



Suicide – Responsibility, Prevention and Autonomy

OPINION • EXECUTIVE SUMMARY

22 September 2022

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>> EXECUTIVE SUMMARY

Introduction

- 1) The numerous and extensive debates on how to deal appropriately with the multifaceted phenomenon of suicide and the controversial topic of assisted suicide and its regulation were further intensified by the judgment of the Bundesverfassungsgericht (Federal Constitutional Court) of 26 February 2020 (ref. 2 BvR 2347/15 i.a.). In this judgment the criminal offence of facilitating suicide as a recurring pursuit was declared unconstitutional and void (Section 217 Strafgesetzbuch [Criminal Code]). Within the German Ethics Council, differing views are held on the moral evaluation of suicidal acts, assisted suicide and the judgment of the Federal Constitutional Court.
- 2) The German Ethics Council had already repeatedly addressed issues of assisted suicide – more particularly in its Ad Hoc Recommendations dated 18 December 2014 and 1 June 2017. The judgment of the Federal Constitutional Court prompted the Council to revisit this

issue once again in a more comprehensive manner. This Opinion does not involve a critical appraisal of the judgment itself or concrete draft bills. Rather, the German Ethics Council is pursuing a more fundamental agenda, in three different respects.

- 3) First, it wishes to create appropriate awareness of the scope and complexity of phenomena related to suicidality, second to define more precisely the internal and external preconditions for fully autonomous suicide decisions, and third to demarcate more clearly the different responsibilities of various stakeholders in the context of suicide decisions and suicide prevention.

Dynamics of suicidal thoughts and their broad range of contexts

- 4) “Suicidality” stands for a broad spectrum of personal, social and societal phenomena. In addition to individual factors, a person’s immediate social contacts and the societal environment influence whether and how suicidal thoughts arise, are reinforced or weakened. The case vignettes outlined in this Opinion illustrate the whole range of phenomena related to “suicidality” and “suicide”. Furthermore, they highlight the dynamics of the emergence and carrying through of suicidal thoughts as well as the different attitudes people have towards their own lives, from which such thoughts emerge.
- 5) As a rule, suicidal thoughts are preceded by a lengthier process of internal and external constraints and stresses. They are discernible in a variety of contexts and may be attributable to very different motives, which often refer to one general motive: namely, a person’s conviction that they can no longer bear life as it is now and how it is likely to be in the future. This conviction often first manifests itself in death wishes which, although often volatile, may also initiate a dynamic in the course of which suicidal thoughts gradually take shape.

- 6) The general motive – no longer wanting to live under the given conditions – can be broken down into situation-specific motives that vary considerably from individual to individual. Some of them are presented, by way of example, in this Opinion in illustrative case vignettes. They range from profound crises of self-esteem triggered by humiliations experienced during childhood and adolescence, over cumulative family, professional and economic crises in early and middle adulthood to experiences of isolation and loneliness as well as fears of worsening symptoms of illness, often dementia, and of an increasing need for care in old age and advanced old age.
- 7) However, suicidal thoughts need not necessarily indicate a loss of the will to live. Nor do they have to lead directly to suicidal acts. They should not be considered in isolation from a person's individual resource–risk constellation. It can lead to very different ways of coping with crises and conflicts in comparable crisis and conflict situations.

Mental disorders and situations of stress and crisis

- 8) Restrictions and stresses may indeed become so dominant that suicidal thoughts become entrenched and people lose the will to live. Mental and especially severe depressive disorders are of particular relevance for the risk of suicide. Other risk factors for suicidality are alcohol intoxication and drug use, personality disorders, acute schizophrenic episodes and biographical risk factors such as traumatic experiences in childhood and adolescence as well as a family history of attempted suicide or suicide. If someone has attempted suicide in the past, there is a considerably increased risk of them doing it again.
- 9) Mental disorders, too, can be regarded as dynamic processes during which suicidal thoughts may gradually take shape. They, in turn, can condense into suicidal impulses and ultimately lead to suicide attempts. People with mental disorders are particularly vulnerable.

There is a likelihood that their response to severe stress and crisis situations will not be solution-oriented but highly emotional. Due to their specific disposition, individuals in a stress or crisis situation are exposed to significantly increased risks linked to strong inner feelings of failure. They, in turn, can lead to suicidal thoughts, impulses and attempts.

