

Assisted suicide as conducted by a “Right-to-Die”-society in Switzerland: A descriptive analysis of 43 consecutive cases

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Abstract

Background and methods: the Swiss “Right-to-Die”-society EXIT enables assisted suicide by providing terminally ill members with a lethal dosage of barbiturates on request. This practice is tolerated by Swiss legislation. EXIT insists on its assumption that people with serious illness and suffering have the competency to take such a decision. The case of two patients who committed suicide a short time after their release from a psychiatric clinic raised some doubts about the practice of EXIT. The files of all 43 cases of suicide assisted by EXIT between 1992 and 1997 in the region of Basle kept in the Institute of Forensic Medicine were examined for accuracy of the medical data. This sample was compared for age, gender-ratio and prior psychiatric treatment with 425 ordinary suicides in the same region. An attempt was made to assess whether only terminally ill and people with intolerable suffering had been assisted with suicide and what efforts EXIT had made to rule out psychiatric illnesses or poor social conditions as the reason for the wish to die.

Results: a medical report of the treating doc-

tor(s) was in the files in only five cases. The “EXIT” cases were older than the “ordinary”-sample. Among those over 65 years old there were almost twice as many women as men. 16 of the 24 women older than 65 years were widowed. There were 20 cases of cancer; but in eleven cases medical files revealed no apparent medical condition to explain a death-wish. Five of the patients declared a social loss or fear of such loss as the reason for their wish to die. Six persons had formerly been in psychiatric care, though this was not mentioned in the files.

Conclusions: due to the scarcity of information in the files as regards previous palliative care, the high proportion of old women and the high percentage of people not suffering from a terminal illness compared to the literature we conclude that psychiatric or social factors are not an obstacle for EXIT to assist with suicide.

Key words: assisted suicide; barbiturates; psychiatry; EXIT; forensic medicine; “Right-to-Die”-society; terminal illness

Introduction

Euthanasia and physician-assisted suicide are issues which are broadly discussed both by the public and professionals [1]. The discussion has gone as far as to raise the question of potential cost savings from legalising physician-assisted suicide even in the medical press [2]. In Holland, physician assisted suicide is tolerated by the authorities, a respective bill has passed the Lower House of the Dutch Parliament on the 28th of November 2000. In Oregon, physician-assisted suicide is legal. The practice in both states has been observed by two medical studies [3, 4].

According to Art. 115 of the Swiss penal code,

assisted suicide is considered to be a felony only if it has been done for a selfish motivation. Killing on request is punishable according to Art. 114 in every case. Physician assisted suicide in Switzerland has never been investigated scientifically, but it does exist and the authorities are aware of it [5].

Swiss public opinion, however, sees euthanasia – or “merciful killing” according to its literal translation – not as being associated with physician assisted suicide in a narrow sense, but rather with the name of the private, non-medical “Right-to-Die”-society “Exit-Society For a Human Way of Dying” which was founded in 1982.

EXIT's activities

EXIT sees itself as countering the paternalistic attitude of physicians of the sixties and seventies as regards the needs of their patients. According to its latest declaration, EXIT wants to grant a decent way of dying for members suffering from a disease with poor prognosis, unbearable pain or unsustainable impairment – even by means of assisted suicide. No further specifications, however, are given concerning these criteria: It is, according to EXIT, the "free will" of the person concerned that matters in the end [6].

Members must approach EXIT of their own free will and have to submit a medical diagnosis, a medical file or a certificate written by a physician. The applicant is then visited by a member of the team of dying companions, who verifies the wish to die. These dying companions are not necessarily medical staff [7], since unlike other "Right-to-Die"-advocates and its sister association in the French speaking part of Switzerland, EXIT does not want to leave the competency for making decisions concerning ending life to the medical body [6]. The applicant may subsequently obtain a prescription from his own doctor or one of the EXIT-physicians. The applicant is then visited by one of the EXIT-dying companions who brings the drug which has to be ingested by the applicant by his own means – in the case of intravenous drips he must be able to open the inlet by himself. If possible, there should be a declaration of support by a relative. A "death"-protocol is handed out to the authorities [7].

These procedures have been somewhat changed over the years, but not in a very decisive way [8, 9].

