



Self-determination and care at the end of life

OPINION

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Preliminary note

The progress of modern medicine has substantially increased life expectancy and improved the quality of life. However, the possibility of the medical treatment of disease, the reduction of suffering and the prolongation of life may become a burden if the full panoply of high-technology intensive care is deployed in such a way that measures to prolong life are taken even at the cost of pointless drawing out of the process of dying and the imposition of suffering. Many people manifestly fear that such a fate might await them at the end of their lives and would prefer a non-lingering death without dependence on technical apparatus. It is precisely this ambivalence that makes the subject-matter of this Opinion so important. After all, now that conscious intervention in the process of dying is possible and indeed unavoidable, matters such as the taking of difficult and conflictual decisions in borderline situations at the end of life cannot be eschewed.

Dying is an individual process which, as such, cannot be removed from the sphere of the individual's self-determination. At the same time, however, it involves a range of different ethical obligations, legal demands and religious expectations, which call for thorough discussion and evaluation in all their aspects.

The National Ethics Council has intensively discussed the issues involved in dealing responsibly with dying. It has perused a large volume of material, obtained expert opinions, consulted with doctors and other medical specialists, and held meetings in Augsburg and Münster at which it exposed itself to public debate. The outcome is enshrined in the Opinion now presented.

Self-determination and care at the end of life continues the examination of the themes addressed in the Opinion *The advance directive* published in June 2005. The present analysis, in conjunction with the clarification of terminology here proposed, may facilitate interpretation of the recommendations set out in that Opinion.

1. MAN AND HIS DEATH

1.1. Knowledge of death and attitudes to dying

Death is the end of a life, and dying is the last phase of life before its onset. The fact that a dying person is close to death may intensify the wish to avert the end. Even if a life cannot be relived, and although not a single moment is repeated, it is only when death itself supervenes that its finality and lack of alternative become manifest. That is why it arouses such great fear while at the same time being associated with so many hopes and expectations.

No living person knows what comes after dying. Some fear what others hope for – namely, that death is the end of all things. It may be that it takes away everything that is dear and important to the individual. It may be that it liberates the individual from all the suffering and fear involved in his' life. No one knows whether it leads to bliss, damnation or total oblivion. Only one thing appears certain: that death leaves the dead person no possibility of further action. It is this finality that runs counter to the instinct of life and makes us more afraid the closer we are to death.

The necessity of dying is an ineluctable fact that human beings share with other living creatures. However, man knows that his death is ineluctable.

This knowledge allows human beings to deal consciously with death. They can bring it about by violence, expose themselves to it by negligence, or attempt to prevent it. They can strive to delay its occurrence for as long as possible. But although they can often succeed in evading death by caution, flight or resistance, in the end they cannot escape it. Everyone who is born must eventually die.

Anyone who experiences the death of another living creature can infer with complete certainty that his life too will end. We are elementally linked to such creatures by our constitution as living beings, by sensation and need, by fear and vulnerability, and above all by the fear of death that stirs within us when danger threatens. That is why the argument that one's own death is not certain until one has actually experienced it is untenable. For a human being, the sight of a dead person is sufficient to convince him that he himself will not escape the same fate.

Yet this tells us nothing about the individual's attitude to death. He may see it as an evil or as deliverance, may do everything possible to postpone it, despise it, long for it, bring it about by violence or curse it; he may try to forget it or keep it constantly in mind. There are many different possibilities, for most of which good reasons can be adduced. One element of the diversity of attitudes towards death and dying is that a person's view can change the closer he himself is to dying. In the face of death, every pronouncement that one has previously made about dying may be forgotten.

1.2. Attitudes to death

The fact of death, it is often said, may be "repressed". This may mean different things according to whether the context is anthropological, psychoanalytic or sociological. This attitude may be based, too, on a diversity of values. Some, for instance, stress that man must not forget, at any stage of his life, that he is mortal. Others, on the other hand, consider that one should not think too much of death because it will then be easier to cope with the day-to-day demands of living and one can more readily experience mutuality, hope, freedom from care or rewarding commitment.

Attitudes to death depend on the cultural and religious character of the community in which the individual lives. This can be illustrated by some selected examples from the history of religion, civilization and philosophy.

¹ For simplicity, the masculine form is used in this Opinion for both sexes.