- 10) The development and carrying through of suicidal thoughts must be considered in the context of interrelationships with the social environment. Isolation, loneliness and the feeling of no longer belonging are risk factors for suicidality, too. Exhaustion, weariness and satiety with life may also drive the wish for assisted suicide. In these states of mind, problematic inner and outer situations manifest themselves resulting in a weakening of life bonds. These states of mind mainly affect elderly people and people with chronic-progressive or even fatal diseases and those with many symptoms. Their likelihood increases in individuals struggling to cope with numerous losses that have stripped away the foundation for their existence.
- 11) The dynamics of suicidal thoughts and suicidal acts clearly demonstrate the major importance of suicide prevention that also explicitly looks at possible risk factors for suicidality and seeks to avert or considerably reduce them. Appropriate medical and nursing care can often alleviate symptoms and the associated psychological stress, as can early diagnosis and intervention which should always be in the service of those affected. Such suicide prevention strategies are, however, dependent on psychiatric-psychotherapeutic and psychological care structures that are not available everywhere in Germany.

Decision-making pressure and external influence

- 12) But there are also situations in which suicidal thoughts are not the result of a development spanning several months or years but occur

more or less abruptly. This is especially the case when a person discovers, out of the blue, that they have a disease that is foreseeably fatal, will take a rapid course and already presents with severe symptoms. With this kind of time pressure, it is far more difficult to provide appropriate professional support in a suicide crisis. In these borderline situations, this support makes particularly high moral and psychological demands on the members of the health care system. After jointly discussing all available options for action, they will respect the decision made by the ill person in favour of assisted suicide and, if necessary, help them find the assistance they need.

- 13) However, in individual borderline situations in which a person is deeply unsettled, is (also) highly stressed emotionally and – at least at that point in time – sees no viable future prospects, the risk of growing external influence increases considerably. People close to that person may increasingly dominate the interpretation of the situation at hand and may even be encouraged in this by members of the caring professions. Consequently, a central task in suicide prevention is to preserve or restore the capacity for self-determination of individuals who are deeply insecure and carry a high emotional burden. In addition, the interrelations between a suicidal person and their social environment must also be taken into account. There must be systematic examination of the way in which a person's environment impacts or seeks to impact processes of reflection, decision-making and action.

Self-determination and full autonomy

- 14) In the debate on suicide and assisted suicide, notwithstanding the distinction between a moral and a legal perspective, there is agreement that a suicide decision that is to be respected as an exercise of the right to self-determined dying formulated by the Federal Constitutional Court must meet certain societally negotiated requirements for self-determination.

- 15) The German Ethics Council builds on the assumption of a relational understanding of self-determination. It sees the sociality of human beings not as a threat but as a condition for the possibility of self-determination. On this basis, it understands self-determination as an individual's concrete attainment of both inner and outer as well as negative and positive freedom.
- 16) Self-determination has cognitive, emotional and volunative components and is, moreover, tied to certain social conditions. The relevant circumstances for the decision to be made must be understood, evaluated and processed as constituting a significant part of the individual's experience of the world. Without this reference to a person's own lifeworld, which is always also emotionally tinted and socially determined, theoretical knowledge has no practical meaning and cannot, therefore, translate into any effective action.
- 17) The cognitive, emotional and volunative factors of self-determination are present to varying degrees in certain phases and areas of life, depending on the external situation or on the inner state. Given the variable nature of these factors, self-determination is always graduated. A decision that is sufficiently self-determined for a person to be morally responsible for it both on their own account and on account of others who are inevitably (also) affected by the decision can be described as fully autonomous. The more difficult it is for the person concerned to oversee and evaluate options for action, and the more serious the consequences of a decision are for fundamental goods of the person themselves or for third parties, the higher the degree of self-determination that will be required for a fully autonomous decision.
- 18) Due to the irreversible nature of a suicide decision, particularly high demands must be placed on its full autonomy. However, they must not vitiate the right to a self-determined death by de facto taking away the affected person's leeway to decide on their most personal good – their life – by imposing overly stiff conditions.