The number of putative suicides assisted by EXIT in Switzerland was revealed for the first time by chance in 1990: In a nation-wide survey of all cases of suicide by lethal drug-intoxication (179 or 12% of all suicides), 29 cases have been found of persons who have committed suicide with a combination of barbiturates and an anticholinergic drug according to EXIT's recommendations [10].

EXIT insists on its assumption of competence of its clients to take such decisions. Consequently, EXIT unequivocally declares in its "Erklärung von Solothurn", that it is not concerned with any kind of suicide prophylaxis [11]. EXIT has been recently criticised in public for its attempt to assist a young woman suffering from mental disorder with her suicide [12]. Even before this public debate, a group of former EXIT-members has split and founded a new "Right-to-Die"-society named "Dignitas". Its influence, however, seems comparatively small today [13].

Since the decision of the city-council of Zurich, to grant "Right-to-Die"-societies such as EXIT access to homes for retired persons and even have a designated room for the procedure of assisted suicide, the question of assisted suicide has again become a matter of great public interest [14].

Methods

In 1996, a study-group for the investigation of suicide in the region of Basle was formed. All 460 cases of suicide known to the authorities of the two half-cantons Basle-city and Basle-county, which had occurred between 1992 and 1996 have been investigated for sociodemographic and medical data such as suicide methods and former treatment in one of the public psychiatric institutions of this region. Of these 460 cases, in which suicide occurred by various means, 35 people were assisted by EXIT. Since the majority of the EXIT-suicides, ie, 27, had occurred after 1995, we have added the year 1997, in order to investigate whether there is a trend of increasing EXIT-suicides. Hence, the total of our sample was 43 cases.

Aims

The aim of this retrospective study was to investigate socio-demographic and medical data of all people who had committed suicide with assistance from EXIT between 1992 and 1997 in the region of Basle. Especially, we were interested in the following questions:

- What are the differences concerning sociodemographic data of the "EXIT" suicides compared to "ordinary" suicides?
- Are there sufficient data in the files to enable an independent examiner to assess the course of the illness and the palliative care of these people, the circumstances which gave rise to their death-wish and the conditions of their dying?
- Which were the serious diseases/diagnoses in question, what proportion was merely suffering from a treatable psychiatric illness or was living in poor social conditions?

Subjects

The Basle region is a relatively compact area with some 400,000 inhabitants. Unusual cases of death such as suicides [15] have to be reported to the authorities and are investigated by members of the "Institute of Forensic Medicine" of the University of Basle (IFM). In cases of unequivocal suicide it is within the remit of the forensic competence to decide whether to perform an autopsy or merely a external inspection.

We consulted all files of "EXIT-suicides" from 1992-1997, which are archived in the Institute of Forensic-Medicine (IFM) of the University of Basle. The files consist normally of an "EXIT-Protocol", a forensic expertise (coroners report, external inspection and/or autopsy and/or toxicological investigation), in some cases there is a police report and in some cases a report by a treating doctor or the hospital.

The EXIT-Protocol is a form in which the personal data, the companion who agrees with the wish to die, the assistant, the date of membership

of the deceased, the date of first personal contact with EXIT in relation to the death wish, the date when the day of death was confirmed, the medical diagnosis and the process of dying of the concerned person are registered.

Age, gender and putative former treatment in a public psychiatric institution of the region of the "EXIT"-suicides have been compared with the available data of all 425 "ordinary" suicides, which have been registered in the IFM between 1992 and 1996. The data of "ordinary" suicides from 1997 are not yet available.

Results

Documentation

In 41 of the 43 files there was a proper forensic examination; in 14 cases a complete autopsy was performed. In 27 (63%) of 41 forensic examinations, a toxicological analysis was performed. In three cases, a lethal dosage of pentobarbital was found, with the remaining cases it was secobarbital.

In 23 (53%) cases, there were police reports, in 38 (88%) EXIT's protocol and in five (12%) of the 43 files there were medical reports of the former treating doctors or hospitals.

Age and gender-distribution of the EXIT-suicides compared to the normal-suicides

The mean age of "EXIT"-suicides between 1992 and 1996 was significantly higher than the mean age of the "ordinary" suicides in the same period (table 1).

The gender-ratio of both samples differed statistically. This was also the case for the above 65 years old, the Swiss age of retirement (table 2).

The proportion of women was greater with the "EXIT"-suicides 1992-1997: 24 (71%) women to 9 (29%) men.

