

## Original Article

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### Author for correspondence:

Martina A. Hodel, Institute of Biomedical Ethics and History of Medicine, University of Zurich, Winterthurerstrasse 30, 8006, Zurich, Switzerland.

E-mail: [martina.hodel@ibme.uzh.ch](mailto:martina.hodel@ibme.uzh.ch)

# Attitudes toward assisted suicide requests in the context of severe and persistent mental illness: A survey of psychiatrists in Switzerland

Martina A. Hodel, <sup>MSC1</sup>, Paul Hoff, MD, PHD<sup>2</sup>, Scott A. Irwin, MD, PHD<sup>3</sup>,

Nikola Biller-Andorno, MD, PHD<sup>1</sup>, Florian Riese, MD<sup>2</sup> and Manuel Trachsel, MD, PHD<sup>1</sup>

<sup>1</sup>Institute of Biomedical Ethics and History of Medicine, University of Zurich, Zurich, Switzerland; <sup>2</sup>Psychiatric University Hospital Zurich, Zurich, Switzerland and <sup>3</sup>Cedars-Sinai Health System, Los Angeles, CA

## Abstract

**Objective.** Switzerland is among the few countries worldwide where a request for assisted suicide (AS) can be granted on the basis of a primary psychiatric diagnosis. Psychiatrists play an increasingly important role in this regard, especially when the request for AS arises in the context of suffering caused by severe and persistent mental illness (SPMI). The objective of the survey was to assess general attitudes among psychiatrists in Switzerland regarding AS requests from patients with SPMI.

**Method.** In a cross-sectional survey of 1,311 German-speaking psychiatrists in Switzerland, participants were asked about their attitude to AS for patients with SPMI, based on three case vignettes of patients diagnosed with anorexia nervosa, treatment-refractory depression, or severe persistent schizophrenia.

**Result.** From a final sample of 457 psychiatrists (a response rate of 34.9%) whose mean age was 57.8 years, 48.6% of respondents did not support access to AS for persons diagnosed with SPMI, 21.2% were neutral, and 29.3% indicated some degree of support for access. In relation to the case vignettes, a slightly higher percentage of respondents supported the patient's wish to seek AS: 35.4% for those diagnosed with anorexia nervosa, 32.1% for those diagnosed with depression, and 31.4% for those diagnosed with schizophrenia.

**Significance of results.** Although a majority of the responding psychiatrists did not support AS for SPMI patients, about one-third would have supported the wishes of patients in the case vignettes. In light of the increasing number of psychiatric patients seeking AS and the continuing liberalization of AS practices, it is important to understand and take account of psychiatrists' perspectives.

## Introduction

Assisted suicide (AS) is now legal in some countries in Europe, in certain US states, in Canada and Colombia, and, since 2019, in the Australian state of Victoria (Dyer et al., 2015; Emanuel et al., 2016). (In the course of legalization and depending on prevailing concepts, established terms differ; these include assisted suicide and [medically] assisted dying. Although we are aware of the controversy surrounding these different terms, the term assisted suicide is used here because it is commonplace in Switzerland.) Traditionally, AS has evolved as a medical intervention, performed by physicians, and confined to the terminally ill as a means of preventing unnecessary suffering and to respect patient autonomy.

In Western societies, there is wide support for AS among both the public and medical professionals (Emanuel et al., 2016), but the degree of support is strongly dependent on the patient group. Specifically, surveys have shown that physicians, including psychiatrists, are generally more reluctant if the request for AS is based on suffering that relates to mental illness compared with suffering as a consequence of physical illness (Bolt et al., 2015; Brauer et al., 2015; Kouwenhoven et al., 2013; Rousseau et al., 2017). AS on the basis of a mental illness is legal in only a few jurisdictions and remains highly controversial (Appelbaum, 2016; Kim & Lemmens, 2016; Miller & Appelbaum, 2018; Schuklenk & Vathorst, 2015; Vandenberghe, 2018). However, the number of persons granted access to AS for a psychiatric disorder is increasing. In the Netherlands, 13 cases were reported in 2011, increasing to 60 in 2016 and 83 in 2017 (Regional euthanasia review committees, 2017). In the absence of a reporting system in Switzerland, there is a lack of information about cases of psychiatric AS. However, cases of AS are known to have increased since 2008, with an absolute increase in nonterminal patients seeking AS (Steck et al., 2018). The Swiss model differs significantly from other approaches in a number of ways (Table 1).

