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The response of a Swiss university hospital's palliative care consult team to assisted suicide within the institution

J Pereira, **P Laurent**, **B Cantin**, **D Petremand** and **T Currat** Service de Soins Palliatifs, Centre Hospitalier Universitaire Vaudois, Lausanne

In January 2006 the Centre Hospitalier Universitaire Vaudois (CHUV), a large university hospital in Lausanne, Switzerland, became the first hospital in Switzerland to allow assisted suicide (AS) in exceptional cases within its walls. However, euthanasia is illegal. This decision has posed several ethical and practical dilemmas for the hospital's palliative care consult service. To address these, the team embarked on a formal process of open dialogue amongst its members with the goal of identifying a collective response and position. This process involved meetings every 4 to 6 weeks over the course of 10 months. An iterative process unfolded. One of the principal dilemmas relates to finding a balance between the team's position against AS and the patient's autonomy and the institution's directive. Although all team members expressed opposition to AS, there were mixed opinions as to whether or not the team members should be present during the act if requested so by patients. Some thought this could be misinterpreted as complicity in the act and could send out mixed messages to the public and other health professionals about palliative care. Others felt that the team's commitment to nonabandonment obliged them to be present even if they did not provide the drug or give any advice or assistance. The implications of nonabandonment are explored, as are several other questions such as whether or not the teams are obliged to provide detailed information on AS when requested by patients. *Palliative Medicine* (2008); **22**: 659–667

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Introduction

Euthanasia and physician assisted suicide (PAS) have both been legalised in the Netherlands[1] and Belgium,[2] Luxembourg may follow suite. The state of Oregon in the United States has legalised PAS, but euthanasia remains illegal.[3] In Australia, The Northern Territories legalised PAS in the late 1990s but federal government intervention rescinded suite after two years.[4] Switzerland has adopted a tolerant view towards assisted suicide (AS) since the early 20th century.[5] The debate on whether or not to allow euthanasia and/or PAS remains active in several other countries. Canada and the United Kingdom, for example, have experienced this debate within the last decade.

In January 2006, the Centre Hospitalier Universitaire Vaudois (CHUV), a 900-bed university hospital in Lausanne, Switzerland, became the first hospital in Switzerland to allow AS, in exceptional cases, within its walls. The University Hospital of the Canton of Geneva (Hopitaux Universitaires de Geneve or HUG) followed suite in early 2007 with a similar decision. As in the case of palliative care professionals and teams in the other jurisdictions that have legalised euthanasia and/or PAS, the decision to allow AS in our hospital has posed ethical and practical dilemmas for our team.

To guide the formulation of a response by the CHUV's palliative care team, the team undertook an internal process of reflection and dialogue. A review of the literature on euthanasia and PAS was also conducted to better understand the various viewpoints, including the impact on other palliative care teams in similar situations. Ganzini, *et al.*,[6] for example, found that almost 50% of hospice nurses had cared for a patient who requested assistance with suicide. Harvath, *et al.*[7] identified several dilemmas that hospice nurses and social workers experience when asked to care for patients requesting AS. These include: 1) an increased sense of responsibility to adequately manage symptoms; 2) challenges to beliefs on patient autonomy; 3) concerns about whether PAS is antithetical to hospice care; 4) missed opportunities for patients to experience spiritual transformation; 5) conflicts over whether helping patients redefine quality of

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Correspondence to: Jose Pereira (Professor), Service de Soins Palliatifs, Hôpital Nestlé, 4ème étage, local 4005, CHUV, Avenue Pierre-Decker 5, Lausanne, CH -1011, Switzerland.
Email: jose.pereira@chuv.ch

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life impinges on their autonomy; and 6) conflicts over whether to advocate for the patient or the family who are against it when PAS is being considered. Some described feeling like a 'failure' if their patients ultimately chose to hasten death by PAS. Some stated that they made efforts to try to convince their patients to make another choice, whereas others expressed concerns about doing so as it could contravene patients' autonomy. Several subjects wondered if they had been inadvertently drawn into an AS to a greater extent than they intended or would have liked to wether or not they should provide information on PAS when requested by a patient or family was identified as a dilemna. Volker, *et al*.[8] have described similar experiences. However, the impact on inhospital palliative care teams has not been specifically addressed.

