treatment that is necessary from a medical viewpoint, pose a major challenge. The key criterion for the decision whether the – possibly life-saving – treatment must be withheld, or whether compulsory treatment should be performed, is the patient's capacity in relation to the danger to his/her health and the need for treatment. If capacity is lacking as a result of disease – as may occur, for example, in certain cases of severe anorexia nervosa or substance dependence – then compulsory treatment may be contemplated.

If, however, patients fully understand the danger to their health and, in refusing a particular treatment, consciously accept the consequences of their decision, then the treatment must not be administered. Nonetheless, the necessary medical support must be provided for these patients, insofar as this can be done with their agreement.

In addition to the above scenarios, two special situations arise where coercive measures may be applied in acute somatic medicine.

Patients with communicable diseases

If patients with communicable diseases refuse medically indicated treatment, coercive measures may be ordered – even for persons with capacity – under the Epidemics Act.¹⁸ In particular, these involve restrictions on freedom of movement (quarantine and isolation). Drug treatments may be ordered and monitored, but not forcibly administered. However, if the person concerned refuses to undergo such treatment, measures restricting liberty may be employed which do not violate the patient's physical integrity.

Pregnant women

In the case of pregnant women, a special situation arises insofar as refusal of treatment may also pose a risk to the health and life of the fetus. However, it is not permissible to impose a medical measure on a pregnant woman with capa-

city who can recognise and assess the consequences of her actions and consciously accepts adverse effects for herself and her child. Complications of pregnancy and childbirth may, however, give rise to exceptional psychological states which compromise capacity. In such cases, coercive measures can be life-saving for mother and child. Situations of this kind are to be avoided as far as possible through the provision of timely information and empathetic care and counselling, with the partner¹⁹ also being involved.

4.1.2. Implementation

Any coercive measures which are required should be implemented appropriately and as gently as possible. Patients whose freedom of movement is restricted by mechanical restraints must be carefully supervised so that any complications can be detected and treated without delay. Coercive measures must be documented in a special section of the medical records. When the measures are first ordered, regular reviews of their appropriateness are to be scheduled, if these are not already specified by the institution's internal regulations. Before their first contact with the patient, visiting relatives are to be informed about the coercive measures applied.

After they have been applied, coercive measures should be discussed by the care team, with the patient also being involved.

4.1.3. Prevention

In order to minimise the use of coercive measures, every effort must be made to prevent the occurrence of delirium. This includes, for example, systematic risk assessment, provision of balanced and readily comprehensible information, adherence to a daily routine including adequate physical exercise, support for physiological processes (especially fluid intake) and the reduction of interventions affecting the patient's physical integrity to an absolute minimum. Particularly in patients with a known history of delirium, dementia or substance dependence, the greatest importance should be attached to adequate pain control and the minimisation of polypharmacy and of instrumental investigations and interventions.

In the case of procedures typically associated with disturbances of consciousness (e.g. delirium after major operations), the patient should be explicitly informed of this risk and given the opportunity to consent to any coercive measures which may prove necessary.

It should be noted that, in general, careful and empathetic explanation and counselling and the provision of alternative treatment options can help to reduce the need for coercive measures.

De-escalation training for situations where patients are agitated or react violently, as well as coaching by external professionals in case reviews, can support the team, helping to ensure that alternatives are discussed at an early stage and the use of coercive measures is minimised. Plans for the management of aggressive behaviour can help staff to cope better with potentially threatening situations.

4.2. Patients with mental disorders²⁰

The use of force is by no means a normal part of psychiatric activities, but always an exception subject to strict, clearly defined and verifiable criteria.

In persons with a mental disorder, coercive measures may become unavoidable, firstly, in emergency situations where there is a serious danger to the patient or third parties as a result of the existing condition (Art. 435 SCC). Secondly, outside of emergency situations, longer-lasting coercive measures – generally drug treatments – may be ordered by a physician in the context of involuntary commitment in accordance with Art. 434 SCC. A coercive measure must be clearly indicated – i.e. it must be required to avert a serious risk to the patient's health or a serious risk to the life or physical integrity of third parties. The person concerned must lack capacity in relation to the treatment. Less intrusive measures must be excluded for reasons which are to be explicitly stated.

Under the child and adult protection law (Art. 434 SCC), in the case of involuntary committed patients, a physician exercising the function of a chief physician²¹ has the authority to order extended drug treatment without consent («compulsory treatment»). The treatment may be initiated immediately – i.e. an appeal²² filed by a patient does not have a suspensive effect, unless this has been successfully contested by the patient. In practice, however, the initiation of physician-ordered compulsory treatment is sometimes delayed until the legal deadline for filing an appeal has expired. Although this may promote de-escalation in individual cases, ethical questions arise because of the delay involved. The decisive factor should be the need for therapeutic action.

The decisive criterion for the ordering of compulsory treatment is not the diagnosis, but the current clinical state and the associated risks.

On no account should a serious diagnosis in itself lead to a higher probability of coercive measures being used. In addition, lack of capacity can never be established solely on the grounds of refusal of treatment.

Follow-up care for involuntarily committed patients is regulated by the cantons (Art. 437 SCC). Provision may be made for outpatient measures, such as regular post-discharge consultations with a psychiatrist, or regular administration of prescribed medication. Such measures are a matter of civil law and should not be confused with the criminal-law measures specified in Articles 59–61, 63, 64, 67 and 67b of the Swiss Criminal Code. Provisions concerning post-discharge treatment requirements for involuntarily committed patients vary from canton to canton. Considerable differences exist, particularly with regard to the possibility of ordering outpatient treatment measures such as compulsory administration of medication.

