



OPEN ACCESS



Check for updates

How patients explain and make sense of their decision for assisted suicide in Switzerland (the Exit Project): qualitative exploratory study

Solenne Blanc,¹ Lea Heistrüvers,² Sofia Savinelli,³ Mathieu Bernard,⁴ Gian Domenico Borasio,⁵ Ralf J Jox,¹ Philip Larkin,⁶ Anca-Cristina Sterie,⁷ Claudia Gamondi⁵

For numbered affiliations see end of the article

Correspondence to: S Blanc (solenne.blanc@chuv.ch; ORCID 0009-0002-6532-421X)

Additional material is published online only. To view please visit the journal online.

Cite this as: *BMJ* 2026;394:e100610 <http://dx.doi.org/10.1136/bmj-2026-100610>

Accepted: 19 August 2026

ABSTRACT

OBJECTIVE

To explore how people actively pursuing assisted suicide in Switzerland frame and report the motivations underpinning their decision.

DESIGN

Qualitative exploratory study using semistructured interviews analysed through reflexive thematic analysis within a constructivist framework.

SETTING

Participants were recruited across Switzerland between October 2023 and July 2025 through three right-to-die associations and contact with healthcare professionals, including palliative care clinicians and general practitioners. Interviews were conducted in French, German, or Italian and were set in participants' homes or in hospitals.

PARTICIPANTS

30 adults with decision making capacity who were able to communicate verbally and had contacted a right-to-die association to initiate an assisted suicide request were recruited to the study. Participants were interviewed while actively engaged in the assisted suicide request process. Fourteen participants

subsequently died by assisted suicide within weeks of the interview.

RESULTS

Participants described the decision to request assisted suicide as the outcome of several motivational processes interacting rather than being caused by a single precipitating factor. Analysis identified six interrelated themes: imagining and shaping one's own death, considering assisted suicide as a trusted commodity, seeking validation and common ground, reclaiming personal power over the medicalisation of dying, crossing the unbearable threshold, and seizing the narrowing window of opportunity. These themes functioned as dynamic, interacting motivations that consolidated, stabilised, and reinforced the choice to pursue assisted suicide over time.

CONCLUSIONS

In this study, the pursuit of assisted suicide emerged as prospective, meaning making processes embedded in personal values, relational considerations, and awareness of time, rather than solely as a reactive response to physical suffering. Recognising this complexity may support more ethical clinical dialogue and inform policy discussions in jurisdictions where assisted dying is permitted or under consideration.

Introduction

Despite once being a marginal practice, assisted dying has become an established end of life option for about 300 million people^{1 2} and now accounts for up to 5% of all deaths in countries where assisted dying is legal.³ Assisted dying comprises two main practices: euthanasia and assisted suicide, defined as the intentional ending of another person's life and the intentional provision of assistance for self-inflicted death at the voluntary and competent request of the individual,⁴ respectively, with the former representing most cases of assisted dying globally.³ For the purposes of this article, assisted dying is used as a broad umbrella term in line with international literature. However, when referring specifically to the Swiss legal context and the participants and findings of this study, we use the term assisted suicide.

Switzerland holds a unique position internationally regarding assisted dying. While euthanasia remains prohibited, assisted suicide has been permitted in Switzerland since 1942 under Article 115 of the Swiss Penal Code, provided that assisted suicide is not driven by selfish motives. Since 1982, right-to-die associations have played a central role within this

WHAT IS ALREADY KNOWN ON THIS TOPIC

Assisted dying is commonly explained in the literature as a decision resulting from factors such as pain, loss of autonomy, diminished dignity, and unbearable suffering

Empirical research has mainly examined healthcare professionals' perspectives, relatives' experiences, or retrospective accounts of people who have died by assisted dying, encompassing both euthanasia and assisted suicide

First person accounts from people actively engaged in the assisted suicide request process remain limited, which restricts understanding of how motivations develop during the request process

WHAT THIS STUDY ADDS

People pursuing assisted suicide describe the decision as the result of multiple interacting motivations relating to personal agency over the dying process, external validation found in relationships with relatives, healthcare professionals or right-to-die associations, finding coherence between the way they live and die, and a sense of urgency to initiate the request before losing the opportunity to pursue assisted suicide

Assisted suicide was framed not only as a response to suffering or illness experience but also as a deliberate and structured way of shaping the end of life that could be considered long before experiencing serious illness or approaching the end of life, highlighting the need for clinicians, ethicists, and policymakers to consider motivations for assisted suicide beyond patient distress and symptom burden

framework in the Swiss assisted suicide process by supporting people wishing to pursue assisted suicide, assisting them in navigating the administrative and procedural requirements, and coordinating access to prescribed lethal medication.⁵

Since 2018, the Swiss Academy of Medical Sciences has explicitly labelled assisted suicide as a non-medical act, while providing professional guidelines for doctors involved in prescribing the lethal drug (ie, sodium pentobarbital), and specified that people must be experiencing unbearable suffering, have decision making capacity, and be able to self-administer the lethal drug to be eligible.⁶ Governance has remained largely decentralised: only a few cantons have enacted legislation regulating assisted suicide, mainly within public institutions such as hospitals and nursing homes, while professional organisations, judicial authorities, and administrative bodies have progressively developed complementary guidance and practice standards. This so-called civil model has been described as an open practice of informal custom rather than positive law, where right-to-die association staff act as the primary coordinators, separate from clinical practice.⁷ Therefore, the civil model functions as a less medicalised model compared with countries wherein assisted dying has been regulated by law and is carried out exclusively by healthcare professionals.⁸ A summary of the current position in Switzerland (requirements, conditions, and process) can be found in the supplementary appendix.

Understanding the complex and deeply personal choice to hasten one's own death with assisted dying remains a challenge for end-of-life researchers and clinicians, and is important for several reasons. As assisted dying becomes increasingly established, clinicians are more frequently asked to respond to requests, policymakers continue to refine regulatory frameworks, and ethics committees are regularly required to evaluate complex cases. Yet relatively few studies have examined why people choose assisted dying as an end-of-life option, and perspectives of those actively pursuing this option are lacking. Previous studies have identified recurring motivations (eg, pain, loss of dignity or autonomy, fears about diminished quality of life, and concerns about burdening others⁹⁻¹²) and have highlighted that a desire to hasten death is often associated with experiences of existential suffering, including loss of meaning, threats to identity and personhood.¹³⁻¹⁴ These factors were identified as contributing to patients' decisions to pursue assisted suicide in Switzerland.¹⁵⁻¹⁶ Quantitative surveys further associate requests for assisted dying with older age, higher education, cancer diagnosis, marital status, and atheistic attitudes.¹⁷⁻¹⁹ However, patients' perspectives remain minimally examined, with most of the evidence being indirect, derived from clinicians, relatives, or posthumous records, rather than from patients engaged in assisted dying requests and procedures.²⁰⁻²²

The limited research capturing the perspectives of people directly engaged in the assisted dying request

process further suggests that motivations are neither fixed nor uniform, rather they evolve during decision making, from early contemplation to active pursuit.²³⁻²⁵ This choice rarely stems from isolated causes, and instead develops through a dynamic interplay of multiple factors shaped by illness experience, unbearable suffering, personal relationships, and institutional contexts. However, how people actively requesting assisted dying make sense of and explain their decisions remains insufficiently understood. Filling this knowledge gap may therefore contribute to more informed clinical practice, ethical reflection, and policy development.

Our study explores the choice to pursue assisted suicide from the perspective of people directly engaged in the request process in Switzerland. Allowing the perspectives of people in this group to be heard is crucial for grasping how assisted suicide is experienced, how motivations interact and consolidate the final decision, refining clinical guidance, and informing the ethical and legal regulations around assisted dying practices in other jurisdictions. Specifically, our study sought to capture how people explain and make sense of their decision and which motivations they consider most influential in shaping their decision to pursue assisted suicide.

Methods

Study design and setting

This qualitative study forms part of the "Understanding altruism at the end of life: an interdisciplinary approach" project funded by the Swiss National Science Foundation (grant No 10001G_207814/1). The project explores patients' expressions of altruism at the end of life, considering the concept of altruism as "a personal and intentional interest in improving the well-being and welfare of others - at an individual, group or societal level",²⁶ and includes a subproject that seeks to understand whether and how altruistic motivations play a role in the decision of a patient to pursue assisted suicide. Our study is part of the subproject and constitutes the primary analysis thereof, aiming to identify the broader contributing motivations behind assisted suicide and to understand more generally how the final decision is shaped.

We sought to identify the patterns of meaning through which participants explained and made sense of their decision to undergo assisted suicide. Rather than seeking to situate, differentiate, or compare motivations across participants' experiences, characteristics, or stages of the assisted suicide process, we focused on identifying patterns of shared meaning through which participants constructed, made sense of, and articulated their decision.

Guided by a constructivist epistemology—which recognises that knowledge is not simply discovered but is situated and constructed through personal experiences, social and cultural contexts, and interactions between researchers and participants—we approached data as co-constructed, reflecting participants' accounts and our interpretation of the

data. We sought to reconstruct the motivations and processes by which individuals made sense of their decision, using field memos, researchers' diaries, and regular team discussions to trace our interpretive journey.

Researchers' position

We acknowledge that our interpretations are shaped by our sensibilities and personal views as an interdisciplinary team working at the crossroads of medicine, ethics, and social sciences. The team included members trained in sociology, nursing, ethics, and medicine, and our multilingual composition mirrored Switzerland's linguistic diversity. The research team comprised members with varying levels of familiarity with assisted suicide: while some had no experience in this field, others had clinical experience caring for patients who had requested or pursued assisted suicide.

