Assisted deaths of very ill foreigners in Switzerland. A study over 5 years (2007-2011)

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**Background:**

The number of foreign residents who apply for assisted death with a Swiss organization is steadily increasing. Often it can be read that Switzerland is the only country that also grants foreign residents the right for assisted death. Actually, this is not the case. There are other countries that grant assisted suicide to foreign residents, for example Belgium. This is why the idea of „death tourism“ must be analyzed and scrutinized.

**Methods:**

The records of two consultants for Switzerland’s largest voluntary-death organizations accepting foreign residents were collected over 5 years. In this way, 476 medical files were analyzed. The data collected regarded country of residence, age, sex, occupation, medical condition and the time span between application for assisted suicide and its accomplishment.

**Results:**

Most candidates come from Germany, followed by the United Kingdom and France. The age peak is 60-69 years, with a tendency to reach older age groups. More women than men choose assisted suicide, confirming previous studies. Occupations with higher qualifications are strongly represented. Carcinomas amount to 42.9%, but neurological disorders like ALS and MS and multimorbidity are also highly represented.

Only 16% of the persons who met all the conditions for assisted death achieve a voluntary death within the first month, 17% within the second month and 13% within the third month. Almost one third of approved cases do not come at all for assisted death although they have received the approval of a Swiss physician based on their files.

**Conclusion:**

Most foreign residents coming to Switzerland for assisted death are Europeans. Women opt for assisted suicide more often than men, who choose violent unassisted suicide. Very old persons increasingly resort to suicide. In most cases, more than two months go by between an application for assisted suicide and its accomplishment.

**Introduction:**

In Switzerland, active euthanasia is generally forbidden in article 114 of the Swiss penal code. However, assisted voluntary death is seen as a human right and can be accessed by anyone, wherever the person may reside. In Switzerland, according to article 115 of
the penal code it is legally allowed to support someone with her/his voluntary death as long as no selfish motives are involved.

Assisted voluntary deaths are usually carried out by specialized organizations. A physician must write the prescription for the most current drug, sodium pentobarbital, as it is controlled by the legislation on narcotic drugs. Thus the decision whether the drug will be prescribed or not is in the physician’s hands. However, assisted deaths are not considered a medical activity. There is usually no physician attending an assisted death, it is usually supervised and conducted solely by trained voluntary death assistants. In any case, the applicant must take the drug her/himself. Until 2011 there were two organizations in Switzerland who offered assisted dying to foreigners without legal residence in Switzerland (Ex International in Bern since 1997, Dignitas in Zürich since 1998). Since 2012, there is a third organization, Eternal Spirit based in Basel. So-called “death tourism”, as opponents call it, is increasing, which is proven by rising figures in recent years. The health status of applicants coming to Switzerland from abroad is usually so poor that most physicians would consider them unable to travel.

Through intensified activity and publicity of all organizations who promote assisted death on a worldwide level (there are 52 of them today), very ill persons and their families have become increasingly aware of this way to end their suffering. Not only does ageing increase but also the self-confidence of the general public. With this comes the desire for self-determination at the end of life as well. Highly-engineered and rationalized medicine has better and better ways to delay death, but not suffering. Prolonged suffering without acceptable quality of life is being refused by an increasing number of people. The voices of persons expressing the view that we may organize death in case of incurable suffering have become more audible. This is underlined by the Arthur Koestler special award for the book “Der organisierte Tod” (“Organized death”), edited by Wehrli et al.

Among physicians and ethicists also, views on life preservation at all costs are changing. Palliative medicine is more and more acknowledged and supported, and death fasting is increasingly being discussed. In the case of assisted dying we know that it is being fought for in more and more countries, as was the case for first-trimester abortion during the 1970s. We can thus expect that one day assisted dying will be legal in many countries and that the organizations enabling foreign residents to have assisted death in Switzerland may end their activities in this regard.