4.2.1. Decision-making processes

The requisite decision-making processes are complex, since decisions need to be taken on a matter – the use of force – which health professionals, on the basis of their self-conception, would wish to avoid. The use of a coercive measure is only permissible if – when all other options have been exhausted – it is unavoidable. In addition, the range of possible measures is very broad. Such a situation

can only be appropriately addressed using an individualised approach: the options available must be tailored to the specific circumstances of the person concerned, with an individual risk/benefit assessment. What must be taken into account are not only external factors, such as the risk of injury for all parties, but also the subjective perspective of the person concerned (how a coercive measure is experienced, risk of traumatisation, impact on the therapeutic relationship).

When the treatment plan is discussed, the person concerned and, if available, the trusted person, must be informed about the proposed measures (Art. 433 SCC). In this particular context, however, the legal force of an advance directive is not absolute: in the case of involuntarily committed persons, an advance directive is only to be honoured to such an extent that the effectiveness of treatment is not compromised. Careful assessment is always required: on the one hand, there should be no systematic discrimination against persons with a mental disorder, in the sense of inadequate account being taken of advance directives merely on the grounds of involuntary committal. On the other hand, it is equally unacceptable to argue (uncritically) that an involuntarily committed person who lacks capacity should be denied urgently required treatment merely because wishes to the contrary are expressed in an advance directive.

In all their decision-making, the professionals concerned must give due consideration to the special role prescribed by law for the trusted person. If such a person has been appointed and is available, he or she should be given any information on the diagnosis, treatment and disease course which is required to enable him or her to fulfil this role, and in particular to provide support in making decisions on medical matters (Art. 432 SCC).

4.2.2. Implementation

Involuntary committal does not necessarily involve admission to an acute psychiatric ward. An institution is appropriate, within the meaning of the Act, if it meets the individual medical needs of the persons concerned with the minimum of restrictions on personal freedom. Accordingly, patients may well be admitted to an open ward or a residential institution, if the goal of the measure can thus best be achieved.²³

The institutional requirements for the application of coercive medical measures must be met and regularly evaluated, and the decision, if necessary, revised. It is essential that medical and nursing staff should be available with adequate experience and appropriate training (e.g. in de-escalation techniques, physical holds, aggressive behaviour management); also required are facilities which make it possible to avoid embarrassment or even humiliation for the person concerned. Every institution where coercive measures are applied should issue written internal guidance and promote interdisciplinary dialogue, also covering attitudes to the use of coercive measures.

Coercive medical measures must be implemented in accordance with a previously specified and well-practised procedure, which also includes informing the patient in advance. The allocation of clearly defined roles must be agreed among the persons involved. It must always be possible for the procedure in question to be adapted in cases

where a significant change in the initial situation means that a coercive measure can be avoided or a less severe measure adopted (e.g. if the patient wishes to engage in discussion). The aim must always be to reduce the application of force to a minimum.

Subsequent discussion of the coercive measure implemented – both within the team and with the patient – is an integral part of the procedure. The key points covered in such discussions are to be documented in the patient's medical records.

4.2.3. Prevention

The most effective way of avoiding the need for coercive measures in patients with mental disorders is to ensure that appropriate psychiatric care is readily and universally accessible.

Advance directives can have a substantial preventive effect with regard to the frequency of coercive measures: many patients – even those who are seriously ill – are aware that they have drawn up an advance directive. The attending physicians should discuss the directive with the patient as soon as possible. The very fact that the directive is taken seriously by members of the treatment team can help to de-escalate the situation. This is particularly true in cases where a sound therapeutic relationship has been established. Even then, however, the treatment team remains responsible for ensuring that the content of the advance directive still reflects the patient's (presumed) wishes.

Coercive measures are to be systematically documented (cf. Annex B, No. 3); ideally, they should also be evaluated in the context of accompanying research. Preventive effects can also be achieved through regular and sustained professional exchanges across institutional boundaries, especially at the complex interfaces between hospitals, emergency physicians, independent specialists, GPs and residential institutions.

4.3. Children and adolescents

Patients in childhood and adolescence have essentially the same rights as adult patients.²⁴ However, because they are not yet fully developed, they are dependent on care and protection and – depending on their age and maturity – require the support of third parties to exercise their rights. In exercising parental responsibility,²⁵ parents²⁶ are bound by the duty to safeguard the child's welfare and are obliged to take the child's views into account as far as possible.²⁷

Children and adolescents with capacity have the right to consent to – or refuse – treatment. If a measure is carried out against the wishes of a child or adolescent, it is to be considered coercive even if consent has been given by the parents. In the case of patients lacking capacity, parental consent is legally sufficient.

With regard to adolescents with mental disorders who refuse medically indicated treatment, the situation is extremely complex and experts take different views on how best to proceed. Even though, in the case of a patient who lacks capacity, consent given by the parents would theoretically be sufficient for hospitalisation against the adolescent's wishes and also for compulsory treatment, it is frequently recommended that an order for involuntary committal should be obtained.²⁸ The establishment of ca-

capacity in cases of this kind is particularly difficult: although the range of decisions for which capacity exists increases with growing maturity, it may be restricted again to a varying degree as a result of the illness. In case of doubt, it may therefore be advisable to obtain an involuntary committal order if adolescents who appear to lack capacity cannot – in spite of extensive counselling – be brought to consent to, or at least submit to, an inpatient therapeutic measure. The adolescent then has the usual rights of appeal. This approach may also relieve the burden on the parents, as it means they are no longer perceived by the adolescent as responsible for the application of force.

