MEDICAL ETHICAL GUIDE-LINES

Treatment and care of elderly persons dependent on care

SAMS Swiss Academy of Medical Sciences

Medical-ethical guidelines and recommendations

Treatment and care of elderly persons dependent on care

Approved by the Senate of the SAMS on 18 May 2004.
The German version is the binding version.

As of 1 January 2013, the guidelines were revised in the light of the new adult protection law.

The Swiss Professional Association for Nurses (SBK/ASI) recommends that its members and all other nurses should abide by these guidelines.

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I. PREAMBLE

The demographic development in Switzerland means that over the next few years the number of elderly, especially very old persons will rise, so that there will also be a marked increase in the number of persons dependent on care. This is happening at a time of change in traditional family structures, at a time when values and attitudes are undergoing great changes and more and more importance is being attached to the autonomy of the individual, and at a time of rising health-care costs.

All these factors mean that the treatment and care of elderly persons dependent on care is associated with various different areas of conflict. There may be a conflict between the necessary care and attention on the one hand and respect for the autonomy of an elderly person on the other. A dilemma often exists between the necessary encouragement and activation of an elderly person and his wish to be left in peace. When should a disease be treated and when should there be no therapeutic intervention? Especially in institutions providing long-term care, conflict also exists between privacy and the public nature of a person's existence, because while an institution represents the private living environment of the elderly person, the care that it provides is at the same time of a collective nature. The discussion regarding costs in the health-care sector has further accentuated the challenges in the treatment and care of elderly persons dependent on care.

In the light of these considerations the following text pursues three objectives: Firstly, it makes it clear that age and the need for care must not lead to the withholding of measures that are deemed necessary; secondly, thanks to the *Guidelines*[1] it offers physicians, nursing staff and therapists[2] help in making decisions in difficult situations; thirdly, in the *Recommendations*[3] it points out the important requirements and conditions for the effective treatment and care of elderly persons dependent on care.

1 SAMS guidelines are addressed to medical professionals (physicians, nursing staff and therapists). On being incorporated into the Code of the Swiss Medical Association (FMH), the guidelines become binding for all members of the FMH.
2 Physiotherapists, ergotherapists, activation therapists, speech therapists, psychologists.
3 As the SAMS has no regulatory authority as far as institutions providing long-term care are concerned, instead of guidelines only "recommendations" are formulated.

Also addressed here, however, are institutions that are involved in pregraduate and postgraduate education and further training, as well as political authorities, who are invited to take these present Guidelines and Recommendations into account when making their decisions in the area of the treatment and care of elderly persons dependent on care.

The treatment and care of younger persons dependent on care is expressly not the subject of these Guidelines. In their case, specific additional aspects have to be considered.

1. Scope

The present Guidelines are addressed to physicians, nursing staff and therapists, who are responsible for the care of elderly persons dependent on care, either at home, in hospitals or in institutions providing long-term care. One speaks of an "elderly person" when a person is over the age of 65 years; "dependent on care" means that a person is permanently dependent on assistance or support in his everyday activities (i.e. dressing, personal hygiene, eating, use of the toilet, mobility, planning the day, social contacts). As a rule, a person's dependence on care increases markedly only after the age of 75 years.

2. Principles

2.1. Appropriate care

Elderly persons dependent on care have the right to appropriate treatment and care up to the end of their life. A patient's age and dependence on care must not lead to the withholding of measures that are deemed necessary. The treating physician, the nursing staff and the therapists base their decisions on a joint evaluation of medical, psychological, social and functional aspects and the person's environment. In the care they provide, they respect the dignity and privacy of the elderly person, even if he[4] lacks capacity or is suffering from a mental disorder.