Internationally, Switzerland is the only country whose legal framework requires neither a terminal (somatic) condition for patients requesting AS nor a specific role for physicians in

**Table 1.** The Swiss model

<p>Regulated by the Swiss Criminal Code, Article 115, on “Inciting and assisting suicide:” Any person who for selfish motives incites or assists another to commit or attempt to commit suicide is, if that other person thereafter commits or attempts to commit suicide, liable to a custodial sentence not exceeding five years or to a monetary penalty.</p> <p><b>Features</b></p> <ul style="list-style-type: none"> <li>• No further regulations regarding content (e.g., eligibility criteria for assisted suicide) or formalities (e.g. procedural measures)</li> <li>• No formal role for physicians</li> </ul> <p><b>Right-to-die organizations</b></p> <p>Although everyone can legally assist someone in dying/suicide (unless guided by selfish motives), in practice, nongovernmental right-to-die organizations evaluate, coordinate, and respond to requests. They formulate their own guidelines and access to assisted suicide based on their personnel’s assessment of a specific case.</p> <p><b>Role of doctors</b></p> <ul style="list-style-type: none"> <li>• Assessment of decision-making capacity (need not necessarily be psychiatrists)</li> <li>• Prescription of the lethal drug</li> <li>• Medical-ethical guidelines (not binding until incorporated into the Code of the Swiss Medical Association [FMH]) of the Swiss Academy of Medical Sciences set out ethical principles and offer guidance for physicians and nurses</li> </ul>
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the request process. Instead, the physician’s involvement is confined to assessing decision-making capacity and prescribing the lethal drug, with no further legal regulations governing access and procedure (Gamondi et al., 2017; Ziegler & Bosshard, 2007). In practice, nongovernmental “right-to-die” organizations (RTDOs) evaluate, coordinate, and respond to AS requests (Ziegler, 2009; Ziegler & Bosshard, 2007). RTDOs define internal guidelines that specify necessary preconditions and procedural requirements, including whether requests can be made on the basis of suffering related to mental illness (Ziegler & Bosshard, 2007).

Criticism notwithstanding, the Swiss model has been described as demedicalizing AS and resolving some ethical dilemmas commonly faced by medical professionals (Ziegler, 2009). Until now, AS in Switzerland has ostensibly been treated as a political and public concern rather than a medical one. Nevertheless, many of Switzerland’s hospitals, nursing homes, hospices, and other institutions, involved in the care of seriously ill patients encounter AS requests. Some institutions have begun to develop their own internal guidelines for refusing or allowing AS in their wards (Harding, 2005; Tuffs, 2007). In cases where suffering caused by mental illness is the primary reason for requesting AS, psychiatrists and other mental health care staff are likely to be involved. In Switzerland, only one study to date has explored physicians’ support for AS in different medical scenarios, including dementia and mental illness that is refractory, chronic, and severe (Brauer et al., 2015). That study was commissioned by the Swiss Academy of Medical Sciences (SAMS) to obtain an overview of physicians’ views on AS and to inform new medical-ethical guidelines for “Management of dying and death” (SAMS, 2018). In the survey, 28% of all responding physicians supported the principle of AS, whereas 22% were clearly opposed. About 40% of respondents believed that physicians should be allowed to perform AS (Brauer et al., 2015). Although the survey sheds some light on the attitudes of physicians practicing in Switzerland, the low response rate of 34.9% and the wide variation of respondents from different professional specialties serve to limit the generalizability of the results. In addition, SAMS has recently revised its guidelines on physician-assisted suicide. The new guidelines propose circumstances in which physician-assisted suicide may be ethically justifiable but notably refrain from including terminal illness as a criterion for AS (SAMS, 2018). The present

study explores psychiatrists’ general attitudes to AS in the context of severe and persistent mental illness (SPMI), with reference to three clinical scenarios presented as case vignettes (Table 1).

