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The Evolution of Physician-Assisted Death: A Comparison of Legislation, Regulation, and Public Opinion between Switzerland and Canada

Samriddhi Mohta

Dubai College, Dubai, United Arab Emirates

Abstract—***T****his paper compares Physician-Assisted Death (PAD) in Canada and Switzerland, highlighting how each country approaches this issue through different legal frameworks, safeguards, and societal perspectives. In Canada, PAD is regulated under Medical Assistance in Dying (MAID), legalized in 2016 with the passing of Bill C-14, and further expanded in 2021 through Bill C-7. The Canadian system requires close involvement from healthcare providers, who overlook the entire process, ensuring that all safeguards are met. This is aimed at protecting vulnerable individuals while respecting their autonomy. The system is highly regulated, with a strong emphasis on ethical oversight, particularly in cases involving non-terminal conditions or mental health concerns.*

Switzerland, by contrast, has had a longer history with PAD, having decriminalized assisted suicide as far back as 1942. The Swiss approach puts more emphasis on patient autonomy, with less direct involvement from doctors. Organizations like Dignitas and Exit facilitate the process, often without stringent medical oversight. While this model supports individual choice, it has sparked concerns about the commercialization of assisted suicide, particularly with the rise of "suicide tourism" and the use of controversial technologies like the "suicide pod."

A similarity between the two countries is the lack of mandatory psychological counseling for individuals pursuing PAD. This raises important ethical questions about whether mental health issues like depression are being properly addressed in these end-of-life decisions. Public opinion varies, with Canada's relatively recent legalization still under debate, while Switzerland's more established system faces growing scrutiny, especially regarding its commercialization. Overall, the paper explores how Canada and Switzerland navigate the complexities of PAD, each balancing patient rights with the need for safeguards, and how these approaches reflect their broader cultural and ethical landscapes.

Keywords: *Physician-assisted death, medical assistance in dying, end of life, euthanasia, bioethics, comparative research.*

Introduction

There is a complex and vexing issue of physician-assisted death (PAD) – the practice of physicians helping terminally ill patients end their lives by providing them the means to lethal drugs. Medicine, law, and society collide at this intersection. Some countries have legal frameworks to deal with assisted dying for terminally ill people who cannot stand their sufferings. In time for 2024, PAD will be legalized in many countries across the world, depicting a growing recognition of it as a legitimate practice within strict regulations (Health Canada, 2024). The leading countries where PAD has been allowed are Belgium, Netherlands, Luxembourg, Canada, and Switzerland. This includes Oregon, Washington, California as well as Vermont being among US states where PAD is legal (Downie, 2017). Altogether, there are over a dozen nations and jurisdictions around the globe that have enacted such laws permitting some degree of PAD. Each country has its own qualifying criteria, safeguards, as well as procedures for safe use of PAD. This trend marked a significant deviation from traditional medical paternalism toward respecting individuals' autonomy in end-of-life (EOL) decision-making processes; however, ethical and legal landscapes differ slightly according to different regions, which makes Canada and Switzerland two interesting examples with divergent approaches towards regulation or facilitation of euthanasia or assisted suicide.

Understanding the different terminology used when discussing PAD is critical for clarity and accuracy. The different terms are often used interchangeably, but they can have distinct meanings based on legal and medical contexts. Definitions for aid in dying terminology are provided in Table 1.

Table 1: Commonly used terminology to describe aid in dying

Terminology	Definition
Medical assistance in dying (MAID)	In Canada, MAID refers to the legal provisions of assistance to a patient by physician or nurse practitioner to intentionally end their life. MAID encompasses both euthanasia and assisted suicide (Canadian Department of Justice, 2016).
Physician - Assisted Death (PAD)	PAD is defined as a physician providing, at the patient's request, a prescription for a lethal dose of medication that the patient can self-administer by ingestion, with the explicit intention of ending life. (AAHPM, 2016)
Physician - Assisted Sucicide (PAS)	Term use in lieu of physician-assisted death. A physician intentionally helps a competent person to terminate his or her life by providing drugs for self-administration, at that person's voluntary request. (Downie, J., & Schuklenk, U, 2018)
Voluntary- Assisted Dying (VAD)	VAD is a term often used in Australia and some other jurisdictions to describe the legal process by which a person with a terminal illness or incurable condition can request and receive assistance to end their life, either through self-administration or with assistance of a healthcare provider. (Downie, 2017).
Euthanasia	Euthanasia involves a healthcare provider directly administering a lethal substance to a patient, resulting in the patient's death. Euthanasia can be voluntary (at the patient's request) or non-voluntary (without the patient's explicit request, often because they are unable to provide consent). (Van der Heide et al., 2003).

