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INDEPENDENT RESEARCH

Assisted Suicide in Switzerland: The Impact of Shifting Public Attitudes on Families and Professionals

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Context: Following the enactment of laws permitting assisted suicide (AS) in Switzerland in 1942, there has been a gradual shift in societal perceptions of this practice from opposition to acceptance. This transformation involves the changing dynamics between palliative care and assisted dying.

Objective: The main research question seeks to address how these changes affect families and professionals involved in the process of assisted suicide in Switzerland. This analysis examines demographic shifts, including age and religiosity, as well as the experiences of families and professionals involved in the process, which shape perspectives on AS.

Method: Primary data were collected and analyzed along with secondary data. Primary data included 3 formal interviews and 2 informal interviews. Secondary data included a critical analysis of systematic reviews and original journal articles.

Results: Palliative care and assisted suicide have reached a stage of mutual respect marked by collaborative efforts across professional fields and growing social acceptance. Demographic, experience-related, and religious ideological factors may continue to shape individual perspectives on AS, but religiosity is no longer as powerful as it was in the past. Palliative care physicians have adopted a more neutral stance toward AS, in contrast to past opposition. Family members are increasingly willing to discuss their experiences with AS and convey appreciation for organizations that facilitate AS.

Conclusion: The change in public attitude and perception regarding assisted suicide has contributed to more positive experiences among both families and professionals engaged in AS practices. Recognition and advocacy from families and healthcare professionals have also progressively influenced public opinion, fostering a more accepting perspective toward AS in Switzerland.

Keywords

Palliative Care • Assisted Suicide • Switzerland • Right-To-Die Associations • End-Of-Life Choices

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Introduction

Modern Western societies—North America and many European countries—tend to refrain from discussion of death (Tradii & Robert, 2017). While some perceive death as cruel, unreasonable, and unpredictable, others may view it as a relief from unendurable pain. The ability to choose how and when to end one's own life has evolved into the practices of euthanasia and assisted suicide (AS).

Assisted suicide has been legal in Switzerland since Article 115 of the Swiss penal code went into effect in 1942. Unlike other countries that have legalized various forms of assisted dying, Switzerland has more permissive regulations around assisted suicide. This characteristic is reflected in Switzerland's cultural, legal, and ethical framework, which stresses the importance of self-determination, personal autonomy, and dignity. The only form of assisted dying punishable under the Swiss penal code is direct active euthanasia. Moreover, there are no regulations restricting who may assist with the dying process. This lack of specificity was intentional, allowing both medical and non-medical professionals maximum freedom to conduct the procedure. The loose regulations of the Swiss penal code have granted the public considerable freedom, but they have also sparked prolonged debates over how assisted suicide should be handled.

Following the implementation of Article 115, public perception has become increasingly accepting of assisted suicide over time, rising from 53 cases in 2005 to 504 cases in 2023, according to quantitative data from EXIT, the first right-to-die organization established in Switzerland (Bise, 2024). However, the path from 1942 to today has been far from easy. EXIT was established in 1982, but the first official assisted suicide case through EXIT did not take place until 1998. Physicians, family members, and other professionals involved in the process of assisted suicide have long battled stigmatization, public accusations, and opposition from palliative care and pro-life organizations. Public opposition has instigated self-doubt, as well as moral and ethical dilemmas, among those assisting with AS requests and has increased stress for those working in the field. Many research studies focus on legislative debates to advance assisted dying, push for euthanasia legalization, or impose more restrictions on existing practices. However, relatively few studies have explored the evolution of public attitudes toward assisted suicide in Switzerland over time, as well as the effects stemming from this shift.

This paper aims to provide an overview of how public attitudes and perceptions toward assisted suicide, as well as the relationship between palliative care and AS, have changed over time. The main research question of this paper is how changes in public attitudes toward assisted suicide affect families and professionals involved in the process of AS in Switzerland.

Arguments for and against assisted dying

Different cultural, religious, and legislative backgrounds have laid the foundation for ongoing debates on voluntary death. According to Mauron & Hurst (2011), four main arguments are made both in favor of and against assisted suicide, as summarized below in Table 1. Some argue that requests for assisted suicide, especially from those who are not terminally ill, maybe a desperate cry for help. If appropriate measures and care are provided, patients may withdraw their request for AS. This concern also leads to the slippery slope argument in cases of euthanasia without the patient's full consent. Some fear that patients may choose euthanasia under pressure to avoid becoming a burden to their loved ones.

