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From Germany: helpful differentiation

Professor Dr FJ Illhardt

Professor Dr Illhardt is Professor of Medical Ethics in Freiburg University. He has been the Executive Director of the Ethics Committee of the University and the University Hospital, and co-ordinated the Ethics Consultation Service at the hospital and its associated institutions.

> *Whether or not euthanasia may be justified killing on request is another matter...*

and

> *understanding and respect for alternative viewpoints is not the same as the ethical acceptance of either euthanasia or physician-assisted suicide*

In the context of ethics consultation, I appreciate especially these two sentences because of the following background.

The ethical debate on euthanasia does not offer a solution or even a consensus in the direction of justification or denial which is reasonable and convincing for all people. What characterizes the debate is the constraining discussion of moral axioms, which is limiting the argumentation. For example, the difference between *active* and *passive* intervention, which appears to many as a moral gap; or the difference between *omitting* a treatment, which results in the death of the patient, and *committing* active killing, which also results in the patient's death. This kind of moral reasoning can be characterized by a term like 'unpotted thinking', which both opponents as well as defenders of the euthanasia 'solution' have to prove.

On the other hand we can observe an increasing reaction against taboos that do not allow even considering such questions. Phrases like 'a Christian position must always deny euthanasia', 'a good physician should never consider medical acts of euthanasia' or even (often used especially in Germany) 'taking euthanasia into account leads to a position like that of National Socialism' (NS committed 'murder' not 'euthanasia' – this document of the EAPC highlights the fundamental difference) . . . taboos similar to these destroy moral thinking.

A positive position (in favour of euthanasia) does not necessarily follow from arguing against limits of thinking. If a possible solution to this debate emerges, then it points at a procedural solution. To accept that there are dilemmas surrounding the terminal phase is the only precondition for reacting to these dilemmas and for beginning a constructive search for a solution. Such a solution must be based on the difference between

- **the concrete act and an ethical principle**
  The difference of act and principle hints towards the direction of what Aristotle phrased the virtue of 'epikeia', i.e., the need to mediate between the *common rule* valid for potentially all persons and the needs of the *concrete situation* of this individual (in this context, dying) person.
- **assessing facts (level of 'is') and stating norms (level of 'ought')**
  Assessing his/her needs and requests does not mean to establish or even follow a rule. Before caregivers assess the needs and requests (perhaps including the request for euthanasia) of the patient and his/her loved ones, they can hardly say what they can do. Palliative care in the view of this document is not a general conviction but a very well-defined care based on empathy and understanding of the patient's autonomous will.
- **voting against prolongation of life and voting proeuthanasia**
  Another very important differentiation makes clear that many patients fear that their interests may collide with the attitude of medicine, which they consider to be attached to an ethos of prolonging life. Patients who want their physicians not to prolong their life and suffering do not automatically demand the right to euthanasia, and also their caregivers may feel the duty not to prolong a hopeless treatment without voting for euthanasia. Patients must regain their trust that their caregivers warrant their ending life.
- **withdrawing/withholding futile treatment and killing**
  Ethical considerations on decisions at the end of life focus on the fundamental difference between discontinuing treatment and killing. The first stops an intervention that has no likelihood of benefiting the patient. The second stops a life that is not necessarily a burden under the given conditions. Withdrawing/withholding is a medical intervention; killing is not, even if it is motivated by mercy.

The euthanasia movement defended the human right to define and control the individual process of dying and

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resisted the control of the end of life and the patient's autonomy by healthcare experts. But the respect for autonomy runs amok when it remains unfettered and does not recognize the negative consequences of being autonomous. Thus, autonomy is not something that people have and that can be monitored. It is something to build up and develop. Palliative care opened the way for the experts to explore the problems of the patients with a terminal disease and to find a pragmatic answer – and not a dogmatic one.

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