



## **Coercive Measures in Medicine**

Medical ethics Guidelines of the SAMS

The German version is the original version.

25 May 2005

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## 1. Introduction

Coercive measures always represent a serious infringement of an individual's rights to self-determination and to personal freedom. Although the avoidance of compulsion is a primary objective in medicine, coercive measures cannot always be avoided as a last resort. In the case of acute danger to the patient or to others, these measures are sometimes the only way to avoid more serious harm.

Coercive medical measures<sup>1</sup> always involve a conflict of medical-ethical principles. On the one hand there is the question of "doing good" or "avoiding harm", while on the other is the requirement to respect the autonomy of the patient as far as possible. In principle, all action must be taken with the agreement of the patient (informed consent). Coercion can therefore only be used in exceptional cases.

In emergencies where the patient is at substantial risk of harming him/herself or others, the need for coercion is usually undisputed. The question is more difficult in situations that are not emergencies but where aspects of safety or harm to health are foremost, notably in geriatric medicine and psychiatry. In these cases it is often unclear whether the principle "for the good of" the patient really justifies the resulting constraints on the rights and freedom of the individual, that is, the violation of the patient's autonomy.

In Switzerland there have so far been no uniform legal bases for coercive measures at the Federal level. The modalities for the coercive medical measures that take place can therefore differ according to the customs of individual institutions and Cantonal regulations. However, whenever there is a possibility that coercion may be necessary, the constitutional rights of the individual and – if they exist – Cantonal laws must of course be respected.

The present Guidelines are intended to clarify this difficult situation in an area where laws differ widely. They are addressed to the entire healthcare team in medical institutions (hospitals and nursing homes), to medical professionals in private practice, and to those involved in outpatient healthcare.

The Guidelines are mainly concerned with the following issues:

- Under what ethical and legal conditions are coercive measures permissible and justified?
- What steps should be taken in order to avoid the coercion envisaged?
- How should the persons concerned and, where relevant, their carers, legal representatives or relatives, be informed?
- If they prove unavoidable, in what way can coercive measures be carried out with as little harm to the patient as possible?
- What type of follow-up care should be provided for persons who undergo coercive measures?
- How should the chosen procedure be documented?

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<sup>1</sup> These are understood to include coercive measures implemented by both medical and nursing personnel.

## 2. Scope

These Guidelines refer to all inpatient and outpatient treatment situations. Special needs and other types of non-medical care are not covered by these Guidelines. The Guidelines are addressed not only to the specialist medical personnel in the different institutions, but also to all other persons involved in treatment of patients. Federal and Cantonal regulations are reserved.

## 3. Principles

### 3.1. Definitions

All interventions carried out against a person's declared wishes, or which a person resists, or which – if he or she is unable to communicate – are against his or her presumed wishes, are described as *coercive measures*. Less invasive measures, such as forcing a person to stand up, to take food or to take part in a therapeutic session are also coercion, and in principle must be handled in the same way. However, these Guidelines refer explicitly to the more serious forms of coercive measures.

In practice it is possible to differentiate between *restriction of freedom* and *involuntary treatment*.

#### *Restriction of freedom*

The term *restriction of freedom* can be used if freedom of movement alone is restricted (e.g. accommodation in a closed ward). Serious restrictions of freedom include physical restraint (e.g. with straps) or seclusion (e.g. in a seclusion ward).

#### *Involuntary treatment*

If it is not just that freedom is restricted, but a person's physical integrity is also invaded (e.g. when medication is given under compulsion or by force), this is a coercive medical measure with violation of the patient's physical integrity. For this, the term *involuntary treatment* is used.

In everyday medical practice, coercive measures are taken in various different disciplines and in different situations. We can differentiate between coercive measures in psychiatric or somatic medicine, and between coercion used with children or adolescents and with adults. Such situations occur particularly often in elderly persons who are in need of care.