This article explores the questions and dilemmas confronted by the CHUV's palliative care consult team and describes key considerations in formulating responses to the questions. It begins by summarising the laws in Switzerland as they relate to PAS and euthanasia and compares these to other countries that allow PAS. It also describes the main elements in the CHUV's institutional directive regarding AS. To place it in context, six patients entered the institution's formal AS process from January 2006 until the end of June 2007.[9] Of these, one of the patients, living in a nursing home belonging to the hospital, died of AS. Two patients died from their disease before the process was completed, and one patient withdrew his request when the palliative care team, working alongside the anaesthesia pain team, was able to control his pain. Assisted suicide was refused in two other patients: one because he lacked decisional capacity and the other because her illness was improving.

Euthanasia and assisted suicide in Switzerland

Although euthanasia is illegal, Swiss federal laws sanction AS. Voluntary active euthanasia is punishable by imprisonment (Article 114), whereas assisting in suicide without any self-interest is not illegal (Article 115).[10] The law, instead of outright legalising AS, limits the circumstances in which AS is a crime. Swiss right-to-die organisations have used this accepted loophole within the legislation to offer AS.[11] The law was originally introduced in 1937 to mitigate the penalties against the families of those who commit suicide and those who assist them. A person assisting someone else committing suicide will not face any sentencing if his or her motives are altruistic (such as the alleviation of suffering). On contrary, a person found to be inciting or assisting with suicide of someone else for selfish reasons could face prosecution.[12] It has been left to individual institutions to decide whether or not AS could be practiced within their walls. This laxity has encouraged foreign citizens to travel to Switzerland to receive AS from a right-to-die organisation (DIGNITAS).[13]

Unlike other jurisdictions such as Holland, Belgium, and Oregon, AS in Switzerland can be performed by nonphysicians; hence, the reference to AS rather than PAS.[5,11] Assisted suicide is provided mainly in persons' homes by physician and nonphysician members of right-to-die organisations such as EXIT and DIGNITAS. In contrast to the Netherlands and Oregon, the process in Switzerland does not require a medical second opinion. As in the Netherlands, a terminal illness is not a prerequisite. Unlike Oregon, there is no stipulation for a mandatory palliative care and/or psychiatric consultation. Contrary to Oregon and the Netherlands, there is also no required minimum period of persistence from when the patient first requests it to when he or she is allowed to receive it; a safeguard against nonpersistent requests.[5]

Bosshard and colleagues reported that, between 1990 and 2000, EXIT assisted in 743 ASs of Swiss residents; most of them in the German-speaking part of the country.[14] Over the study period, the annual number of EXIT-assisted deaths more than tripled, reaching almost 350 in the year 2000. Approximately 47% of the 331 who died in the Canton of Zurich had cancer, 31% had other incurable illnesses, and 21% had conditions that were not considered fatal. Of interest, is that in the initial years, all the lethal substances were taken orally, but by the end of the study period 14% were administered via infusion or PEG catheter. Although these cases have been classified as AS by the authorities, some have expressed the concern that they border on euthanasia.[15] Since the publication, EXIT has become more active in the French-speaking part of Switzerland.

It is estimated that there are approximately 1800 requests to EXIT and DIGNITAS by Swiss residents per year for AS and that 600 of these are accepted.[11] Half of these persons go on to die of AS, which accounts for approximately 0.45% of all deaths in Switzerland. In the Netherlands, euthanasia and PAS currently account for about 1.8% of all deaths (0.3% by AS),[1] and in Oregon, 0.09% of all deaths are by AS.