For involuntary committal, the provisions of the adult protection law apply *mutatis mutandis* (Art. 314b SCC). As involuntary committal to an appropriate institution affects the parents' right to decide on the child's place of residence (Art. 301a SCC), their consent, or passive acceptance, is required. If the parents responsible for the child oppose involuntary committal and the child's welfare is threatened as a result, the child protection authority must be brought in (Art. 307 SCC); it may order the revocation of the parents' right to decide on the child's place of residence (Art. 310 SCC). In order to avert an immediate danger to life or limb, a child or adolescent may be hospitalised even against his/her and the parents' wishes (acts of necessity; Art. 17 and 18 Swiss Criminal Code). A valid order must, however, be obtained as rapidly as possible.

In the case of adolescents lacking capacity who are involuntarily committed to a hospital, it is a matter of controversy whether compulsory treatment requires the parents' consent or the application of Art. 434 SCC. In most cases, however, it appears advisable to try to obtain the parents' consent for treatment. If these efforts prove unsuccessful, it will be necessary to involve the child protection authority, which can restrict parental responsibility and appoint a deputy to act as a representative in medical matters (Art. 308 SCC).

4.3.1. Decision-making processes

Decision-making capacity develops gradually from early childhood to majority and beyond. Expertise in developmental psychology is therefore required in order to assess the capacity and promote the self-determination of children and adolescents. Experience has shown that, when measures are required, cooperation can be substantially improved – even in young children – if as well as receiving a detailed, age-appropriate explanation, they are granted the greatest possible degree of self-determination.

Even though, in their second decade, adolescents' decision-making skills in medical matters can develop rapidly, the slow maturation of certain brain areas means that older adolescents often still have difficulty in appropriately evaluating more complex decisions. In particular, they may find it difficult to appreciate the significance of long-term risks and harmful consequences, or to consider the possibility that their own assessment of these risks could be different in some years' time. For this reason, the assessment of capacity calls for particular care and expertise in cases of decisions involving irreversible consequences. The exercise of self-determination should not be tolerated at the cost

of irreversible damage to an adolescent's subsequent development and hence future capacity for self-determination.

Although the right to make decisions on medical measures passes from the parents to the adolescent when the latter attains capacity, even before this point is reached and for a long time thereafter, decision-making processes involve complex interaction – often not visible to those responsible for treatment – between parents and child. Ideally, parents will allow a child who still lacks capacity as much of a say as possible, and adolescents who have capacity – if they feel unable to cope by themselves – will seek their parents' advice and support in decision-making.

For particularly burdensome and high-risk interventions, even if consent is jointly granted by the parents and the adolescent, it should be carefully examined whether the latter's consent is truly autonomous. Adolescents, especially oncology patients, can sometimes (consciously or unconsciously) be pressurised by their parents into consenting or refusing.

If an intervention for which there is a clear medical indication is refused both by the parents and by the adolescent, the involvement of the child and adult protection authority must be considered. In cases of disagreement, where the adolescent refuses a measure to which the parents have consented, the question of capacity determines, from a legal perspective, whether treatment must be withheld or can be carried out as a coercive measure. The more far-reaching the consequences of the refusal of treatment, the more stringent should be the criteria for the assessment of capacity.

If the adolescent with capacity consents to a medically indicated measure which – in spite of detailed discussions – is opposed by the parents, the measure should be carried out, if necessary with the involvement of the child and adult protection authority.²⁹

4.3.2. Implementation

In infants and young children, because of the pain or discomfort associated with many medical interventions, it is frequently not possible to secure passive acceptance, let alone active cooperation. Anxious resistance then has to be overcome by the application of some kind of force. There are many ways of enabling this to be done as gently as possible: by selecting the least intrusive measures, and with the aid of optimal prior pain relief or, if appropriate, sedation or anaesthesia, a peaceful atmosphere (with familiar persons present), age-appropriate explanation before and distraction during the intervention, it is usually possible to avoid the use of forcible restraint. If oral medication has to be administered, various options are available to make it as palatable as possible.

In addition, with older children, efforts should be made to obtain the fullest possible cooperation. Here, the use of suitable information media (e.g. stories, pictures, objects and demonstrations) may be helpful, but also techniques such as relaxation and hypnosis. Rewards for cooperation can also be useful.

For adolescents, the principles for the application of coercive measures are the same as for adults. However, such measures should be carried out exclusively at institutions

specifically designed for adolescents, with specially trained personnel.

4.3.3. *Prevention*

In children, the best way of preventing anxiety about medical interventions is to familiarise them at an early stage with medical treatments, professionals and institutions. Here, appropriate picture books and toys can be useful, as well as tours of hospitals and regular paediatric check-ups. In adolescents, future coercive measures can best be prevented by early diagnosis and treatment of mental health problems, eating disorders, self-harm and risky behaviour. Appropriate management of adolescents' oppositional behaviour and need for autonomy can also have preventive effects, as well as jointly agreed treatment plans in some cases.

4.4. *Patients in long-term care*

Stays in residential or nursing institutions for the elderly or for persons with disabilities or chronic physical or mental disorders are regulated by the adult protection law (Art. 382–387 SCC), which includes provisions on measures restricting freedom of movement (Art. 383–385 SCC). In the elderly, coercive measures are contemplated mainly in the event of a progressive loss of capacity due to dementia, or increasing frailty. Acute and fluctuating disturbances of consciousness (delirium)³⁰ may also occur. In younger persons, capacity may be lacking as a result of a mental disability or a chronic physical or mental disorder, which may make coercive measures unavoidable in certain situations. Measures restricting freedom of movement are only permissible in cases where less severe measures are patently inadequate or prove to be so. Such measures must be designed either to avert a serious danger to the person concerned or to remedy serious disruption to community life resulting from challenging behaviour.

