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Perspective: legal, ethical, and medical perspectives of the landscape of assisted suicide in Austria

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On 1 January 2022 the Statute on the will to die (StVfG), which regulates assisted suicide (AS) in Austria, came into force. In recent years, the discourse surrounding assisted dying (AD) has attracted considerable attention, sparking debates at the intersection of legal, ethical and medical domains. This report aims to provide a comprehensive examination through the lens of legal frameworks, ethical considerations and medical perspectives. Exploring AS in Austria requires a nuanced analysis that takes into account the evolving legal landscape, the ethical implications for patients and healthcare professionals and the complex medical intricacies that underpin end of life decisions.

In Austria AS is restricted to people with a serious, incurable and lifelong illness. Minors are excluded and the process involves consultation with two physicians, one with a palliative care (PC) diploma or specialization, before a notary, lawyer or patient advocate draws up a dying will. The patient's capacity must be confirmed, and mental health assessment by a psychiatrist or psychologist is required if impairment is suspected. A waiting period of 12 weeks, shortened to 2 weeks for terminal cases, is mandated to address symptoms and crises. A valid will to die (*Sterbeverfügung*) allows individuals to obtain a lethal preparation (i.e., phenobarbital) from a pharmacy (Table 1).

Currently, there is still a great deal of uncertainty in practice about how to deal with requests for AS [1]. Many healthcare professionals report feeling overwhelmed. There is a lack of guidance from employers and a sense of insecurity.

In 2022 Austria recorded 57 (34 female, 23 male) persons claiming AS. Within the specified age cohorts, 22 were aged 75 years and over, 19 were aged 60–74 years and 16 were aged 40–50 years, contributing to the total of 57 [2].

The Assisted Suicide Critical Incident Reporting System (ASCIRS) platform (www.ascirs.at) of the Austrian Palliative Care Association enables the submission of reports on experiences with AS. These reports are of great value as they provide insights into how patients and their families can be better supported in such a difficult situation.

The data are based on subjective reports only and are not comprehensive. According to ASCIRS there were 112 requests, 5 cancellations and 68 AS performed. Patients ranged in age from 30 to 97 years and were mainly affected by tumors or neurological diseases.

Motives for AS were experienced suffering (existential crisis), inadequately relieved physical symptoms, fear of future suffering, psychological problems and lack of PC.

Phenobarbital was administered orally in 35 cases and intravenously in 15 cases, while the site of administration was not reported in 18 cases.

The majority of AS cases occurred at home (56), followed by nursing homes (6), hospices (3) and hospitals (1). The site of administration was not reported in two cases.

Physicians were present in 14 cases, carers in 5, the supervising psychologist once, and 5 patients performed AS alone. Reported complications included vomiting of the preparation, loss of consciousness before complete ingestion, prolonged time to death, akinetic crisis due to metoclopramide (in the presence of Parkinson's disease) and panic in carers.

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Table 1 Procedure according to the Statute on the will to die

Medical part	Legal part	Pharmacy	Place of death
General practitioner and/or specialist 1 × diploma in palliative medicine or specialization	Notary, lawyer or patient advocate to draw up a patient's dying will	Dispensing phenobarbital + antiemetic	The person wishing to die should choose the place
Limited to individuals with a severe, permanent illness affecting their entire life. Minors are excluded. There must be no doubt that the person is capable of making a decision. A mental health assessment (psychiatrist/psychologist) is required if there is a suspicion of pathological mental impairment. A waiting period of 12 weeks is mandated to address acute and distressing symptoms and treatable crises. For those in the terminal phase of an illness, this period is reduced to 2 weeks. A valid patient's dying will allows individuals to obtain a lethal preparation from a pharmacy.			

The slippery slope argument in the context of AD is the concern that the legalization or acceptance of AD in certain circumstances may lead to a gradual expansion of its scope, possibly to include situations or individuals not originally intended [3]. Proponents argue that once a society accepts AD in limited cases, there is a risk that the practice could be gradually extended to include broader criteria, such as those who are not terminally ill, those with chronic conditions, or even those who are unable to give explicit consent. For example, in the Dutch annual reports on AD, there is a separate category known as multiple geriatric syndromes, which includes visual and hearing impairment, osteoporosis, osteoarthritis and balance problems relevant to medical aid in dying (MAID). In 2019, this category accounted for about 2.7% of all MAID-related deaths in the country [4].

Critics of the slippery slope argument, on the other hand, argue that with appropriate legal safeguards and ethical guidelines it is possible to limit the practice to specific, well-defined situations without cascading into broader and potentially problematic scenarios [5]. The debate over the slippery slope argument remains an important aspect of discussions about the ethical, legal and social implications of AD.

Since its legalization in 2016, the use of MAID in Canada has shown a steady upward trend. In the first year, approximately 1000 people chose this option, and by 2022 this number had risen to more than 13,000 [6]. In contrast, California, with a comparable population to Canada and a parallel timeline for legalizing MAID, reports an annual number of MAID-related deaths of less than 1000 [7].

One difference between Canada and the USA is the way in which MAID is predominantly administered. In Canada, physicians play a primary role in the provision of MAID, whereas in the USA, as is currently the case in Austria, patients are required to self-administer the lethal drug. Eligibility criteria in Canada include having a grievous and irremediable condition, which includes disability, without the need for a terminal prognosis of less than 6 months. Patients can have prognoses ranging from years to decades. Although the proposed extension of MAID to people with a mental illness has been delayed until March 2024, the Canadian Parliament is awaiting a report on the possible extension of MAID to mature minors. The provision of MAID could potentially save between Canadian $ 34.7–$138.8 million in annual healthcare costs in Canada [8].

The discussion about AD is inordinately complex. It seems important that we study the subject in depth, familiarize ourselves with legal frameworks and treat patients in a nonjudgmental way; however, it must be emphasized that the desire to die is ambivalent and that we, as healthcare professionals, have an obligation not to rush to find an "operational solution" to the deepest human needs and concerns.

The PC is associated with a reduced likelihood of suicide, and incorporating aspects of this patient-centered approach could provide valuable insights to strengthen efforts in suicide prevention and treatment [9].

Conflict of interest E.K. Masel declares that she has no competing interests.

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