Sufficient knowledge of the aspects relevant for a decision

- 19) A fully autonomous decision to commit suicide presupposes that the suicidal person is sufficiently informed about the subject matter of the decision to be made, i.e. that they are sufficiently familiar with the aspects relevant for that decision. Regardless of the reasons for the lack of such information – no suicide decision which is made without it can be considered fully autonomous.
- 20) When determining the aspects relevant for the decision, pertinent facts must be distinguished from their subjective evaluation. Only the circumstances that constitute the facts are of importance for full autonomy. As such, they must be accessible from a third-party perspective and, consequently, to intersubjective verification. Since the full autonomy of a decision must be strictly distinguished from the moral correctness of its result, the values of the person making the decision must be completely respected when assessing full autonomy – even if they deviate markedly from the ideas generally prevalent in society, and any suicide decision based upon them may, therefore, appear incomprehensible.
- 21) Because suicide wishes can take shape for very different reasons, the subjective perspective of the person making the decision determines the minimum informational requirements for a fully autonomous suicide decision. The aspects and information that are to be deemed relevant to the decision depend on the reasons why the persons concerned wish to put an end to their lives. Depending on the constellation, the relevant information for decision-making in stressful life situations may encompass the type and extent of the stress or, in the case of physical and mental illnesses, the expected course of the illness and the treatment options. The more concrete the reasons are, the easier it should be to determine whether the person's respective assumptions are based on realistic judgements, pertinent errors or gaps in knowledge.

- 22) Consequently, it is solely on the basis of an individual's suicide motives, personal attitudes and value options that an assessment can be made as to whether and, if so, the extent to which offers of help promise to avert or alleviate the stresses underlying the suicide wish.

Informed consent

- 23) The scope of the duty of third parties to provide information – especially on the part of persons acting in a professional capacity (e.g. in medicine, psychology, psychosocial counselling, pastoral care) – is disputed in certain circumstances. On the one hand, it is argued – also within the German Ethics Council – that an individual standard should already be applied here, i.e. the duty to inform should be determined by the concrete need for information and the will of the person concerned. The latter would thus have the chance to forego more detailed information about certain options for averting the stresses motivating them to commit suicide during the informed consent process if recourse to these options is out of the question for them due to their personal values which must always be respected.
- 24) In contrast, others – also within the German Ethics Council – argue that the scale of information to be qualified as relevant should not depend on the subjective assessment of the suicidal person, which in any case cannot be anticipated in advance of the informed consent process, and hence that comprehensive information should be provided. It is only on the basis of comprehensive information and mandatory counselling that a suicidal person would then be free to reject alternative courses of action presented to them with recourse to their personal values and to decide on a fully autonomous basis to commit suicide.

Sufficient capacity for self-determination

- 25) In addition to knowledge of the relevant aspects, a fully autonomous suicide decision presupposes the capacity to assess these aspects against a sufficiently broad and differentiated horizon of experience, and to realistically weigh up the preferences resulting from this assessment.
- 26) As a general rule, it can be assumed that people possess this capacity to a degree which is sufficient for full autonomy. However, this presupposes that the individual's horizon of experience is already sufficiently developed for the decision at hand. Consequently, suicide decisions require a high degree of mental maturity that is not usually acquired until a person comes of age. Whether, in exceptional cases, certain procedural safeguards could replace the requirement of coming of age is disputed – within and without the German Ethics Council.
- 27) In addition, mental disorders can impair a person's capacity for self-determination to such an extent that the high standards for fully autonomous suicide decisions are no longer met. All the same, a mental illness as such does not preclude that a suicide decision can be fully autonomous. Unless, in the individual case, there is substantial reason for assuming a normatively significant impairment of the capacity for self-determination, the freedom of choice of people suffering from a psychiatric disorder must be respected, too.
- 28) Within the Germany Ethics Council, too, views differ about the importance of advance directives, by means of which a person with sufficient capacity for self-determination asks for suicide assistance in a future situation in which they will no longer be able to act with full autonomy. Some people argue that an advance request for assisted suicide should generally be ruled out as a basis for assisted suicide because it can only be provided in cases where suicide is committed in a fully autonomous manner. In contrast, others believe that, with

a view to protecting autonomy, it is necessary to accept in principle advance directives regarding a suicide wish. However, this would only be acceptable if the person concerned were to express their desire for suicide assistance repeatedly and permanently whilst in a state of insufficient self-determination. This is not likely to happen very often given the frequently highly unstable expressions of “natural will”.