Although subtle (psychological) measures restricting freedom, such as excessive monitoring, threats, manipulation, withdrawal of luxuries, etc., are not mentioned in the legislation, they affect – like any other restrictive measures – the constitutionally protected right to personal liberty and are ethically questionable.

If the placement of patients with dementia takes the form of involuntary committal, this can be highly distressing for the patient concerned and the relatives. In individual cases, therefore, it is essential to assess whether involuntary committal is appropriate or whether instead a care agreement can be concluded in accordance with Art. 382 SCC. Even if a placement does not formally involve involuntary committal, it must be necessary (medically indicated) and proportionate to the degree of danger, and always represent the least burdensome alternative. If, in pursuing a placement, the authorised representative appears not to be acting in the patient's best interests, the child and adult protection authority must be brought in.

4.4.1. *Decision-making processes*

The decision paths specified by the child and adult protection law vary, depending on the type of measure to be adopted: measures restricting freedom of movement by mechanical restraints can be ordered by the institution (Art. 383

SCC), but the use of medication requires the consent of the authorised representative (Art. 378 SCC). These different paths complicate the decision-making process and may lead to the choice of a measure restricting freedom of movement which is more burdensome for the patient.

Before the use of a coercive measure can be considered, all the relevant diagnostic possibilities must be exhausted (e.g. exclusion of a urinary tract infection, dehydration, untreated pain or adverse drug effects in a restless patient).

In general, the method to be chosen is that which enables the best possible outcome with the minimum possible intrusiveness. The subjective burden imposed by a coercive measure depends to a large extent on the individual personality and the particular situation. Some individuals may be more disturbed by failure to respect their wishes through deception (e.g. concealment³¹ of medication in food or drink), others by the physical discomforts associated with a coercive measure (e.g. unpleasant taste of medication, or administration by injection). Likewise, the invasion of privacy arising from constant supervision may be felt to be more intrusive than the use of a mechanical restraint, or vice versa.

Both the choice of coercive measure and the decision to actually apply such a measure are to be discussed with the relevant person lacking capacity; in addition, his/her preferences are to be ascertained and complied with as far as possible.

The care team must specify the expected duration of the measure, the intervals for reviews and appropriate monitoring measures.

In the case of a serious disruption to community life resulting from challenging behaviour (e.g. sexual disinhibition, aggression, screaming), efforts must be made to resolve the problem through appropriate interventions (e.g. eliminating unsettling influences, providing distraction, or modifying existing procedures) before the use of restrictive measures or medication is considered.

4.4.2. *Implementation*

Any coercive measures which are required should be carried out appropriately and as gently as possible. Before such a measure is introduced, it must be explained to the person concerned what is involved, why the measure has been ordered, how long it is expected to last and who will be taking care of him/her during this period.

In some cases, measures restricting freedom of movement do not have the desired effect or lead to complications. They should therefore be accompanied by appropriate monitoring. Patients whose freedom of movement is restricted by mechanical restraints must be carefully monitored so that any complications can be immediately detected and treated. Records must be kept of all coercive measures. The records must include details of the purpose, nature and duration of the measure (Art. 384 SCC), but the effects (i.e. outcome or complications) should also be described (cf. Annex B, No. 3). When a measure is first ordered, regular intervals must be specified for reviews of its appropriateness.

Before their first contact with the patient, visiting relatives should be informed about the coercive measures applied.

Within the care team, subsequent discussion of any coercive measures carried out must always be possible.

4.4.3. Prevention

Systematic regulation of decision-making processes is useful in the prevention of measures restricting freedom of movement, in communication with representatives, and for the application of such measures, should they be required. Residents' values and preferences with regard to future treatment should be discussed while this is still possible – ideally as soon as they are admitted to the institution. The results of these discussions are to be recorded in writing. In the case of residents lacking capacity, it is also advisable to discuss possible measures proactively with representatives and to draw up an agreed treatment plan.

The aim of prevention is served by the following measures:

- preparation of internal institutional guidelines (defined decision-making processes/responsibilities/criteria, practical guidance);
- training and awareness-raising regarding the questionable value of restrictive measures, and alternative options (focusing on management of aggressive behaviour, delirium and challenging behaviour, legal and ethical aspects);
- provision of advice by an external professional, e.g. a nursing expert or geriatrician/psychogeriatrician;
- interdisciplinary case reviews;
- discussion of attitudes adopted within the institution (e.g. how is residents' autonomy restricted or promoted?).

4.5. Patients in domiciliary care

Coercive measures should not be used in domiciliary care (Spitex). If such measures are indispensable for patients lacking capacity, the principles described above are applicable. Spitex staff may, however, be confronted with coercive measures applied by third parties – e.g. personal hygiene against the wishes of the person under care, measures carried out without consent (as the person's wishes have not been determined), or restrictions on freedom of movement.

Situations of this kind should be avoided or reduced as far as possible through cooperation based on partnership with the person concerned and with his/her caregivers, and respect for the right to self-determination. Tools such as standardised evaluation of the needs of the person under care can help to ensure that risk situations (abuse or neglect) are identified in good time and appropriate measures³² taken. This requires an interprofessional assessment of the situation, with the involvement of the person concerned and his/her caregivers. Among the main preventive measures are the provision of appropriate information for the person under care and family members, appropriate training of carers, regular contacts between Spitex staff and the attending physician, coordination with caregivers, and regular evaluation of the needs of the person under care and family members.

4.6. Patients undergoing execution of sentences and measures³³

Clear, binding guidelines are essential for physicians and nurses employed in prisons, since the organisation of many health services in Switzerland is dependent on prison management; medical decisions must, however, be taken independently of prison management. Dependence can give rise to conflicts of interest or of loyalty and prompt health-service employees to take unethical decisions or actions – for example, if coercive measures are ordered which run counter to the patient's interests.