The degree to which Swiss physicians specifically support AS and euthanasia is unclear. A 2005 report which compared the attitudes of doctors from three (German, French, and Italian) of the country's four language regions found that approximately 56% of physicians supported the use of lethal doses of drugs should be allowed in patients with uncontrolled pain or other symptoms.[16] The support was higher amongst French-speaking physicians (65%) than Italian (41%) or German-speaking ones (53%). French speakers were also less likely to comply with a patient's request to forego treatments. These data are not very different from similar studies in Germany, France, and Italy.[17] This study may, however, have over-

estimated the support for AS.[18] Between 64% and 77% of physicians in the study felt that palliative care could not reduce requests for AS; an interesting perception given that palliative care services are absent or lacking in most of the country's 26 cantons and the average number of obligatory hours dedicated to palliative care education is only 8 h in 6 years of undergraduate medical education in Swiss medical schools.[19]

The Swiss Academy of Medical Sciences (SAMS) supports AS in exceptional cases. In its 2004 position paper, SAMS recognises that in a personal doctor-patient relationship, out of respect for the autonomy of the patient, a doctor may assist a person to commit suicide if that person so desires [http://www.samw.ch/]. Following the decision by the CHUV, SAMS published a statement in which it explains that from the ethical point of view 'it sees no convincing arguments to basically exclude AS in acute hospitals,' but at the same time it stresses that a hospital is 'a place where primarily patients are cured.' In January 2007, it reaffirmed its stand that hospitals should decide themselves on whether or not to allow AS within its walls but stated that '*it is not appropriate that the staff within an acute hospital should be involved, in any way, in an assisted suicide*.'

The Centre Hospitalier Universitaire Vaudois'policy towards assisted suicide

The CHUV's decision to allow AS has not been uniformly supported by physicians and nurses in the hospital.[20,21] Specific criteria need to be met. These include: 1) transfer of the patient to another institution or home is not possible; 2) the patient must have the capacity and competence to make the request him or herself and provide consent; 3) the patient's request must be persistent; and 4) the patient must have a terminal illness. Assessments by the hospital's psychiatry and palliative care services are mandatory. Once all these criteria have been met, a formal request is made to the hospital's medical administration (Direction Medicale) who then appoint a committee (Commission d'Evaluation Institutionnelle) that confirms that the criteria have been met and makes the final decision. The Commission consists of a physician member of the Direction Medicale, a representative of the nursing administration, and two members of the institution's clinical ethics committee. One of these persons will see the patient. If the request is accepted by this committee, the patient may receive the lethal prescription from his or her attending physician in the hospital (if he or she is agreement) or from an external person such as a member of EXIT or DIGNITAS. Therefore, staff members are not obliged to provide AS.

Following the decision by the CHUV, other Swiss hospitals have reviewed their own positions on the matter. In early 2007, the HUG also opened its doors to AS. Contrary to the CHUV's directive, the HUG's protocol requires neither a palliative care nor a psychiatry consultation. Moreover, hospital staff are prohibited from providing AS; AS has to be provided by persons who are nonstaff members (usually members of right-to-die associations). In 2007, the University Hospital of Zurich (the largest city in the country) rejected access to AS within the hospital. Contrary to the decisions by the CHUV and HUG, the decision by the Zurich hospital received scant media attention.