Sufficiently reflected, serious and independent decisions

- 29) Due to the stiff requirements to be met by a fully autonomous suicide decision, it must first be sufficiently reflected and sufficiently serious. A suicide decision can be deemed to be reflected if a person uses their capacity for self-determination to thoroughly weigh up all the relevant aspects from their point of view and then makes their decision on this basis. The requirement of a sufficiently serious decision takes into account the ineluctable volatility of suicide wishes. For a suicide decision to be taken seriously, the decision must be stable and present a certain degree of constancy in order to rule out or reduce the risk of a rash decision. Although intensive and, possibly, controversial discussions about a person's suicide wishes are often the essential prerequisite for an independent and, by extension, fully autonomous decision, the influence exerted by other people can also jeopardise or even preclude a fully autonomous decision by the suicidal person. This is the case when a suicide decision merely bows to the dominating influence of other people. Such heteronomous decisions are not sufficiently independent and do not, therefore, count as fully autonomous suicide decisions.
- 30) In order to determine whether the degree of independence of suicide decisions is sufficient for them to qualify as fully autonomous, a distinction must be made between different forms and degrees of influence. Obvious forms of external influence that rule out full autonomy are coercion, threats and deception. But more subtle forms of influence

can likewise lead, in individual cases, to substantial heteronomy and may thus rule out the full autonomy of a suicide decision. Less intensive forms of influence, such as incitement or advertising, also impair self-determination under certain circumstances, but do not suffice to rule out full autonomy. In practice, there are often borderline cases that do not lend themselves to a precise conceptual distinction.

Full autonomy in emergency situations

- 31) Even sufficiently reflected and serious suicide decisions reached in full knowledge of the relevant aspects, with sufficient capacity for self-determination and without inadmissible influence by third parties, probably result predominantly from constraining life situations in which the meeting of basic needs – which also include needs of participation – is far more difficult objectively or subjectively.
- 32) The motivation engendered by such emergencies does not in itself justify disqualifying a suicide decision by deeming it to be no longer fully autonomous. If people who are capable of self-determination are able to handle a situation in their lives that places a heavy burden on them in a sufficiently independent manner, and if they decide, after thoroughly weighing up the pros and cons, that they no longer wish to bear this burden, a decision motivated by an emergency is to be recognised as fully autonomous, too.
- 33) Nonetheless, the recognition of people's right to decide not to continue their lives, also and especially on grounds of existential distress, does not relieve the state and society of their responsibility to alleviate such predicaments. Already because of their obligation to protect integrity and life, the state and society must ensure as far as possible that people do not get caught up and remain trapped in situations in which they feel compelled to give preference to death, a supposed lesser evil, over life.

Suicide prevention

- 34) Consequently, suicide prevention is primarily about warding off those circumstances of life in which people feel compelled to commit suicide in order to escape from a life situation that, at least subjectively, is deemed to be unbearable. This prevention encompasses multiple interventions and responsibilities of different stakeholders at various levels of activity (“multi-actor responsibility”).
- 35) Three basic types of suicide prevention interact with each other: General prevention targets the population as a whole and aims to forestall suicide wishes by means of awareness raising campaigns, low threshold counselling, helplines or general strategies. Selective prevention focuses its efforts on groups for which a significantly elevated risk of suicide is typical. Indicated prevention concentrates on individual persons who, as a result of various circumstances or incidences, are obviously at immediate risk of suicide.

Interconnected multi-actor responsibility

- 36) Pan-societal and state institutions on the macro-level, institutions on the meso-level and professional and/or ordinary individuals on the micro-level are responsible for the different prevention strategies. If it is to be successful in the long term, suicide prevention depends on the interconnectedness of these levels and on the interlocking of the areas of responsibility assigned to different actors by the concept of multi-actor responsibility. The objective behind the interconnectedness of the responsibilities and activities on all three levels is to enable people to engage in a self-determined way of life in the midst of psychosocially intense suicidal life situations, and to take due account of the demanding situational requirements for a fully autonomous decision.