For the implementation of medically indicated coercive measures, the same principles apply as for any other patients (equivalence of care principle).

III. Annex

A. Force – a multidimensional concept

In medical practice, force can take a wide variety of forms, whose ethical acceptability varies across a continuum extending from *imperative* (performing a life-saving intervention in an uncooperative infant) to *completely unacceptable* (compulsory drug treatment in a patient with capacity). For greater clarity, the various forms of force can be classified within a multidimensional grid.

The four dimensions defined here comprise (1) the patient's wishes, (2) the patient's behaviour, (3) the purpose and (4) the intrusiveness of the measure.

The first dimension covers the patient's autonomous wishes with regard to the measure in question. Ideally, these will be freely and consistently formulated on the basis of complete information and in a state of capacity. Often, however – particularly in disease situations – the patient's wishes are unclear or ambivalent. In such cases, autonomous wishes can only be formed through a lengthy process of explanation and counselling. The formation of wishes may also be compromised or distorted (e.g. as a result of illness or cognitive impairment) to such an extent that decision-making capacity is absent. If capacity was formerly present, it may be possible to ascertain the patient's wishes from an advance directive (prior wishes), or from information provided by persons close to the patient (presumed wishes). If it is not possible to establish autonomous wishes, treatment must be guided by the patient's interests and presumed wishes. In this dimension, force occurs if action is taken contrary to the currently expressed wishes of a person with capacity or – in the absence of capacity – contrary to the person's prior or presumed wishes. A coercive measure carried out in this situation must be based on specific legal provisions (child and adult protection law, Swiss Criminal Code, Epidemics Act).

The second dimension describes the behaviour of the person concerned vis-à-vis the measure in question. This can range all the way from explicit agreement, through implicit consent and passive acceptance, to explicit verbal refusal and physical resistance. In difficult clinical situations, the behaviour manifested may also be equivocal or variable. It can often be influenced by what is said and the approach adopted by members of the treatment team. In this dimen-

sion, force occurs if a measure is carried out in spite of verbal refusal or physical resistance.

For practical purposes, it is important to ascertain whether or not the behaviour observed in the present situation (external perspective, second dimension) is in accordance with the wishes identifiable in the first dimension (internal perspective). If autonomous wishes are considered in conjunction with behaviour, four different types of case can be distinguished:

1. The measure has been consented to and the patient is cooperative or exhibits passive acceptance. Here, consent may be based on the patient's current autonomous wishes, or previously expressed or presumed wishes, or on the decision of an authorised representative. This is the rule in everyday medical practice. Even if the patient's personal freedom is significantly restricted as a result of the measure, it cannot be said to involve force.
2. In contrast, if a measure is carried out in spite of verbal refusal or physical resistance, in the knowledge that wishes to the contrary have been expressed in a state of capacity, this represents the highest degree of force. This can only be permissible in connection with an involuntary committal or an official order with a legal basis, and even then such measures can only take the form of restriction of freedom. Forcible drug treatment is not permissible in persons with capacity, even in the context of an involuntary committal. A treatment order (e.g. in the case of open tuberculosis) may, however, be accepted by a patient in order to avoid or reduce the duration of measures restricting freedom which would otherwise be adopted.
3. In patients with capacity, concordance between the first and second dimension is the rule. If, however, capacity is lacking in an acute situation, a discrepancy may be observed between the two dimensions. Firstly, a patient may – as a result of clouding of consciousness or cognitive impairment – passively accept or even agree to a measure although it is contrary to his or her prior or presumed wishes. In this situation, performance of the measure would constitute an impermissible use of force, and it must not be carried out unless it can be shown that, despite appearances to the contrary, capacity is still present and the patient's views have changed in the course of the illness.
4. The opposite situation arises when, in a state of incapacity, patients refuse a measure – verbally and/or through physical resistance – which is in fact in accordance with their prior or presumed wishes, or where they have never been able to make a competent judgement (e.g. owing to cognitive deficits). Efforts to overcome opposition, especially physical resistance, are perceived as force both by the person concerned and by the treatment team, even if consent to the measure has been given either in prior written form or by an authorised representative. Situations of this kind are a common area for the application of coercive measures in medicine.

In a third dimension, coercive measures can be divided into three categories according to the purpose for which they are ordered: therapeutic measures (to treat a disease), preventive measures (where patients pose a serious danger

to themselves) and measures for the protection of third parties. While individual measures may serve more than one purpose at the same time, they may not be equally suitable for each purpose. In particular, the significance of the administration of medication varies depending on the main purpose intended. Measures in the first category are described as compulsory treatment, while those in the second and third category are measures restricting liberty.

The fourth dimension concerns the intrusiveness of coercive measures. The possible means whereby a patient can be brought to agree to, or passively accept, treatment lie on a continuum extending from absence of force to a high degree of force. If a proposed measure is initially refused, efforts may be escalated according to the following series: informing, advising, recommending, convincing, persuading, manipulating, deceiving, applying pressure, threatening sanctions, continuously supervising, introducing mechanical barriers, using physical force. The transition to force occurs at the point where support for the patient's autonomous formation of wishes ceases and the therapists' wishes become dominant – without adequate participation of the person concerned – i.e. between «convincing» and «persuading» in the above-mentioned series. The extent to which measures are subjectively perceived as force by the individual patient need not increase in the same order. For example, certain patients may consider continuous supervision to be more intrusive than physical confinement, or deception more offensive than visible barriers, while for others the converse is true. Also important is whether or not a coercive measure affects the patient's physical integrity (e.g. drug treatment, blood sampling, surgical procedure), since physical integrity must not be violated by a medical intervention against the wishes of a person with capacity even under a court order.