Process undertaken by the CHUV's palliative care service

From the outset, the decision by the CHUV's ethics committee to allow AS raised, individually and collectively, several questions and concerns for the members of the palliative care team. At the core of these concerns is the dilemma of remaining true to the principles and philosophy of palliative care whilst respecting individual patient's requests and the institution's directive. Harvath, *et al*.[7] in Oregon highlighted this dilemma for hospice nurses and social workers who felt that the biggest dilemma for them arose from the conflict between two important hospice values: honouring patient autonomy versus promoting a death experience in which personal and spiritual transformation are possible.[6]

A formal process of dialogue and deliberation, that allowed individual members to express their respective concerns and viewpoints, was initiated within our team. The process consisted of one-hour long meetings every 4 to 6 weeks over a period of 11 months. The goal of the process was to develop a collective position for the team. The importance of such an open process has previously been highlighted by an Australian team.[22]

Questions, considerations and responses of the palliative care team at the CHUV

The process unearthed several key questions for the team. These are listed in Table 1. It became evident early in the process that numerous sessions would be required as the questions and dilemmas often eluded straightforward responses and required considerable reflection. An iterative process unfolded in which responses to the questions were formulated and reformulated in subsequent meetings as members reflected further on the issues. Team members expressed that they underestimated the complexity of the

issues and the varying opinions within the team. At times no clear responses were forthcoming.

Do we as a palliative care team endorse assisted suicide?

Although this may appear to be a rhetorical question, a strong uniform opposition to the legalisation of PAS and euthanasia is not universal within the Swiss palliative care community. In a survey of members of the Swiss Palliative Care Society (Palliative CH), 18% of respondents indicated that they would practice AS if it were legalised.[23] Eight percent of the physicians and 4% of nurses reported having practised AS, and 3% of physicians and nurses reported actively participating in euthanasia (although some erroneously considered palliative sedation as a form of euthanasia). Nineteen percent of respondents encouraged the Society to support the liberalisation of AS and euthanasia. Members of the German Palliative Care Society expressed similar sentiments; almost 25% and 10% of members expressed some support of legalising PAS and euthanasia respectively.[24]

These sentiments stand in contrast to the membership of the United Kingdom's Association for Palliative Medicine.[25,26] In a large recent survey, in which 82% of its members responded (723 responses), 92% of members indicated that they would not support the legalisation of PAS or euthanasia. (It should be noted that the United Kingdom Palliative Care is formally recognised as a 'specialty,' which is not the case in either Switzerland or Germany.) These attitudes are more consistent with the definition of palliative care used by many international and national organisations such as the World Health Organisation[27] and European Palliative Care Associations,[28] which state that palliative care does not intentionally hasten death.[29]

The team also reviewed the arguments against and for the legalisation of AS and euthanasia. One of the central arguments made against PAS and euthanasia is the 'principled' argument, which points to the intrinsic wrongness of health professionals' involvement in hastening death.[30] Killing patients violates physicians and nurse professional integrity and endangers the physician (and nurse)-patient relationship. Opponents argue that requests for AS are often fluctuating and are frequently driven by underlying problems such as fear of future suffering, feelings of hopelessness and burden to others, depression, and uncontrolled symptoms, all of which need to be addressed. Many palliative patients, whilst open to the notion of having PAS or euthanasia available, will not seek them when provided with good palliative care.[31]

On contrary, support for legalising AS is largely grounded on two principles: self-determination (or autonomy) and mercy (avoidance of suffering).[5,11,32,33] Autonomy represents the right to live ones' life as one sees fit, subjects only to the limitation that this not involve harm to others. Persons have the right to choose the way they wish to live and to die. The second principle is grounded in the obligation to avoid doing harm whilst doing good (the principles of nonmaleficence and beneficence).[34] Right-to-die organisations often defend the notion that persons should not be allowed to suffer, and that AS or euthanasia offers a merciful way out for individuals experiencing refractory suffering.