## 3.2. Legal framework

### 3.2.1. Principle

The following description of the legal framework is largely limited to civil law. Coercive measures exist in a legal field of tension. On the one hand, every case of coercion is an infringement of the patient's constitutionally protected human rights<sup>2</sup>. But on the other, a therapeutic injunction on the part of the State or a duty to provide help can imply a legal obligation to apply coercion to protect the patient or third parties.

In terms of the legal conditions, a distinction must be made in each case between involuntary commitment to an institution with consequent restriction on freedom of movement, and further coercive medical measures. In Switzerland, compulsory commitment to an institution is only permissible under the legal preconditions for deprivation of liberty in the interests of welfare, as laid down in Article 397a of the Civil Code<sup>3</sup>, or in another legal framework (e.g. the Law on Epidemics). The decision to commit a patient to an institution for his or her own welfare is taken by a guardianship authority at the patient's place of residence. For cases where delay would constitute a risk, or if the person is mentally ill, the Cantons can transfer this responsibility to another appropriate authority (Civil Code, Art. 397b). Many Cantons have transferred the authority to commit patients to District Medical Officers, Public Health Officers or independently practising physicians. It is recommended that the commitment of patients to an institution be the responsibility of experienced or specially trained doctors. The patient and persons close to him or her have the right to a judicial assessment of the decision for commitment to an institution (Civil Code, Art. 397d).

The dispositions relating to deprivation of liberty in the interests of welfare do not contain any legal basis for implementing coercive medical measures in the stricter sense (involuntary treatments)<sup>4</sup>. Nevertheless, as a rule such measures are only prescribed together with the deprivation of liberty in the interests of welfare (see Special Conditions for Minors, 3.2.2.). Emergency situations are an exception in this respect.

Whether and under what conditions coercion is permissible is determined by cantonal health legislation. There are however major differences in both form and content between the existing legislation in the various Cantons. This complex and confusing situation is unsatisfactory from the point of view of legal certainty, which makes the need for comprehensive, uniform legislation over the whole of Switzerland all the more important.

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<sup>2</sup> According to the Federal Constitution, these include the right to personal liberty, in particular to physical and psychological integrity and to freedom of movement. As violations of a patient's rights, coercive measures are only permitted if they are based on a legal principle, are in the broader ie overwhelming public interest or are justified by the protection of the basic rights of third parties, are proportionate, and do not infringe the essence of the patient's basic rights. In principle, all these conditions are necessary in order to be able to carry out coercive measures. However, in many Swiss Cantons there is still no legal basis for this.

<sup>3</sup> On the basis of this article, "a person who is competent or incompetent may be placed and/or restrained in a suitable institution because of mental illness, mental deficiency, alcoholism, other addictions or severe neglect, and if his necessary personal welfare cannot be ensured in any other way."

<sup>4</sup> As the deprivation of liberty is primarily in the interests of the welfare of the person concerned, the lack of competence is, in principle, not a precondition. On the other hand, compulsory treatment may be prescribed only if the patient is unable to discern the need for treatment.

The participation of physicians in coercion ordered by the police, and medical attention for persons in prison, are dealt with in the relevant SAMS guidelines (The exercise of medical activities in respect of detained persons: Medico-ethical guidelines of the Swiss Academy of Medical Sciences).

### 3.2.2. Special conditions for minors<sup>5</sup>

#### *Minors who are competent*

In principle, a minor who is competent must give consent for any medical treatment. A minor is competent if he or she can understand the importance of a medical intervention and the consequences if it is not carried out, and is capable of expressing his or her free will. Adolescents who are capable of competent of their parents, provided these do not concern measures resulting from risk to themselves or others. In the event of the minor's refusal, a coercive measure can only be implemented if it is essential for the wellbeing of the individual. In this case the procedure must be the same as for adults.

#### *Minors who are incompetent*

In the case of minors who are incompetent, the right to agree to or to refuse a treatment lies with the patient's legal representative (parent, guardian).