This comparative study aims to explore and analyze key aspects of physician-assisted death (PAD) and medical assistance in dying (MAID) in Canada and Switzerland, focusing on their legal frameworks, eligibility criteria and procedural safeguards, social attitudes and practical application. By examining these two different contexts, we seek to understand the challenges, implications and lessons learned from the different approaches to PAD regulation in Western jurisdictions.

History of PAD in Switzerland

Switzerland has a tradition of assisted suicide according to certain legal and ethical guidelines dating back to the 1940s. The history of PAD in Switzerland began with the introduction of the Swiss Criminal Code in 1942, which decriminalized assisted suicide if it was not done for selfish reasons. This unique legal position laid the foundation for future practice (Swiss Criminal Code, 1942). In the 1980s, right-to-die organizations such as Exit and Exit A.D.M.D. emerged, advocating for a dignified death for terminally ill patients (Exit, n.d.). The establishment of Dignitas in 1998 further expanded these services to international clients, making Switzerland a center for "suicide tourism" (Dignitas, n.d.). In 2023, the number of assisted suicides in Switzerland rose by 11%, with a total of 1,359 cases reported, continuing a trend that has seen significant increases over the past decade (SwissInfo, 2023). From 1999 to 2018, Switzerland saw a fourfold increase in assisted suicides, particularly among elderly women, which has been attributed to a combination of liberal laws and societal acceptance (Stettler, Zwahlen, & Fischer, 2020).

This practice has become more visible and has sparked ethical debates, reinforcing Switzerland's role as a prominent country that allows PAD. However, recent reports have raised concerns about the growing commercialization of assisted suicide and the potential erosion of ethical standards, with 2023 witnessing the introduction of controversial technologies like the "suicide pod," further complicating the landscape (New York Post, 2024). As a result, Switzerland's approach to PAD is increasingly scrutinized both domestically and internationally, reflecting ongoing tensions between patient autonomy and the need for robust ethical oversight (Alliance Vita, 2023).

The process to be eligible for PAD in Switzerland is quite straightforward as it has been around for the longest time. This process can be summarized in Figure 1 below.