Reflexive practices (eg, the writing of memos) and meetings gave opportunities to discuss interview experiences, methodological challenges, and emerging interpretations, allowing researchers to critically examine how their perspectives and experiences shaped the analysis and to develop a collaborative analytical methodology. Reflexive discussions revealed the complementary views brought by different disciplinary backgrounds. For example, researchers from the social sciences emphasised an open, inductive exploration of participants' accounts, whereas researchers with clinical backgrounds encouraged reflection on how participants understood and articulated their decision to pursue assisted suicide.

Participants and recruitment

We recruited participants in collaboration with healthcare professionals (including palliative care clinicians and general practitioners) and with right-to-die associations (Exit ADMD, Life Circle, and Exit Ticino) across Switzerland's three main linguistic regions: German speaking (Zürich), French speaking (Lausanne), and Italian speaking (Ticino).

We adopted a sampling strategy by convenience because of the limited number of eligible individuals, the vulnerability of the study population, and the practical challenges of identifying and contacting individuals actively pursuing assisted suicide. The final sample size was thus determined iteratively. Recruitment continued until the research team judged that the dataset provided sufficient diversity of experience and richness of information to adequately answer the research question, in line with Braun and Clarke's recommendations for reflexive thematic analysis.²⁷

Inclusion in the study required participants to meet the following criteria: to be adults actively pursuing assisted suicide (ie, having contacted a right-to-die association to initiate the application process, a step commonly understood to be marking the transition from an expressed wish to a formal request for assisted suicide), to have sufficient capacity to give informed

consent, and to be fluent in one of Switzerland's official languages (German, French, or Italian).

Healthcare professionals and right-to-die association staff members identified eligible participants, shared study information with them, and obtained consent from the participants to be contacted by the researcher for further information. In accordance with Swiss practice and as part of the assisted suicide evaluation process, all participants had already undergone decision making capacity assessment by the referring doctor and/or right-to-die association. Additionally, interviewers assessed participants' capacity at the time of the interview, before which written informed consent was given by all participants. Potential participants were encouraged to take a few days before agreeing to take part in the study, and were reminded that they could withdraw at any time without consequence. To preserve diversity in the sample and to avoid normative judgments about the appropriate stage at which assisted suicide decisions should be explored, we intentionally recruited individuals at different points in their trajectory, from those who had only recently initiated contact with right-to-die associations to those who had already scheduled a date for assisted suicide. This approach reflects our constructivist epistemology, which views decision making as a dynamic and evolving process co-constructed through lived experience, relational context, and reflection.

Data collection

Between October 2023 and July 2025, in-depth semistructured interviews were conducted using an interview guide (supplementary appendix). The guide was developed collaboratively by the research team in English and translated into German, French, and Italian. Researchers who natively spoke these three languages and were equally competent in English agreed on the coherence of the translation in team meetings. The guide provided a structured and shared framework to facilitate a common approach across interviews conducted in different languages, while allowing participants to elaborate freely on their motivations, reasoning, and reflections regarding their decision.

Interviews were held privately in participants' preferred settings. Interviews were conducted in the participant's native language by a member of the interdisciplinary team (SB for French speakers, LH for German speakers, and SS for Italian speakers). Conducting interviews by native speaking researchers enabled participants to discuss highly personal and sensitive experiences in their preferred language and cultural context, while helping to preserve linguistic nuance and foster rapport between participant and interviewer. Each researcher received preparatory training to conduct interviews in sensitive contexts and participated in monthly reflexivity workshops, giving opportunities to discuss methodological, ethical, and emotional challenges associated with interviewing individuals who were near the end of life.²⁸ All interviews were audio recorded and transcribed

verbatim in the original language to preserve nuance using AIKO,²⁹ an AI powered audio transcription software selected for its local data security storage. Final transcripts were stored in a secure, institutional, restricted access database. Researchers manually reviewed and corrected all transcripts for accuracy, anonymisation (ie, mainly names and locations), and readability.

Data analysis

The research team analysed data using reflexive thematic analysis.³⁰⁻³² This approach is consistent with a constructivist epistemology, emphasising inductive investigation of the meaning and significance of the data over causal, objective explanation in participants' narratives, while also requiring researchers to acknowledge their interpretive role throughout the study.

We conducted reflexive thematic analysis to construct descriptive, rich, and multifaceted themes. This approach enabled the identification of common patterns of meaning shared across participants' narratives. Data analysis proceeded in multiple stages: firstly, each interviewer (SB, LH, and SS) was invited to document their initial impressions, emotional responses, observations, and preliminary ideas of the interview they conducted. Initial semantic level coding was performed in the original language (ie, the language the interview was conducted in) in MAXQDA³³ using codes that captured a single factor motivating the decision and summarised the apparent meaning conveyed in each excerpt. Coding was done by the interviewer, a native speaking researcher familiar with the linguistic and cultural context, aimed to maintain participants' intended meanings.

Particular attention was paid throughout coding and analysis to preserving culturally embedded meanings and idiomatic expressions by explicitly coding these context specific expressions rather than relying on literal translation. To improve familiarity with the material collected in each region and to enhance consistency in the coding, one transcript from each linguistic region was translated into English by a bilingual researcher, then reviewed and crosscoded by SB, LH, SS, and CG. We then met regularly to compare coding orientations, discuss emerging patterns in the data, and agree on a working list of codes that were incorporated in the software. These meetings provided opportunities for researchers to critically reflect on emerging interpretations, examine how their disciplinary and professional perspectives shaped the analysis, and discuss potential differences emerging across linguistic regions. An example of this process is presented in supplementary appendix.

Transcript coding continued independently in each language, with new codes added inductively to the list. After initial coding, SB and CG grouped similar codes into potential themes. Following reflexive thematic analysis, we aimed to build themes to reflect patterns of shared meaning (ie, themes that clustered the data around a central idea).³⁰ To guide this process,

we examined how and why, from the participants' perspective, the factor contained in each code was described as meaningfully shaping the decision (ie, why the participant referred to this factor, and what meaning the factor contributed to their decision). We extracted and documented the different motivations emerging from each factor and returned to the transcripts to assess which motivations were most meaningful across participants. The central organising idea (or pattern), of each developing theme emerged by logically assigning codes together around one motivation. Rather than representing recurrences in the data, themes show the interplay between participants' narratives and the researchers' interpretation of the data.

These themes were then discussed and refined during multiple collective analytic sessions involving the full research team (SB, LH, SS, and CG) during which extracts were reviewed, alternative interpretations were considered, and the developing thematic structure iteratively honed. During theme consolidation, we did not seek to establish coding reliability, inter-rater agreement, nor did we use respondent validation as indicators of analytical quality, because these criteria are not considered appropriate measures of the quality of theme development. Instead, we emphasised transparency, reflexivity, and collaborative interpretation by systematically questioning how researchers' views shaped the analysis and considering how best to represent and privilege participants' perspectives. Rather than seeking uniformity, objectivity, or conformity of themes in the data, we aimed to develop rich, multilayered themes by grouping divergent and contradictory data to improve the depth of the analysis. We kept cultural and idiomatic expressions when they contributed essential meaning to the developing themes.

Themes were considered final when they were sufficiently coherent and meaningful to capture a salient shared pattern of meaning across participants' diverse experiences and to provide a convincing answer to the research question. The supplementary appendix presents a detailed example of the coding tree for one theme. In reporting findings, each theme is presented as an analytical narrative supported by illustrative data excerpts. For analysis and manuscript preparation, selected excerpts were translated into English, the working language for the study. Translations were prepared by the interviewer and reviewed by another bilingual team member to ensure that meaning and tone were preserved. When necessary, we returned to the original transcripts.

Patient and public involvement

Patients and the public were not involved, at any stage of the study, nor in the design, conduct, reporting, or dissemination plans of this research. The study was conceived as an exploratory qualitative investigation aimed at documenting the first person experiences of individuals actively pursuing assisted suicide, a

Table 1 | Characteristics of participants in the study

Identifier*	Age	Sex	Primary language spoken	Diagnosis received	Days between interview and assisted suicide†	Cause of death
PERS1102	73	Female	French	Renal failure	3	AS
PERS1103	65	Female	French	ALS	21	AS
PERO100	66	Female	Italian	Breast cancer	60	AS
PEREF107	83	Male	French	Multimorbidity‡	Unknown	Unknown§
PEREF105	97	Female	French	Multimorbidity	31	AS
PERO106	80	Male	German	Throat cancer	Unknown	Unknown
PERS3101	85	Male	German	Bladder cancer	Unknown	Unknown
PERS3102	83	Male	German	ENT cancer	16	AS
PERO104	54	Male	Italian	Lung cancer	Unknown	Unknown
PERO105	74	Male	Italian	Lung cancer	Unknown	Unknown
PERS1111	69	Male	French	Oesophageal cancer	14	AS
PERS1112	50	Male	French	Lung cancer	Unknown	Unknown
PERS1113	88	Female	French	Pancreatic cancer	20	AS
PERS1118	64	Female	French	Acute pancreatitis	5	AS
PERSO100	82	Female	French	Unknown cancer	45	AS
PERS1121	84	Female	French	Bone cancer	31	AS
PERS1122	83	Female	French	Unknown cancer	NA¶	Unknown
PERO107	52	Male	Italian	Colon cancer	Unknown	Unknown
PERO108	35	Female	Italian	Psychiatric disease	40	NA**
PERS1125	90	Male	French	Bile duct cancer	1	AS
PERS1127	86	Male	French	Renal failure	7	AS
PERS1130	93	Female	French	Heart failure	3	AS
PERS1131	74	Female	French	Breast cancer	120	AS
PERS1132	74	Male	French	COPD	Unknown	Unknown
PERS1115	59	Male	French	Pancreatic cancer	Unknown	Unknown
PERS1141	75	Female	French	COPD	Unknown	Unknown
PERO109	64	Female	German	COPD	Unknown	Natural death
PATO110	77	Female	German	COPD	Unknown	Unknown
PERO111	82	Female	German	Colon cancer	Unknown	Natural death
PERS5112	63	Female	German	Heart failure	Unknown	Unknown

ALS=amyotrophic lateral sclerosis; AS=assisted suicide; COPD=chronic obstructive pulmonary disease; NA=not applicable; ENT=ears, nose, throat.