Table 1. Summary of arguments for and against assisted suicide.

Arguments	Proponents	Opponents
Autonomy	Autonomy extend to decision to live and die	Autonomy does not extend to decision over death
Intention of request	Avoidance of therapeutic obstinacy	Request for AS may not be the true intention but rather a desperate cry for help
AS vs. Indirect euthanasia	Trivial moral significance of the distinction	Fundamentally different in intention
Slippery slope	Invalid because if laws forbidding euthanasia exist, stricter regulations controlling euthanasia would not be difficult to enforce	Readily available and legal euthanasia may pressure people into choosing it to avoid continuous burdening on loved ones

Proponents of AS, on the other hand, argue that palliative care cannot effectively address all types of suffering and highlight the concept of therapeutic obstinacy—the persistence of life-sustaining treatment despite the patient's refusal, leading to prolonged suffering. They also argue against the validity of slippery slope arguments and claim that if people can abide by rules forbidding euthanasia, then enforcing stricter regulations to control the circumstances of euthanasia should not be difficult.

Research Methodology

This study relied on secondary data, including literature reviews, documentary sources, and secondary qualitative and quantitative data from interviews recorded in published journals, as well as primary data from interviews, transcripts, and notes taken during the interviews. The primary research question of this study required the use of qualitative data due to its focus on attitudes, emotions, and personal encounters as reported by professionals and relatives. However, quantitative data were also valued to illustrate the annual increase in assisted suicide requests within right-to-die associations as an indication of growing social acceptability.

Interview questions addressed: (1) the interviewee's personal stance on AS, (2) the interviewee's professional background and experience working with AS cases, and (3) anecdotal experiences handling difficult AS cases or mitigating conflicts between physicians, family members, patients, and AS volunteers with differing perspectives on AS.

Interviewee selection and ethical considerations

Interviewees were identified through online research, insights from local host families, and contact information provided by program alumni. The top candidates for interviews were volunteers and employees from seven right-to-die associations in Switzerland, selected based on their expertise, familiarity with AS requests, and direct involvement in the entire AS process. Other contacts included authors of published journal articles. In addition to their expertise and familiarity with AS, research scholars also represented a different perspective than the right-to-die association volunteers. Many researchers were also physicians, and the majority worked in palliative care. This study targeted palliative care physicians and right-to-die association workers for interviews, as the Local Review Board (LRB) ethical constraints prevented direct interviews with family members of individuals who underwent assisted suicide. These family members are considered a vulnerable population, making direct interviews highly sensitive and potentially distressing. While their firsthand experiences—witnessing the entire process from beginning to end—could offer invaluable insights, the ethical complexities of interviewing them, even with protective measures in place, precluded their direct participation in this study.

Two formal interviews—one virtual and one in-person—were conducted with the co-president of EXIT A.D.M.D, Mr. Jean-Jacques Bise. Another formal interview was conducted with Dr. Claudia Gamondi, an M.D. specializing in palliative and supportive care services in Switzerland. Two informal interviews included an email conversation with the Dignitas team and in-person presentations about EXIT A.D.M.D. that took place in the Novotel Hotel conference room in Geneva, Switzerland. All interviews were conducted in English.

Analysis of data

The analysis incorporated data from existing research studies, as well as quotes and paraphrased insights from both formal and informal interviews. The data were analyzed and categorized by role—physicians, volunteers, and families—to compare how the shift in AS is perceived from different perspectives.

This research was reviewed and approved by the Local Review Board (LRB) of the School for International Training (SIT). All research guidelines and human subject policies were adhered to.

Results

Different Forms of Medical Aid in Dying (MAiD)

Euthanasia and AS are two fundamentally different concepts and cannot be used interchangeably. The emphasis of AS is on suicide, meaning that patients must actively end their own lives without support from anyone else (Güth et al., 2023). If an intravenous injection were to be used, medical professionals may help the person insert the needle. However, the person requesting AS must be the one independently turning on the valve to initiate the flow of the lethal substance into their body (J-J. Bise, personal communication, April 11, 2024). In contrast, euthanasia is more passive than AS, and the death of the patient results from another person's action.