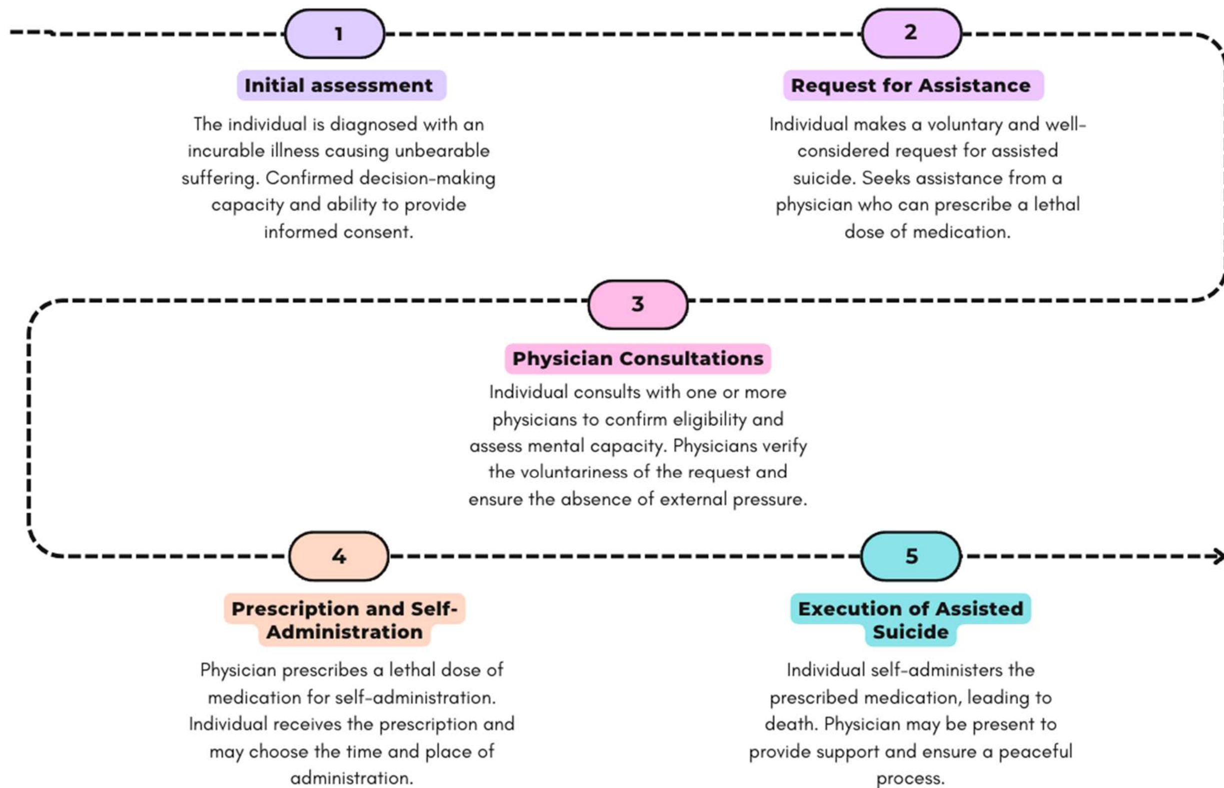

Figure 1: Physician-assisted death process in Switzerland

History of PAD in Canada - (Stettler, C., Zwahlen, M., & Fischer, S., 2020). (Swiss Criminal Code 1942). (SwissInfo 2023). (Alliance Vita 2023). (Dignitas)

Canada legalized medical assistance in dying (MAID) in 2016 with Bill C-14, which allows terminally ill adults experiencing unbearable suffering to request euthanasia or assisted suicide (Canadian Department of Justice, 2016). This legislation was a response to a 2015 Supreme Court ruling that overturned an earlier ban on assisted dying (Carter v. Canada, 2015). Since its inception, MAID has seen significant uptake, with the fourth annual report in 2022 documenting 13,241 MAID provisions, marking a 31.2% increase from the previous year (Health Canada, 2023). This growing demand highlights the increasing acceptance of MAID within Canadian society, particularly among older adults suffering from cancer, who represented the majority of cases (Health Canada, 2023).

In 2021, Bill C-7 further expanded eligibility for MAID to include individuals whose natural death is not reasonably foreseeable, thereby removing the requirement for a "reasonably foreseeable" death (Canadian Department of Justice, 2021). This expansion also introduced provisions for individuals with mental illness, though these were met with controversy. In response to public concern and ongoing debates, the Canadian government introduced legislation in 2024 to delay the expansion of MAID eligibility for individuals with mental illness by three years, emphasizing the need for careful consideration and additional safeguards before extending such a sensitive practice (Health Canada, 2024).

The legal framework for MAID continues to evolve, reflecting ongoing discussions and the need to balance ethical considerations with ensuring accessible and compassionate end-of-life care. As Canada navigates these changes, the impact on patients, healthcare providers, and society at large remains a crucial area of focus. The process to be eligible for PAD in Canada is a bit lengthier than Switzerland, making it more thorough and definitive. The process is summarized in Figure 2.