Some of the openness from within palliative care to AS may be consistent with the stand made by Quill and Battin who contend that in addition to making palliative care a standard of care for those who are dying, strong philosophical, ethical, and religious principles (especially autonomy, mercy, and nonabandonment) support access to PAS as a last resort for those rare circumstances in which suffering becomes intolerable despite the best palliative care possible or if patients find the best palliative care unacceptable.[34–36] The key here is that good pallia-

Table 1 *Questions confronted by CHUV palliative care team*

Questions for which a stand has been taken
Do we as a group endorse assisted suicide?
Should we participate in the institution's ethics work group on assisted suicide?
If we participate in developing the guidelines, does it make us complicit in the process?
Should we be involved in the assessment process?
Should we continue caring for patients who have requested assisted suicide?
What does nonabandonment imply?
What do we do if a patient asks us to be present during the act even if we do not prescribe or endorse the practice?
How do we respond to patients who enquire about or request assisted suicide?
Unresolved questions
What if someone in our team assists in suicide?
Are we in a position to apply any penalties?
Should we allow assisted suicide in a palliative care unit in the future, even if we do not do it ourselves?
What if our position contradicts the institution's directive?
Are we legally obliged to conform to the institution's directive?
Should we enter into a regular and open dialogue with the right-to-die societies in our region?
Should we consider screening future employees on the basis of their beliefs on AS? Legally are we allowed to do so?

tive care has been applied. Quill and Battin[35] stress that if requests for AS stem from inadequately delivered palliative care, then the best answer would be to improve the standard of care rather than providing PAS or euthanasia.

The individual members of our team were unanimous in expressing their opposition to AS while supporting the need to improve palliative care resources, including the establishment of an acute palliative care unit in the near future within the CHUV.

Should members of the palliative care team participate in the institution's committees on assisted suicide?

In 2005, two members of the palliative care team were invited to participate in a working group established to advise the institution on whether or not to allow AS. This presented the team with a dilemma. The absence of palliative care representation in the group risked that opposition to AS would be reduced and that palliative care assessments would not be included in any directive that would allow AS. On the contrary, participation risked being interpreted as complicity if the institution went on to allow AS. Two team representatives joined the working group but, despite their objections, AS was endorsed. Although the participation by the team members may have prompted the inclusion of a mandatory palliative care assessment, some in the institution continue to believe that the involvement of palliative care service in the process compromised its ability to be a strong opposition in the future; a view held by one of this article's authors (JP). A more prudent approach may have been for the team to have provided testimony rather than participating actively as members of the working group.

More recently, the palliative care service has been asked by the institution to debrief a team of health professionals who had expressed concerns about assisting a patient's request for AS. The palliative care team turned down the request on the grounds that it did not have the necessary skills to do so, that participation in the process would be seen as complicity with the process, and that it could aggravate the situation because its own values were more consistent with that of the attending team's views.

For similar reasons, it would not be judicious for members of the palliative care team to be involved in any committee (Commission d'Evaluation Institutionnelle) established by the institution to make a final decision on whether or not to accede to a person's request for AS in the future.

Should we be involved in the assessment process?

The CHUV's directive calls for an obligatory palliative care assessment. This is welcomed by the palliative care service as it provides an opportunity to identify strategies that may still not have been exhausted in addressing the reasons underlying the person's request for AS.[31,37] In Oregon, Harvath, *et al.*[7] have highlighted the opportunities that mandatory palliative care assessments provide to increase broader discussions with terminally ill patients and to increase attention to symptom control by all health professionals involved.[6]

However, limitations of a single assessment should be recognised. A single visit may not suffice to uncover underlying psychological and existential sources of distress. Only 6% of Oregon psychiatrists, for example, felt confident that a single assessment could enable them to decide whether or not mental illness is influencing a person's request for PAS.[7] Kelly and McLoughlin[38] have expanded on the concerns of single psychiatric assessments. Referring specifically to the role of psychiatric assessments, they argue that there is a marked lack of clarity about the goals of mandatory psychiatric assessment in all patients requesting PAS. More worryingly, there are no clinical criteria to guide such an assessment, just as there are no criteria to assess the rationality of any person's decision to commit suicide.