### Research questions

To determine the attitudes of physicians with specialist training in psychiatry to AS requests from patients with SPMI and, specifically, their willingness to support a patient’s decision to make such a request, two research questions were asked: (1) whether German-speaking psychiatrists in Switzerland support the possibility of AS in patients with SPMI in general and (2) whether they would be willing to play an active role in AS. Additionally, the participants were asked to evaluate three case vignettes: a patient with severe and enduring anorexia (vignette 1); a patient diagnosed with treatment-resistant depression (vignette 2); and a patient suffering from severe persistent schizophrenia (vignette 3). The third research question asked (3) whether their support would differ for the patients in the three case vignettes.

### Methods

The quantitative cross-sectional survey was conducted in cooperation with the Swiss Society for Psychiatry and Psychotherapy (SSPP), based on a previously reported protocol (Trachsel et al., 2019). The study fell outside the scope of the Swiss Human Research Act because no personal data related to human diseases or the structure or function of the human body were collected. However, the study was assessed according to the Checklist for the ethical evaluation of empirical studies that do not need mandatory authorization (No. CEBES-2016-04). Participants’ identities were anonymized, and the study was noninterventional in nature. All participants received a copy of the survey by mail with an enclosed prepaid return envelope, followed four weeks later by a postcard reminder.

### Sample

The total sample ( $n = 1311$ ) included all German-speaking members of the SSPP, corresponding to approximately 30% of psychiatrists in Switzerland. Data were collected during the period February–March 2016.

**Table 2.** Case vignettes based on modified versions of previously published cases**Case 1: 37-year-old female with anorexia nervosa, onset at age 11**

Symptoms: general muscle weakness; loss of bone density; amenorrhea; current weight 24 kg/52 lb; body mass index 9.5 kg/m<sup>2</sup>; no recent weight gain or stabilization; no acute danger of dying as her body is adapted to being underweight.

The patient underwent 10 previous inpatient treatments (in both somatic and psychiatric hospitals), three of which were in specialized psychiatric institutions. Throughout the course of disease, different intensive psychotherapies have been tried without success. During hospitalizations, the patient underwent several artificial refeedings, sometimes under sedation. The patient now refuses artificial refeeding and treatment. She states that, for years, her life has been focused exclusively on trying to overcome her anorexia, leaving her without friends or hobbies. She suffers from physical symptoms, including general muscle weakness and loss in bone density, saying that she would rather die than undergo further treatment and wishes to be left in peace. She does not want to be forced into eating anymore. Two experts have declared that the patient has decision-making capacity to refuse further treatment, with consequent risk of dying.

**Case 2: 33-year-old male with schizophrenia, onset at age 17, no significant comorbidities**

Positive symptoms: auditory and visual hallucinations, persecutory delusions. Negative symptoms: apathy, social withdrawal, poverty of speech (all rated severe).

Despite long-lasting, high-dose pharmacological treatment (several atypical neuroleptics, haloperidol, clozapine, and combinations of these), as well as electroconvulsive therapy, the patient has never been free from positive or negative symptoms. Multiple psychotherapies of various kinds have also failed to stabilize the patient or to improve his quality of life. He does not wish to continue assertive community treatment because he feels it is too intrusive. Although the positive symptoms were more dominant in the first years following initial diagnosis, he went on to develop severe negative symptoms, as well as aggression and self-injurious behavior such as burning himself with cigarettes. The negative symptoms and his strong functional deficits are exacerbated by chronic unemployment and inability to live independently; the patient has no family system. His persisting illness has left him completely isolated, with no social contacts and no hobbies or interests. Two experts have declared that he possesses decision-making capacity in respect of his illness and its treatment.

**Case 3: 40-year-old male with major depressive disorder, no significant comorbidities**

Symptoms: energy loss, insomnia, fatigue, persistent suicidal ideation over 20 years, current acute and concrete suicidal intent.