*Participant identifiers (eg, PERS1102) are anonymised codes comprising a site-specific identifier and a unique participant number.

†Number of days between the interview and assisted suicide (eg, 3=interview conducted 3 days before assisted suicide).

‡Multiple diagnoses received.

§No reliable information regarding the participant's subsequent trajectory was available to the research team after the interview. As the study did not include systematic follow-up, this designation does not indicate whether assisted suicide had been scheduled or ultimately occurred.

¶Participant changed their mind and did not undergo assisted suicide.

**Request for assisted suicide pending approval.

population that is particularly difficult to involve in protocol development because of advanced illness, vulnerability, privacy concerns, and the sensitive nature of the topic.

Results

Interviews

Interviews lasted between 15 and 90 minutes. Variation in interview length reflected participants' medical, physical, and emotional condition; those with greater frailty generally giving shorter interviews. Despite their brevity, these interviews provided meaningful insights and were therefore retained in the analysis.

Participants

The study population comprised 30 participants. Given the challenges around involving individuals actively pursuing assisted suicide owing to health instability, we based sample completion on the inclusion of participants from different linguistic regions, clinical backgrounds, ages, and stages of the assisted suicide process. The sample comprised 17 women and 13 men, with a mean age of 73.5 years (range 35-97

years). Participants were recruited across Switzerland's three main linguistic regions, predominantly from the French speaking region (n=18), followed by the German speaking (n=7) and Italian speaking regions (n=5). The sample represented a broad range of clinical conditions, although cancer was the most common diagnosis received by the participants (n=17). Additional participant characteristics are given in table 1, including the interval between interview and assisted suicide (if completed), as well as the cause of death, where available.

Participants differed substantially by stage reached in the assisted suicide process at the time of interview. 14 participants had completed the process and later died by assisted suicide, 12 had not yet scheduled a date for assisted suicide, two later died from other causes, and the outcome of the remaining participants remains unknown. One participant was waiting for her request to be granted, and another was interviewed after deciding to withdraw from assisted suicide on the day it had been scheduled. Because our study aimed to explore motivations for pursuing assisted suicide rather than decision outcomes, this case was included in the sample.

Table 2 | Accounts of motivations behind the decision to pursue assisted suicide

Theme	Quote No	Participant quote
Imagining and shaping one's own death	1	I think it matured in me, so I had read a lot . . . but it matured in me, I think, even in my life in a nursing home, let's say, I met lots of people who it could have helped, who weren't aware of it [assisted suicide] or who didn't dare to be aware of it, either for religious reasons or for emotional reasons. But it's this desire to <i>mourir debout</i> [die standing up], you know. That's really what was on my mind. I couldn't say that there was a specific day [when I decided] . . . No, it just turned out that way. (PERS1113) My brother, who took two weeks to die, was in intensive care, then was just waiting [to die] and now he's finally gone. But well, it's still really hard, you know. (PERS1122)
	2	Dependence on other people is a terrible thing. If you are perhaps 85-90 years old, you may already be a little dependent on other people, but at 50-52 you don't want other people to be dependent on you, because without belittling anyone with my cancer, the day will come when you wet yourself and you won't be able to clean yourself up (. . .) You want to make it to the last day, but you don't know when that will be (. . .) having the option, I have it there, I take it and finish, no, even that isn't given to you, and we're in Switzerland (. . .) not having anyone, I don't want to depend on people I don't know or spend my last weeks in a bed, no, that's not for me. (PER0107) I didn't want it to come to that, because that would have been awful. For me, my death, and also for the children. Seeing me suffer, et cetera. And perhaps, even then, always needing more help and even more help, etc. I didn't want that. I wanted to leave while I was still in good shape. (PERS1121)
	3	Birth is something we prepare for. But death too, I believe we must prepare for it. Because death doesn't just 'happen'. It's the only thing that is certain. (PEREF107). I've been thinking about a bunch of things. The organist, for example, he's amazing at playing the organ. I've always said about my funeral, I don't want anything sad (. . .) We've already talked a bit about it, all that. I think it's kind of nice to prepare a little in advance. (PERS1121)
	4	I used to say, no, I'd like to be able to leave quickly. A cardiac arrest, just like that. Now I think to myself, but experiencing your own death isn't so bad (. . .) Sharing, saying goodbye . . . Daring to say that you're ill and that you're going to die soon . . . (PER0100).
Considering assisted suicide as a trusted commodity	5	In the past, [deaths by] suicides were buried outside the graveyard. We are fortunate that we have evolved in this regard. (PER0106).
	6	We experienced the entire [assisted suicide] together. I'm not worried about why I'm doing this, because I've seen how fair and completely controlled everything is (. . .) It couldn't be better; it couldn't be more honest. I'm happy because I know that nothing will be done that I don't want. And right up until the end, they ask, "Are you really sure?" You can still say no, right up until the end. No one is pressured to say "Yes" before deciding. (PERS3101).
	7	I'm all for safe things (. . .) I've always said, even if I throw myself off a bridge, they [people] will still manage to pull me up, maybe even half alive (. . .) Even hanging myself. I'm all for things done well (. . .) done right and safely. And then, in the end, it's something you do [for] yourself. It's still a pathway, something that seems to me, not better, but . . . yes, less impactful than, I don't know, a parent opening your bedroom door and finding you hanged. In my opinion, it's something else. I mean, for me, it's awful. (PER0108) So slowly she is led to an assisted death. As I do it, when I do it this way, I take the drug, the medicine, all at once, I touch it myself, I do it, but I am assisted in this. For me it's the same thing, only without suffering and with presence. And I want presence, because for me it is a joy to leave the body. (PERS0100)
	8	I don't want to shout it from the rooftops. It's nobody's business. And I think that's the good thing about it. (PERS3101).
Seeking validation and common ground	9	I told some of [my family] on the phone, I told some of them in person, and many hung up on me when I told them . . . (. . .) afterwards they told me that they were so shocked that they couldn't speak or anything, and in the end, they hung up on me. (PERS0104) There were no big discussions or anything that needed to be explained in detail. Just say what's really there, where it's going and why you want it for yourself. And the children understand that too, intellectually anyway. That their own hearts then cry "No!" is also quite logical. (PER0109)
	10	But I'm going down this path, no matter what [whether they accept it or not] (PER0111)
	11	I want to be remembered in a positive way, because that is also my son's wish. He said, "It's right that you don't go to that place, Mom . . . I understand you, because it's hard for those close to you too." Many people say, "I know how much I suffered and how much I remember my mother, how bad it was. How wonderful that you have this courage, that you are also helping your children" and, it's true. (PER0100).
	12	Everyone is helping me. You couldn't ask for anything better. That's why I'm convinced that this is the right thing to do. (PERS3101).
Reclaiming personal power over the medicalisation of dying	13	For me, an individual's right to self-determination is an important fundamental right. This right should not be restricted by ethical or religious considerations. I want to have a say in when and how I physically leave this earth. (PER0106).
	14	I don't trust them [doctors] because I want to know the side effects of these dissolving tablets. What are they giving me? What are they leaving in my blood? What? I don't believe it [in medical care], I don't believe it anymore, I don't believe in oncology anymore. And the fact that I don't believe it, I'd rather die, understand? (PER0105).
	15	I saw others suffering and unable to die. Because they can't die, because they are given medication, given and given. Nevertheless, you know that no help is possible. (PERS3101) In hospitals, in nursing homes, one might think that they prolong treatment simply because it pays off. (PEREF105).
Crossing the unbearable threshold	16	For my residence permit, I had to go to [place]. How do I get there on my own? And what if I don't have any money? Who will pay for my train ticket? How do I get from the station to the consulate? How long will it take? Can I walk there? (PEREF107).
	17	I had a neighbour at the table with whom I was talking. I realised that I couldn't understand [her] anymore. Three months earlier, I could understand everything. Then suddenly, the lady in the dining room, everything, echoed in my head. I realised that I was becoming increasingly deaf. I realised that my life was changing completely. That's when I called [the right-to-die association] (. . .) now, obviously, I'm no longer part of everyday life. (. . .) Everything is drifting away. (PERS1130)
	18	I made the circle. Soon, I will become a <i>centrale chimique</i> [chemical plant]. The medications I take, some suit me, and some don't. Then, there is this, and then, there is that. They [the medication] make you feel this, they make you feel that... It's a vicious circle. You cure one little thing and another one comes out. (PEREF107).
	19	I came three times for operations, only to have them all fail. There were even problems caused by the operations. So, I'm fed up, I'm really fed up. Because medicine has this ability to keep you on your toes, which I consider to be borderline unecological and illogical. (. . .) The tragedy for medicine is that if we force the healing of one of these crucial points, we can cause harm on the other side. (. . .) I have little chance of getting through this anyway. (. . .) What made me decide was that every time I got through [an operation], I went down a level. And now there are no more levels. If I go down, I dig into the ground. (PERS1125).
Seizing the narrowing window of opportunity	20	Peace. Eternity, tranquillity, gratitude. Gratitude is foremost, but it means peace, bliss, no struggle, no more struggle, peace. (PER0111)
	21	And then, you have to wait for death to come, but it doesn't seem to be coming. Well, I'll stay like this. As I said, I might still have a year or two to live, in my case. And then, I don't really want to, but that's how it is. (PERS1122).
	22	I said straight away: since it's incurable, I'm going to die with Exit. And then [the doctor] said 'But you know, you could think about palliative care. They also come to your home' I said yes, but with that (. . .) I can't be at home until the end. I need someone to be there to help me (. . .) Or it's the hospital (PER0100).
	23	Since death does not want to come, I will go and find it myself. (PEREF105) The sooner I can do it, the better. The sooner I'm in the box, the better. (PERS111)
	24	There is really no other option [than assisted suicide]. Or you can hold on to the illness. But that's so uncertain. (PERS3101).