**Approach:**

**Aim:**

In this study we want to show under which circumstances incurably ill foreigners apply for assisted dying in Switzerland. It is especially interesting to learn more about the type of illness, age distribution, origin of the applicant and the time span between their application for an assisted death and its accomplishment.

**Data collection:**

We had access to personal documents and notes on all the persons evaluated between 2007 and 2011 by two consulting physicians for the voluntary death organization Dignitas, so that we could include 476 applicants in this study. One physician noted the occupations, thus there was enough material to elicit social status via education. We
examined 476 case histories. All of them included medical reports from the patients’ physicians abroad. They included diagnosis, therapy and in most cases current medication as well. Many case histories did not show if the family physician abroad had been informed of the patient’s death wish. In addition to reports from physicians abroad, all cases included two reports by the physician who made the evaluation in Switzerland. They usually stated consistency of the death wish, ability to judge, presence or absence of influence from a third party, mental condition and type of illness. There was also a copy of the prescription for sodium pentobarbital. Most cases included a living will and the person’s personal application. All data were recorded in a table divided along nationality, sex, age group, occupation, type of illness, existing suicide attempts, period between application, “provisional green light” (see next paragraph) and assisted death, number of rejections and number of provisional green lights without subsequent assisted death. All data were anonymous.

Explanation of the term „Provisional green light“

The „provisional green light“ means that a patient’s documentation (external medical reports and personal application) was evaluated by a Swiss physician and that based on these documents, the physician could acknowledge the death wish. The “provisional green light” puts the patient in a position to travel to Switzerland for two personal interviews with a Swiss physician. However, even with the “provisional green light” the physician can refuse the patient if he feels during the interview that the death wish is not justified, which leads to refusing the “definitive green light” and thus assisted dying.

Results:

Country of origin:

This study involves 476 persons who applied for assisted dying in Switzerland from 2007 to 2011. For a larger scope, the Swiss residents who had filed an application (3.6 %) with this organization were also included. Swiss residents mostly file applications with the organization Exit Deutsche Schweiz which is not accessible to foreign residents. Exit only accompanies Swiss citizens or residents over 18 years of age. With 65’000 members (2013) this is the largest Swiss assisted dying organization.

The majority of foreign patients who filed an application come from Europe. Most applications came from Germany (45,0 %), almost as much as all other European countries added together (45,4 %). The United Kingdom comes next (18,3 %), followed by France (9,7 %) and Italy (5,7 %). People also come from very religious countries such as Italy (n=27) or Israel (n=7). There is a remarkable number of applications from countries involving an extremely long plane journey. 46 applications were filed from overseas, including 1 from New Zealand and 7 from Australia.

Illnesses (figure 1):

A total of 24 illnesses were mentioned. For each person only the illness leading to the death wish was registered. If a person suffered from several diseases that would have been non-serious individually but the whole of which led to the death wish, these were listed as multimorbidity.
The majority of death wishes were caused by carcinoma (42.9 %). Neurologic disorders (ALS, MS, Huntington, Parkinson, MSA, polyneuropathy) came second (29.8 %), followed by multimorbidity (19.7 %). Only in rare cases were other diseases the reason for a lasting death wish.

**Figure 1: Illnesses mentioned in medical diagnoses of persons applying for assisted dying**

**Sex / age (figure 2):**

Women were a visible majority (56.7 %) compared to men (43.3 %). Regarding age, only few were under 50 (8.4 %), but many over 80 (20.6 %). There was a 60-69 age peak (26.9 %). Looking at the sex distribution in the different age groups, we see that the percentage of women is always visibly higher than men (except in the 40-49 age group), with a maximum in the 70-79 age group.

**Figure 2: Sex distribution among persons applying for assisted dying**
Education/occupational background (figure 3):

Occupation was indicated in 306 cases. For this study, the different occupations were grouped into seven occupational groups. The group of higher occupational education (completed apprenticeship with additional education) was the most frequent (33.7 %). There were also many persons holding a university degree (32.4 %). Craftsmen (4.6 %) and housewives (2.6 %) only constituted a small percentage. Persons from caring occupations (9.5 %) and artists (5.2 %) were slightly more represented.