By analysing these various dimensions, it is possible to assess a coercive measure in depth and ensure that the goals corresponding to each dimension are optimised and harmonised. These are, for the first dimension (wishes), the highest possible degree of patient autonomy; for the second (behaviour), the greatest possible agreement between patient and treatment team; for the third (purpose), the best possible orientation of the measure towards the intended purpose; and, for the fourth (intrusiveness), use of the means perceived by the patient as least intrusive.

B. Procedural guidance for implementation of the guidelines

1. Decision-making process: use of coercive measures

Definition of problem:

- How does the problem manifest itself?
- Who perceives the situation as a problem?
- Does the patient lack capacity?
- Are there factors which could be remedied, thus helping to resolve the problem?

Goal: What is to be achieved by using a coercive measure?

Suitability: Is the measure suitable for achieving the desired goals?

Necessity: Does the measure appear to be indispensable in the interests of the person concerned, or is it disproportionate?

Alternatives: Have all less intrusive measures already been unsuccessfully applied, or has their suitability been assessed?

Preferences of the person concerned: Are the patient's preferences taken into account as far as possible?

Conditions: Are the conditions specified in the child and adult protection law met? Do the staff have the skills required to carry out coercive measures?

Prevention: Are there any preventive measures which could reduce the use of coercive measures in the future?

Rights of appeal: has the patient been informed about his/her legal rights?

Any other relevant points, depending on the situation.

2. Involuntary committal

2.1. Admission by involuntary committal

For admission by involuntary committal, the relevant cantonal regulations are to be complied with in addition to the Swiss Civil Code.³⁴ Of crucial importance are the physician's personal examination of the person concerned and the clear written statement of the reasons why involuntary committal, rather than a less intrusive measure, is to be initiated. The committal order must contain at least the following information (Art. 430 SCC):

- the place and date of the examination;
- the name of the physician;
- the findings, reasons for and purpose of the committal;
- details of the rights of appeal.

The person concerned and the admitting institution each receive a copy of the committal order. If possible, a person close to the person concerned is to receive written notification of the admitting institution and the rights of appeal.

2.2. Procedure for institutions admitting involuntarily committed patients

When a patient is admitted by involuntary committal, the following steps are to be taken or considered:

- determine whether or not the person admitted has capacity;
- determine whether the person admitted has appointed a trusted person to provide support; in cases of incapacity: determine whether the person admitted has prepared an advance directive;
- draw up a written plan for the treatment of the mental disorder in close consultation with the patient and, if applicable, the trusted person; if the patient lacks capacity, the advance directive is to be taken into account in the treatment plan;
- inform the patient and the trusted person about the proposed measures (reasons, purpose, nature, modalities, risks and adverse effects, consequences of failure to treat, and any alternative treatment options);
- obtain consent, if the patient has capacity; for patients lacking capacity, see also Section 2.3 below;

- regularly adjust the treatment plan and document treatment measures;
- document the pre-discharge interview, giving particular consideration to any preventive measures discussed or initiated if there is a risk of relapse.

2.3. Treatment without consent in involuntarily committed patients (Art. 434 SCC, compulsory treatment)

Before an order for treatment without consent is given by the chief physician, the following points are to be considered and the results are to be documented:

- If the person concerned is not treated, is there a risk of serious harm to his/her health, or a serious risk to the life or physical integrity of third parties?
- Does the person concerned lack capacity in relation to the need for treatment?
- Have other less intrusive (but still appropriate) measures been excluded?
- Has an advance directive, if available, been implemented? If not, why not?

Only after these four points have been considered can treatment without consent be ordered. The person concerned and the trusted person receive written notification of the order, together with information on rights of appeal.

3. Documentation of coercive measures

Written records are to be kept of coercive measures; it is recommended that the following points should be included, although the list can be adapted according to the area of application. The documentation can also take the form of a legally valid notice:

- the patient's personal details;
- description of the problem (the patient's interests);
- goals and purpose of the measure (therapeutic, protection of the patient/third parties);
- alternatives which were rejected or proved ineffective (to be specified, why were they rejected?);
- patient's (presumed) wishes (availability of an advance directive, etc.);
- incapacity determined in relation to the planned measure (assessed by ...);
- emergency or planned measure;
- type of measure and duration;
- monitoring or concomitant measures required;
- interval for evaluations;
- date on which measure is initiated;
- dates of evaluations;
- responsible decision-making authority/person;
- provision of information (including rights of appeal): discussed with the patient? With the authorised representative? (when?, who?, with whom?);
- outcome of the measure (reference to where details are recorded);
- follow-up discussion (when?, who?, with whom?);
- other relevant points.

