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Assisted suicide in an acute care hospital: 18 months' experience

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Summary

Question under study: In 2006 the University Hospital of Lausanne (CHUV) introduced an institutional directive specifying the conditions for assisted suicide, in accordance with professional guidelines and the recommendation of the Swiss National Advisory Commission on Biomedical Ethics that every acute care hospital take up a position on this subject.

Methods: 18-months follow-up analysis of patient requests and application of the directive by hospital staff.

Results: Of the 54 000 patients hospitalised between January 1, 2006, and June 30, 2007, six requests were recorded, all within the first 7 months after introduction of the directive and in the context of severe and life-threatening diseases. However, only one of the six patients, living in a nursing home belonging to the hospital, died by assisted suicide. Two patients died from their diseases, one during the assessment procedure and the other shortly after. One patient withdrew his request after pain control, returned home and died several weeks later. Another patient, although she was severely ill and died several months later, was denied the procedure because her condition was improving. Only one patient was declared incompetent and his request refused. The time distribution of requests seems to be associated with initial media coverage of the assisted-suicide directive's introduction. Only minor amendments to the directive were needed.

Conclusions: The recommendations of the Swiss National Advisory Commission on Biomedical Ethics are applicable in an acute care hospital.

Key words: assisted suicide; professional guidance; acute care hospital; ethics

Introduction

In Swiss law assisted suicide is not illegal if not motivated on selfish grounds [1], whereas direct active euthanasia is illegal. Non-governmental right-to-die organisations exist and have progressively extended their activity both at home and in nursing institutions [2]. They sometimes interfere with hospital activity if one of their members needs to be hospitalised and has already arranged a date for assisted suicide with the organisation.

In 2005 the Swiss National Advisory Commission on Biomedical Ethics recommended that every acute care hospital determine whether it would accept assisted suicide within its walls [3]. This prompted Lausanne University Hospital (CHUV), on favourable advice from its ethics committee, to prepare an institutional directive specifying the conditions for assisted suicide [4]. The main argument was that patients condemned to stay in hospital for the rest of their lives should have the same rights as other citizens. Access would be restricted to competent patients in a severe condition and without medical alternatives of proven efficacy or treatment supporting vital functions; patients had to be expected to stay in hospital until death because the severity of their medical or social handicap would make it impossible for them to return home or be transferred to another institution. The procedure guarantees that no healthcare professional is required to participate against his/her will, and specifies that no hospital physician will provide the lethal drug. The directive flowchart is given in figure 1. Each step represents a criterion and is examined by the designated hospital committee before the patient fulfilling all criteria is given permission to contact the assisted suicide organisation. The directive complies with professional guidelines as issued by

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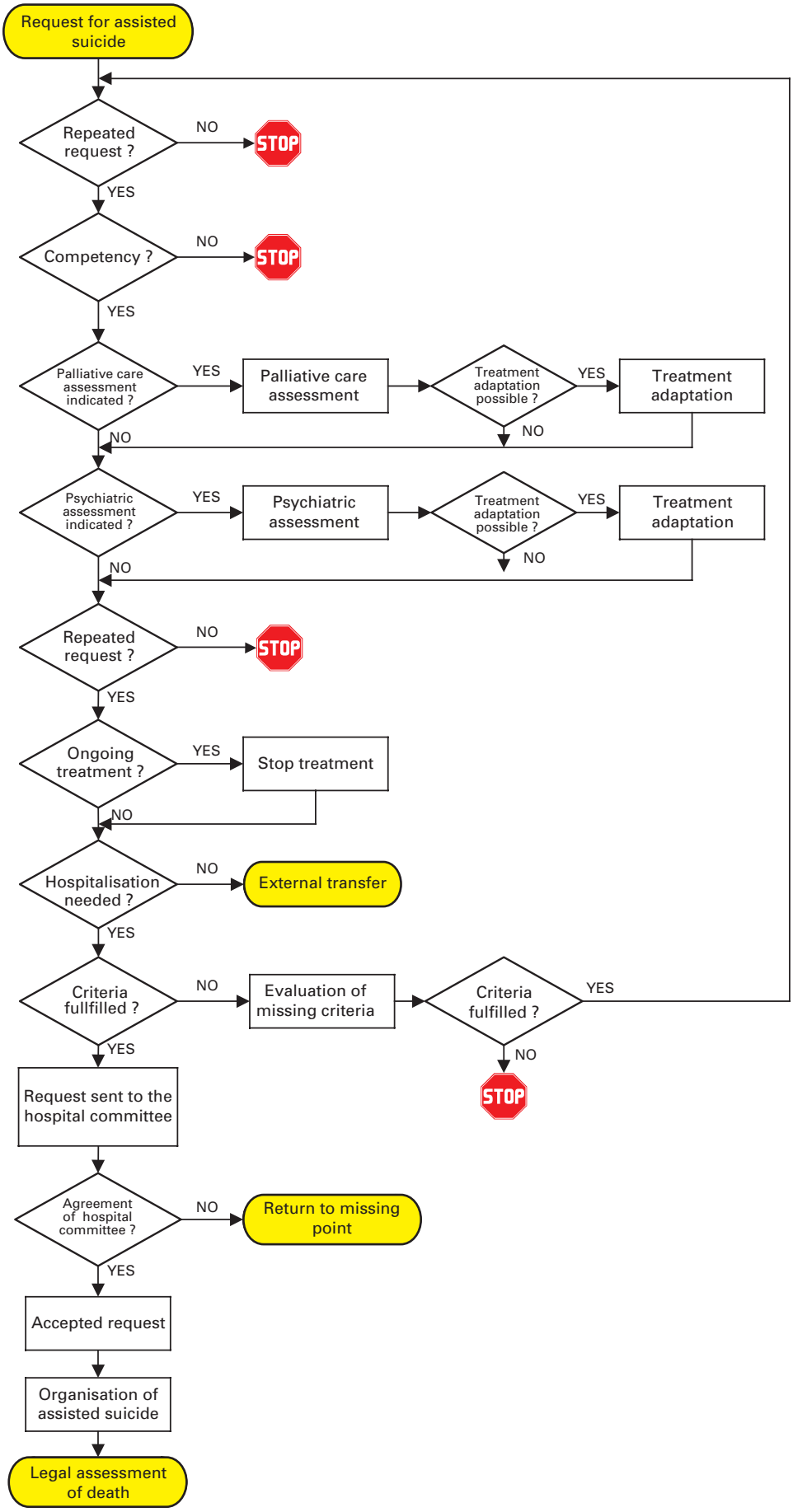
the Swiss Academy of Medical Sciences [5], the ethical position of the Swiss Nursing Association [6] and the recommendations of the Swiss National Advisory Commission on Biomedical Ethics [3].