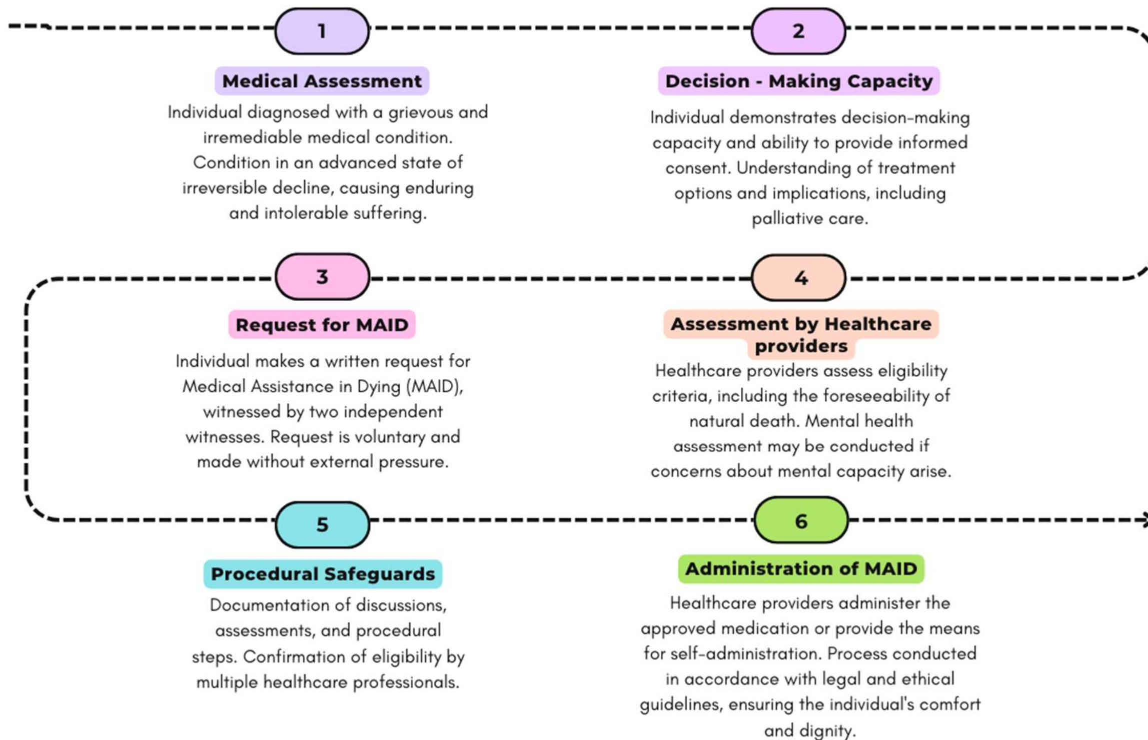

Figure 2: Physician-assisted death process in Canada

(Canadian Department of Justice, 2016). (Health Canada, 2023). (Carter v. Canada, 2015). (Downie, J, 2017). (Canadian Department of Justice, 2021).

Comparison of physician-assisted death between Switzerland and Canada

Physician Participation

A key difference between Canada and Switzerland concerning physician participation in physician- assisted death (PAD) lies in the roles and responsibilities of healthcare providers within the legal frameworks of each country. In Canada, it is obligatory to have a doctor or nurse assist in Medical Assistance in Dying (MAID), which is a highly regulated process. The healthcare provider should be centrally involved in evaluating the patient's eligibility for MAID, ensuring that all conditions are met, obtaining consent from the informed party, and administering lethal drugs. Canadian law stipulates that at least two independent health care providers must verify an individual's suitability for MAID (Canadian Department of Justice, 2016). Doctors and nurses are required to adhere to strict guidelines and procedural safeguards, such as documenting the entire process and ensuring that there is a waiting period between application and MAID treatment. The main reason for this wide participation is to keep ethical standards high and protect vulnerable individuals from being manipulated into making hasty decisions.

However, Swiss doctors face fewer regulations regarding PAD than they do when it comes to end-of-life decision-making. There must be a medical practitioner's prescription for such medicine that will put one out of life; essentially, though, the physician only makes sure the person meets the criteria of knowing what he/she wants (informed) as well as being free from any external pressure during their last moments on earth (Dignitas, n.d.). Dignitas or Exit often facilitates self-administration by patients themselves, where at times it can be done with an organization volunteer or non-medical personnel instead of involving a doctor who would otherwise help in euthanizing oneself (Exit, n.d.). This model accentuates respect for patients' autonomy, and physicians are not directly involved in administering the lethal dose.

Differences in physician participation reflect conflicting priorities in the two countries' approaches to PAD. The Canadian model prioritizes strict medical oversight and procedural safeguards to protect patients, potentially reducing the risk of malpractice or error. At the same time, it also places a significant burden on healthcare providers, who must assume complex legal and ethical obligations. The Swiss model, on the other hand, emphasizes patient autonomy and minimizes the direct role of doctors, perhaps making the process more accessible, but also raises concerns about the depth of medical supervision and possible less stringent safeguards.