2.2. Continuous personal care

For adequate care to be assured, personal contact between the physician and the elderly person dependent on care is essential. In these elderly persons a change in the place where they live (at home, in hospital or in an institution providing long-term care) can also mean a change in the medical responsibility. Physicians who are responsible for the care of elderly patients in a hospital or an institution have to organize themselves in such a way that it is at all times clear with whom the medical responsibility lies; they have to keep the elderly person (or, if he lacks capacity, the relevant person of trust [see 3.3.] or the legal representative) informed accordingly. In the case of a change of medical responsibility, the physicians concerned must ensure that the responsible physician is provided with all the information necessary for the continued care of the patient.

4 For the sake of simplicity, although both male and females are meant, only the masculine personal pronouns (he, him, his) are used throughout this text.

Often, various professionals are involved in the care of an elderly person, which makes it difficult for him to know which of these professionals is in fact responsible for the coordination of the care being provided. In the field of the Spitex home-care service, in hospitals and in the long-term care institutions, the care and therapy team names one qualified contact person for each elderly patient and informs him, and if appropriate also his family, of this accordingly.

2.3. Collaboration with the patient's social environment

Whenever possible, the treating physician and the appointed contact person maintain close contacts with the elderly person's social environment (relatives, friends, acquaintances), in regard to the various aspects concerning his treatment and care. Such contacts are of course subject to the agreement of the elderly person with capacity, and to the rules of professional secrecy and confidentiality. Under the new adult protection law (Art. 360 ff. Civil Code), relatives or people close to a person lacking capacity are accorded certain rights of representation (cf. Section 3.7.).

In the care of elderly persons who are living at home, a large part of the necessary tasks are undertaken by family members; this can be very demanding. It is the duty of the physicians, nursing staff and therapists to advise and support these relatives or others who are looking after the elderly person.

2.4. Interdisciplinary collaboration

Physicians, nursing staff, therapists and many other individuals and professional groups are involved in the care and treatment of elderly persons dependent on care. For this reason it is necessary that the physicians, the nursing staff and the therapists collaborate with one another systematically and in the framework of appropriate structures, and with the other professional groups involved. In institutions providing long-term care, attention also has to be given to collaboration with the house and kitchen staff and with the administrative personnel, observing the rules of professional secrecy and confidentiality.

2.5. Appropriate pregraduate and postgraduate education and further training

Elderly persons dependent on care are often also at the same time suffering from several different chronic diseases (multimorbidity). In addition, psychological, social, spiritual and environmental factors play an important role in the care of these patients. This requires that the physicians, the nursing staff and the therapists involved should have specific experience and competence in geriatrics, gerontology and geriatric psychiatry. This competence also includes, in particular, collection of data on the patient's state of health through a multidimensional assessment and the implementation and evaluation of appropriate measures.

Physicians, nursing staff and therapists who look after elderly persons dependent on care are under the obligation to increase this competence through further education and training.

3. Decision-making processes

3.1. Principle

The right to respect of human dignity, personal freedom and autonomy applies, without restriction, to every individual. The law recognizes the basic rights, which are respect of personal dignity, protection of physical integrity and self determination.

The limitations on personal autonomy, which increase with advancing age and which disturb the balance between an individual's dependence and independence, should in no way affect his *right* to respect for dignity and autonomy. Therefore it is necessary to have binding decision-making procedures and structures, which make possible a decision-making process that takes into account the self-determination and the dignity of the elderly individual. In this connection special care must be taken to ensure that the elderly person is able to express his wishes, that he has sufficient time for important decisions and that he can make decisions without being under pressure.

3.2. Advance directive[5]

Each person may draw up instructions in advance in regard to the medical treatment and care that he may wish to receive or that he would reject if he should become incapacitated. Provided a patient has capacity, he may alter or cancel the advance directive at any time.

5 Cf. "Advance directives" (medical-ethical guidelines and recommendations of the SAMS).

Physicians and nursing staff point out to elderly persons that they have the option of preparing an advance directive; they discuss together who should undertake this task.