Somatic illnesses

In only five cases were there reports by hospital doctors. In the other cases, the diagnoses could be taken from the forensic certificates, the EXIT-protocols or the police-reports. The diagnosis were classified as follows.

1. Neoplastic diseases (section C or D of ICD 10): 20 out of 43 (47%) were suffering from a neoplastic disease; of which 19 were malignant, in one case a basal-cell carcinoma causing significant destruction of the face.
2. Neurological diseases (section G of ICD 10): Five out of 43 (11%) were suffering from neurological problems, two with multiple sclerosis, one with bulbar palsy and in one case hemiplegia.
3. Pulmonary diseases (section J of ICD 10): 4 cases out of 43 (9%).
4. AIDS (Chapter B of ICD 10): 3 cases out of 43 (9%).
5. "Others": 11 cases out of 43 (26%). No severely disabling or terminal illness was recognisable from the files. In five of them, the reason for the death wish was a major bereavement. These cases are presented in table 3.

Psychiatric illnesses

Six of the "EXIT"-suicide-cases (or 14%) had at least once been treated in a public psychiatric institution, either as in- or out-patients. The files of these patients had been available for us (table 4). Their cases have been extensively discussed elsewhere [12]. As in the whole of Switzerland, however, no statistics are available about former private psychiatric treatment of patients.

Among the 425 "ordinary" suicides between 1992 and 1996, 136 (37%) had been treated in a public psychiatric institution.

Table 1

Age of the "ordinary"-suicides compared to "EXIT"-suicides between 1992 and 1996.

	"Ordinary"-suicides (n = 425)		"EXIT"-suicides (n = 35)	
Mean age of men	50 y	(SD 20,2)	75 y	(SD 18,0) t (df =300) = 3,5; p <0,001
Mean age of women	52 y	(SD 18,6)	74 y	(SD 13,1) t (df =156) = 5,4; p <0,001

Table 2

Gender distribution of "ordinary"-suicides compared to "EXIT"-suicides between 1992 and 1996.

Number of men*	287 (68%)	15 (43%)
Number of women*	138 (32%)	20 (57%)
Number of men over 65 y**	79 (65%)	9 (37%)
Number of women over 65 y**	42 (35%)	15(63%)

* Chisquare (df = 1) = 7,67; p < 0,01

** Chisquare (df = 1) = 5,37; p <0,05

Reasons for the wish to die

Specified reasons for wishing to die, besides somatic illness, could be found in the files of only 31 cases. In 11 cases (26%) there was a severe deterioration of the general state of well-being, six complained of increasing respiratory failure. In 14

Table 3

"EXIT"-suicides with no apparent disabling or terminal illness.

Case 9:	Diagnosis according to psychiatric out-patient clinic: Depressive neurosis. Diagnosis according to EXIT: Cancer pain. Autopsy: No tumor
Case 11:	Diagnosis according to EXIT: Old age, general impairment. Police report: According to his son, the patient was impaired by his artificial hip-joint. Autopsy: None.
Case 12:	Diagnosis according to psychiatric clinic: Delusional depression (ICD-10 F 33.2) Diagnosis according to EXIT: Intolerable impairment. Loss of the capacity to smell. Autopsy: None
Case 13:	Diagnosis according to EXIT: None! Police report: The Patient wanted to die in order to avoid the amputation of a leg. Autopsy: Generalised arteriosclerosis.
Case 15:	Diagnosis according to EXIT: Intolerable impairment. Police report: Impaired vision and hearing and chronic pain. Autopsy: None (the suicide occurred 10 days after the suicide of her husband had committed suicide assisted by EXIT as well).
Case 18:	Diagnosis according to EXIT: Intolerable impairment, blindness. Police report: Impaired vision, fear of impending referral to an old people's home and of being a burden to his relatives. Autopsy: None.
Case 23:	Diagnosis according to EXIT: Severe rheumatism. Police report: According to general practitioner deformation of major joints with polyarthritis. Autopsy: None
Case 26:	Diagnosis according to EXIT: Malignant hypertension after Hashimoto's thyroiditis. Police report: Impaired hip joint. Autopsy: None
Case 36:	Diagnosis according to EXIT: Severe polyarthritis. Autopsy: None.
Case 37:	Diagnosis according to EXIT: Different complaints, no hope. Police report: Blindness and incapacity to walk. Decubital ulcer. Autopsy: None
Case 43:	Police report: Insulin-dependent Diabetes mellitus with four injections per day. Autopsy: No major pathology.