C. Glossary

Authorised representative in medical matters	Person who represents a patient lacking capacity in medical matters. Under Art. 378 SCC, the following persons are entitled, in the following order, to represent the patient: persons appointed in an advance directive or power of attorney; a duly authorised deputy; relatives and other close associates who regularly provide the patient with personal support (spouse or registered partner, person sharing the same household, offspring, parents, siblings). In the case of patients who are minors, the holders of parental responsibility are entitled to act as representatives.
Capacity	Capacity is assessed for a specific action (consent) in a specific situation. It requires, firstly, the ability of the person granting consent to perceive reality and to form judgements and wishes, and secondly the ability to act in accordance with such wishes. No schematic solutions are available for the assessment of capacity (cf. Section 2.4.). The following criteria can help to establish capacity: – the ability to understand information relating to the decision to be made; – the ability to weigh up the situation and the consequences resulting from possible alternatives; – the ability rationally to attach weight to the information obtained in the context of a coherent system of values; – the ability to express one's own choices.
Coercive measure	A medical measure carried out against the patient's self-determined wishes or in spite of opposition. Wishes can be identified as the currently expressed wishes of a patient with capacity, or as the prior or presumed wishes of a patient who lacks capacity at the time the measure is carried out. Opposition can be expressed through verbal or non-verbal refusal or by active resistance (cf. Chapter 2. and Annex A).
Compulsory treatment	Medical measure designed to maintain or restore health, carried out against the patient's wishes or in spite of opposition (cf. Section 2.2.).
Detention of persons admitted voluntarily	Involuntary detention of a person with a mental disorder who has entered an institution voluntarily. Such detention is only permissible if a serious risk of harm to the patient or others can thereby be averted (cf. Art. 427 SCC).
Involuntary committal	Admission to an appropriate institution for treatment and care against the wishes of the person concerned (cf. Section 2.3.).
Measures restricting liberty	Restrictions of freedom of movement and other measures curtailing fundamental rights (cf. Section 2.1.).
Medical	This term is to be understood in a broad sense, covering the activities of physicians, nurses and therapists.
Presumed wishes	Consideration of what decisions would be made by patients who are no longer able to express their wishes, were they able to do so. Presumed wishes are determined by assessing all available information (e.g. the patient's earlier written or verbal statements, the views of authorised representatives and relatives).
Restriction of freedom of movement	Restriction imposed on personal mobility by means of mechanical restraints, medication or psychological methods (cf. Section 2.1.1.). In contrast to the broad definition used here, Art. 383 SCC is concerned exclusively with restrictive measures involving mechanical restraints.
Serious disruption to community life	Disruption to community life which is so intense that the effects for those concerned are intolerable (cf. Section 2.6.).
Severe neglect	Condition which is usually the result of a mental or physical illness and which may necessitate involuntary committal of the person concerned. This is not a technical term in medicine, and there is no generally accepted definition (cf. Section 2.7.).
Subsidiarity and proportionality	Principles used to assess whether a coercive measure is necessary and appropriate: all alternative options must have been considered in advance and a coercive measure must be the only appropriate way of averting the danger in question. If more than one measure would be appropriate, the least burdensome is to be chosen. These requirements must be individually reviewed for each patient (cf. Section 3.2.).
Treatment without consent	Compulsory treatment in an involuntarily committed patient (cf. Art. 434 SCC).
Trusted person	Person appointed by an involuntarily committed patient to provide support during his/her stay and until all related procedures have been concluded (cf. Art. 432 SCC).
Urgent situation	Situation where immediate treatment, nursing or other care is required to save life or to prevent serious harm (cf. Section 2.5.).

IV. Information on the preparation of these guidelines

Mandate

In March 2013, the Central Ethics Committee (CEC) of the SAMS appointed a sub-committee to draw up medical-ethical guidelines on «Coercive measures in medicine».

Responsible sub-committee

Professor Dr. med. Dr. phil. Paul Hoff, Psychiatry, Zurich (Chair)
Andreas Bolliger, Nursing Expert, Affoltern am Albis
Professor Dr. iur. Marco Borghi, Law, Pro Mente Sana, Comano
Dr. med. Verena Gantner, General Practice, Muri
Dr. med. Monique Gauthey, Child and Adolescent Psychiatry, Geneva
Dr. med. Daniel Grob, Geriatrics, Zurich
Professor Dr. med. Christian Kind, CEC President, Paediatrics, St Gallen
PD Dr. med. Tanja Krones, Ethics, Zurich
Sophie Ley, Nursing Expert, MA Health Care Management, Monthey
lic. iur. Michelle Salathé, MAE, SAMS, Law, Bern
lic. theol. Christoph Schmid, CURAVIVA, Bern
PD Dr. med. Martin Siegemund, Intensive Care, Basel
Bianca Schaffert-Witvliet, Nursing Expert, MSN, Mägenwil
Professor Dr. med. Hans Wolff, Correctional Medicine, Geneva

Experts consulted

PD Dr. med. Georg Bosshard, Winterthur
Dr. med. Christian Henkel, St Gallen
Dr. med. Georges Klein, Monthey
Dr. phil. Franziska Rabenschlag, Basel
Dr. iur. Beat Reichlin, Langnau am Albis
Professor Dr. med. Undine Lang, Basel
Professor Dr. med. Armin von Gunten, Lausanne

Consultation procedure

On 19 May 2015, the Senate of the SAMS approved a draft version of these guidelines to be submitted for consultation to professional associations, organisations and other interested parties. The comments received have been taken into account in the final version.

Approval

The final version of these guidelines was approved by the Senate of the SAMS on 19 November 2015.

German version available at <http://www.samw.ch/de/Ethik/Richtlinien/Aktuell-gueltige-Richtlinien.html>

French version available at <http://www.samw.ch/fr/Ethique/Directives/actualite.html>