3.3. Authorized representative for medical matters

Every person with capacity can, by means of an advance directive or power of attorney, appoint in advance a representative for medical matters who, in the event of their incapacity, can consent, on their behalf, to medical, nursing and/or therapeutic measures. Physicians and nursing staff make elderly persons aware, in good time, of the possibility of appointing a representative; they discuss together who should undertake this task.

3.4. Drawing up of basic principles for decision-making within the team

Various measures such as the treatment of a behavioural disorder, the treatment of decubitus ulcer or the placement of a feeding tube often call for an interdisciplinary decision-making process. Before the treating physician suggests such a measure to the elderly person and then prescribes it, with the person's agreement, he discusses the patient's care and treatment with the responsible contact person and takes his opinion into account.

The resolution of complex situations (e.g. questions of future planning, advice to the patient's relatives, problems of living with other people in a home) often calls for an interdisciplinary decision-making process that is oriented towards the wishes of the elderly person and takes into account his ideas, his objectives, his wishes and his needs. Such situations have to be discussed and possible solutions and corrective measures agreed on by all those involved before they are suggested to the elderly person by the responsible professional.

The need for interdisciplinary collaboration does not relieve the treating physicians, the nursing staff and the therapists from their obligations and responsibilities in regard to relevant decisions within their particular area of professional responsibility.

3.5. Information of the patient

The elderly person dependent on care has the right to be informed by the physician, by the person responsible for his care or by the therapist, of any diagnostic, nursing or therapeutic measures that are to be taken, so that he can give his informed consent. The information must be provided in a suitable manner, i.e. it must be understandable and clearly defined – with details of possible alternatives – and adapted to the situation. The benefits and risks of each alternative must be explained. If possible, and if the elderly person is in agreement, a person close to him should also be informed, so that he can support the patient in making his decision.

If the elderly person lacks capacity, his representative will receive this information; this person must of course also receive the information in an appropriate form.

3.6. Consent of the elderly person with capacity[6]

Physicians, nursing staff and therapists may carry out a particular measure only with the freely given consent of the elderly person, who has been fully informed and has capacity.

If an elderly person with capacity refuses the measures suggested to him, after he has been informed of these and of the possible consequences of refusal, then the physician and the nursing staff must respect this decision. If in the opinion of the responsible professionals this decision to refuse the measures suggested is not in the best interests of the elderly person concerned, they will then seek another possible treatment that would be likely to be acceptable to him.

6 The following criteria help to determine whether a person has capacity (Source: H.B. Staehelin, Ther Umschau 1997; 54: 356–358):
- the ability to understand information in regard to the decision that is to be made;
- the ability to correctly weigh up the situation and the consequences arising from possible alternatives;
- the ability to rationally assess the information received in the context of a coherent value system;
- the ability to make and express his own choice.

It is the task of the responsible health-care professional to assess, in each individual case, whether the person has capacity. In the case of difficult decisions, a specialist (e.g. a psychiatrist or a geriatrician) must be consulted. Capacity is assessed in relation to a particular treatment (and in fact in relation to the nature and the degree of complexity of this treatment); it must be present at the time the decision is made. Either the person has or does not have capacity in regard to a certain treatment.
Under the law, any person has capacity if he or she does not lack the capacity to act rationally by virtue of being under age or because of a mental disability, mental disorder, intoxication or similar circumstances (Art. 16 Civil Code).

3.7. Procedure for obtaining consent in the case of an elderly person who lacks capacity

If an elderly person lacks capacity as far as making a decision is concerned, the physician or the nursing staff ascertains whether he has drawn up an advance directive or whether a power of attorney is available. In an advance directive, a person with capacity gives binding instructions concerning the medical interventions to which he consents or does not consent in the event of incapacity.