If the parents or the legal representative make a decision that is not in accordance with the welfare of the child, then the final decision must be made by the guardianship authority, except in emergencies (e.g. refusal to agree to a life-saving blood transfusion, forced feeding).

### 3.3. Proportionality

Coercive measures can be extremely traumatic. Special attention must therefore be paid to the principle of proportionality; this means that such measures must first be necessary, second be proportional to the degree of risk involved, and third not be replaceable by less invasive measures. In each individual case it must therefore be determined which measure is least traumatic for the person concerned. There must also be an assessment of whether the expected (personal and social) benefits considerably outweigh the possible disadvantages of such an intervention, and whether the consequences are less serious than for any other measure. The duration of the coercion must also be adapted to the circumstances. A coercive measure must also be chosen on the basis of the latest knowledge, and be reversible.

In evaluating the situation, account must be taken of the fact that physical and psychological harm may be caused. There may be a risk of physical damage (e.g. thromboses, infections) due to prolonged immobilization (e.g. physical restraint or sedation) or to physical force (e.g. contusions, fractures). With coercive measures, the more the intervention is felt by the patient to be unjustified, humiliating or even a retaliation or deliberate injury, the more psychological trauma is to be expected.

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<sup>5</sup> In law, all persons under 18 years old are "children" and "minors". In everyday language, children over the age of 11 or 12 years are described as "adolescents". In these Guidelines, however, the term "minor" is used for all persons under the age of 18 years.

## 4. Decision-making procedures

### 4.1. General

In principle, all possible steps must be taken to avoid coercion, and before any coercive measure is taken all the less invasive therapeutic alternatives with a chance of success must have been exhausted.

Coercive medical measures must be prescribed by a doctor. In emergencies, measures involving limitation of freedom can also be initiated and implemented by members of a therapeutic team, including nursing personnel. The various persons involved must agree to the measure. In institutions, the decision-making procedures should be set down in writing and those responsible must be named.

If emergency situations reoccur, each crisis must be evaluated anew wherever possible. Particularly in the hospital environment, the prescription of coercive measures “in advance” is not acceptable. In such cases, coercion can often be avoided if adequate precautions are taken.

#### 4.1.1. Information

In principle, a patient must be informed as completely and as objectively as possible before every medical treatment. This duty to explain the treatment to the patient must specifically cover the diagnosis, the examinations and treatments that are planned, the therapeutic alternatives and the consequences if the treatment is not carried out, and the risks and any possible side effects.

This duty to explain remains in the case of coercive measures. Exceptions are only acceptable in cases where the treatment must be carried out immediately and the patient is clearly not able to understand the situation. In this case, the information must be given later, as soon as the patient is competent again. The family members whom the patient has named, as well as other persons of trust and if necessary the patient’s legal representative, must be informed.

If the patient has the right to appeal against the prescription of coercive measures, a corresponding explanation of his/her rights of appeal must be given. If the patient’s condition renders him/her unable to receive or to understand this explanation, then it must be repeated as soon as possible. Where the patient has been deprived of liberty in the interests of welfare, the explanation must be given by the institution responsible for carrying out the measure. At the same time, the family members whom the patient has named, as well as carers and, if necessary, the patient’s legal representative, must be informed accordingly.

#### 4.1.2. Treatment plan and consent

##### *Outpatients*

In an emergency it is often the case that the responsible physician cannot delegate responsibility for any possible coercion. Where the indication is for deprivation of liberty in the interests of welfare (see 4.3), the patient must be informed that involuntary commitment to an institution is the only reasonable measure that can be considered at that time.

Because a commitment based on deprivation of liberty in the interests of welfare requires special authority and experience, it is advisable to delegate this task to specially trained doctors. Where this is not possible, the responsible physician must protect the interests of the patient, even if pressure is exerted by the patient's family members or the police, and proceed carefully with the necessary examinations.