This purely descriptive report describes the experience of our institution over the first 18 months after issuing its institutional directive. It does not examine the ethical aspects of assisted suicide in health care institutions.

Figure 1

Flow chart for evaluation of requests for assisted suicide at the CHUV.



Methods

After three information sessions the directive went into force on January 1, 2006, and was mailed to all hospital nurses and physicians.

Requests until June 30, 2007, were evaluated by analysing patient charts, minutes of the procedure assessment and of the debriefing sessions following each procedure implementation.

Results

Of the 54 000 patients hospitalised between January 1, 2006, and June 30, 2007, six requests were recorded, all within the first seven months after introduction of the directive.

Patient histories

Patient 1: 53-year-old male with a history of psychiatric hospitalisation for depression due to bipolar and personality disorder, diagnosed in January 2004 with myelofibrosis. Treatment by bone marrow transplantation was not indicated because of the high risk of postoperative non-compliance with medication. In December 2005 the patient was hospitalised for acute leukaemia, severe pain due to bone metastases and hypomania only partly responsive to medication by fentanyl, hydromorphone, NSAID corticosteroids and quetiapine. The haematological disease likewise failed to respond to therapy. The patient repeatedly asked for assisted suicide and repeated his request in January 2006 as soon as the directive was issued. The institutional procedure was under way when he died from the consequences of the haematological disease.

Patient 2: 72-year-old female admitted in November 2005 for acute severe necrosing pancreatitis, undergoing several surgical interventions such as right hemicolectomy, cholecystectomy and repeated necrosis removal, for which she gave informed consent. After she left the intensive care unit her condition improved although severe sequelae persisted, with recovery expected to last for several months. The patient requested assisted suicide in March 2006 while hospitalised in the intermediate care unit and a transfer to a rehabilitation facility was contemplated. Her request was denied because her condition was not terminal. She died several months later in a rehabilitation unit from complications of the abdominal condition.

Patient 3: 60-year-old female institutionalised in a CHUV-owned nursing home, diagnosed twelve years previously with amyotrophic lateral sclerosis leading to progressive loss of autonomy in activities of daily living. Her medication (clozapine, laevodopa, sertraline), was adequate to her disorder and successful in relieving pain (ibuprofen, paracetamol, gabapentine). However, her condition rapidly deteriorated over the last year, making her totally dependant for activities of daily living. She repeatedly requested assisted suicide and assessment in March 2006 revealed that she fulfilled all criteria. As a result, she was allowed to contact an assisted suicide organisation and died by assisted suicide in the nursing home.