Treatment strategies such as psychospiritual counselling and support require time and the establishment of a therapeutic rapport between caregivers and patients. This is particularly true when the reasons include feelings of hopelessness and being a burden, loss of meaning, and depression. Indeed, patients' requests for AS may be determined more by psychosocial traits and beliefs than by disease severity or symptomatic distress.[39] Pressure to move the AS process along deprives the palliative care team of the important therapeutic option of time. The lack of an inhospital palliative care unit is also a major impediment as the team relies on the attending caregivers to implement its recommendations. There are not uniformly applied..

There also exists the risk that the palliative care team is put into a position of gatekeeper for AS or mediator between patient, family, and attending medical staff. The team may, inadvertently or wittingly, be put in the position of assisting the process rather than preventing it; a concern expressed by some Oregon hospice nurses and social workers.[6] Consider, for example, a situation where a patient's request for AS may be contrary to his or her family's views. The palliative care professional is then left in a situation of either supporting the family's viewpoint or advocating for the patient's autonomy and right to decide even though it contradicts the palliative care professional's own values.

Therefore, it is not surprising that many palliative care specialists and psychiatrists express concerns about carrying out assessments related to a patient's request for AS. Only 35% of British psychiatrists, for example, would be willing to carry out such assessments,[40] and approximately two-thirds of members of the United Kingdom's Palliative Medicine Association would not wish any

involvement in the assessment process of patients seeking AS.[26]

The CHUV's team has decided to continue availing itself of the opportunities afforded by the mandatory palliative care assessments to identify strategies that could still be attempted to address patient's reasons for requesting AS. In all cases, it will state that AS is not an appropriate option. The decision by the HUG to make palliative care assessments optional is a concern as there exists the real risk that opportunities to adequately address some underlying problems will be missed.

Do we continue caring for patients who are persistent in their requests for assisted suicide?

The team was unanimous in its belief that these patients should not be abandoned, and that we should continue caring for patients who have requested AS or are members of a right-to-die society. It was felt that the principle of nonabandonment is fundamental to the physician or nurse-patient relationship. This principle acknowledges and reinforces the centrality of an ongoing personal commitment to caring and problem solving between the professional and patient.

However, the notion of nonabandonment is more complicated than meets the eye for palliative care teams. The central commitment of nonabandonment as an obligation of health professionals must be balanced by other ethical considerations. Although physicians and nurses should try to respond to the needs and requests of their patients over time, they must not violate their own values in the process. This is particularly true if a team does not endorse AS. Quill and Cassell[41] argue that there should be a dynamic interplay between patient and physician, individuals and society, traditional and personal values, subjective interpretations and objective analysis, and emotion and intellect.[41]

A physician or nurse who, on one hand, states that he or she does not support AS yet on the other commits himself or herself to nonabandonment may have to transgress one of these principles if the relationship continues. Battin [34] has proposed that as time goes on and the patient's condition declines, the patient's rights grow stronger both on grounds of self-determination and of mercy, and thus, the physicians's obligation grows correspondingly more difficult to evade. One strategy to avoid this situation is to inform a patient early in the relationship that one (or one's team) does not assist in suicide, allowing the patient to decide whether or not to continue the relationship. Our team have adopted this option. This is particularly important in the Swiss situation where right-to-die organisations are involved in an active public campaign to recruit new members and to include the option of AS in these persons' advance directives.

Should a team member be present during the suicide of a patient if a patient so requests?

In one case, a patient requesting AS asked a physician member of the palliative care team to be present when he took the lethal drug (which he would obtain from the right-to-die organisation). He had developed a close relationship with that physician. A member of the right-to-die organisation would also be present to assist with the process. This presented the physician and team with a dilemma. Although, on one hand, the team did not want to abandon the patient, on the other its presence could be misinterpreted as complicity or even active involvement. The local right-to-die organisation's stand that AS represented good palliative care, and its publicity of previous cases of AS, heightened this concern. Any publicity which suggested that palliative care was present during, an act of AS would send out mixed messages to a public that already does not fully understand palliative care. Indeed, surveys in several countries have shown that the majority of the public do not understand well what palliative care is and what it provides.[42–44]

Although, the majority of members appeared to favour a position that team members should not be present during the act, some individuals felt strongly that nonabandonment compelled them as individuals to be present and accompany the patient, despite the potentially negative consequences. Therefore, a position has been taken that the default position is "not to be present", and that this would be explained to patients and their families. If, despite this, a patient insists on a presence, the issue would be brought back to the team for further discussion.