Normalisation trends

- 37) The public debate on the admissibility of assisted suicide draws attention to the risk of normalisation and the accompanying insidious spread of suicides. Talk of normalisation oscillates between the descriptive determination of a statistical average, the prescriptive setting of a desired or desirable standard and the feeling of a condition that is taken for granted and requires no special justification.
- 38) Whilst the normalisation of respect for a person's ultimate responsibility can be rated positively from a descriptive, prescriptive and emotive perspective, normalisation trends become problematic from an ethical and legal perspective if they are associated with risks for the individual exercise of freedom. Such a threat to individual self-determination regarding a person's own death can justify or even necessitate countermeasures.

Responsibilities on the micro-level

- 39) On the micro-level, there are three groups of stakeholders who interact closely with each other in suicide prevention and who each bear a moral responsibility: family members/friends, professionals and the suicidal persons themselves.
- 40) In a suicidal crisis people bear fundamental moral responsibility first of all for themselves. But this also extends to persons who will inevitably be affected by their decision. Ideally, they should be involved as far as possible and acceptable in the clarification and decision-making process.
- 41) For their part, family members and friends have a moral responsibility towards the suicidal person to maintain social contact as far

as possible and reasonable and to keep certain “vistas on life” open through their (physical) presence and care.

- 42) Counselling of the persons directly affected and the persons indirectly involved is one of the wide-ranging interventions that multi-professional teams have to carry out as part of their profession-specific interconnected responsibility. This includes counselling for people for whom first death wishes have manifested as well as for people who begin to form the resolve to commit suicide or who have possibly already reached the stage of seeking access to the means of ending their lives with the help of third parties.
- 43) In addition to professional counselling in the narrower sense that provides information, for instance, about medical and nursing issues, but also discusses and weighs up psychosocial aspects, the responsibilities of professional caregivers also extend to ethical counselling. The aim here is to support people’s capacity for insight and judgment in a suicidal crisis. This also entails opening windows for reflection by asking “challenging empathetic questions” about things that the person perceives as normal and by encouraging a more in-depth discussion in the pursuit of a well-considered decision.
- 44) Given the irreversible nature of suicide, everyone wishing to commit suicide must be given the opportunity to weigh up and reach their personal decision in accompanying conversations with due consideration of their responsibility for themselves and others. The process of joint counselling and reflection often reveals to the suicidal person the prospect of alternative courses of action and decision-making that enable a fully autonomous decision in the first place by offering options to choose from. The design of all formal and informal conversational and counselling services must avoid any hint of paternalism or obtrusion. The ultimate decision-making responsibility of the suicidal person must be respected even if the contemplated suicide seems alienating or absurd.

Responsibilities on the meso-level

- 45) These responsibilities on the micro-level can only be shouldered by those affected, their family members, friends and professionals if, on the meso-level, the facilities and institutions of the health, social and educational system orient their offers of support and counselling towards the goals of suicide prevention. This entails first of all the responsible analysis and containment of any institutional, conversational and interactional cultures that encourage suicide.
- 46) In addition, there is a need for institutional and outpatient structures that promote social participation and, by extension, a strong sense of belonging in order to provide dignified end-of-life care and, more particularly, to safeguard the quality of life and dying, and to focus on the will to live. The precondition for this is a lived palliative, farewell and dying culture in the institutions, which ideally counters death and suicide wishes in the interest of general prevention. Professional support should already come into play in the early stages of emerging death wishes and suicidal thoughts and it should not become directive at any time.
- 47) In responsible initial, further and continuing training programmes in the nursing, health care and therapeutic professions and in pastoral care professions, the topics of suicide prevention, the accompaniment of people in suicidal crises and, in the future, suicide assistance along with the associated diverse moral and professional areas of tension and challenging questions are all genuine topics relevant for education and qualification processes. This applies in a similar way to the qualification of all volunteers who are in close contact with suicidal persons either in a counselling or support capacity.
- 48) If, despite all suicide prevention efforts, a person's desire to commit suicide crystallises into a firm wish, facilities and institutions can guarantee the option of a "farewell to life" within a framework of dignified

suicide assistance. Depending on the suicidal person's self-conception, this could take place within the facility itself, at another location or with the help of an assistant. Should assisted suicide be made possible within the facility in which the person resides at present, then special consideration must also be given to staff members.