Counseling requirements

One significant similarity between Canada and Switzerland regarding PAD is the absence of mandatory counseling requirements before proceeding with PAD. Both countries emphasize informed consent and voluntary decision-making but neither make psychological counseling a compulsory part of the process. (Downie, 2017)

MAID in Canada involves strict examination of the suitability of candidates to ensure that their application is well thought out and voluntary. They must be capable of making decisions and should comprehend some ramifications for making such choices. Where there are reasons to suspect that a patient may not have capacity or if mental disorder may be influencing, an assessment by a psychiatrist is undertaken, but there is no general requirement for counseling in every case. (Health Canada, 2024). This reflects the principle of autonomy, which means individuals should be allowed to make end-of-life decisions without compulsory psychological intervention unless there is clinical need. (Canadian Department of Justice, 2016).

In Switzerland also, it's required by law for assisted suicide to be voluntary and free from undue influence from others. Physicians should confirm a patient's competence and determine that his/her request does not arise as a result of short-term crisis or external factors (Swiss Criminal Code, 1942). Nevertheless, the law doesn't require obligatory psychotherapy services for all patients with suicidal thoughts who seek medical help. Exit and Dignitas offer or suggest therapy; however this relies on a patient's will only and this happens only when one wants so (Exit, n.d.).

The absence of mandatory counseling in both countries underscores a commitment to respecting patient autonomy and individual choice in end-of-life decisions. It acknowledges that while psychological support can be beneficial, it should not be a compulsory barrier to accessing PAD. The lack of mandatory counseling in both countries emphasizes the duty to respect the patient's right to self-determination and individual choice in end-of-life decisions. It acknowledges that although psychological support can be helpful, it should not be a mandatory barrier to receiving PAD. This approach is consistent with the broader ethical principles of respect for autonomy and self-determination, allowing patients to seek PAD based on their values and circumstances, provided they meet the legal criteria and are able to make an informed decision. However, the lack of mandatory counseling in PAD processes in Canada and Switzerland can be seen as a negative, because it can ignore the complex physiological factors that influence a patient's decision to seek assisted dying. Without mandated psychological support, there is a risk that underlying mental health problems, such as depression or coercion, may not be adequately treated, which may compromise the integrity of patient voluntariness (Stettler, Zwahlen, & Fischer, 2020).

Public Opinion

Public opinion and social attitudes toward physician-assisted death (PAD) differ significantly between Canada and Switzerland, reflecting the broader cultural, ethical, and historical context.

In Canada, public opinion on medical assistance in dying (MAID) has changed significantly since its enactment in 2016. Although there is general support for the right of Canadians to choose MAID, the issue remains controversial as ethical discussions and debates continue. Support is often framed in the context of compassion, patient autonomy, and relief of suffering (Health Canada, 2023). However, public debate continues to be fueled by concerns about potential abuses, the adequacy of safeguards and the impact on vulnerable populations such as people with disabilities (Canadian Department of Justice, 2021). Canadian media, advocacy groups, and professional organizations often participate in these discussions, reflecting a society that continues to grapple with the moral complexities of MAID (Downie, 2017).

Switzerland, on the other hand, has a long and widely recognized practice of assisted suicide, dating back to the 1940s, when the act was decriminalized under certain conditions (Swiss Criminal Code, 1942). Swiss society generally views assisted suicide through the lens of personal autonomy and self-determination. Organizations such as Dignitas and Exit are well known and operate with significant public support, facilitating both domestic and international cases (Dignitas, n.d.). The concept of 'suicide tourism' is relatively accepted, reflecting a pragmatic approach to the issue (Stettler, Zwahlen, & Fischer, 2020). Swiss public debates focus more on practical ethical governance and regulation, rather than questioning its fundamental legitimacy (Alliance Vita, 2023).

The difference in public opinion and attitudes towards PAD between Canada and Switzerland highlights the influence of cultural and historical context on societal acceptance and ethical considerations. In Canada, the relatively recent legalization of MAID means that public and professional opinion continues to form, and much attention has been paid to improving safeguards and ethical guidelines (Health Canada, 2024). The well-established acceptance of assisted suicide in Switzerland reflects a broader social consensus on the right to die, emphasizing autonomy and personal choice (Exit,n.d.).