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Footnotes

- 1 On being incorporated into the Code of the Swiss Medical Association (FMH), SAMS guidelines become binding for all members of the FMH.
- 2 Hereafter, the term “medical” is used in a broad sense to refer to the activities of physicians, nurses and therapists.
- 3 The broad definition used here may lead to problems in those cantons which, on the basis of cantonal regulations, require a written order for every coercive measure.
- 4 In a person with capacity who is involuntarily committed, federal law essentially permits a restriction of liberty, but not compulsory treatment. In contrast, compulsory treatment – including treatment of somatic disorders – is permitted under certain cantonal laws (cf., for example, § 26 of the Canton Zurich Patients Act, LS 813.13).
- 5 Under Art 435 SCC, in emergency situations, compulsory treatment of involuntarily committed patients is also possible for the protection of third parties.
- 6 In contrast to the broad definition used here, Art. 383 SCC, which is applicable for patients in residential and nursing institutions, only provides for measures restricting physical freedom of movement, i.e. mechanical restraints. Art. 383 SCC applies *mutatis mutandis* for involuntarily committed patients (cf. Art. 438 SCC). It should be noted, however, that while Art. 383 can only be applied in the case of patients *lacking* capacity, the provisions concerning involuntary committal (Art. 426 ff. SCC) are also applicable for patients with capacity.
- 7 In the case of involuntarily committed patients, the term used in the child and adult protection law is not compulsory treatment, but treatment without consent (Art. 434 SCC). This does not, however, mean that any treatment undertaken without consent amounts to compulsory treatment in accordance with Art. 434. Consent is lacking, for example, in the case of medically indicated measures where, for reasons of urgency, information on the patient’s wishes cannot be obtained (e.g. because the patient lacks capacity and no relatives can be consulted) (Art. 379 SCC).
- 8 Under the SCC, the following persons are entitled, in the following order, to act as representatives in medical matters: persons appointed in an advance directive or power of attorney; a duly authorised deputy; relatives and other close associates who regularly provide the patient with personal support (spouse or registered partner, person sharing the same household, offspring, parents, siblings). In the case of patients who are minors, the holders of parental responsibility are entitled to act as representatives.
- 9 Cf. in particular Section 2.4. («Capacity»), where it is noted that incapacity must not be automatically inferred from failure to consent to a proposed procedure which is medically indicated.
- 10 Formerly known as «involuntary custody».
- 11 The requirements specified for the detention of persons admitted voluntarily are more stringent than those specified for involuntary committal; in particular, there must be a serious risk of harm to the patient or third parties which cannot otherwise be averted.
- 12 In an emergency, Art. 435 SCC is applicable for the treatment of a mental disorder in an involuntarily committed patient. The urgency of treatment may be due to the need to protect the patient or third parties.
- 13 Cf. Art. 438 SCC («Measures restricting freedom of movement»).
- 14 Necessary and appropriate means that all alternative options must have been considered in advance and a coercive measure is the only appropriate way of averting the danger in question.
- 15 Cf. Annex B, No. 3 («Documentation of coercive measures»).
- 16 Delirium is an acute, typically fluctuating, disturbance of consciousness associated with a somatic or mental illness, characterised by attentional and cognitive deficits (impairments of memory, orientation, speech and abstract thinking) and psychomotor disorders (apathy, hypoactivity to hyperactivity). The acute onset and essential reversibility of delirium differentiate it from dementia.
- 17 Cf. Art. 379 SCC («Urgent cases»).
- 18 The revised Federal Act of 28 September 2012 on the Control of Communicable Diseases (Epidemics Act) is to come into force at the beginning of 2016. Under Art. 30 ff., (coercive) measures targeted at individuals can be ordered.
- 19 It should be borne in mind that the accompanying partner may not be legally authorised to represent the mother and/or the newborn.
- 20 The principles set out in the present guidelines are also applicable for forensic psychiatry; however, specific aspects which are only relevant in this area are not addressed here (cf. Section 4.6.). The term mental disorder is used in accordance with the terminology of the Swiss Civil Code and is based on the International Classification of Diseases (ICD-10) issued by the WHO.
- 21 The physician’s responsibilities are decisive; thus, in this case, a medical head of department, for example, can assume the function of a chief physician. The responsibility specified in Art. 434 SCC should not, however, be assumed by the physician who prepares the treatment plan, but by a hierarchically superior physician.
- 22 An appeal filed in accordance with Art. 450 ff. SCC represents a legal remedy against decisions ordering measures, as specified in Art. 439 SCC.
- 23 Cf. Section 3.3. («Appropriate environment»).
- 24 Cf. the UN Convention on the Rights of the Child (CRC), which has been ratified by Switzerland and forms part of Swiss law.
- 25 Art. 296 ff. SCC («Parental responsibility»).
- 26 In cases where parental responsibility is shared, the sole parent present can grant consent for treatment to the attending physician if this is consistent with the parents’ agreed division of duties. In the case of critical treatment decisions, the physician must make sure that both parents have been informed and agree to the proposed procedure.
- 27 Minors with capacity also have the right to state their wishes in an advance directive (Art. 370 SCC).
- 28 In the case of a patient with capacity, committal to a psychiatric hospital under Art. 314b SCC would essentially be possible, but treatment without consent under Art. 434 SCC would not.
- 29 The authority can appoint a deputy to act as a representative in medical matters and, if necessary, can restrict parental responsibility in this area (cf. Art. 308 SCC).
- 30 In cases of delirium, the principles set out in Section 4.1.3. essentially apply.
- 31 It is necessary to distinguish different types of cases where medication is concealed: if a tablet is crushed with a mortar and pestle and mixed with food purely so as to facilitate administration to a patient with dementia who has difficulty swallowing, this does not represent a coercive measure. It is, however, coercive to conceal medication in order to deceive a patient who refuses to take a particular (e.g. antipsychotic) drug. It should be borne in mind that the efficacy of a drug may be affected if the mode of administration is altered.
- 32 In serious cases, this may include notifying the competent authority.
- 33 Cf. the SAMS medical-ethical guidelines «Medical practice in respect of detained persons» (2002, updated 2012).
- 34 For example, under Art. 429 SCC, the cantons may designate physicians who, in addition to the adult protection authority, are authorised to order committal for a period specified by cantonal law.