The patient underwent different intensive, evidence-based, long-term psychotherapies, including specialized treatment approaches such as cognitive behavioral analysis system of psychotherapy (CBASP) and interpersonal psychotherapy (IPT). His depression was not improved either by psychotherapy alone or in combination with adequate treatment trials of antidepressants (selective serotonin reuptake inhibitors, tricyclic antidepressants, venlafaxine, augmentation with lithium and antipsychotic medications [quetiapine and aripiprazole]). The patient experienced significant adverse effects with several of the medications. Exhausted and as a last resort, he has decided to undergo electroconvulsive therapy. However, maintenance electroconvulsive therapy proved equally ineffective in preventing the reappearance of suicidal ideation; indeed, the symptoms worsened. The patient experiences severe hopelessness and states that his quality of life is very poor, that he doesn't want to deal with his illness anymore, and that he plans to commit suicide in the near future. Two experts have declared that he possesses decision-making capacity regarding his illness and its treatment.

**Survey and case vignettes**

This article reports 5 of 42 items targeting different aspects of care for SPMI patients, with particular reference to the suitability of palliative care approaches for this group of patients (Trachsel et al., 2019) (Tables 2 and 3). The two subsets of items (palliative care approaches and assisted suicide in the context of SPMI) are purposefully reported separately because they relate to two distinct topics. Participants were asked to respond to the statements on a 7-point Likert scale, ranging from completely disagree (−3) to completely agree (+3), with midpoint neutral (0). The case vignettes have previously been published in other contexts (Baweja & Singareddy, 2013; Brenner et al., 1990; Trachsel et al., 2015) and were adapted to suit the purpose and format of the survey. Participants also had the option to make additional comments in a General Comments section; any such comments were translated into English.

**Statistical analysis**

Arithmetic means were calculated for age and work experience, and descriptive statistics (percentages) were calculated for gender, as well as for the Likert scale items. IBM SPSS Statistics 24 was used to perform the analysis.

**Patient and public involvement**

Because the goal of the study was to investigate the attitudes of psychiatrists, there was no direct patient involvement in the survey's development. However, the survey design was informed by studies involving patients (as in the case vignettes). An advisory board of experts from psychiatry, psychology, and palliative care was involved in all steps of the study, and further research from the patient perspective is planned.

**Results****Sample characteristics**

The response rate was 34.9% (457 of 1,311 recipients). Respondents' mean age was 57.8 years, 37% were female, and 4.2% did not indicate their gender. The gender distribution reflected the total sample of active SSPP members (62.9% male vs. 37.1% female). Mean work experience was 27.7 years (missing,  $n = 23$ ).

**Attitudes to assisted suicide on the basis of SPMI**

Overall, 48.6% of respondents stated that they did not generally support access to AS for persons diagnosed with SPMI (−1, −2, or −3, where −3 designates strongly disagree). A further 29.3% stated that they supported access to AS to some degree (1, 2, or 3, where 3 designates strongly agree), whereas 21.2% remained neutral (rating 0) (missing,  $n = 4$  or 0.9%). There were no differences in age and work experience between those who remained neutral and the remainder.

In total, 55.6% of respondents would not support an AS request from a patient with SPMI by writing a psychiatric report or referring them to an RTDO (−1, −2, −3, where −3 designates strongly disagree). A further 27.4% would provide support (1, 2, or 3, where 3 designates strongly agree), whereas 16.0% remained neutral (missing,  $n = 5$  or 1.1%) (Figures 1 and 2).

**Responses to vignettes**

In total, 45.8% of respondents would not support the explicit and enduring wish for AS of the patient described in case vignette 1 by referring her to a relevant organization (−1, −2, or −3, where −3 designates strongly disagree). In contrast, 35.4% would provide support (1, 2, or 3, where 3 designates strongly agree), whereas 17.5% remained neutral (missing,  $n = 6$  or 1.3%).

**Table 3.** Survey items\***1: Questions on the treatment of patients with severe and persistent mental illness (SPMI)**

In the treatment of patients with SPMI, how important is:

- A. curing the illness
- B. reduction of suffering
- C. the patient's ability to function in daily life
- D. the patient remaining autonomous in their decision making
- E. impeding suicide

**According to the World Health Organization, palliative care “is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.”**

How strongly do you agree or disagree with the following?