### *Inpatients*

For inpatients, a distinction must be made between emergency and planned coercion. Planned coercive measures that do not occur in an emergency and that continue over a long period must be included in a comprehensive treatment plan and must assume that the patient is incompetent. In these cases, the consent of proxies named by the patient,<sup>6</sup> or of the patient's legal representative, must be obtained. If the patient drew up instructions when competent, they must be observed in the framework of any legal directives and in the light of the existing possibilities. In addition to the commitment to an institution by a doctor, the Head Physician or deputy should give their consent to any coercive measures that may be planned in institutions. In emergencies, the responsible physician can give the necessary instructions in the same way as in outpatient care. For measures that are coercive in a broader sense (e.g. forcing a patient to get up and dress etc.) the nursing personnel are responsible, as long as the legal bases and the medical realities are taken into account and the permissibility of the coercive measures has been agreed by the physicians.

#### **4.1.3. Decision-making procedures in the case of minors**

Decisions on the treatment and care of minors must be taken in the best interests of the child or the adolescent, in agreement with the parents or legal representatives.

Since the principle of self-determination also applies to minors who are competent, it is the professionals' duty to include a minor in the decision-making process as far as possible, depending on competence, and to obtain the minor's consent. Including the minor improves communication between medical professionals and family members, and children and adolescents who are included comply better with their treatment. Nevertheless, there is a danger that consent given by a minor to an authority figure is not genuinely voluntary.

Care must be taken not to demand too much of the child or adolescent. However, decisions should not be made on behalf of minors who are in fact willing and able to contribute actively to decisions about their treatment. Self-determination is a human right that – with appropriate modifications – applies to children and adolescents as well as to adults. As with self-care, the right to self-determination can be exercised only gradually and to a limited extent through childhood and adolescence, until with increasing maturity it is exercised to the full.

If a minor does not consent to a proposed treatment that he or she clearly understands, then this treatment should not be carried out. If the minor is not considered competent to make this decision, and if the proposed measure is necessary because of possible risk to the minor or to others, then the parents, as the minor's representatives, may give their consent to a particular treatment. If the parents refuse, the guardianship authority must consider placing the child or adolescent under protection.

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<sup>6</sup> Representatives authorised by the patient for medical matters

## 4.2. Situations of special difficulty

### 4.2.1. In somatic medicine

#### *Emergencies:*

- In patients with acutely life-threatening conditions who refuse treatment because they are in a state of shock or agitation, it can be assumed that they are temporarily incompetent. Treatment decisions must then be made in accordance with the patient's presumed wishes.
- In first aid after attempted suicide, when medical help is not requested but is necessary to save life, it is generally assumed that the patient is temporarily incompetent (e.g. because of depression).

#### *In subacute situations:*

In the case of notifiable infectious diseases, the Law on Epidemics states that the health authorities must, if necessary, take measures that are against the wishes of the patient (seclusion, compulsory medication). However, every effort must still be made to persuade the patient to accept these measures voluntarily. The same applies analogously to nosocomial infections (infections acquired in hospital).

### 4.2.2. In psychiatric medicine

#### *General*

Severe psychological disorders can lead to loss of control and to behaviour that may be an acute danger to the patient concerned or to others. Only then may coercive measures be taken. Severe disturbances of the ability to live with others also have to be considered. In every case, the patient must be considered to be a danger to him-/herself: this can include situations where the patient causes serious harm to others and is markedly affected by it.

Self-endangerment, endangerment of others and severe disturbances of the ability to live with others may be described as follows:

#### *Severe self-endangerment*

Self-endangerment exists if the pathological behaviour threatens immediate harm only to the patient him or herself. As with any type of coercion careful consideration of proportionality of response is required, and in particular the feasibility of individual therapy must be examined. Coercive measures on the grounds of self-endangerment are therefore only permissible when patients are considered genuinely incompetent.

#### *Severe endangerment of others*

Endangerment of others exists if the patient presents a foreseeable risk to other persons. Danger exists especially where there is aggressive behaviour, threats of severe violence, or actual physical attack. The preconditions for medical intervention against the wishes of the person concerned are that the cause of the behaviour leading to the endangerment of others is a mental disorder, and that the endangerment is considerable.