Factors that influence attitudes towards AS

Demographic, experience-related, and ideological factors may be predictive of attitudes toward AS (Worthen & Yeatts, 2001). Studies have found that physicians' experience, defined roughly by the number of contacts with terminally ill patients, may be related to their attitude toward AS. Studies

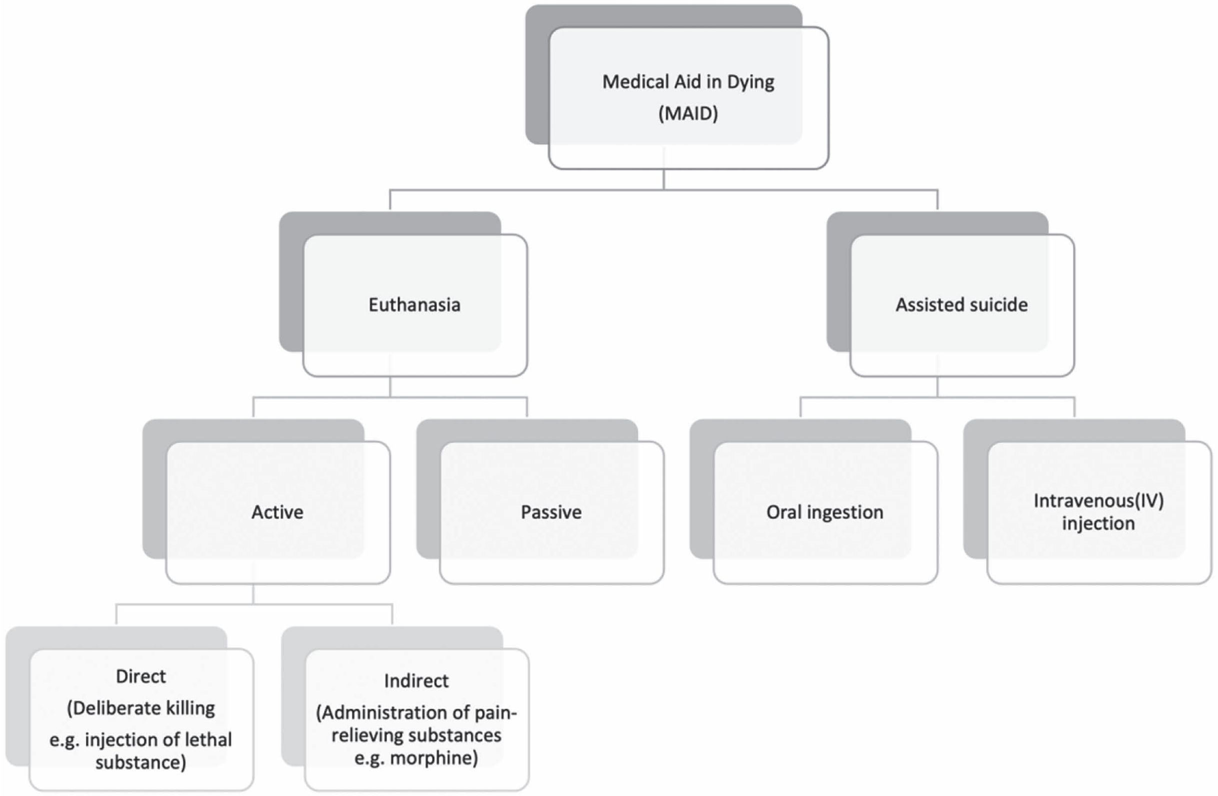

Figure 1. Different concepts of MAiD. Based on the interview and information from the EXIT A.D.M.D. presentation. The Swiss Penal Code only deals with direct active euthanasia.

by Bachman et al., 1996 and Cohen et al., 1994 observed that physicians who most frequently work with terminally ill patients tend to be the ones who are less supportive or even strongly oppose assisted dying, whereas physicians with the least exposure to terminally ill patients (psychiatrists) are the most supportive of AS (Ganzini et al., 1996). However, findings from these studies are not up-to-date, and some findings may no longer hold in today's context. Furthermore, initial findings from when the studies were first published are conflicting, making experience-related factors inconclusive (Worthen & Yeatts, 2001).

Upon analyzing age as a demographic factor in attitudes toward AS, past and contemporary studies have both shown the trend that younger respondents tend to be more supportive of AS compared to older respondents (Blendon et al., 1992; Mickiewicz et al., 2012). This trend has not changed much over time, making age a commonly recognized contributing factor. In addition, Leinbach (1993) found that individual attitudes did not vary significantly over time as participants aged.