- 49) Because no-one is obliged to provide suicide assistance, it can be denied to any resident on the grounds of an institution's self-concept, its professional ethical values or its staff members' private attitude towards assisted suicide. However, nursing homes and similar long-term care facilities are already being increasingly confronted with the desire for assisted suicide. They should, therefore, adjust their mission statements to explicitly include reflections on the culture of dying in order to make it clear to both potential residents and staff whether and, if so, how suicide assistance is handled in their remit.

Responsibilities on the macro-level

- 50) State and societal institutions on the macro-level bear major responsibility for suicide prevention that is as comprehensive as possible – across a person's entire lifespan, in all relevant areas of life, available anywhere and in a timely manner. A broad area for systemic improvements is emerging as a consequence of the increasing loneliness of many elderly people in particular, social hardship, and the ongoing – in some cases even mounting – deficits in terms of access to low threshold psychotherapeutic services and to palliative medical/nursing and hospice care for the seriously ill. These improvements must include more particularly the expansion of hospice and palliative care, which is still centred around oncology, for instance to areas such as frailty, life crises or social isolation.
- 51) Macro-level institutions also bear responsibility for reducing the risk of precarious self-determination. This risk can be reduced by means

of a comprehensive strategy of general, selective and indicated suicide prevention. State and societal institutions are responsible for ensuring that the different levels of responsibility interconnect as effectively as possible, and for creating suitable framework conditions that make it possible for stakeholders on the micro- and meso-levels to assume their own professional and role-specific responsibilities. These framework conditions also include, first and foremost, sufficiently precise legal regulations that do not merely provide a reliable legal framework for suicide assistance.

State and societal suicide prevention

- 52) State responsibility likewise extends to monitoring the accessibility of the means to suicide, as well as improving and addressing the determinants of people's mental and psychological health – especially among groups whose mental health is particularly precarious. Dedicated government programmes and initiatives by other societal institutions to expand care in these areas can have a general preventive effect.
- 53) Responsible media reporting on risk factors and forms of suicidality, as already demanded in relevant press codices, cannot be valued highly enough in the context of suicide prevention, too. This reporting should also include reference to relevant offers of help. This must also apply to a comprehensive, differentiated and factual presentation of the motives for assisted suicide and the care and counselling requirements that arise from these motives. (Self-)critical media reflection applies to all media formats – fictional, documentary, reportage and infotainment.
- 54) Of course, on social media people can outline in detail their motives for a possible suicide as well as their thoughts about methods of suicide without any form of control. This factor should not

be underestimated when it comes to copycat effects. Consequently, there is also a need for the responsible handling of personal messages on the Internet. The extent to which statements by individuals (or groups) on suicidality impact other people needs to be researched extensively and discussed publicly.

- 55) The monitoring, evaluation and coordination of prevention, communication and education programmes are primarily the responsibility of public health institutions. During curriculum development under the aegis of the federal and state ministries, suicide prevention and suicide assistance must be taken up as important topics for society – especially, but not only, for the health care professions – in a dedicated and target-group-specific manner.
- 56) The special responsibility of institutions on the macro-level also involves cautiously raising awareness about suicide risks amongst the public at large. This responsibility is flanked by comprehensive support for suicide research to remedy existing knowledge deficits about the genesis of suicidality and effective prevention options. What is needed for the collection and analysis of data on the complexity of suicidal thoughts and impulses in terms of their emergence, development and intensity and the relevant social, cultural, legal and personal determinants is a multidisciplinary research approach. Such an approach is particularly suited to both identifying the interaction between different determinants of the formation and carrying through of suicidal wishes, and to registering their respective importance.
- 57) Suicide prevention structures must be reinforced, and adequate, permanent and reliable funding must be guaranteed. This includes ensuring the availability of human resources from specially trained professions as well as promoting interventions and corresponding competences. This regular funding must also increasingly include practice-oriented initial and continuing training provision.

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