#### *Severe disturbances of the ability to live with others*

A severe disturbance of the ability to live with others exists if the behaviour of a mentally ill person affects his or her immediate environment so severely, or impairs the freedom of others, to such an extent that living with others becomes impossible<sup>7</sup>.

#### *Special aspects of psychiatric emergencies*

If a psychiatric emergency cannot be resolved in any other way, deprivation of liberty should be considered (see Chapter 3.3). With deprivation of liberty, other measures that cannot otherwise be justified for the patient's welfare, such as seclusion, physical restraint and compulsory medication, may be necessary under certain circumstances. Reasons for secluding the patient can include temporary loss of control with manifest violent behaviour, serious threat of violence or danger to others, or serious disturbance of the ability to live with others. Reasons for physical restraint include serious attempts at or an acute risk of self-injury. Compulsory medication may be necessary in acute states of agitation, with self-endangerment or endangerment of others, or to avoid repeated or prolonged seclusion or physical restraint that would otherwise be necessary. As a rule, seclusion and physical restraint should be imposed only for a matter of hours at the most.

In psychiatric emergencies other possibilities for de-escalation must first be tried, initially as part of a graduated plan, as long as the patient is not in immediate danger. For inpatients in particular these procedures can include verbal de-escalation ("talking down"), verbally setting limits, "time out" for the patient in his or her own room, stimulation of mobility, or suggestions for other possible solutions. Individual longer-term care with constant support should also be considered, as long as the carer's safety can be guaranteed.

#### **4.2.3. In geriatric medicine**

In the care of patients with, for example, dementia, symptoms of confusion or aggression often mean that limiting the patient's freedom is unavoidable. The Swiss Academy of Medical Sciences has drawn up guidelines on the treatment and care of elderly persons who are in need of care<sup>8</sup> and has also made recommendations on the limitation of freedom that may become necessary in confused persons:

"Unless the legal regulations require otherwise, a measure that restricts personal freedom may be used only under the following conditions:

- a) The person's behaviour represents a considerable danger to his own safety or health, or to those of others, or it impairs to a large extent the peace and well-being of third persons.
- b) The abnormal behaviour observed cannot be attributed to obvious causes such as pain, the side effects of drugs or interpersonal tensions and conflicts.
- c) Other measures that restrict personal freedom to a lesser extent have failed or are not possible.

A measure that restricts personal freedom is discussed jointly by the doctor, the nursing team and the therapist before it is suggested to the elderly person concerned (or, if the person is incapable of discernment, to his person of trust or his legal representative).

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<sup>7</sup> A serious disturbance of the ability to live with others due to illness could mean, for example, that a mentally ill person constantly impairs the way of life of other persons in the family or in the nursing home, through serious neglect, persistent troublemaking, or insults and threats. In a psychiatric clinic antisocial behaviour, verbal and non-verbal aggression or throwing objects around may make it necessary to put the patient into temporary isolation, if alternative measures have failed.

<sup>8</sup> Medical-ethical guidelines on the treatment and care of elderly persons who are in need of care, SAMS, 2004

The elderly person, or his person of trust or his legal representative, must be informed of the purpose, the nature and the duration of the proposed measure in an understandable and appropriate manner; at the same time he must be told the name of the person responsible for carrying out the measure in question (see under Para. 7.3).

In principle, a measure restricting personal freedom may be taken only with the agreement of the elderly person or, if he is incapable of discernment, with the agreement of his therapeutic representative of his legal representative.

If a person is incapable of discernment and has neither a person of trust nor a legal representative, or if a request for further instructions in an emergency situation is not possible, the doctor, the nursing staff and the necessary responsible therapist have to decide on such a measure in the best interests of the person concerned, in the framework of an interdisciplinary decision-making process including the person's relatives in accordance with the above mentioned criteria. Short-term decisions taken by an individual professional must be discussed and decided a second time in accordance with this procedure."