An advance directive is to be complied with unless it contravenes legal requirements or there are reasonable doubts as to whether it was voluntary or still reflects the patient's presumed wishes. If no instructions concerning treatment have been given by a person who lacks capacity, the new adult protection law specifies who is entitled to act as a representative and to consent to a medical intervention on behalf of the person lacking capacity.[7]

Decisions on medical interventions are to be made – in accordance with the presumed wishes and objective interests of the person lacking capacity – by the authorized representative. While, under certain conditions, physicians are not required to comply with instructions concerning medical interventions given in an advance directive, they are generally bound by the decision of the authorized representative. However, if the interests of the person lacking capacity are endangered or no longer protected, the adult protection authority may appoint another representative, either at the request of a physician or other close person, or on its own initiative.

In treating patients who lack capacity, physicians are obliged to prepare a treatment plan, which is to be adapted to ongoing developments (Art. 377 Civil Code). The treatment plan is to be discussed with and explained to the authorized representative so that the latter is in a position to give informed consent to treatment. As far as possible, the person concerned is to be involved in the decision-making process.

In urgent cases, physicians are to take the necessary medical measures in accordance with the presumed wishes and the interests of the person lacking capacity.

7 Under the law, the following persons are entitled, in the following order, to act as representatives in relation to medical interventions: persons appointed in an advance directive or power of attorney; a duly authorized deputy; relatives and other close persons who regularly provide the patient with personal support (spouse or registered partner, person sharing the same household, offspring, parents, siblings).

4. Treatment and care

4.1. Health promotion and prevention

It is the task of physicians, nursing staff and therapists to suggest to the elderly person dependent on care, and to make possible, measures that will allow him to retain or to promote his physical, mental and social faculties and resources. Elderly persons dependent on care are particularly frequently exposed to certain risks (e.g. falls, immobility, depression, eating disorders, bedsores, violence and abuse). It is the task of physicians, nursing staff and therapists to recognize these risks in good time and, after informing the elderly person and obtaining his agreement, to take the necessary preventive measures.

4.2. Acute treatment

It is the task of physicians, nursing staff and therapists to ensure that in the event of acute illness elderly people dependent on care receive adequate assessment and treatment. In this case, the specific care required in view of the patient's dependence (e.g. in dementia, decubitus ulcer or incontinence), also in the acute hospital, must be guaranteed.

4.3. Rehabilitation

It is the task of physicians, nursing staff and therapists to suggest to the elderly person dependent on care, and to make possible, those treatments and other measures (e.g. physiotherapy, psychotherapy, ergotherapy, speech therapy, dental treatment, provision of hearing aids) and care (including social contacts, diet, mobilization, physical activity, organization of everyday activities) that will allow him, as far as possible, to retain or to regain his physical, mental and social faculties and resources.

4.4. Palliative care[8]

All elderly persons dependent on care must be guaranteed access to palliative medicine, nursing and care in good time, irrespective of where they are living. Both in institutions providing long-term care and in outpatient therapy or in hospital, the physicians, nursing staff and therapists know and apply the concepts of palliative care. The physician, the nurse and the therapist recognize particularly troublesome symptoms such as pain, anxiety, depression and hopelessness and, with the cooperation of the patient's family, treat them thoroughly. Palliative care is an interdisciplinary process; if needed, and if wished by the elderly person concerned, spiritual help may be provided.

8 Cf. "Palliative care" (medical-ethical guidelines and recommendations of the SAMS).

5. Dying and death[9]

5.1. Support and care for the dying

Support and care for the dying is discussed in "End-of-life care" (medical-ethical guidelines of the Swiss Academy of Medical Sciences).

5.2. Dealing with a person's wish for assisted suicide

If an elderly person dependent on care expresses the wish to commit suicide, the team responsible for his care tries to discuss this with him. In any case, the physician and the nursing staff take steps to provide the person concerned with the best possible protection and support. In particular, they explore possible improvements in his treatment and care. In this connection, account has to be taken of the elderly person's many different dependencies, which can increase the risk of suicidality. The team responsible for his care ensures that the necessary palliative, therapeutic and/or psychiatric measures are suggested and carried out, and also that spiritual help is suggested and, if desired, provided.