![Graph showing educational and occupational background of persons applying for assisted dying]

Figure 3: Educational and occupational background of persons applying for assisted dying

Suicide attempts:

In 7.6 % of cases, a suicide attempt preceded the application for assisted death.

Time between application, provisional green light and assisted death:

In most cases, two to three months passed from the application to the completed assisted death (36.2 %). In some cases, it took over three, sometimes up to six months (29.1 %). Some took a long time, more than 6 months up to several years (25.2 %). Only few applicants realized an assisted death within one month after the application (7.8 %).

Once the provisional green light was given, many persons made use of assisted death within one (16.5 %) or two (17.4 %) months. Only in few cases (1.3 %) more than a year passed until assisted death.

Non-use of the provisional green light:

A considerable number of persons who had received the provisional green light from a Swiss physician never made use of this possibility (32.6 %).

Rejections after application (figure 4):
Each year, the provisional green light was not modified into a definite green light for some patients. This means that their application was rejected by the physician, based on the first personal interview (4.6%). This is a considerable percentage.

![Figure 4: Rejected and accepted cases of persons applying for assisted dying](image)

**Discussion**

When conducting a study on „death tourism“ in Switzerland, we need to remember that Switzerland is not the only country that accepts foreign residents for assisted death. In the Benelux countries, the law does not explicitly exclude foreigners. However, in these countries, foreigners have to come in repeatedly for medical consultations or accept to stay in a hospital for some time. This kind of repeated travels is impossible for many persons looking for assisted death. Also, as this possibility is not well known, foreign residents rather seldom apply in the Benelux countries. We were not able to access detailed figures about “death tourism” in the Benelux countries.

In the Benelux countries not only is it possible for people with terminal and non-terminal diseases to have assisted dying, but they also allow active euthanasia for discriminating persons, which is illegal in Switzerland\textsuperscript{11-13}. Along with the Benelux countries and Switzerland, three states in the United States of America accept assisted death, but only in case of terminal illness and if the person is a resident of that state\textsuperscript{14}.

It must be mentioned that many applicants with any Swiss organization accepting foreign residents either desist from their death wish after counseling by phone or are rejected during preliminary clarifications. The only applications that are accepted and have a chance of success come from persons who suffer from an incurable illness, are in unbearable pain or perceive their handicap as unacceptable. Most persons suffering from a psychiatric disease are rejected if they do not also simultaneously suffer from a somatic disease. This is due to the obligation that in case of a psychiatric disease a detailed psychiatric expertise should be provided. This is not demanded by law but by a guideline of the “Schweizerische Akademie der medizinischen Wissenschaften” (SAMW, Swiss Academy of Medical Sciences) that has been included in the code of occupational conduct. Thus, if a Swiss physician writes a prescription for the death agent for a person with an underlying psychiatric illness without a detailed expertise, he takes a risk. As only few psychiatrists are willing to write such an expertise, only a very
small number of assisted suicides occur for persons with a psychiatric disease (0.8 %) although for unassisted suicides in Switzerland, this percentage amounts to around 56 %.

**Countries of origin:**

Regarding the applicants’ countries of origin, it needs to be mentioned that Dignitas has a very close cooperation with a German organization that counsels patients in Germany and helps them to apply for assisted death with Dignitas Switzerland. The number of applicants from Germany thus visibly increases.

In the UK, the right for assisted death has widely been discussed for many years now. Motions have repeatedly been filed at the High Court to authorize assisted death. Even though the penalty for assisted suicide still officially amounts to several years of imprisonment, no relative accompanying a person wanting to die to Switzerland has been convicted. In Great Britain and in Scotland there are large and very active right-to-die associations like SOARS and FATE who inform their members about the possibilities in Switzerland. Consequently, increasing numbers of applications originate from these two countries as well.