Another factor studied was religiosity. Different religions and the depth of religious commitment could both influence attitudes toward assisted suicide. Most religious members, including Muslims, Christians, and Jews, hold a negative view toward assisted dying (Cayetano-Penman et al., 2021). Religiosity was negatively correlated with approval of AS, especially among Christian participants surveyed (Rajkumar, 2021; Chakraborty et al., 2017). Opposition stems from the belief that "[life and] moment of death belongs to God" (Parpa et al., 2010). According to a study by Spoerri et al. (2010) that investigated the correlation between religious affiliations and suicide, both assisted and non-assisted, the effect of religious affiliation seemed to shield more Catholics than Protestants, older individuals than younger ones, and more women than men from assisted suicides. The findings from this article also supported and matched conclusions about the demographic factors mentioned above. "Religion is difficult . . . and in the past, when we visited Cantons or villages that were more religious than others, we sometimes feared being rejected . . . but now, [the situation] is better . . . the Swiss society is becoming more secularized" (J-J. Bise, personal communication, April 11, 2024).

Physicians' attitudes and experiences with AS

Assisted suicide emotionally affects professionals, leading to ethical dilemmas and concerns about respecting patients' rights and autonomy (Castelli Dransart, D.A., Scozzari, E., & Voélin, S.. 2017). Unfortunately, there is little to no training for medical professionals on how to respond to AS requests. Therefore, most professionals reported feeling uneasy and preferred avoidance rather than taking on AS requests (Gamondi et al., 2019). "A physician working in a hospital, which is a system where you have a framework, clinical ethics, and procedures they could refer to and follow and there's more support" (C. Gamondi, personal communication, March 25, 2024). In contrast, a general physician (GP) has a very different level of freedom and tends to work alone, with less capacity to reach out for help.

In the past decade, a significant proportion of staff have reported being "ready to assist patients themselves" and being "quite open to more active involvement," despite restrictive institutional policies around AS (Gamondi et al., 2022). In a survey conducted by the Swiss Association for Palliative Medicine in 2000, a little over half (56%) of physicians and nurses working in palliative care units opposed assisted suicide (Bittel et al., 2002). In 2015, Dr. Gamondi conducted an interview study with 23 palliative care physicians in Switzerland to explore physicians' perspectives on assisted suicide. Among the participants selected for this study, one-third expressed strong opposition, one-third considered AS a potential tool in palliative care, and one-third remained ambivalent (Gamondi et al., 2019).

EXIT volunteers' experiences with AS

EXIT will try to meet with both the person requesting AS and the family members who oppose their decision together. If mutual understanding is still not reached and the conflict remains unresolved after the meeting, EXIT volunteers will prioritize the autonomy of the person requesting AS and act in accordance with the person's final decision, as long as the person is a Swiss citizen and meets EXIT's AS acceptance criteria. In that case, the person requesting AS would be asked to write a letter to their family, explaining their decision to continue with AS. The person requesting AS has full legal rights and autonomy protected by the law—under Article 10 of the Swiss Constitution and Article 8 of the European Convention on Human Rights (J-J. Bise, personal communication, April 11, 2024).

During the in-person formal interview, Mr. Bise brought with him a recent newspaper, which had a section of appreciation from family members of someone who recently died with EXIT's assistance. "[The family members] don't use [openly thank EXIT] . . . in the past, families may have understood and not opposed assisted suicide, but they would not [have made an effort] to thank EXIT like this" (J-J. Bise, personal communication, April 11, 2024).

Families' attitudes and experiences with AS

If the public learned that there are no remarkable differences in grieving experiences among families who have lost a loved one through AS or other forms of death (e.g., natural death via palliative care or accidental deaths), then the public might have a more proper and correct understanding of AS. "[Assisted suicide] is not an easy death, but there are no easy deaths. We have no data that will tell us that this [assisted suicide] is a more difficult death [than other deaths]. [Assisted suicide] is a more prepared death, which means families know when, how, and why, and the goodbyes are done, and everything is very clear. There is no part of agony . . . it's a very clean death" (C. Gamondi, personal communication, March 25, 2024). A study by Laperle et al. (2022) also provided evidence suggesting that MAiD does not increase the risk of prolonged grief and that MAiD generally does not require additional specialized services or intensive aftercare either.