Conclusion

Comparative studies concerning physician-assisted death (PAD) in Canada and Switzerland demonstrate how end-of-life decision-making is influenced by legal frameworks, procedural safeguards, and societal attitudes. While both countries have adopted PAD in their respective legal systems, the differences between them regarding autonomy, regulations and the role of doctors are striking.

The Canadian story on PAD started with a ruling from the Supreme Court of 2015 in Carter v. Canada which led to the passage of Bill C-14 in 2016 that decriminalized Medical Assistance in Dying (MAID). This legislative framework has since been further developed through Bill C-7 passed in 2021 expanding eligibility to include those for whom natural death is not reasonably foreseeable. This development represents Canada's pursuit of balance between patient choice and safety through stringent safeguards, ensuring ethical and legal protections.

Supplementary Table 1: Comparison of physician-assisted death in Canada and Switzerland

→ Physician assisted death in Canada and Switzerland

	SWITZERLAND (SINCE 1942)	CANADA (SINCE 2015)
Supply of legal drugs for self - administration or by a third party	Supply is permitted as long as the motive for doing so is not 'selfish. However, the final act must be carried out by the individual themselves.	Permitted by an Act amending the Canadian Criminal code, referred to as 'Medical assistance in dying (MAID). This act was permitted after the Supreme Court of Canada deemed that the country's ban on Assisted Suicide was unconstitutional.
Reason for administration of legal drugs	Assisted suicide is permitted irrespective of the condition of the person who requests it. Individual organisations have their own intern policies which set out eligibility. However, within these organisations, psychiatric illness is not deemed 'approaching the end of life'. Therefore, is not a plausible reason for it.	Individuals must have a 'grievous and irremediable medical condition' meeting the criteria stated on the Government website. However, since March 2021, individuals do not need to have a fatal or terminal condition to have access to MAID. From March 17, 2023, individuals with mental illnesses as their only medical condition are eligible for MAID.
Voluntary request from a patient with capacity	Individual organisations have their own policies and processes for making a request. However, guidance for doctors is clear that the person must have made a voluntary, persistent and well considered request.	Request must be made in writing and witnessed by at least one independent person.
Medical Involvement	Swiss Law does not require doctors to be involved. However, they are the only ones who can prescribe the lethal drugs, therefore are present in every case.	Two doctors or nurse practitioners must confirm the individual meets the eligibility criteria. There are additional procedural safeguards for assessing the eligibility of a person who is not dying in the foreseeable future.
Conscientious objection	Doctors are not required to participate in the process of assisted suicide.	No one is required to provide or assist in MAID. The responsibilities on doctors who hold conscientious objection varies in different states/provinces.
Regulation and reporting / Data	No central regulatory body. No data available to public and recorded causes of death do not differentiate between suiide and assisted suicide.	Doctors and nurses must report all written request of MAID to their health departments. The federal government also publishes data annually.

Switzerland's experience regarding PAD dates back to days when assisted suicide was decriminalized in the 1940s. The establishment of organizations like Exit and Dignitas in the 1980s and early 1990s legalized PAD, making Switzerland an attractive destination for those who want euthanasia by other means than self-termination. In Switzerland, this approach

emphasizes personal choice while physicians are distanced from it as they are only involved indirectly thus changing according to practice rather than legislation's amendments or approvals.

The evolution of PAD in both countries highlights ethical complexities. Canada's mandatory healthcare provider involvement ensures rigorous oversight but places significant ethical and legal responsibilities on them. Switzerland's minimal physician involvement prioritizes patient autonomy but raises questions about medical oversight and safeguards.

Public opinion continues to evolve in both countries. In Canada, the relatively recent legalization of MAID has led to ongoing debates and adjustments to improve safeguards and address ethical concerns. In Switzerland, the established practice of assisted suicide enjoys broad societal support, reflecting a consensus on personal autonomy.

In conclusion, the evolution of PAD in Canada and Switzerland illustrates diverse approaches to end-of-life care, balancing patient autonomy with ethical and legal considerations. This comparative paper offers valuable insights into how different societies navigate PAD complexities, informing ongoing debates and policy developments worldwide. By examining these contrasting models, we gain a deeper understanding of the challenges and implications of regulating assisted dying, emphasizing the importance of context-specific approaches that respect cultural values and ethical principles while ensuring protections for vulnerable individuals.

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