6. Documentation and data protection

6.1. Medical records and care dossier

The physician keeps records for each elderly person dependent on care for whom he is responsible. Here, the physician records data on the patient's medical history, investigations carried out, the results of these investigations and their assessment, other measures taken and the course of the patient's condition, and attaches medically relevant documents. The nursing staff also keep a care dossier.[10] The relevant aspects of the medical documentation are made available to the responsible nursing staff and therapists.

The therapists document the therapeutic procedures (observations on the drawing up and planning, and on the setting of the objectives, the planning and the evaluation of the measures taken). A compilation of the most important observations, objectives and results is made available to the responsible physician and nursing staff.

9 Cf. "End-of-life care" (medical-ethical guidelines of the SAMS).

10 The purpose of the care dossier is as follows:
- it presents the patient's situation from the nursing point of view (assessments);
- it defines the aims of the nursing measures, the principal interventions carried out and the results of these;
- it makes it possible to check the way in which the nursing measures have been carried out (procedure sheet).

The elderly person (or the representative for medical matters, in the event of incapacity) has the right to see the medical records and the care dossier and to have these explained to them; they can request copies of these documents.

The medical records and the care dossier include the current version of any advance directive, details of the representative, and any protocols on measures that restrict the patient's freedom of movement.

6.2. Duty of confidentiality

The physician, nursing staff and therapists are bound to professional secrecy.

Data may be collected, filed, evaluated and passed on to third parties only under strict observation of the legal requirements covering data protection.

The geriatric assessment instruments to be used must have first been checked for their reasonableness and informative value, and the elderly persons concerned must be informed of the purpose of the study and that data will be collected.

Data that require particular data protection are the care dossier and medical records, which are handled and stored in such a way that only authorized persons can have access to them. For electronic data-processing, the strict requirements regarding data-access protection and the security of data transfer and data filing must be observed.

The data may be used for statistical and scientific purposes, only after they have been rendered completely anonymous. Non-anonymized data may be passed on to third parties only with the express consent of the person concerned (or the representative in the event of incapacity).

7. Abuse and neglect

Elderly persons dependent on care are particularly vulnerable and must be protected against the use of violence in any form, whether physical or psychological, abuse or neglect. All signs of the use of violence, abuse or neglect which the nursing team observes in an elderly person must be carefully documented in the medical records and care dossier, and all the objectifiable findings (size, localization, appearance etc.) must be recorded. The nursing staff and the therapists must report any signs of violence that they observe to the treating physician.

The physician, nursing staff and therapists must take the necessary steps to prevent further mistreatment. If necessary, and with the consent of the elderly person concerned (or, if he lacks capacity, with the consent of the representative), this information is to be passed on to the responsible authority. If for any reason this consent is not obtained, if it is in the best interests of the patient, the responsible authorities must still be informed.

8. Admission to a long-term care institution

The elderly person should leave the place where is at present being treated and be admitted to an institution providing long-term care only if, because of the lack of facilities for his proper care or the limited possibility for rehabilitation, remaining at home or returning home is no longer in his best interests. In certain situations, early admission to such an institution can be very useful, for example if in this way the person's social integration can be promoted.

Before a patient's planned admission to an institution providing long-term care, the responsible physician carries out a multidimensional geriatric assessment. This assessment must be carried in the hospital with the participation of the nursing staff and the therapists and, if possible, in collaboration with the treating physician, the Spitex personnel responsible for the outpatient therapy and persons from the elderly person's social environment. The physician informs the person concerned and, if appropriate, also the persons from his social environment of the result of this assessment and discusses with him the need for admission to an institution providing long-term care, and the possible alternatives that exist.