### **4.3. Deprivation of liberty in the interests of the patient's welfare**

#### **4.3.1. General**

Mentally ill persons who have to be involuntarily committed to a psychiatric institution (see 3.2, Legal framework) are, on account of their condition, often considered incompetent or only partly competent. However, simply because a patient has been forcibly committed to an institution it must not be assumed that this justifies all medical measures (and other measures that also limit personal freedom within the institution) against the wishes of the patient. In principle, even persons involuntarily committed to an institution have a claim on all the rights of patients, such as the right to a complete explanation of their illness, the therapeutic possibilities and their risks and side effects, and the consequences of not treating the illness. Generally, even patients who are involuntarily committed to an institution must give consent to all diagnostic and therapeutic measures. In emergencies this consent may be dispensed with only if immediate intervention is urgently indicated and is essential in order to avoid immediate harm to the health or life of the patient. If a medical measure against the wishes of the patient proves unavoidable, the relevant legal requirements must be observed. Under deprivation of liberty, coercive measures may only be carried out for as long as the situation requiring such measures (self-endangerment, the endangerment of others or severe disturbance of the ability to live together with others within the institution) persists.

#### **4.3.2. Deprivation of liberty in the case of minors**

In the case of minors, the deprivation of liberty in the interests of welfare in fact constitutes withdrawal of the protection provided by the guardianship authorities. The minor is cared for in an institution (children's home, clinic, observation ward etc.). For the procedure and for the judicial assessment, the conditions of deprivation of liberty in the interests of welfare for adults are applicable. An adolescent over the age of 16 years can ask for a judicial assessment and may make an application for discharge from the institution at any time (Civil Code, Art. 314 a, 405 a). The authorities responsible for committing persons to an institution must, as far as possible, guarantee a 24-hour service, including Sundays and holidays. In most Cantons, practising physicians are also authorised to commit mentally ill minors to an institution.

Minors should be accommodated separately from adults.

## **5. Implementation**

### **5.1. Principle**

Every coercive measure must follow a clear action plan. Once the decision has been made, it should be implemented in an objective, coordinated and decisive fashion by all the persons involved. In a hospital it should be discussed within the treatment team. Any unnecessary aggression – including verbal – should be avoided. In both inpatient and outpatient therapy, all possible measures that can contribute to de-escalation must be taken.

In principle, only measures that correspond to currently recognised standards of the particular specialist medical field concerned are permitted.

Treatments that are unnecessarily painful or that restrict personal freedom, namely freedom of movement, more than is absolutely necessary, are forbidden. Coercion may not be applied in order to discipline or punish patients.

### **5.2. Special aspects**

In carrying out involuntary treatment, especially in psychiatric institutions, special attention must be paid to the following points:

- The treatment must be carried out in an environment that is as safe as possible; objects that could be a danger to the patient or to staff must be removed. The location where the treatment is to be carried out must be chosen carefully.
- The patient's privacy must be respected and the presence of persons who are not involved must be avoided.
- The start of the implementation must be explained to the patient concerned, clearly and in an understandable manner. It is helpful if only one person is responsible for this. Hesitant behaviour or contradictory instructions complicate the procedure and are disturbing to the patient.
- The coercive measure must be carried out as calmly as possible.
- As the coercive measure proceeds, the individual steps must be announced clearly and concisely.
- In many cases, the relatively large number of persons involved tends to inhibit any aggression on the part of the patient.

Before the forcible administration of any injection, the following steps are recommended: oral administration of the medication should be offered again, in the knowledge that this procedure is already coercion. Only if the patient continues to refuse to take the drug by mouth should the medication be administered parenterally.

#### **5.2.1. Duration**

The duration of every coercive measure, especially in hospitals, must be limited from the outset. At the point of prescribing the measure, the time for the next monitoring must be established. In the case of seclusion or physical restraint, monitoring should be done as frequently as possible (e.g. hourly). Generally, coercive measures should be carried out only for as long as is absolutely necessary, and should be ended as quickly as possible.