Discussion

The change in public attitude toward AS over time may not have been triggered by any specific event or policy. It may simply be because those "young respondents" from the past who favored AS grew to become authoritative representatives, experts, and professionals in the field today while still holding their favorable attitudes toward AS. Their opinions on AS continue to influence the younger population, facilitating the development of a more open environment for discussion of AS and more favorable views toward the practice of AS. The increase in secularization may also be due to generational effects, similar to the effects of age on public attitudes toward AS.

Physicians play an important role in the initial stages of AS, and their attitudes and values could have a great impact on the experience of patients and families throughout the process of assisted suicide. This suggests that proper training and guidance are essential for palliative care physicians. Some physicians may mistake their feelings of uncertainty and unfamiliarity as opposition to AS, turning down AS requests because they are unsure how to help or unaware of their own values. Institutional-level support could also help alleviate the uneasiness of palliative care physicians. The more professionals realize and identify with their own values, the better it is for themselves, their patients, and the experience of the families. To prevent negative emotions arising from a clash of personal values and professional missions from affecting the quality of care, clear and open communication early on is the best solution to avoid intentional or unintentional gatekeeping. When providers realize their own limitations in handling AS requests, they should take the initiative in referring the patient to a different person whose philosophy may align more with AS and who is willing to assist. More education and training in the future, both at the individual and institutional levels, could help physicians better understand their own stance and minimize emotional distress when dealing with requests for AS. Many professionals, about half of the respondents, wished to receive more reliable information and support on issues surrounding end-of-life care at the institutional level, whether it is palliative care, assisted suicide, or euthanasia (Castelli Dransart, D.A., Scozzari, E., & Voélin, S.. 2017).

With the trend of increasing support and acceptance of AS among the public and professionals, more palliative care medical professionals and nurses who used to take a critical and opposing stance against AS are slowly changing and evolving to adopt a neutral perspective on AS. As they become familiar with the act of AS through professional exchanges and interactions with right-to-die associations, medical professionals may become more motivated to learn about and be involved in the process of AS (Gamondi et al., 2022). Physicians' attitudes and experiences with AS are highly valuable and have a significant influence on the public perspective on AS. Following the increasingly neutral stance and decreasing hostility toward assisted suicide, more people may adopt the philosophy of being personally disagreeing yet empathetically supportive and supportive. This means that they may never choose AS for themselves or still have unresolved value conflicts against the idea of AS, but they will understand and unconditionally support the choice of their loved ones if they choose AS.

The relationship between EXIT volunteers and families was discussed during the interview. In cases where there is a conflict between the patient requesting AS and their family members, EXIT volunteers remain neutral while attempting to mitigate the conflict and respect the autonomy of the person requesting AS. Typically, the illnesses of patients who meet EXIT's criteria for AS exacerbate over time, and the suffering becomes increasingly intolerable. Family members slowly come to understand the patient's decision, even if they are still against the concept of AS. In recent years, more families have begun to openly thank right-to-die associations such as EXIT for their contributions to freeing their loved ones from suffering. Once again, this change in behavior reflects the increasingly supportive attitude of the public toward AS. The change in public attitude will undoubtedly continue to influence future generations, helping normalize AS in the public mind. These small acts of kindness from family members will become new sources of motivation and signs of affirmation for volunteers assisting in the process of assisted suicide.

In the ongoing discussion on assisted suicide, the experiences of families sometimes go unrecognized, and clinical guidelines seldom take their perspectives into account. Family support is crucial throughout the process of AS. The Swiss model of assisted suicide especially requires families to invest much more time and effort than alternative models in other countries. Family members sometimes get caught up in the battles between palliative care and right-to-die associations. There are mixed feelings about families' decisions regarding the disclosure of their experiences with AS. Part of the reason is personal, and another part is fear of negative judgments from others. This also ties into the evolving public attitude and stigmatization surrounding AS. Some families prefer secrecy and high confidentiality throughout the process of AS, minimizing the discussion of AS and their own emotional burdens with other families or professionals. While this may protect them from perceived judgments in the eyes of the public, it may also intensify the sense of isolation and exacerbate their grief during the bereavement period (Wagner et al., 2012; Gamondi et al., 2020). Nonetheless, other families value sharing their experiences and having clear and open communication around both AS and other end-of-life issues so that patients' and families' needs can be expressed and addressed in a timely manner. However, doing so may make families the target of opponents of AS and victims of stigmatization. Philippkowski et al. (2021) conducted research comparing public stigma toward those bereaved of AS with those bereaved of death from different causes. The stigma elicited did not differ significantly between AS and other deaths (e.g., long-term illness), suggesting no evidence of more severe stigma against assisted dying. The perceived public stigma may be unfounded or significantly reduced due to the evolving public attitude toward greater favorability of assisted dying. Sometimes, self-stigma due to perceived, though unproven, public stigma is the biggest barrier preventing families from seeking external support.