- F. For me, the term “palliative” relates directly to end of life.
- G. For some SPMI patients, palliative care is indicated.
- H. In psychiatry, applying a palliative care model is important in providing optimal support for certain patients without a life-limiting medical illness.
- I. In severe, chronic and therapy-refractory anorexia nervosa, a palliative approach would be suitable.
- J. In severe, chronic and therapy-refractory schizophrenia, a palliative approach would be suitable.
- K. In severe, chronic and therapy-refractory depression, a palliative approach would be suitable.
- L. In severe, chronic and therapy-refractory bipolar disorder, a palliative approach would be suitable.
- M. In severe, chronic and therapy-refractory substance disorder, a palliative approach would be suitable.

How strongly do you agree or disagree with the following?

- N. SPMI can be a terminal illness.
- O. Sedation for the reduction of unbearable refractory psychological symptoms is justifiable in certain cases of SPMI.
- P. I would generally be willing to perform sedation as mentioned in item O.
- Q. I generally advocate for the access to assisted suicide for patients with SPMI.**
- R. I would generally support a patient in his or her wish to seek assisted suicide by writing a medical report or referring him or her to a respective organization.**

**2: Questions about the three case vignettes†**

Please evaluate the case vignettes.

- S. I would not be surprised if this patient died within the next 6 months.
- T. For this patient, further interventions to cure the anorexia would most likely be futile.
- U. In this case, I would be comfortable with a reduction of life expectancy to increase or maintain quality of life if consistent with the patient's goals.
- V. In this case, I would accept a temporary decrease in quality of life because of coercive measures.
- W. In this case, I would not proceed against the patient's wishes.
- X. In this case, sedation to reduce an unbearable refractory symptom is reasonable.
- Y. If there is an explicit and enduring wish for assisted suicide, I would support this patient in his or her plan and refer him or her to a respective organization.**

\*Relevant items for this article in **bold**.

†Questions S–Y applied to all three case vignettes in Table 2.

About one-half (50.3%) of respondents would not support the explicit and enduring wish for AS of the patient described in case vignette 2 by referring him to a relevant organization. A further 31.3% would provide support, whereas 16.6% remained neutral (missing,  $n = 8$  or 1.8%).

Finally, 48.6% of respondents would not support the explicit and enduring wish for AS of the patient described in case vignette 3 by referring him to a relevant organization. However, 32.1% would provide support, and 17.7% remained neutral (missing,  $n = 7$  or 1.5%) (Figure 3).

### Comments section

Anecdotes recorded in the General Comments section of the survey indicated that psychiatrists may experience conflicts of interest when confronted with an AS request. One respondent wrote: “As a psychiatrist, I would help to abolish my own profession if I were to support suicide.” Another respondent stated:

I would only dare to make an assessment if I had known the patient over a longer period of time but not on the basis of a single cross-sectional consultation. Generally, I do not support suicide in my position as a treating physician, regardless of my personal stance. Reason: I believe that my own personal judgement is dangerous because the patient initially consulted me to improve his life. However, the patient has the possibility of being assisted to commit suicide independent of me.

### Discussion

To our knowledge, this is the first study to systematically assess the attitudes of psychiatrists working in Switzerland to the practice of AS for psychiatric patients. In light of recent developments surrounding AS and psychiatry, this quantitative study makes an important contribution to current discourse.