How do we respond to a patient's request for assisted suicide in the institution?

It is recognised that in some cases a patient's request for AS represents a fleeting comment that is not intended as a literal wish to die.[37] It may represent a plea for assistance with underlying existential, psychological, or physical problems rather than a concrete, well formed, and consistent desire for hastened death.[45] Zylicz[46] provides a framework to guide the assessment of the request and its underlying reasons. He categorises the profile of patients requesting euthanasia into five groups: 1) Patients whose request is based on fear of the future (anxiety); 2) Patients who are exhausted with their illness trajectory (burnout); 3) Patients who desire to control an illness process which appears out of control; 4) Patients with significant depressions; and 5) Patients whose main motive is based on their belief that it is their right to choose the time and manner of their deaths. Patients whose request is driven by uncontrolled physical symptoms and psychological and existential factors such as profound feelings of hopelessness, burden to others, lack of meaning, and loss of dignity are included in these categories.[37,47] Although the team feels

that its role is to identify potentially reversible causes and to suggest strategies to address these, it does not have the competencies to provide patients with detailed information on how to proceed with AS should they ask for this. These patients will be referred to the institution's medical direction.

In addressing this question, the team also took note of the literature exploring the emotional and psychological impact on health professionals of assisting in AS or euthanasia.[6,7,21,48,49] Stevens, for example, in a review of the literature, noted some strong negative repercussions for some physicians who were personally involved in providing AS and euthanasia. Some physicians described being shocked by the suddenness of the death and feeling caught up in patients' drive for AS. These physicians expressed feelings of powerlessness and isolation. There was evidence of pressure on, and intimidation of, physicians by some patients to assist in suicide.

Unresolved questions

Several questions remain unresolved for the team. These include the issue of whether or not it would be appropriate to reprimand a team member who practices AS, and if so, what type of penalty would be appropriate. Whether or not the service may use a person's beliefs and values on AS to triage potential staff members is also fraught with legal and ethical considerations. Although the hospital does not have an inpatient palliative care unit, the team would not support allowing AS within the unit. Allowing it would send out mixed messages (particularly to a public that is already largely unaware and misinformed about palliative care[50]), and it could cause significant tension amongst palliative care staff.

Conclusion

Clearly, the decision to allow access to AS within the hospital has had a significant impact on the palliative care consult service which does not endorse the practice of AS or euthanasia. It has created tensions between the philosophy and beliefs of the palliative care team and the institution's directive on AS. It has also raised some difficult ethical and practical questions for the team members, both individually and collectively. It has prompted significant discussion within the team and a deeper understanding of the implications of principles such as nonabandonment, patient autonomy versus caregiver values and positions, and larger impact on society as a whole. The main dilemma has been to balance personal and professional ethics with patient autonomy. Importantly, a service needs to take a stand and explore with its administration if this stand is contrary to the institution's position. Reconciling the differences between the two in ways that do not disrupt patient care and respects individual's principles need to be sought. Clear answers to some questions remain elusive.

The team continues to monitor the evolving situation. It is with concern that it observes what may represent elements of a 'slippery slope' phenomenon. EXIT, one of the right-to-die societies, is increasingly proposing that AS also be made available for those individuals with diseases that have resulted in irreversible handicaps (polypathologie invalidante irreversible).[51] The leader of the organisation in French-speaking Switzerland has also indicated that elderly persons without any underlying physical or psychological disease who feel that they have lived full lives and now wish to die should also have access to it [Personal communication. Dr J Sobel, Lausanne].

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