Overview of thematic analysis

Through reflexive thematic analysis, we identified a set of motivations that participants described in explaining their decision to pursue assisted suicide. These were organised into six themes (table 2).

Each theme captures a distinct motivation that participants described as contributing to their choice to pursue assisted suicide. The themes represent shared patterns of meaning identified across participants' accounts, regardless of their sociodemographic characteristics, personal trajectories, or stage in the assisted suicide process. However, the relative salience, timing, and significance of these motivations varied between participants, and not all themes were equally prominent in every participant's account.

When explaining their decision, participants often described several motivations acting simultaneously that gave meaning primarily through their interaction as a collective, emphasising difficulty in separating the motivations. Rather than accumulating in sequential order over time, motivations interacted dynamically, shaping and reinforcing one another in unique ways. The importance of each motivation and convergence varied, and not all patterns were present in every participant's account. A key example of this is illustrated by the participant who ultimately decided not to proceed with assisted suicide, highlighting that the identified themes should not be understood as deterministic causes, but as interacting processes whose importance and configuration differed between individuals. Most importantly, the decision to pursue assisted suicide became clear when these motivations converged to consolidate the decision in a way that was personally meaningful.

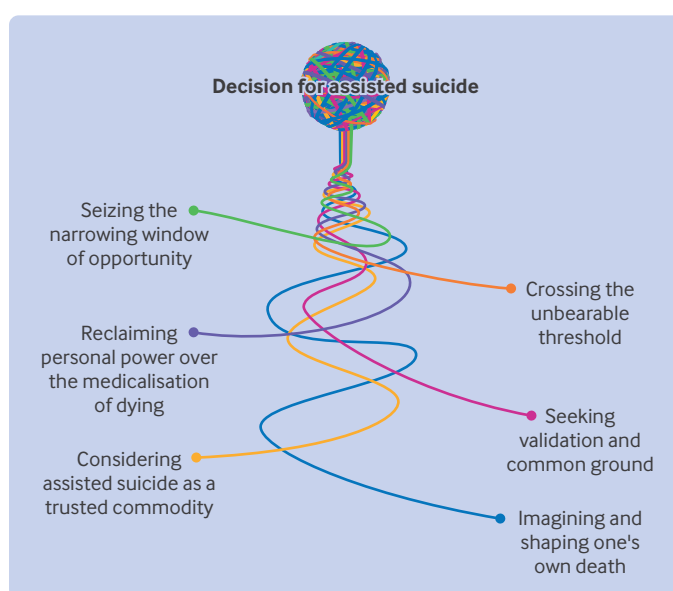


Figure 1 | Six themes that interact to influence the final decision to pursue assisted suicide in Switzerland. Read from top to bottom, the ordering reflects the analysis, according to which the first four themes function as background factors, while the final two appear more meaningful in reinforcing the decision. The sequence, intensity, and timeframe of these factors are highly dependent on the individual participant.

These themes also appeared to play different roles in participants' accounts: the first four themes provided a broader interpretive background against which participants made sense of their decision, whereas crossing the unbearable threshold and seizing the narrowing window of opportunity were more frequently described as themes that drove or crystallised the decision to pursue assisted suicide.

To capture this complex interplay, we developed a conceptual map (fig 1). The map summarises the motivations identified and illustrates how motivations occur, interact dynamically, and converge to reinforce the decision to pursue assisted suicide.

Imagining and shaping one's own death

This theme highlights how participants framed assisted suicide as the result of a longstanding reflection on dying well: the decision represented a culmination of a personal "end-of-life philosophy" (PERS1102) of autonomy and self-determination, an effort to align the manner of dying with the participant's values, beliefs, and sense of self.

For many in the study, the decision to pursue assisted suicide was part of existing views on death and a sense of personal responsibility to plan ahead for the end of life. The choice of assisted suicide was not only an end-of-life option but the culmination of earlier reflections grounded in autonomy, responsibility, and coherence between the chosen way of living and the chosen way of dying. Participants expressed a profound commitment to ensuring that their final moments, including the act of dying itself, would reflect their personal values, moral beliefs, and sense of identity.

Several participants explained that their interest in assisted suicide predated their illness, and that their reflections were rooted in broader philosophical considerations about the nature of a so-called good death, comparing desirable forms of dying with feared ones. Many spoke about specific scenarios they wanted to avoid, such as unrelieved pain or prolonged suffering, immobility, incontinence, cognitive decline, and loss of communication. One participant described this scenario as a greater fear than death: "I am absolutely not afraid of dying. It is suffering that I am extremely afraid of" (PERS1132). These fears were often shaped by past experiences of witnessing the prolonged decline and suffering of family members that served as moral and emotional touchstones, reinforcing participants' determination to avoid what they perceived as undignified or dehumanising deaths. These experiences further prompted the participants to view assisted suicide as a means of ensuring a peaceful and meaningful end (table 2, quote No 1).

In addition, participants expressed a desire to avoid leaving their relatives with distressing memories of their deterioration, a concern they reported had emerged several years before receiving their diagnosis. Therefore, they perceived assisted suicide as a means to alleviate the emotional and moral burden placed on loved ones (table 2, quote No 2).

Preparation emerged as a central expression of this philosophy of self-responsibility. The dying process—and ultimately, death itself—was described as a deeply intimate matter that belongs to individuals and ought to be decided on their own terms. Hence, participants reported taking an active role in preparing for death, which included drafting advance directives, writing farewells, arranging funerals, and organising practical matters. Several reported having joined right-to-die associations long before contacting them to organise the request as a practical safeguard and a symbolic affirmation of their decision. These preparations were described as empowering, allowing participants to anticipate their death (table 2, quote No 3).

We interpreted these acts of preparation as allowing the participants to mitigate the uncertainty and abruptness of dying. Participants were able to shape the process from what might otherwise be experienced as passive decline into an active, coherent process. Within this framework, assisted suicide offered a way to anticipate and orchestrate one's own dying in advance, a structured process perceived as a personal "exit project" (PERS1132) that emphasised self-determination, autonomy, and existential coherence, rather than leaving dying suddenly and out of one's control (table 2, quote No 4).

For the participants in our study, assisted suicide was not merely a means of ending life but a way to experience the dying process in accordance with deeply held moral values and final decisions. Assisted suicide represented an ethical stance and an existential project: a final, prepared act of authorship over one's life.

Considering assisted suicide as a trusted commodity

This theme describes how participants experienced the Swiss model of assisted suicide as a structured, safe, and trustworthy process. The procedural transparency and demedicalised nature of the right-to-die associations changed assisted suicide from an abstract moral idea into a legitimate, reliable, and socially accepted way of dying.

Participants consistently expressed trust in the Swiss model of assisted suicide as not merely as a legitimate end-of-life option but as a social privilege, a marker of social progress and collective moral acceptance. Perceptions of the Swiss model were remarkably consistent across the dataset: participants described the system as reassuring, trustworthy, and supportive. Participants associated the model with fairness and safety, qualities that, for many, transformed assisted suicide into a reliable and even desirable pathway to dying. Importantly, the Swiss model was experienced as a structuring mechanism that could actualise philosophical views on autonomy and dignity into tangible pathways for action.

Right-to-die associations held a pivotal role in participants' views on assisted suicide: the associations were described as trustworthy institutions providing guidance through administrative and procedural steps,

ensuring that participants' wishes would be respected and that the process would be carried out with care, respect, and dignity. Several participants reported joining these associations well before the onset of illness, viewing membership as both a symbolic endorsement of their values and a practical safeguard for the future.

Many compared this model with systems abroad, where assisted dying is perceived as being highly medicalised or tightly regulated by legal authorities. In comparison, the so-called civil model used in Switzerland was valued for placing decision making in the hands of the individual rather than institutions or healthcare professionals. Participants perceived the Swiss model as unique in prioritising the autonomy of the individual rather than that of a medical or legal authority, and emphasised the privilege of having access to this option. One participant expressed gratitude and pride in belonging to a society that offers assisted suicide and recognises the legitimacy of death by this method (table 2, quote No 5).

Another central concept was the perception of assisted suicide as a "clean" (PEREF107), reliable, and well structured procedure that minimised uncertainty, pain, and distress for both the dying person and their relatives. One participant, who had supported a relative through the procedure in the past, emphasised the comfort and control that came with witnessing the procedure firsthand (table 2, quote No 6).