#### General support for AS in patients with SPMI

Although almost one-half of the respondents opposed access to AS for patients with SPMI, more than one-fifth were neutral,

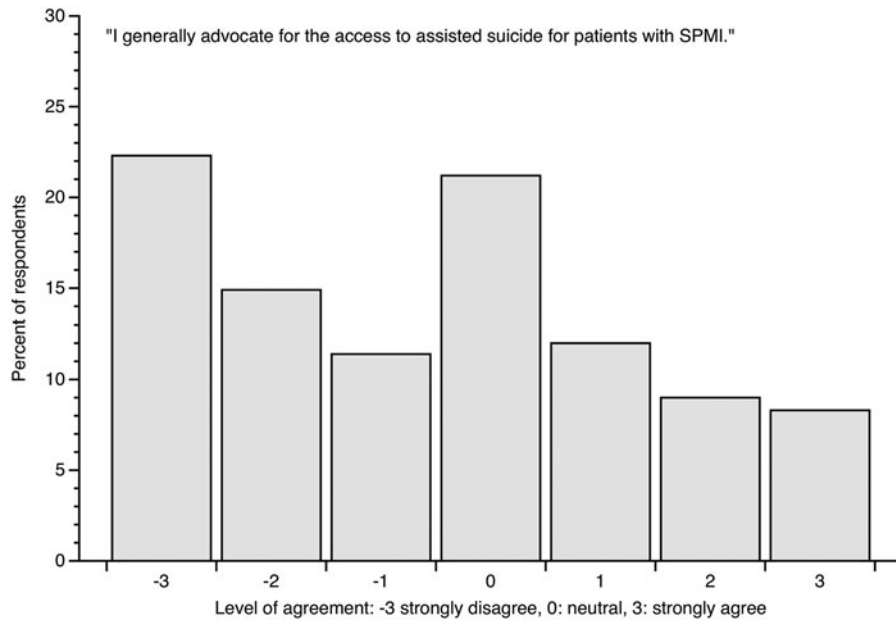


Fig. 1. Attitudes toward assisted suicide requests by patients with severe and persistent mental illness.

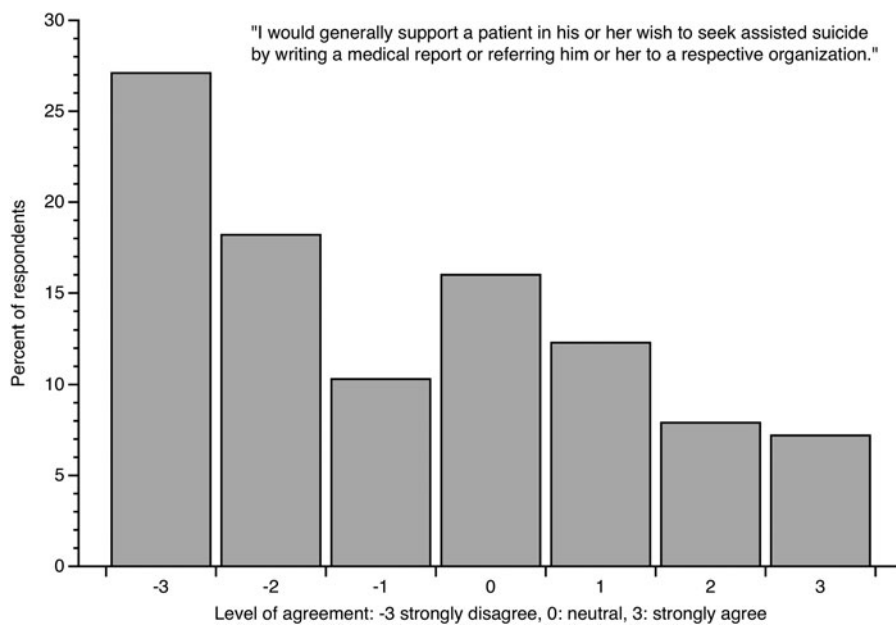


Fig. 2. Support with regard to assisted suicide of patients with severe and persistent mental illness.

and 29.3% agreed that patients with SPMI should have access to AS. These results correspond to the findings of another study of Swiss physicians of all subspecialties, in which about 32% of respondents considered AS to be justifiable for SPMI (Brauer et al., 2015). That study also revealed that acceptance of AS for psychiatric patients is no higher or lower among psychiatrists than among medical providers in general (Brauer et al., 2015). Similarly, a survey of Canadian psychiatrists' attitudes to AS in the context of a primary psychiatric diagnosis found that 29.4% were supportive, with general support for AS in some circumstances (e.g., terminal illness) at 72% (Rousseau et al., 2017).