More applications from Italy and Israel may indicate that concerning suicide, restraint because of religious bonds is decreasing. People tend to lose their religious doubts about ending their suffering through suicide. In all countries, this will have an effect on the wish to actively determine the moment of death and refuse intense suffering for months or even years.

The fact that people put up with very long plane travels from Canada, the USA and even Australia and New Zealand in order to facilitate assisted death should be food for thought and cannot be considered humane. The aim of right-to-die societies worldwide is to make this “death tourism” obsolete through worldwide legalization of assisted dying. Specifically, the three organizations that make assisted death in Switzerland possible for foreign residents should actively help with the legalization of assisted death. There are various publications that point to the wish of foreign residents to be allowed assisted death in their country of origin.

**Illnesses:**

The SAMW guidelines only stipulate acceptance of assisted dying in Switzerland for terminal illnesses (when death is expected within days or weeks). The SAMW does not comment on non-terminal diseases. This leads to uncertainty among physicians. Swiss law explicitly permits assisted suicide as long as there are no selfish motives. However, the guidelines of the SAMW limit acceptance of assisted dying to terminal diseases. Every Swiss physician who is a member of the occupational association Foederatio Medicorum Helvetiorum (FMH, Swiss Physicians’ Federation) is also subject to the SAMW guidelines. Consequently, he should write the prescription for the lethal drug only for terminal illnesses.

If we look at the type of illnesses and their incidence, more than half of all diseases must be classified as non-terminal. A large study regarding assisted death in Switzerland through Exit shows that 21.2 % of all cases involved non-fatal conditions. Non-fatal could be equated with the concept of multimorbidity in our study. In the study by Bosshard et al mentioned, all neurological disorders and several other diseases

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1. [www.soars.org.uk](http://www.soars.org.uk)
2. [www.friends-at-the-end.org.uk](http://www.friends-at-the-end.org.uk)
classified as “fatal” would be classified as non-terminal diseases which do not conform with the SAMW guidelines\textsuperscript{22}.

If we classify illnesses according to whether they are terminal and fatal and compare with the aforementioned study of 748 Exit cases, we can see interesting facts: the percentage of patients with carcinomas is only slightly lower among our patients (42.9 to 47.4 \%). This group of illnesses usually corresponds to the SAMW’s “terminal” condition. The percentage of diseases classified by Bosshard as “fatal” is minimally higher in his study than among our patients (77.8 to 78.9 \%). In comparison, in our study neurological disorders are visibly higher (29.6 to 12.4 \%).

In this context we wish to mention that in the three states of the USA where assisted death is accepted, carcinoma covers about 80 \% of assisted deaths. This might be so because the respective states only accept terminal diseases for assisted dying. Consequently, many seriously ill persons cannot apply for assisted dying because they do not correspond to the narrow limits of “terminal”. In our study, this would explain for example the large proportion of neurological diseases (ALS, MS, Parkinson, dementia) and many other diseases that lead to severe handicaps and unacceptable pain (e.g. quadriplegia, polyarthritis). If we also look at the studies regarding the diseases reported for assisted deaths with Exit, we see that over thirty years and for all organizations in Switzerland, at least 50 \% of all diseases have not matched the terminal limit\textsuperscript{22,23}. This fact and the very high proportion of very old persons committing unassisted suicides, which is well visible in the age-standardized representation, underline the population’s wish that not only persons with terminal illnesses should have the right to assisted dying but also persons who wish to end their lives because of their advanced age and the related multimorbidity. In Switzerland various parties have increased pressure in order to revise the SAMW guidelines and adapt them to the patients’ wish\textsuperscript{18,21}.