Such accounts framed assisted suicide as a humane and organised alternative to violent, solitary, or desperate forms of suicides. Participants clearly distinguished assisted suicide from impulsive, tragic, or morally transgressive acts of self-destruction, instead describing the procedure as deliberate, legitimate, and dignified (table 2, quote No 7).

Collectively, these narratives show that participants did not see assisted suicide as merely an end-of-life option but rather as a trusted commodity that could be acquired: a reliable, dignified, and socially acceptable way of dying. From this point of view, perceptions of safety, fairness, and reliability embedded in the Swiss civil model became powerful legitimising motivations, reinforcing assisted suicide as a socially acceptable personal choice.

Seeking validation and common ground

This theme highlights the relational aspects of the decision, showing how participants negotiated the delicate process of disclosing their choice to pursue assisted suicide to loved ones. While deeply personal, the decision was often reinforced through emotional validation, shared understanding, and collaborative preparation.

During the interviews, participants described the process of disclosing their choice as a profoundly delicate and challenging step. Communicating such an intimate choice required participants to find common ground between asserting personal autonomy and seeking understanding from loved ones. As one participant put it, disclosing this information meant

making relatives “enter the game” (PERS0100), a metaphor that encapsulated both the desire to find support from loved ones and the maintenance of personal authority.

Participants generally disclosed their intention only to selected and trusted family members, most often those perceived as emotionally mature, empathetic, or capable of respecting their choice. Some deliberately chose not to inform certain relatives (particularly children or grandchildren) to protect them from distress, conflict, or moral disagreement, and to preserve their privacy in an intensely personal matter (table 2, quote No 8).

Reactions from family members were reported to vary widely. For some participants, disclosure provoked shock, sadness, or even opposition (table 2, quote No 9). Yet, such reactions rarely influenced participants’ resolve to proceed with assisted suicide. Instead, negative reactions were often interpreted by participants as a sign that others failed to grasp the depth of their suffering. Without external validation or support, many emphasised that they were not open to reconsidering their decision because they perceived their choice as profoundly intimate (table 2, quote No 10).

Conversely, when relatives accepted and supported the decision, participants described a strong sense of relief. In these cases, the family’s acknowledgment of the participants’ suffering and respect for their pursuit of assisted suicide gave moral validation that strengthened participants’ sense of coherence and peace with their choice (table 2, quote No 11).

This support was often framed as solidarity, which reinforced the participants’ determination to complete the assisted suicide process. When relatives showed acceptance, the process of sharing often changed from a declaration of intent to a collaborative effort to pursue assisted suicide, involving active participation in the project. Family members were sometimes involved in administrative steps, emotional preparation, or planning the practical aspects of the procedure. This form of shared engagement fostered a sense of closure and mutual understanding, which participants experienced as deeply meaningful (table 2, quote No 12).

While participants described assisted suicide as an act of personal self-determination, their accounts also revealed important relational factors motivating their decision to pursue assisted suicide and the ways in which the decision unfolded within a moral and emotional web of relationships. In some cases, family members provided reassurance and reinforcement, giving moral and emotional validation to participants and transforming assisted suicide from a solitary act into a shared preparation for death and dying.

Reclaiming personal power over the medicalisation of dying

This theme reflects participants’ desire to reclaim autonomy and agency from a dying process that is perceived to be medicalised and paternalistic.

Participants saw assisted suicide as one of the few remaining end-of-life decisions in which they could fully express self-determination, reassert moral agency, and retain ownership over the conditions of dying, as opposed to more medicalised pathways of dying.

Participants consistently emphasised the importance of preserving autonomy and decision making authority over the dying process. For them, this meant ownership over decisions that define personal dignity and identity. Self-determination was described as a fundamental “human right” and an “expression of freedom” (PERS1125) symbolising moral agency and empowerment in later life and when facing death (table 2, quote No 13).

Participants described experiences of disempowerment within medical settings, wherein they felt disregarded in clinical decision making by healthcare professionals. Several reported episodes of poor communication, misunderstanding of their experience of illness and suffering, and inappropriate medication management. Such encounters eroded trust in medicine and fostered scepticism about whether their autonomy would be respected in future care or decision making contexts (table 2, quote No 14).

Hence, participants viewed self-determination as essential and described loss of decision making capacity as one of the most feared aspects of their declining health. They were particularly uneasy about the prospect of becoming dependent on others or entering a vegetative state, expressing concern that this could result in treatments or decisions being imposed upon them. Participants strongly criticised the prospect that medical professionals could one day make decisions on their behalf, expressing little confidence that healthcare staff would act in their best interest. Earlier encounters with perceived medical futility (ie, overtreatment) contributed to a conviction that doctors make decisions at the expense of patients’ quality of life, and showed a reluctance to confront death (table 2, quote No 15).

This theme reveals that participants’ decisions to pursue assisted suicide were shaped by a need to reassert their voice and reclaim a sense of empowerment and ownership in medical settings where these had been marginalised, while maintaining an active role in decisions concerning their care.

Crossing the unbearable threshold

This theme captures how participants described their decision about assisted suicide as arising from a cumulative, multidimensional experience of suffering that had become unbearable. Physical, psychological, existential, treatment related, and social dimensions of distress intertwined over time, forming a self-sustaining sense of decline in which continuing to live was perceived as impossible.

For participants, the choice to pursue assisted suicide was closely associated with a sustained experience of suffering. Although the manifestation and intensity of suffering varied between participants, five interrelated

factors emerged from their accounts of suffering: physical (fatigue, pain, loss of mobility, and functional decline), psychological (anxiety, rumination, and loss of joy or pleasure in life), existential (uselessness, loss of meaning, and erosion of life purpose), treatment related (exhaustion associated with prolonged treatments and the burden of care), and social (unwanted social isolation, perceived loss of social roles, and challenges in fulfilling everyday activities) (table 2, quote No 16).

Participants frequently emphasised that these factors were rarely isolated, and that they interacted dynamically and reinforced one another, giving the impression of a self-perpetuating cycle of decline, an experience often described as unbearable. This perception extended beyond the physical or symptomatic dimensions of illness to encompass a broader sense of existential exhaustion. Participants regularly described ageing as emblematic of this spiral: physical limitations reduced autonomy, which in turn deepened dependency, social withdrawal, and feelings of uselessness. As one participant affected by hearing loss explained, this progressive disconnection eroded the sense of belonging and identity (table 2, quote No 17).

Many participants expressed the conviction that improvement was no longer attainable and that further efforts to reverse this cycle of decline would be futile. Several noted that living with coexisting long term conditions implied endless care and treatment (table 2, quote No 18).

The repetition of medical interventions was experienced to be exhausting and dehumanising. Participants described their situation as “survival” or “torture” (PERS1127), explaining that they had reached a personal limit with their treatments and no longer wished, or felt able, to continue them. Some cited a lack of physical strength, fear of dependency on drugs to manage their illness, or believed that further invasive interventions could not be tolerated at an advanced age. The exhaustion caused by continuous treatment, compounded by physical deterioration, reinforced the impression of an uncontrollable and self-perpetuating cycle of decline, often accompanied by a pervasive sense of hopelessness (table 2, quote No 19).

For many, treatment became part of the problem rather than a source of relief, leading the participants to view medical interventions as perpetuating the cycle of decline rather than halting it. Unbearable suffering was therefore experienced not as a static state, but as a dynamic process: a trajectory of progressive exhaustion in which medical care actively drove distress.

In this context, participants framed assisted suicide as a reassuring option, a final and only means of escaping a relentless, uncontrollable, self-perpetuating cycle of deterioration prolonged by ongoing medical interventions. As one participant expressed, the decision was ultimately shaped by the hope of finally finding relief (table 2, quote No 20).

Seizing the narrowing window of opportunity

This theme describes how participants experienced time as a critical determinant in shaping their decision to pursue assisted suicide. Fearing the loss of physical or cognitive capacity, they perceived assisted suicide as a closing window of opportunity—a limited period during which they could still act to ensure a self-determined and dignified death.

Participants often referred to assisted suicide as a reassuring “safety net” (PERO110), and described the process as an option they could reserve until the necessary time. However, they repeatedly expressed concerns about missing the opportunity to do so. Their eligibility for assisted suicide depended on maintaining physical and cognitive capacities, which they feared might be lost as their illness progressed. Several mentioned trying to slow the progression of their illness by engaging in sport to maintain physical strength. Loss of decisional capacity or worsening functional decline was described as a looming threat that could render them ineligible or prevent them from actualising assisted suicide. The prospect of becoming ineligible and facing refusal was commonly described as one of the greatest fears. For participants, this would mean becoming trapped in a state of severe paralysis or incapacitation, losing the opportunity to request assisted suicide, and enduring a prolonged dying process with no possibility of relief. This perception was vividly illustrated by the only participant we met who decided, at the very last moment, not to proceed with assisted suicide and expressed regret at this decision (table 2, quote No 21).

Therefore, the fear of losing necessary capacities (eg, decision making capacity, the ability to swallow or to move a finger, detailed in supplementary appendix) acted as a meaningful trigger for pursuing assisted suicide. For participants, this fear fostered a sense of urgency to act before their capacities declined and the chance to access assisted suicide was lost. We conceptualise this temporal awareness as a narrowing window of opportunity: participants felt the pressing need to proceed with their request before their illness advanced to the point of impairing decision making capacity, but also before entering institutions where they might face potential barriers such as restrictive policies on assisted suicide in hospitals or nursing homes. For some, even receiving the diagnosis of illness marked the beginning of this closing window of time, prompting early arrangements for assisted suicide to avoid future loss of control (table 2, quote No 22).