### **5.2.2. Observation of inpatients**

The person undergoing the coercion should be kept under constant observation and the situation monitored accordingly.

According to the measure and the condition of the person concerned, appropriate prophylactic measures must be taken (pneumonia prophylaxis, prevention of decubitus ulcers etc.)

### **5.2.3. Supporting measures and follow-up**

Coercion is experienced by the patient as a major event, and can have substantial physical and mental consequences. Therefore the overall situation must be re-assessed regularly, so that the coercion lasts for as short a time as possible.

As far as is possible and accepted by the patient, both in outpatient and inpatient care, every coercive medical measure requires thorough follow-up discussion with the patient, possibly involving other persons in accordance with the patient's wishes, as soon as his or her condition allows. In this discussion, the reasons why the coercion was considered necessary should again be explained by the responsible doctor. The patient must be given ample opportunity to offer his or her experience and viewpoint. The patient should also be given the possibility of writing an account of the experience, for inclusion in the case file. It must be recognised that the more an intervention is experienced by the patient as unjustified, humiliating or even deliberate harm, the more likely it is that psychological trauma will result. In due course, it must be determined whether the coercion has led to psychological impairment that might require specialist treatment. Once the coercive measures have been carried out, they must be re-discussed by the treatment team.

### **5.2.4. Documentation**

All coercive measures must be carefully recorded in the case file and in the nursing care documents. The following aspects at least must be recorded: the reasons and possible legal basis for the measure taken, the nature, duration and time of the actual force exerted, the persons responsible for prescribing and carrying out the coercive measure, the monitoring carried out, and the information given to the patient.

A ruling to deprive the patient of liberty in the interests of his/her welfare should document at least the following: the time of the medical examination, the nature of the mental disorder diagnosed, the time and place of commitment to an institution, a brief explanation of the reasons for the deprivation of liberty in the interests of the patient's welfare, and confirmation that the patient has been informed of his/her right of appeal. A copy of the ruling must be given to the patient.

### **5.2.5. Right of appeal**

Access to the legal means of objection or complaint must be guaranteed.

Before a planned coercive measure is prescribed, the patient, and if necessary his/her nominated proxy, must be informed, if possible in writing, of the basic legal provisions and the patient's concrete possibilities for appeal (see 3.2.1).

## 6. Framework for personnel and institutions

In every establishment it is essential that the staff and institutional conditions do their utmost to avoid coercion, as far as possible. The limitations of an institution or its personnel have a decisive influence on the decision to impose coercive measures, but may not justify such measures. Care must therefore be taken to ensure that the necessary, adequately trained staff are available, especially in psychiatric and geriatric institutions, for both inpatients and outpatients.

Specialised institutions are necessary for mentally ill offenders.

The institution is responsible for ensuring that the relevant legal bases and guidelines are known to the personnel involved and that the decision-making processes and responsible persons are clearly defined and set down in writing.

It must also ensure that there are enough personnel available who are adequately trained to implement these Guidelines.

Further training and supervision for de-escalation and the management of coercive measures and use of force must be provided.

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### Approval

Approved by the senate of the SAMS on 24 May 2005

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### We thank the following experts for their valuable advice:

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**Guidelines of the SAMS cited:**

- “The exercise of medical activities in respect of detained persons: Medico-ethical guidelines of the Swiss Academy of Medical Sciences”; 2002
- “Medical-ethical guidelines on the treatment and care of elderly persons who are in need of care”; 2004

**Other important regulations:**

- Bioethics Convention of the European Commission  
<http://conventions.coe.int/Treaty/en/Treaties/Word/164.doc> (not yet ratified by Switzerland)
- Convention on the Rights of the Child. Office on the High Commissioner for Human Rights.
- Draft of the new law on the protection of adults ([www.ofj.admin.ch/d/index.html](http://www.ofj.admin.ch/d/index.html))
- Principles for Policy on Mental Health (UNO)