Families play a crucial role in dispelling fear and misunderstandings about AS in the public. Perceived stigma and negative public attitudes often originate from insufficient understanding and fear of the unknown. Thus, family members who have been through the entire process are the best candidates to educate the public about AS through their personal experiences. Physicians, guided by professional obligations, are fundamentally committed to preserving life, while right-to-die association volunteers, due to self-selection bias, are predisposed to support assisted suicide. In contrast, family members are relatively independent in their perspectives, as they are not bound by professional ethics or organizational ideologies, making them key in mitigating potential conflicts between physicians and volunteers. The changing societal perception of AS and public attitudes have a great impact on families' experiences with AS. Conversely, family members who have been involved in AS are influential figures with the potential to shape the development of public attitudes toward AS in the future.

Conclusion

Data from both literature reviews and interviews support the fact that Swiss society is becoming more tolerant and supportive of assisted suicide. After a long history of conflict and debates, palliative care and AS have finally reached the point of mutual respect, marked by collaborative efforts across professional fields and growing social acceptance. Demographic, experience-related, and religious ideological factors may continue to influence people's stances on AS, but religiosity is no longer as powerful as it was in the past.

Palliative care physicians' attitudes toward AS are shifting toward greater neutrality, with decreased hostility and increased curiosity to understand and potentially be more involved in AS. Perhaps due to both the influence of changing public attitudes toward AS and generational effects, more palliative care physicians have approved the practice of AS within hospitals.

EXIT volunteers' consistent and reliable support and families' advocacy about their experiences with AS have also greatly contributed to shaping a positive image of assisted suicide in Switzerland. The public's acceptance motivates volunteers from right-to-die associations to continue helping more families as the demand for AS increases annually.

Having public understanding encourages families to dispel potential self-stigma and have more open conversations in public regarding their personal experiences with AS. The influence of public attitude and the attitudes of families and professionals is reciprocal. The change in public attitude and perception toward assisted suicide has facilitated better experiences for family members and professionals involved in AS. Vice versa, the acknowledgment and support from families and professionals sway public perception to be more favorable toward AS in Switzerland.

Strengths and Limitations of the Study

All interviewees recruited for formal interviews were highly relevant experts in the field. The discussions and conversations during the interviews were extremely helpful to this study. Dr. Gamondi, whose publications were frequently cited throughout this paper, provided valuable perspectives as a palliative care physician. Mr. Bise, the co-president of EXIT A.D.M.D., provided a detailed background on the history of assisted suicide in Switzerland and legislation around AS using his background in law. Mr. Bise's experience also shed light on the experience of families involved in AS, who could not be interviewed directly due to ethical concerns in the research.

A limitation of this study is that interviewees who self-identified as "opposed in principle," "professionally compromised," and "difficult to reconcile" were not found. Their perspectives and how they proceed through the process of AS with conflicting personal values would be an asset to this study. It would help present both sides of the argument more equally and holistically.

The difficulties and limitations of the methodology used in this paper include a small sample of interviewees and language. The small sample was due to both lack of response and time constraints. The language limitation was due to my personal inability to speak French. Because of this, all interviews were conducted in English rather than French, which was the first or preferred language of many interviewees. Important nuances may have been lost in the interviewees' responses due to language barriers and the struggle with translation from French to English.

Recent discussions about AS have centered around broadening the practice to patients with Alzheimer's disease, dementia, or mental disorders. The biggest issue would be the violation of the principle that patients must be mentally capable of independently making their own decisions. Many feared that if this regulation around AS is compromised, it would validate the slippery slope argument. Therefore, more research needs to be done before the practice of AS can be expanded to a wider population.

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