Table 4

Synopsis of the psychiatric history of six "EXIT"-suicide-cases.

Case 9	The 68 year-old patient had been in psychiatric out-patient treatment for years after several suicide attempts. She had been diagnosed with adjustment disorder (ICD-10 F 43.2 and Dysthymia (ICD-10 F 34.1). She had undergone surgery several times for "intolerable abdominal pain". She wanted to die because of "cancer pain" after the death of her disabled friend, for whom she was caring. No cancer could be found, however, at autopsy.
Case 12	The 87 year-old widow had contacted EXIT in order to avoid the fate of her sister who was unable to feed herself and in hospital care after several strokes. Her relatives informed the authorities about her wish and she was admitted to psychiatric care against their will. After six weeks treatment she was released, the diagnosis was delusional depression (ICD-10 F33.3). She committed suicide assisted by EXIT 49 days later.
Case 19	The 65 year-old widow had been seen by a consulting psychiatrist in a somatic hospital after a suicide attempt. She had been diagnosed with adjustment disorder (ICD-10 F. 43.2). Ten years later, she was suffering from lung-cancer, but rejected any consequent therapy. Due to her increasing shortness of breath, she asked EXIT to assist her with suicide.
Case 20	The 35 year-old, married man was in hospital care because of Glioblastoma multiforme. The consulting psychiatrist did not see any suicide risk and diagnosed a Depersonalisation- and Derealisation-syndrome (ICD-10 F 48.1) After four months of chemo- and radiotherapy without success the patient committed suicide assisted by EXIT.
Case 21	The 62 year-old patient knew about his positive HIV-state for years. He had been referred to psychiatric care against his will after having attracted attention in public by his strange behaviour. Ten days later, he was released; the diagnosis was subacute organic delusional state (ICD-10 F 0.58). He had contacted EXIT in the clinic and committed suicide 10 days after his release.
Case 29	The 62 year-old patient, living separated from his wife, was in hospital care due to his oat-cell carcinoma of the lung. A consulting psychiatrist diagnosed Dysthymia (ICD-10 F34.1) and arranged psychiatric care. The patient, however, contacted EXIT 49 days later and committed suicide assisted by EXIT after a further 65 days.

Table 5

Not medical reasons for the wish to die.

Case 4	A 91 year-old patient was unable to continue to play cello, after having suffered from a stroke.
Case 9	A 68 year-old patient had lost her impaired friend, for whom she had cared.
Case 11	A couple who wanted to commit suicide together had declared their wish to "fall asleep" together. The 72 year-old wife was in the terminal state of cancer, the husband was afraid of being dependent on others after the death of his wife.
Case 12	A 87 year-old widow wanted to escape the fate of her sister who had to be artificially nourished after a stroke.
Case 23	A 91 year-old widow lived alone in her apartment. She had to be transferred to an old people's home and did not want to become a burden to others.

cases (33%), intolerable pain was the main reason for the wish to die. Five patients (12%) were suffering from a social loss or the fear of such a loss. These cases are outlined in table 5.

Contact to EXIT

In 3 of the 43 cases, there was no information available in the files as to when EXIT had first been contacted in connection with the death wish. In ten out of 43 cases (23%) the time between a first personal contact with EXIT and the suicide was less than a week, in four of them even less than a day.

No data could be found in the files in five cases (12%) as to when the members had joined EXIT.

28 (65%) had been members for more than three months, five for less than three months (12%). In five cases (12%), it was impossible to establish whether membership had lasted less or more than three months, since the exact date of joining was not registered, though they had joined EXIT in the year of their suicide.

State of marriage

In 4 cases, the marital status could not be deduced from the files (9%). 17 were married (17%), 4 (9%) were unmarried and 18 (42%) widowed, of whom 16 were widows above 65 years of age.

Discussion

Age and gender-distribution

There appears to be no doubt, that the majority of the EXIT-members in this survey were suffering from a severe somatic condition. Hence, it might not be surprising that the average age at time of death among cases of "EXIT"-suicide is higher than among "ordinary"-suicides. More surprising (and worrying) is that the ratio of women to men is 2:1, which is in direct contrast with international figures for suicide in general, where the ratio is inverse [16]. Even van der Wal [17], van der Maas [4, 18] and Sullivan [3] found in their papers on physician-assisted suicide, that among their samples population half were men.