If a person lacking capacity is to be cared for in a residential or nursing institution for a longer period, a written care agreement must be concluded with the authorized representative, specifying the services provided by the institution and the costs thereof (Art. 382 Civil Code). The legal requirement for a written agreement is designed to promote transparency and to prevent risks of abuse. As far as possible, the wishes of the person concerned are to be taken into account. These wishes may also have been expressed at a time when the person still had capacity. Responsibility for representing the person lacking capacity in concluding, amending or terminating a care agreement is governed *mutatis mutandis* by the provisions on representation relating to medical interventions (Art. 378-381 Civil Code).

The residential or nursing institution is required to protect the privacy of a person lacking capacity and where possible encourage contacts with persons outside the institution (Art. 386 para. 1 Civil Code). If no one outside the institution expresses an interest in the person concerned, the residential or nursing institution is required to notify the adult protection authority, so that it can if appropriate establish an assistance deputyship (Art. 386 para. 2 Civil Code). In addition, residential and nursing institutions are required under federal law to guarantee a free choice of physician, unless there is good cause for not doing so (Art. 386 para. 3 Civil Code).

III. RECOMMENDATIONS (FOR LONG-TERM RESIDENTIAL CARE INSTITUTIONS)

1. Scope

The following recommendations are addressed primarily to the managements of institutions providing long-term care and to the responsible authority; however, they can similarly be addressed to other institutions (hospitals, Spitex services), that also treat and care for elderly persons dependent on care. These recommendations are thus also addressed to physicians, nursing staff and therapists who operate in these institutions.

The following recommendations constitute the basic conditions that are essential in these institutions for the satisfactory treatment and care of elderly persons. Such recommendations are formulated for each area of activity defined in the foregoing Guidelines.

2. Principles

The institution protects and respects the rights of the elderly person.

Protection of personal freedom and dignity

The elderly person has the right to have his personal freedom respected. He has the right to be treated with politeness and respect, and also the right that account be taken of his dignity, his well-being and his individuality.

Respect for the person's privacy

The institution respects the elderly person's privacy, including his sexual freedom.

The room (or the part of the room) in which the elderly person lives is part of his private sphere and must be respected as such by the staff of the institution. In discussion with the institution, the elderly person may arrange the room (or part of it) according to his own wishes and tastes, particularly by bringing his own furniture and pictures etc. He is provided with a lockable cupboard in which he can keep his personal belongings. If a room is occupied by several persons, the institution takes the necessary steps to protect the privacy of each individual.

The staff of the institution treats any observations from the elderly person's private or intimate spheres, or events that he wishes to share only with a limited circle (friends, relatives) ,with discretion, and passes these observations on to third parties only if this is necessary in order to ensure the proper treatment and care of the person concerned.

Maintenance of social contacts

The institution supports the maintenance and development of the elderly person's relationships with his relatives and his social environment. It informs the authorized representatives and other close persons about the cultural activities within the institution and endeavours to integrate them. The institution makes it possible for private, confidential discussions and encounters to take place in undisturbed surroundings.

The elderly person has the right to maintain external contacts (letters, visits, newspapers, telephone, television, Internet etc.).

Freedom of opinion and religious freedom

The elderly person is free to express his opinions, so long as they do not give offence to third parties or infringe the law (e.g. racism). The institution ensures that the opinions expressed are respected.

The institution respects the elderly person's freedom of religion and conscience and allows the practice of religious rites or forms of expression; however, these must not encroach upon other persons or the social environment.

Right of assembly

The institution respects the elderly person's right of assembly. The institution encourages its residents to get together as much as they can and provides rooms where they can meet each other socially.

Political rights

The institution sees to it that the elderly person can freely exercise his political rights. It ensures that another person does not exercise these rights on his behalf and does not take advantage of his dependence on others in order to influence him.

Participation in everyday organization

The residents of the institution who are able to express their opinions are invited to take part in decisions on questions concerning organization of the everyday life of the institute, living together and arranging events. The institution regulates the nature and form of this participation in the making of decisions.

Right of appeal

The institution establishes an internal procedure for the handling of complaints (on medical, nursing and/or administrative matters). The elderly person himself, his representative and/or his relatives may lodge complaints.