Patient 4: 46-year-old male with disseminated small cell lung cancer with painful bone and lumbar metastases. After emergency hospitalisation in April 2006 for urinary incontinence associated with acute lumbar pain with leg irradiation, he requested assisted suicide. Medication was modified, dexamethasone, palliative radiotherapy introduced, and a peridural catheter inserted for continuous analgesia. These procedures allowed complete alleviation of pain. As a result, the patient withdrew his request and was discharged home where he died a few weeks later.

Patient 5: 61-year-old male with prostate cancer with pulmonary metastases since 2004 and a long-term depressive disorder. After hospitalisation in June 2006 for progressive asthenia he requested assisted suicide. A paraneoplastic Cushing's syndrome with behavioural disturbances was diagnosed and treated. Since he was considered incompetent his request was refused, palliative care was introduced which alleviated pain and agitation, and the patient died three weeks later.

Patient 6: 96-year-old male with pulmonary adenocarcinoma and left pleural effusion since December 2005, hospitalised in July 2006 for progressive asthenia, ischaemic cardiac disease, hypertension, dyslipidaemia and denutrition. During hospitalisation the patient expressed suicidal wishes and a desire for assisted suicide; a psychiatric consultant concluded that he was competent. While he was informed that he could be discharged at home and organise assisted suicide, his wife refused the transfer. Because of suicide threats he was admitted compulsorily to a psychiatric hospital to help in assessing his request for assisted suicide. On admission he was diagnosed with adjustment disorder and an acute stress reaction and died of cancer two days later.

Use of the directive

In all six situations the directive was adequately and effectively used in evaluating patient requests and in initiating, when necessary, appropriate palliative and psychiatric assessment and care. Two modifications, however, were introduced after the third request.

Since some of the health care professionals involved experienced major emotional upsets, regular psychiatric support for the staff is now proposed from the beginning of the procedure to its end, instead of only at the end as initially planned.

Since it was felt that the committee in charge of supervising all steps of patient assessment should not be constituted only of members of the ethics committee, it was complemented by members of the medical and nursing managements.

Discussion

Assisted suicide and euthanasia constitute highly controversial topics in most northern countries, including Switzerland. Evaluation of the first 18 months' experience at the Lausanne University Hospital indicates that the directive concerning assisted suicide allows careful and comprehensive assessment of patients, including physical and psychological status and competence, and provides an adequate framework for handling such requests. Only one of the six patients died by assisted suicide. The directive therefore seems to act as an effective filter and not as an incentive for assisted suicide. Since it is well known that assisted suicide and even direct active euthanasia or

life-terminating acts not expressly requested occur in Swiss hospitals [8], this institutional procedure may even have reduced the number of such acts.

Patients' histories and review of the charts and minutes of debriefing procedures revealed that all requests for assisted suicide were made in the context of severe and life-threatening diseases. Only one patient, although she was severely ill and died some months later, was denied the procedure because at this time she was not terminal. The often evoked danger that a directive of this kind would initiate numerous inappropriate requests for assisted suicide was thus not confirmed.

With regard to the crucial question of patients' competence, only one patient was declared incompetent and his request denied. Psychiatric disorder, not directly linked to incompetence, was identified in three patients out of six, suggesting some vulnerability on the part of patients requesting assisted suicide. However, except for the incompetent patient suffering from paraneoplastic Cushing's syndrome, a psychiatric disorder did not hamper access to the institutional procedure, one of whose aims is to initiate psychiatric and palliative care.

For health care professionals the directive provided guidance on how to respond to patients' suicide requests, and set a framework for careful and comprehensive assessment and care without delay. This impact is well illustrated by the patient who withdrew his request after effective treatment of his symptoms by a palliative care specialist. The procedure also served to regulate relationships between the hospital and assisted suicide organisations, and to document such requests.

Our experience showed that the directive needed only limited modifications. Involvement of both the medical and nursing managements in patient assessment and provision of psychological support from the beginning of the procedure guaranteed institutional support to all staff members in this field of conflicting values and opinions.

The time distribution of the requests seems to be associated with initial media coverage of the directive's introduction, which was followed by some confusion in the public mind about the role of the hospital in euthanasia and assisted suicide. The time and effort devoted to correcting misinformation about the directive for both public and professional bodies initiated debate or prompted adoption of similar directives in several other hospitals. Moreover, the Swiss Academy for Medical Sciences modified its position to acknowledge that discrimination with regard to assisted suicide on the basis of place of residency was not sustainable but that, considering the actual rarity of these cases, caution is indicated in formulating guidelines on this subject [5].

Our experience is limited, involving only one institution over a short period of time. It did not address the ethical aspects of assisted suicide in health care institutions or the question of supervision of assisted suicide organisations. However, it showed that the recommendations of the Swiss National Ethics Committee are applicable to a given institution, provided that support from management is available to the nursing and medical team involved in a patient's request for assisted suicide.

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