From their perspectives, the immediacy of the decision was not described as being shaped by impulsiveness, but rather as resulting from a deliberate evaluation of timing and the risks of losing the opportunity, which consequently triggered the proceed with assisted suicide. Several participants thus reported the need to organise the request as soon as possible (table 2, quote No 23).

This theme captures how participants negotiated the tension between time and personal agency. Facing

the unpredictability of illness and the constraints of eligibility, participants saw assisted suicide as a time narrowing opportunity, resulting in a strong sense of urgency to initiate the request. Ultimately, the decision to pursue assisted suicide was shaped by a desire to safeguard their longstanding wish for this option before their illness or institutional policies could end the possibility of dying by assisted suicide (table 2, quote No 24).

Discussion

Key findings

This study, based on first person accounts collected while participants were actively engaged in the assisted suicide request process, provides unique insights into reflections and motivations of participants regarding their decision to pursue assisted suicide in Switzerland. Our findings demonstrate that participants view their decision as the result of multiple interacting motivations based on personal agency, external validation, regain ownership, and sense of urgency. Most importantly, participants in this study framed assisted suicide not only as a response to suffering or decline, but as a deliberate and structured way of shaping the end of life, which some had considered pursuing even before experiencing serious illness or approaching the end of life.

Our findings add to ongoing work exploring lived experiences of assisted dying by generating new insights into how people construct and make sense of their decisions to pursue assisted suicide. Although our study focused on the Swiss civil model of assisted suicide, many of the motivations and processes that were personally meaningful described by the participants resonate with findings reported in jurisdictions where other forms of assisted dying are practised. Consistent with existing international literature investigating the motivations leading individuals to pursue this route, participants described an experience of a multidimensional suffering characterised by physical decline, loss of autonomy, exhaustion, erosion of personhood, and negative treatment experiences.^{14 34-37} Previous studies have often interpreted these experiences as triggering a wish to hasten death through assisted dying, as either an urgent attempt to alleviate suffering or a so-called cry for help, while attempting to preserve some sense of control and identity.^{38 39} Our findings confirm that suffering plays a central role, but the results also show that suffering alone is not sufficient to explain how individuals make sense of their decision to pursue assisted suicide. Participants did not describe their choice merely as a wish to find relief from suffering, but as part of a broader process in which multiple meaningful motivations contributed to and consolidated the decision.

A key contribution of this study lies in showing that several motivations were not described as immediate reactions to illness or crisis, but as part of longstanding considerations on autonomy, responsibility, dignity, and the desired manner of dying. For many

participants, these reflections predated their illness and shaped subsequent experiences of declining health. Assisted suicide was frequently described not as an exceptional or impulsive act, but as the culmination of a life philosophy and preparation for death, oriented towards self-determination and coherence between their preferred ways of living and dying. The decision to pursue assisted suicide was therefore seen as the outcome of a longstanding process (often called a personal project) of reflection, planning, and active preparation that may unfold over several years. Earlier studies have shown that stages of early contemplation for this option can play a substantial role in individuals' decision making processes.^{25 40} These studies also suggest that particular concerns become more or less salient at different stages of the decision making process: for example, fears of becoming a burden have been identified during earlier stages of contemplation,^{12 41} a finding that may reflect broader concerns about autonomy and personal responsibility identified in the present study.

Our findings may also be understood through the lens of existential suffering, loss of personhood and disruption of the sense of self at the end of life as a form of suffering arising from threats to identity, dignity, meaning, and continuity of self in the context of advanced illness.^{14 42} While previous studies have largely described existential suffering as a factor contributing to requests for assisted suicide, our findings suggest a more nuanced interpretation. Threats to identity and personhood emerged not only as important sources of existential suffering (particularly reflected in theme 4), but also as concerns that shaped participants' desire to restore continuity and preserve coherence between the self and the way they wished to die. In this sense, assisted suicide was frequently described not only as a response to existential suffering, but also as a means of preserving selfhood at the final stage of life.

At a broader level, our findings give an understanding of the personal importance that participants attach to their decision to undergo assisted suicide, showing that decisions were also grounded in negotiations with relatives and cultural contexts. These results align with international scholarship emphasising that assisted dying decisions are relational, temporally situated and socially embedded, rather than solely driven by symptoms of illness or psychologically reactive, and shaped by prevailing discourses and practices that render assisted dying as socially acceptable.^{43 44}

Our study further shows the important role of the institutional framework in shaping participants' decision to pursue assisted suicide. Within the Swiss civil model, individuals are generally expected to initiate and navigate the assisted suicide process themselves, often in parallel with ongoing medical care. Earlier studies have suggested that awareness of and access to assisted suicide may be influenced by factors such as health literacy, education, social resources, language, and familiarity with the healthcare system.⁴⁵ In addition, our findings suggest

that trust in the Swiss system played a substantial role in decision making, providing reassurance that their wishes would be respected and that assisted suicide would remain a feasible option should their suffering become unbearable. Right-to-die associations were consistently described as trustworthy intermediaries that translated abstract values into legitimate pathways towards death, in contrast with more medicalised models of dying. Procedural clarity, demedicalisation, and perceived fairness contributed to participants' confidence that assisted suicide was a safe, reliable, and morally acceptable option. In this sense, institutional frameworks did not merely enable access but actively shaped how participants imagined, prepared for, and consolidated their decision. These findings suggest that the design of assisted dying systems influences the lived experience and moral intelligibility of the practice. Such a perspective is particularly relevant for jurisdictions currently debating or implementing assisted dying legislation, underscoring the limits of linear or checklist based models of eligibility and assessment.

Participants in our study also experienced assisted suicide as a means of reclaiming agency in response to perceived medical paternalism and the medicalisation of dying: firsthand accounts revealed that earlier experiences of poor communication, misunderstandings, disregard for their experience of illness, and inflexibility in treatment methods contributed to mistrust in the capacity of medical professionals to respect the wishes of the individual, and support them in the dying experience. In this context, choosing assisted suicide functioned practically and symbolically to reassert authority over dying and to reposition oneself as an active moral agent. These findings echo the work of Schwarz and colleagues,⁴⁶ showing that navigating and supporting patients' sense of control in the final act of dying remains a challenge for healthcare professionals. Comparably, international researchers have also interpreted assisted dying as part of a broader shift towards partial demedicalisation of death, shifting the governance of dying from healthcare professionals to relatives and other non-medical groups.⁴⁷

Awareness of time passing emerged as a further central dimension. The perception of a narrowing window of opportunity transformed assisted suicide from a hypothetical option into an urgent decision, reinforcing the need to act before illness progresses too far or institutional constraints prevent self-determination. This finding adds nuance to existing debates by showing how urgency can coexist with prolonged reflection and careful planning.

Although not central among the factors for assisted suicide described above, the data contained several instances of possible altruistic motivations, such as participants wishing to spare their loved ones the emotional and moral burden of witnessing painful end-of-life experiences or withholding the information from others to protect them from distress. These accounts suggest that assisted suicide decisions may

occasionally incorporate prosocial considerations for others involved in the assisted suicide process. Thus, altruism could play a role in the motivational structure for assisted suicide, the extent of which may vary considerably between patients. However, such concerns were typically mixed with broader reflections on autonomy, dignity, identity, and the kind of legacy participants wished to leave behind, rather than functioning as independent motivations for assisted suicide.

Strengths, limitations, and future research

A major strength of this study is the documentation of first person accounts from individuals actively pursuing assisted suicide, many of whom were interviewed close to the scheduled death. Such research remains rare internationally, and the inclusion of participants from multiple linguistic regions at different stages of the request process prioritised diversity of experience over diagnostic or temporal uniformity and allowed identification of shared patterns of meaning across diverse participant experiences.

Several limitations should be considered. Firstly, although we sought to include participants with varied characteristics, the sample was predominantly composed of women and French speaking participants, and may not reflect the full range of individuals considering or pursuing assisted suicide in Switzerland. Some interviews were also relatively short because of participants' physical frailty, which may have limited the depth of exploration of certain accounts, although these interviews still contributed meaningful data.

Secondly, recruitment through healthcare professionals and right-to-die associations may have shaped the sample. The research team had limited oversight of which eligible individuals were informed about the study, and individuals who were more physically or emotionally vulnerable, socially isolated, ambivalent towards their decision, or less able to discuss their situation may therefore be underrepresented. Broader social and educational inequalities, including health literacy and access to information, may also have influenced who was able or willing to participate.

Thirdly, all participants had already initiated the assisted suicide process. The study therefore did not capture the perspectives of individuals who considered but did not pursue assisted suicide, abandoned the process, or remained uncertain. In addition, participants were interviewed at different stages of the process. As participants' stage in the assisted suicide process was treated as contextual information rather than as a factor influencing the emergence of specific motivations, we did not differentiate or compare findings according to participants' stage in the process. Future studies specifically designed for comparative and longitudinal analyses should examine how motivations may be shaped by, and differ between, diagnostic groups, social contexts, linguistic regions, stages of decision making, and proximity to death, and

should examine how motivations evolve as individuals move closer to making a final decision.