The institution ensures that complaints are dealt with rapidly, carefully, in confidence and without any disadvantage for the complainant. If the complaint is justified, the institution takes the necessary measures. If the institution rejects the complaint, it informs the complainant of the possibilities of appeal or, if necessary, refers him to the cantonal authorities responsible for supervision of residential and nursing institutions, the adult protection authorities, the ombudsman or other independent appeal authorities.

3. Decision-making processes

Within the framework of the procedure for admission, the institution ascertains whether the elderly person has a representative in the event of incapacity (spouse or registered partner in accordance with Art. 374 Civil Code), or whether he has appointed a representative by means of a power of attorney, who can look after his interests in administrative (incl. financial) matters, and an "authorized representative for medical matters" who can make decisions on his behalf in regard to treatment and care.

If this is not the case, the institution advises the elderly person to designate persons of his choice; if necessary, the institution assists the elderly person in seeking suitable persons. The institution records the names of the representatives in the administrative dossier; it ensures that the physician, nursing staff and therapists are informed of the existence of a representative.

4. Treatment and care

Guarantee of adequate treatment and care

Before the institution takes a person into its care, it checks whether his state of health and his level of dependence on others make it possible to care for him in the institution, and whether it has the staff and the facilities necessary for adequate treatment and care.

Quality assurance

All institutions that treat and care for elderly persons dependent on care ensure that they have comprehensive quality management for the adequate treatment and care of their patients.

Qualified personnel

The institution ensures that its professionals have the appropriate education and training which qualify them for the functions that they perform. The institution also supports and promotes the regular postgraduate and further training of its personnel, with particular attention to problem-oriented training in interdisciplinary teams.

The institution appoints a home-physician who is responsible for the organization of the medical care provided in the institution and who has the necessary knowledge for this. If there are several physicians working in the institution, after discussion with them all, one of them should be appointed as the responsible home-physician.

5. Dying and death[11]

Support and care for the dying

The care and accompaniment of an elderly person in the terminal phase of life must take into account his needs and his convictions. The institution take steps to ensure that the elderly person is supported as much as possible (and as much as he himself wishes) by his social environment. The dying person must be able take leave of those closest to him, undisturbed and in a suitable place, and has the right to the spiritual support of his choice.

The institution creates the right environment for the funeral rituals and rites for all those involved. The institution respects the special religious and cultural funeral rituals of the surviving dependants.

Dealing with a person's wish for assisted suicide

A special situation arises when, in an institution providing long-term care, an elderly person dependent on care plans to commit suicide with the assistance of others (e.g. an assisted dying organization). This situation can arise because according to Swiss law assisted suicide is not a criminal offence, except when selfish motives are involved (Article 115 Criminal Code). There are certain institutions which for these reasons allow assisted suicide. In such situations account has to be taken of the fact that an institution providing long-term care has a special duty of protection and must therefore take into account the following:

a. It must ensure that the person concerned has capacity.
b. Care must be taken to ensure that the decision for suicide is not due to outside pressure or to inadequate explanation, treatment or care.
c. Care must be taken to ensure that the feelings of the other residents and the staff of the institution are respected.

Elderly persons dependent on care have a special relationship of dependence on the staff of the institution; for the staff, this relationship can lead to a conflict of interests. For this reason and out of consideration for the other residents, the staff of an institution providing long-term care must at no time be actively involved in the suicide of a resident.

11 Cf. "End-of-life care" (medical-ethical guidelines of the SAMS).

6. Documentation and data protection

The elderly person (or, if he lacks capacity, his representative) may consult the relevant administrative dossier and have it explained to him.

The institution respects the legal provisions on data protection. In the case of electronic data-processing it pays special attention to these dispositions (namely for the purpose of fixing tariffs, quality assurance or research).