The strong over-representation of women above 65 years of age cannot be explained merely by the putative greater risk of the elderly contracting a serious or lethal illness, it must be kept in mind, that of the 18 who had lost their spouse, among the 43 EXIT-cases, 16 were women over the age of 65 years.

Accuracy of the files

The protocols completed by the EXIT-dying companions, the written observations made by the coroner, and the statements by witnesses registered in the police reports on the whole succeeded in communicating the suffering which led to the wish to die. In one case, however, how a tetraplegic woman was able to grasp and swallow the lethal drug without assistance remains unclear.

In only five cases where a medical report of the treating doctors could be found in the files it was barely possible to assess what kind of curative or palliative care had been given to the patient prior to his or her wish to die.

Terminal illness

Fewer than half of the people who committed suicide assisted by EXIT between 1992 and 1997 were suffering from cancer. This figure seems remarkably low compared to the international literature. Van der Maas [4] found, that 68% of the Dutch who died by euthanasia or assisted suicide

had been suffering from cancer. A further Dutch study revealed, that 78% of the people who committed assisted suicide, had been suffering from [17] cancer. Sullivan [3] found, that among the 43 patients, who died after the prescription of a lethal drug according to the "Death with Dignity"-act in Oregon 31 (71%) were suffering from cancer.

There is no doubt, of course, that there are other medical conditions satisfying EXIT's assumption of "poor prognosis, unbearable pain or unsustainable impairment". It must, however, be kept in mind, that in more than a quarter of the cases classified as "others" no evidence for such a condition could be found and five had unequivocally declared that a social loss or the fear of such, rather than a deterioration of their state of health, had been the motive for the wish to die.

EXIT's efforts to rule out psychiatric illness or poor social conditions

In almost a quarter of the EXIT-cases the time between the first contact with EXIT because of the wish to die and the completed assisted suicide was less than a week; in 4 cases, it was even less than a day. Considering the fact, that the wish to die among the terminally ill fluctuates considerably, this short time gap seems to allow insufficient time for any serious evaluation of the mental or social conditions of the individuals involved [19].

EXIT seems not to consider former or even actual psychiatric treatment as a reason to doubt the competence of an applicant for assisted suicide: Two patients of the Psychiatric University Clinic of Berne had been assisted in their suicide whilst they were in-patients [20]. Six of our 43 patients had been treated in a psychiatric institution in the region, two of them, however, had only been discharged from a psychiatric hospital a short time before their suicide. Even though there is only scanty information about the personal conditions of the deceased in the files there are some relevant and treatable psychiatric problems easily to be identified: The patient who died 49 days after her release from hospital, was diagnosed as having

delusional depression in the clinic, whilst another patient, with a former diagnosis of neurotic depression, who had undergone abdominal surgery on several occasions and was probably suffering

form non-delusional dysmorphophobia (ICD-10 F 45.2), had been classified by EXIT as having "cancer pain", to name but two examples.

Conclusions

This paper deals with assisted suicide performed by lay-people who act without outside control and violate their own rules, as must be concluded from the examined files. It is neither a manifesto against nor an argument in favour of assisted suicide, nor is the aim to suggest how a "Right-to-Die"-society such as EXIT could "improve" their work: Like Sullivan for example, [21] we do not consider it appropriate to charge psychiatrists with a gatekeeper role for assisted suicide.

Sullivan's [3] optimistic conclusion in the case of Oregon was that, concerns that physician-assisted suicide might mainly be applied to people in poor social conditions, had not become a reality. In the case of assisted suicide performed by EXIT, we are unable to share this favourable view.

As this paper deals with cases from 1992–1997, one might argue that the data are not up to date. In a latest declaration, the present chairman of EXIT commends the good co-operation with the medical body in general, with the exception of psy-

chiatrists and psychologists, whose assumption that severely ill people might be suffering from depression he still regards as an example of undue paternalism, coming from people whose professional shortcomings are easily seen in their poor prognoses concerning probation of sexual offenders [4]. Hence, we feel the danger can not be ruled out that assisted suicide carried out by this lay-organisation, which clearly disregards the psychosocial implication of suffering, still offers a radical, over simplified solution, not only for people suffering from serious medical but from difficult social conditions, as well.

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