Finally, the findings are embedded in the Swiss civil model of assisted suicide, particularly the role of right-to-die associations and the relatively demedicalised structure of the process. These contextual features limit direct transferability to jurisdictions governed by more medicalised or legally regulated frameworks. At the same time, several processes identified in this study (eg, the role of longstanding individual values, existential concerns, external validation, and sense of urgency) may be relevant to clinicians caring for patients considering forms of assisted dying in other contexts. Future research should use comparative and longitudinal designs to examine how different legal and institutional configurations shape the motivations, experiences, and meanings associated with assisted dying over time and across contexts.

Clinical implications

From a clinical perspective, these findings emphasise that requests for assisted dying should not be interpreted as isolated or purely reactive expressions of distress. Rather, they often reflect the actualisation of longstanding values, anticipatory reasoning, and broader life narratives.

Our study highlights that conversations about assisted suicide need not be limited to patients with advanced illness or to those making a formal request. Several participants described reflecting on assisted suicide long before becoming seriously ill, suggesting that patients' questions about assisted suicide in primary care settings may offer valuable opportunities to explore anticipated sources of unacceptable or avoidable future suffering, future care preferences, and what matters most to each individual. Beyond discussing the legal and practical aspects of assisted suicide, clinicians may use these conversations to initiate advance care planning, co-construct care plans that reflect patients' priorities, and provide reassurance that their values and preferences will continue to guide clinical decision making throughout the course of illness, irrespective of whether assisted suicide is ultimately pursued.

When patients with serious illness request or express an interest in assisted dying, clinical assessment should extend beyond the evaluation of physical and psychological symptoms to include exploration of their lived experience of illness, anticipated future, and the meanings attached to autonomy, dependency, dignity, and dying. These requests may represent the beginning of an important dialogue through which clinicians can better understand patients' concerns, priorities, and expectations. Importantly, the aim of these conversations is not to confirm nor challenge a patient's wish for assisted dying, but to better understand the person, the values underlying the request, and the goals that should guide care regardless of the patient's eventual decision.

Clinicians may therefore approach such requests as entry points for dialogue, inviting patients to

articulate how suffering, autonomy, relationships, and timing interact in their decision. Open, reflective conversations may help clarify motivations, strengthen trust, and reduce perceptions of medical paternalism. These conversations should be guided by open ended, explorative and non-leading questions that invite patients to describe the personal meaning of their request, the values they wish to preserve, and the aspects of their identity and future that matter most to them. (1) Can you tell me how assisted dying has become part of your thinking? (2) How does this request fit with the way you have thought about your life and the end of your life? (3) When you think about the future, are there situations that feel incompatible with the way you wish to live? (4) What do you hope this request will make possible for you? Questions like these may help clinicians better understand the broader significance of a request for assisted dying and identify concerns relating to identity, autonomy, relationships, or existential distress that may not emerge through symptom focused assessment alone. Clinicians should also take care not to reduce requests for assisted suicide to expressions of symptom burden or existential distress alone. Among our participants, requests for assisted suicide often represented an attempt to preserve coherence between identity, personal values, and the way they wished to die.

As assisted dying becomes legally available more widely, and as some patients travel internationally to access these practices, clinicians may increasingly encounter individuals seeking information, prognostic clarification, emotional support, or opportunities to discuss assisted dying, regardless of whether it is legally available within their own healthcare system. For palliative care clinicians in particular, these findings reinforce the importance of integrating discussions about identity, dignity and anticipated decline in health into routine care, irrespective of whether assisted dying is legally available or ultimately pursued.

From a policy perspective, assisted dying frameworks should be accompanied by structured opportunities for reflection, communication, and exploration of patients' values, goals, and concerns throughout the decision making process. Policies governing assisted dying should also ensure that individuals are supported, not only in accessing information about assisted dying, but also in engaging in advance care planning and person centred discussions that preserve their autonomy.

AUTHOR AFFILIATIONS

¹Palliative and Supportive Care Service, Chair in Geriatric Palliative Care and Institute of Humanities in Medicine, Lausanne University Hospital and University of Lausanne, 1011 Lausanne, Switzerland

²Institute of Biomedical Ethics and History of Medicine, University of Zürich, Zürich, Switzerland

³Palliative and Supportive Care Service, Chair of Palliative Care Nursing, Lausanne University Hospital and University of Lausanne, Lausanne, Switzerland

⁴Palliative and Supportive Care Service, Chair of Palliative Psychology, Lausanne University Hospital and University of Lausanne, Switzerland

⁵Palliative and Supportive Care Service, Lausanne University Hospital and University of Lausanne, Switzerland

⁶Palliative and Supportive Care, Chair of Palliative Care Nursing and Institute of Higher Education and Research in Healthcare, Lausanne University Hospital and University of Lausanne, Switzerland

⁷Palliative and Supportive Care Service and Service of Geriatric Medicine and Geriatric Rehabilitation Chair of Geriatric Palliative Care Lausanne University Hospital and University of Lausanne, Switzerland

We are deeply grateful to the participants for generously sharing their experiences and reflections on assisted suicide, often during times of great vulnerability. We also extend our thanks to the right-to-die associations in Switzerland for their support in recruiting participants, and we are deeply grateful to the medical staff at all participating sites for their substantial efforts in facilitating recruitment. We are indebted to the entire Swiss National Science Foundation research project team for their constructive feedback and reflections on the methodology throughout the study. We would also like to extend our warmest thanks to the graphic designer who helped us create the figure for this manuscript.

Contributors: SB collected the data, contributed to its analysis and wrote the manuscript. LH and SS collected the data, contributed to analysis, and critically revised the manuscript. CG conceived the design of the study, supervised the work, contributed to the data analysis of the study, and critically revised the manuscript. RJJ, GDB, ACS, MB, and PL contributed to the protocol and development of the methods for the study, provided regular feedback on the analysis, reviewed and edited the manuscript. All authors critically reviewed, contributed, and approved all intellectual content of the manuscript and accept full responsibility for the final manuscript. SB is responsible for the overall content as guarantor. The corresponding author attests that all listed authors meet authorship criteria and that no others meeting the criteria have been omitted. During the preparation of this paper, the authors used ChatGPT, DeepL, and Grammarly to improve sentence flow, and to correct grammar, spelling, and coherence. After using these tools, the authors reviewed and edited the content as needed and take full responsibility for the publication's content. The AI powered tool AIKO was used to audio record and transcribe all interviews verbatim in the original language to preserve nuance.

Funding: This study was funded by the Swiss National Science Foundation (grant No 10001G_207814/1). The project also received additional funding from the Pallium Foundation. The funding bodies had no role in the design, conduct, analysis, or reporting of this study.

Competing interests: All authors have completed the ICMJE uniform disclosure form at www.icmje.org/disclosure-of-interest/ (available on request from the corresponding author) and declare: no support from any organisation for the submitted work; no financial relationships with any organisations that might have an interest in the submitted work in the previous three years, no other relationships or activities that could appear to have influenced the submitted work. Swiss National Science Foundation (grant No 10001G_207814/1) funded this study, and the project received additional funding from the Pallium Foundation. The funding bodies had no role in the design, conduct, analysis, or reporting of this study. The collaborating right-to-die associations (Exit ADMD, Life Circles, and Exit Ticino) assisted with identifying potential participants and were not involved in data collection, analysis, interpretation, or manuscript preparation.

Ethical approval: Ethical approval was granted by the Ethics Committee of the Canton of Vaud, Zürich and Ticino, Switzerland, (No 2023-00088, 23 June 2023). Participant consent was assessed on two occasions: by agreeing to meet the researcher to obtain detailed information about the study, and by signing the informed consent before the interview.

Data sharing: Relevant anonymised patient data underlying the analyses, results, and conclusions reported in this paper are available upon reasonable request from the corresponding author. Researchers interested in accessing the data may contact the corresponding author to discuss possible arrangements, subject to approval and compliance with applicable ethical guidelines.

Transparency: The lead author affirms that the manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned (and, if relevant, registered) have been explained.

Dissemination to participants and related patient and public communities: The findings of this study will be disseminated through

presentations at national and international congresses and scientific meetings, public lectures and educational events on assisted dying and palliative care. The results will also be shared with collaborating healthcare professionals and the right-to-die associations to facilitate dissemination among citizens, patients, families, and other interested stakeholders. A plain language summary of the findings will be shared with participating right-to-die associations to support dissemination among their members and the wider community. In addition, the findings will be disseminated through the Swiss Society for Palliative Medicine, communication channels, including articles published in its national journal in the national languages to reach interdisciplinary healthcare professionals across Switzerland. Relevant federal stakeholders, including the Swiss Federal Office of Public Health, will also be informed of the study findings.

Provenance and peer review: Not commissioned, externally peer reviewed.

This is an Open Access article distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 4.0) license which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited and the use is non-commercial. See: <http://creativecommons.org/licenses/by-nc/4.0/>.