7. Abuse and neglect

The institution takes steps to ensure that there is no abuse or neglect of elderly persons; it sees to it that Section 7 of these Guidelines is known to, and is applied by all those concerned.

8. Admission to a long-term care institution

Information

Before an elderly person agrees to enter an institution providing long-term care, he (and, if appropriate, the person appointed to act as a representative in the event of incapacity) must be given the opportunity to get to know the institution personally, to have a discussion with a responsible person in the institution and to receive all the relevant information (incl. the Regulations).

The institution must provide him (or, if he lacks capacity, his representative) with written documentation containing easily understandable information on the general conditions for admission and residence, the rights and obligations, the modalities and costs of the care provided and the internal and external appeal authorities. The elderly person's financial situation must also be discussed.

Consent

After he has received the necessary information, the elderly person with capacity himself decides whether he will enter the institution. If he lacks capacity, the decision may be made only by his representative. In cases of incapacity, a care agreement is to be concluded (Art. 382 Civil Code).

Handling of financial affairs

In order to avoid conflicts of interests, the assets and income of the elderly person are to be administered by the person himself (or his representative) and not by the institution. The institution sees to it that members of staff do not accept any donations (or financial gifts or legacies), except for occasional small presents.

Care agreement and termination of agreement

In the case of a person lacking capacity, a written care agreement is to be concluded, specifying the services provided by the institution and the costs thereof. Unless there is good cause to do so, the institution may not at a later stage terminate the agreement with an elderly person dependent on care whom it has admitted. If necessary, the institution is to help the elderly person to find another institution that can care for him in a manner appropriate to his state of health and his need for care.

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Information on the elaboration of these guidelines

Mandate

On 26 October 2001 the Central Ethics Committee of the SAMS appointed a sub-committee to draw up guidelines on the treatment and care of elderly persons dependent on care.

Responsible sub-committee

Prof. Dr. med. Andreas Stuck, Bern, Chairman
Dr. med. Hermann Amstad, Basel (ex officio)
Dr. theol. Ruth Baumann-Hölzle, Institut Dialog-Ethik, Zurich
Angeline Fankhauser, former Member of Federal Parliament, President of the VASOS, Oberwil
Prof. Dr. Annemarie Kesselring, Basel
Prof. Dr. iur. Audrey Leuba, Neuchâtel
Prof. Dr. med. Charles-Henri Rapin, Geneva
Dr. med. Regula Schmitt, Ittigen
Hansruedi Schönenberg, Head of Residential Home, Zurich
Dr. med. et phil. Urban Wirz, Subingen
Prof. Dr. med. Michel Vallotton, President of the CEE, Geneva (ex officio)

Experts consulted

Prof. Lazare Benaroyo, Lausanne
Dr. Georg Bosshard, Zurich
Claudine Braissant, Belmont
Anja Bremi, Zollikon
Dr. Charles Chappuis, Bern
Oskar Diener, Champagne
Werner Egloff, Laupen
Marianne Gerber, Zurich
Prof. Daniel Hell, Zurich
Prof. François Höpflinger, Zurich
Nicolas Kühne, Lausanne
Domenica Schnider Neuwiler, Wil SG
Prof. Hannes Stähelin, Basel
Dr. Markus Zimmermann-Acklin, Lucerne
Vérène Zimmermann, Zurich

Consultation

The Senate of the SAMS approved a first version of these guidelines for a general consultation process on 29 May 2003.

Approval

The definitive version of these guidelines was approved by the Senate of the SAMS on 18 May 2004.

Revision

In 2012, these Guidelines were revised to reflect the legal situation in Switzerland as of 1 January 2013 (Swiss Civil Code; Adult Protection Law, Law of Persons and Law of Children, Art. 360 ff.; Amendment dated 19 December 2008). For this reason, the previous Section "Coercive measures" was deleted. At the end of 2012, the Central Ethics Committee appointed a sub-committee to prepare a complete revision of the guidelines on coercive measures in medicine.

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