In light of current scholarly debate and the multiple objections raised by many experienced clinicians, the level of support reported here for AS in patients with SPMI is significant, as is the high percentage of neutrals (ranging from 16% to 21.2% for

different items). Importantly, there were no differences in age and gender between neutrals and the rest. Although interpretation of a neutral rating is speculative, it may reflect the ambivalence and role conflict currently experienced by psychiatrists in relation to AS (Miller & Appelbaum, 2018); indeed, this ambivalence was stressed by some respondents in the General Comments section. As several of those comments noted, the practice of AS is often thought to conflict with the high priority psychiatry assigns to suicide prevention (Hewitt, 2013; Schuklenk & van de Vathorst, 2015). This is curious because AS and unassisted suicide have traditionally been viewed as distinct phenomena; only recently (and solely within psychiatry) have scholars begun to discuss a possible overlap. Specifically, it has been argued that psychiatric AS is difficult to distinguish from suicide because of certain shared characteristics, and this may ultimately affect societal commitment to suicide prevention (Kim et al., 2018).



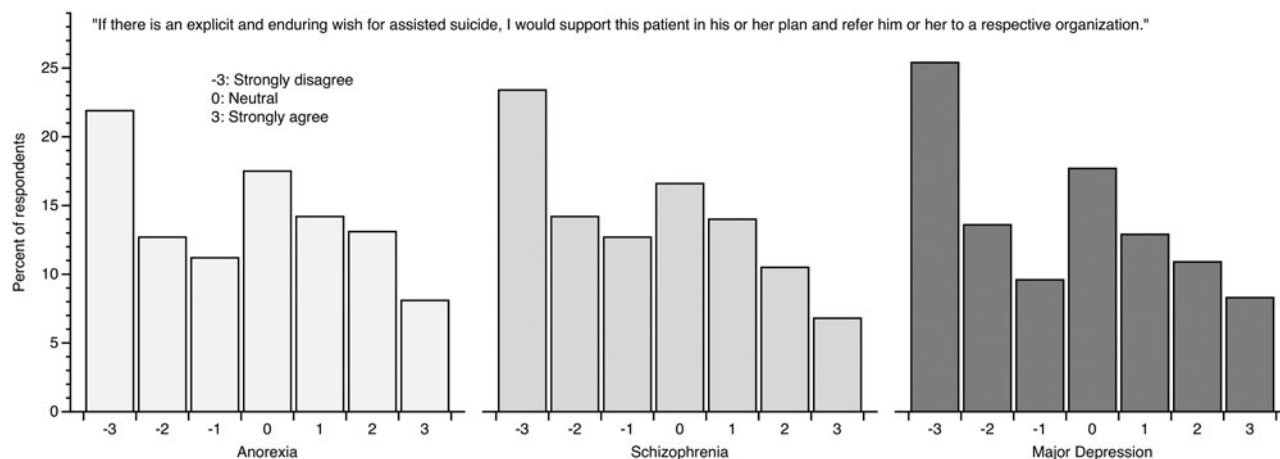


Fig. 3. Support for assisted suicide by patients in case vignettes.

### Willingness to provide active support for psychiatric patients seeking AS

Of the responding psychiatrists, 27.4% would actively support SPMI patients in the event of a concrete AS request—for instance, by writing a psychiatric evaluation or referring the patient to an RTDO. Willingness to provide support was even higher for the specific case vignettes (35.4% for the patient with anorexia nervosa; 31.4% for the patient with schizophrenia; and 32.1% for the patient with depression). These findings contrast with a previous qualitative study of palliative care physicians in Switzerland, which found that establishing contact with the RTDOs was clearly perceived to be the patient's responsibility (Gamondi et al., 2017).