- Colombo AD, Dalla-Zuanna G. Data and Trends in Assisted Suicide and Euthanasia, and Some Related Demographic Issues. *Popul Dev Rev* 2024;50:233-57. doi:10.1111/padr.12605
- Mroz S, Dierickx S, Deliens L, et al. Assisted dying around the world: a status quaestionis. *Ann Palliat Med* 2021;10:3540-53. doi:10.21037/apm-20-637
- Sillitti P, Meier C, Blanc S, et al. A public health perspective on assisted dying and its different modalities. *Lancet Public Health* 2025;10:e1001-5. doi:10.1016/S2468-2667(25)00245-2
- Radbruch L, Leget C, Bahr P, et al. Euthanasia and physician-assisted suicide: A white paper from the European Association for Palliative Care. *Palliat Med* 2016;30:104-16. doi:10.1177/0269216315616524
- Pillonel A, Berthod M-A, Dransart DAC, Stavrianakis A. *La mort appréciée. L'assistance au suicide en Suisse*: Antipodes2021.
- Académie Suisse des Sciences Médicales. *Attitude face à la fin de vie et la mort: Directives médico-éthiques*. Berne: ASSM, 2021.
- Hurst SA, Mauron A. Assisted Suicide in Switzerland: Clarifying Liberties and Claims. *Bioethics* 2017;31:199-208. doi:10.1111/bioe.12304
- Hardes Dvorak J. Is Assisted Dying Really a Matter for Medical Regulation? *J Law Med Ethics* 2025;53:1-12. doi:10.1017/jme.2025.10117
- Emanuel EJ, Onwuteaka-Philipsen BD, Urwin JW, et al. Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe. *JAMA* 2016;316:79-90. doi:10.1001/jama.2016.8499
- Fischer S, Huber CA, Furter M, et al. Reasons why people in Switzerland seek assisted suicide: the view of patients and physicians. *Swiss Med Wkly* 2009;139:333-8. doi:10.4414/smw.2009.12614
- Ganzini L, Goy ER, Dobscha SK. Oregonians' reasons for requesting physician aid in dying. *Arch Intern Med* 2009;169:489-92. doi:10.1001/archinternmed.2008.579
- Rodríguez-Prat A, Balaguer A, Crespo I, et al. Feeling like a burden to others and the wish to hasten death in patients with advanced illness: A systematic review. *Bioethics* 2019;33:411-20. doi:10.1111/bioe.12562
- Balaguer A, Monforte-Royo C, Porta-Sales J, et al. An International Consensus Definition of the Wish to Hasten Death and Its Related Factors. *PLoS One* 2016;11:e0146184. doi:10.1371/journal.pone.0146184
- Chochinov HM. Fractured Personhood, Suicide, and Lessons from Those Nearing Death. *J Palliat Med* 2023;26:1037-9. doi:10.1089/jpm.2023.0299
- Gagnard ME, Hurst S. A qualitative study on existential suffering and assisted suicide in Switzerland. *BMC Medical Ethics* 2019;20doi:10.1186/s12910-019-0367-9
- Gagnard ME, Pautex S, Hurst S. Existential suffering as a motive for assisted suicide: Difficulties, acceptability, management and roles from the perspectives of Swiss professionals. *PLoS One* 2023;18:e0284698. doi:10.1371/journal.pone.0284698
- Steck N, Egger M, Maessen M, et al. Euthanasia and assisted suicide in selected European countries and US states: systematic literature review. *Med Care* 2013;51:938-44. doi:10.1097/MLR.0b013e3182a0f427
- Bartsch C, Landolt K, Ristic A, et al. Assisted Suicide in Switzerland: An Analysis of Death Records From Swiss Institutes of Forensic Medicine. *Dtsch Arztebl Int* 2019;116:545-52. doi:10.3238/arztebl.2019.0545

- 19 Heidinger B, Webber C, Chamber K, et al. International Comparison of Underlying Disease Among Recipients of Medical Assistance in Dying. *JAMA Intern Med* 2025;185:235-7. doi:10.1001/jamainternmed.2024.6643
- 20 da Silva MDAP, Corradi-Perini C. The Mapping of Influencing Factors in the Decision-Making of End-of-Life Care Patients: A Systematic Scoping Review. *Indian J Palliat Care* 2023;29:234-42. doi:10.25259/IJPC_292_2022
- 21 Grove GL, Lovell MR, Hughes I, et al. Voluntary-assisted dying, euthanasia and physician-assisted suicide: global perspectives-systematic review. *BMJ Support Palliat Care* 2025;15:423-35. doi:10.1136/spcare-2024-005116
- 22 Hudson PL, Kristjanson LJ, Ashby M, et al. Desire for hastened death in patients with advanced disease and the evidence base of clinical guidelines: a systematic review. *Palliat Med* 2006;20:693-701. doi:10.1177/02692163060071799
- 23 Blake RR, Blake C. Why People Think They Might Hasten Their Death When Faced With Irremediable Health Conditions Compared to Why They Actually Do so. *Omega (Westport)* 2023;87:1109-26. doi:10.1177/00302228211033368
- 24 Young JE, Lyons AC, Dew K, et al. Is there a right time to die? How patients, families and assisted dying providers decide on and anticipate a date with death. *Death Stud* 2026;50:103-15. doi:10.1080/07481187.2024.2414277
- 25 Gamondi C, Pott M, Preston N, et al. Family Caregivers' Reflections on Experiences of Assisted Suicide in Switzerland: A Qualitative Interview Study. *J Pain Symptom Manage* 2018;55:1085-94. doi:10.1016/j.jpainsymman.2017.12.482
- 26 Bernard M, Gamondi C, Sterie AC, et al. Interdisciplinary research approach based on a mixed-methods design to explore patient altruism at the end of life: a study protocol. *BMJ Open* 2024;e085632. doi:10.1136/bmjopen-2024-085632
- 27 Braun V, Clarke V. To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *Qual Res Sport Exerc Health* 2019;13:201-16. doi:10.1080/2159676X.2019.1704846
- 28 Blanc S, Acién C, Savinelli S, et al. "How to say goodbye": A reflective exercise on field experience in palliative care research. *Revue internationale de soins palliatifs* 2025;39:48-58. doi:10.3917/inka.251.0048
- 29 Sindre Sorhus. Aiko [program], 2024. Available: <https://apps.apple.com/de/app/aiko/id1672085276>
- 30 Braun V, Clarke V. *Thematic analysis: A practical guide* : sageLondon, 2022.
- 31 Braun V, Clarke V. Toward good practice in thematic analysis: Avoiding common problems and becoming a knowing researcher. *Int J Transgend Health* 2023;1-6. doi:10.1080/26895269.2022.2129597
- 32 Braun V, Clarke V. Supporting best practice in reflexive thematic analysis reporting in Palliative Medicine: A review of published research and introduction to the Reflexive Thematic Analysis Reporting Guidelines (RTARG). *Palliat Med* 2024;38:608-16. doi:10.1177/02692163241234800
- 33 MAXQDA [program]. 2022 version, 1989-2024.
- 34 Chochinov HM, Wilson KG, Enns M, et al. Desire for death in the terminally ill. *Am J Psychiatry* 1995;152:1185-91. doi:10.1176/ajp.152.8.1185
- 35 Dees MK, Vernooij-Dassen MJ, Dekkers WJ, et al. 'Unbearable suffering': a qualitative study on the perspectives of patients who request assistance in dying. *J Med Ethics* 2011;37:727-34. doi:10.1136/jme.2011.045492
- 36 van der Lee ML, van der Bom JG, Swarte NB, et al. Euthanasia and depression: a prospective cohort study among terminally ill cancer patients. *J Clin Oncol* 2005;23:6607-12. doi:10.1200/JCO.2005.14.308
- 37 Pesut B, Wright DK, Thorne S, et al. What's suffering got to do with it? A qualitative study of suffering in the context of Medical Assistance in Dying (MAID). *BMC Palliat Care* 2021;20:174. doi:10.1186/s12904-021-00869-1
- 38 Monforte-Royo C, Villavicencio-Chávez C, Tomás-Sábado J, et al. What lies behind the wish to hasten death? A systematic review and meta-ethnography from the perspective of patients. *PLoS One* 2012;7:e37117. doi:10.1371/journal.pone.0037117
- 39 Rodríguez-Prat A, Balaguer A, Booth A, et al. Understanding patients' experiences of the wish to hasten death: an updated and expanded systematic review and meta-ethnography. *BMJ Open* 2017;7:e016659. doi:10.1136/bmjopen-2017-016659
- 40 Emanuel L, Bennett K, Richardson VE. The dying role. *J Palliat Med* 2007;10:159-68. doi:10.1089/jpm.2006.0134
- 41 Wilson KG, Curran D, McPherson CJ. A burden to others: a common source of distress for the terminally ill. *Cogn Behav Ther* 2005;34:115-23. doi:10.1080/16506070510008461
- 42 Walbaum C, Philipp R, Oechsle K, et al. Existential distress among family caregivers of patients with advanced cancer: A systematic review and meta-analysis. *Psychooncology* 2024;33:e6239. doi:10.1002/pon.6239
- 43 Xu H, Stjernswärd S, Glasdam S, et al. Circumstances affecting patients' euthanasia or medically assisted suicide decisions from the perspectives of patients, relatives, and healthcare professionals: A qualitative systematic review. *Death Stud* 2024;48:326-51. doi:10.1080/07481187.2023.2228730
- 44 Norwood F. Nothing more to do: euthanasia, general practice, and end-of-life discourse in the Netherlands. *Med Anthropol* 2007;26:139-74. doi:10.1080/01459740701283165
- 45 Steck N, Junker C, Zwahlen M, et al. Increase in assisted suicide in Switzerland: did the socioeconomic predictors change? Results from the Swiss National Cohort. *BMJ Open* 2018;8:e020992. doi:10.1136/bmjopen-2017-020992
- 46 Schwarz JK. Understanding and responding to patients' requests for assistance in dying. *J Nurs Scholarsh* 2003;35:377-84. doi:10.1111/j.1547-5069.2003.00377.x
- 47 Ost S. The de-medicalisation of assisted dying: is a less medicalised model the way forward? *Med Law Rev* 2010;18:497-540. doi:10.1093/medlaw/twq025

Web appendix: Supplementary appendix