\textit{Sex and age:}

Our study shows a visibly higher proportion of women, which corresponds to other Swiss studies\textsuperscript{22,23}. On the other hand, during the same period, we can see that women are underrepresented concerning unassisted suicides. We can assume that women do not lay hands on themselves as often and tend towards more security than men. The fact that the proportion of women among the 70-79 age group is only slightly higher than in all other age groups attenuates the theory that many women in this age group lose their husbands and consequently the zest for life, which could then abet to suicidality. This theory was expressed in a Swiss study \textsuperscript{21}, but no similar trend could be noted in other countries\textsuperscript{24}.

The mean age was at 72 years, as in other studies, with an increased incidence among very old persons (figure 5), which may also reflect the increased life expectancy. More and more voices speak of “life satiety” instead of “tiredness of life” among very old persons, for example the theologian Hans Küng \textsuperscript{25}.
Looking at the classification according to social strata, we notice the proportion of highly educated persons (30% with a university degree). During the medical interviews it was noted that persons who applied for assisted death mostly had a very strong, self-confident character, independently of their education. In many cases, persons who applied for assisted death had highly responsible occupational positions. Thus, Sullivan’s assumption that it is rather persons from lower social strata who use assisted death is not confirmed by our study. It is remarkable that many persons come from caring occupations. They mostly explained their decision for assisted death with negative experience linked to how patients died during their occupational career.

Time span between application and assisted death:

Before an application for assisted death can be filed, there have been various contacts with the organization. After handed in all medical records and the application, the organization assesses if there is a chance to give the provisional green light. Only applications that are eligible for assisted death are transferred to the physicians. They study the documents and give the provisional green light if they can acknowledge the death wish on the basis of the records. After this, the person can travel to Switzerland for personal interviews. During the personal interview with the patient, the Swiss physician decides if the provisional green light can lead to a definite green light. This means that the assisted death can be arranged anytime. The fact that only few interviews are scheduled within the first month after the application has been filed shows that the death wish can continue to mature during this preparatory period.

That there should also be rejections after filing the application, and that not all provisional green lights issued should lead to an assisted death shows that physicians as well as applicants deal very critically with the procedure of assisted dying. By far not all persons who received the provisional green light came to Switzerland to die (n=146, 32.6%). Often, knowing that assisted death is possible is a relief for the person.
concerned. Thanks to this “resource” they can temporize and bear their heavy suffering until the arrival of natural death.

Conclusion:

According to the latest study by Petermann et al\textsuperscript{18}, the wish to have assisted death legalized is very strong in all European countries. “Death tourism” in Switzerland underlines an independent will to decide when to die. From voting results in Zurich\textsuperscript{27} and a survey in Basel\textsuperscript{28} we can see that the Swiss population is open to the accompaniment of foreign residents. Thus it cannot be the right path to exclude foreign residents from the possibility of an assisted death in Switzerland. Rather, everything should be done to grant these persons the human right to an assisted death in their country of origin.

Assisted death should not be limited to terminal diseases. Neurological diseases especially cause people to suffer during an extremely long period of time before they lead to death. People from all over the world do not seem to want to bear this fate. This is proven by the high proportion of patients with neurological diseases concerned by assisted death in Switzerland. Swiss physicians writing prescriptions for the death agent not only for foreign residents but for Swiss people should not have to violate Swiss legislation anymore, it is urgent to adapt the guidelines to the patients’ wish. The guidelines should be extended to non-terminal diseases.

This is especially valid considering that at least thirty percent of the persons whose wish for assisted death is accepted by physicians choose neither unassisted suicide nor assisted death but opt for the palliative path, thanks to this “emergency exit”.

Finally it must be also considered that unsuccessful unassisted suicides are extremely costly\textsuperscript{29}. If only a few of all unassisted suicides could be converted into safe assisted deaths, not only could suicides be prevented or postponed, but some of the follow-up costs of unsuccessful suicides could also be avoided. The heavy burden of participation and damage for third persons such as police officers, coroners and passers-by could be also lessened.

An open conversation where the wish for voluntary death can be expressed without fear of reprisals can also have a therapeutic effect and may lead to continued toleration of the subjective suffering.

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