### Lack of variation in diagnoses

There is evidence that the source of a patient's suffering can determine the physician's willingness to grant an AS request, and that for a majority of physicians, physical symptoms are a prerequisite for "unbearable" suffering (Bolt et al., 2015; Rietjens et al., 2009; Van Tol et al., 2010). To our knowledge, no study to date has investigated the variation of physician support for different psychiatric diagnoses. In the present work, there was only a small degree of variation in support for the three different patients in the case vignettes. This is somewhat surprising because their prognosis varied, especially in relation to fatal outcomes. Although all three patients had an increased risk of death (Ivbijaro, 2017; Laursen et al., 2014), those with anorexia nervosa are known to have the highest mortality rate of all mental illnesses (Arcelus et al., 2011). Additionally, the case patient suffering from major depressive disorder exhibited concrete suicidal intent, making a potentially fatal outcome more likely. Interestingly, this did not significantly influence the participating psychiatrists' willingness to support the depressed patient in seeking AS, with 32.1% supporting access to some degree. The lack of variation in diagnoses may be linked to general underlying attitudes to AS in psychiatric patients—that is, the participating psychiatrists either generally approved or generally disapproved of the practice as a whole.

### Strengths and limitations

The present study has several strengths. It is the first to specifically assess the largely unexplored attitudes of psychiatrists to AS in psychiatric patients in Switzerland using quantitative methods.

Additionally, the inclusion of distinct case vignettes provides a more differentiated picture of psychiatrists' support for AS in patients with SPMI.


The study also has several limitations. The nonresponse rate raises the possibility of nonresponse bias, although respondents' age and gender correspond to the total population of SSPP members. We did not explore other possible confounding variables such as sector (e.g., private practice or hospital; adult or geriatric psychiatry) or personal experience of AS. Because only about 50% of all psychiatrists are members of the SSPP, there is a risk of sampling bias; additionally, only German-speaking psychiatrists were recruited for this survey, and it is known that attitudes to end-of-life practices differ across language regions in Switzerland (Fischer et al., 2006). Nevertheless, our results correspond with those from a recent survey of Swiss physicians in all three language regions (Italian, French, and German), in which 33% of all respondents tended to support AS for patients with SPMI (Brauer et al., 2015). Finally, it is important to stress that Likert scale items shed no light on underlying concepts that may have influenced the psychiatrists' responses. Additionally, the decision to include a neutral midpoint made interpretation more difficult. A neutral response might indicate indecision or ambivalence; on the other hand, respondents may have chosen the midpoint because they were not sufficiently concerned or engaged. The decision to offer this neutral option was deliberate because we considered it important not to force respondents to take a side to avoid possible frustration, especially in relation to such a controversial subject. In any event, it seems unlikely that respondents would not be sufficiently concerned to adopt a clear position, given that AS is a reality of increasing importance in Switzerland.

### Future Directions and Implications for Clinical Practice

In the few countries where AS on the basis of a primary psychiatric diagnosis is legal, the number of patients seeking AS continues to increase (Dierickx et al., 2017; Kim & Lemmens, 2016). Given the ongoing global liberalization of AS practices and the likelihood of psychiatrists' involvement—especially if the suffering relates to a mental illness—it is important to understand and take account of psychiatrists' perspectives. More research (especially qualitative research) is needed to systematically assess the reasons underpinning psychiatrists' views. That knowledge should in turn inform psychiatrists' formal training in responding to requests

and end-of-life issues in general, particularly where AS is a legal option for psychiatric patients.

In Switzerland, there is a particular urgency to develop a systematic approach to AS to adequately safeguard vulnerable patients with SPMI. The authors contend that psychiatrists who openly endorse the option of AS for some SPMI patients have an obligation to remain critical and to accept professional responsibility. To ensure adequate safeguards for SPMI patients, it is essential that psychiatrists are involved in the evaluation process (e.g., assessment of decision-making capacity and possible alternatives). Those psychiatrists who generally refuse access of AS for SPMI must remain committed to the care of any of their patients contemplating AS. To abandon any patient on the basis of divergent moral beliefs is unethical and ultimately harmful to chronically suicidal patients. Refusing to openly discuss the option of AS with SPMI patients in a value-neutral environment is clearly counterproductive in caring for suicidal SPMI patients.

**Author ORCIDs.**  Martina A. Hodel, 0000-0003-1547-472X

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