The early Egyptians considered it the height of wisdom to prepare for death and thereby to ensure that the memory of one's existence would persist. According to the teachings of ancient India, death was associated with the expectation of permanent oblivion. The Greek tragedians glorified death because the individual could bring it about for himself, while their philosophical successors held that life carried with it the obligation to learn to die a virtuous death. Yet the mythical conception of the horrors of Hades, the realm of shades, continued to hold sway. The Old Testament view of death was of a sphere of influence remote from God; it was only later that Israel conceived the hope of a saving communion with God even in death. The New Testament interprets death in the light of the hope of partaking in the resurrection of Christ, and therefore speaks of eternal life in communion with God. For Islam, death offers the believer the prospect of a continuation of life devoid of any want or need. In certain Far Eastern religions, the individual fate of a human being is not the finality of death but persists in a cycle of reincarnations or rebirths. Buddhism, too, includes the idea of deliverance from the compulsion of constant rebirth provided that one succeeds by meditation in overcoming narrow earthly concerns.

The Renaissance saw a revival of the ancient doctrines and offered a choice between Stoic contempt for death, Epicurean disregard for death and sceptical indifference. Next came the Baroque yearning for death, which enabled many to use aesthetic means to overcome the vale of tears of earthly existence. This approach was countered by the Enlightenment, in its action-based orientation towards finite life: a free man, according to this view, would think of nothing less than he would of death, and his wisdom lay in a reflection on life. This remained the attitude of Kant, who maintained an obstinate silence about death. The Romantics rekindled the fear of death in the literary field, but subsequently spawned such a multitude of moods and attitudes that no single posture towards death and dying can be said to predominate. Only the fear of punishment

in death for one's sins seems to have appreciably declined. Yet the uncanny aspect of death persists. It is therefore all the more important for each individual to be able to rely, in his attitude towards death, on the respect of others – and particularly of those belonging to different traditions.

Death remains a singular event for every individual. "Everyone dies his own death," wrote the poet Rainer Maria Rilke – a maxim that enjoins us to respect death and dying in every single instance. This implies that everyone is entitled to his own opinion and should respect the fact that a person's attitude may change the closer he is to dying.

1.3. The notion of control over illness, dying and the moment of death

Throughout the history of civilization, human beings have endeavoured to exercise control over illness and to ward off the occurrence of early death. For this purpose, recourse was and is had to magic and prayers, medicinal herbs and surgery. The common element in all these approaches is that they see the specific forms of illness and suffering that afflict human beings not as inescapable calamities but as controllable and – perhaps – avoidable. The innovation in modern cultures is not the fact that health is perceived as falling within the realm of controllability, but the means deployed, the expectations nurtured, and the extent to which the control actually succeeds. The ideal of the control of disease is pursued not only by curative medicine directed towards the treatment of individual patients, but also by hygiene, dietetics, occupational medicine and social policy, which prevent the occurrence of disease through changes in living and working conditions.

However, what distinguishes modern cultures is the assumption that the limits encountered in the control of disease can be pushed back ever further. The expectation is of progress, whether in the control of pathologies of all kinds or in that of

disease-inducing social conditions. What is not possible today might well be so tomorrow. This prospect certainly reinforces the expectation that health and a long and good life – as well as, perhaps, happiness – are achievable. It is a moot point whether this means that people today are at risk of losing the capacity to reconcile themselves to unavoidable suffering and to see it as meaningful. It is surely undeniable that a good life and the associated avoidance of suffering are among the highest values of our culture. Efforts to improve the prospects of curing disease can rely on wide support. Survey after survey shows that health comes top in the scale of desirable goods; in Germany, health-care accounts for over 10% of gross domestic product.

The control of death does not fall within the purview of the potential for human action. However, the prolongation of life and the determination of the form and setting in which people die are included among our present-day expectations. Early death in infancy or middle age is seen no longer as a likely fate simply to be borne, but as a misfortune to be averted. A “good death” is seen as part and parcel of a good, successful life. Many hope for the avoidance of suffering even in the process of dying: painless dying is an element of a “good death” for most people. One aim of modern palliative medicine is to translate this notion into reality by preventing or alleviating the suffering and pain of dying. The progress of modern medicine, with its capacity to treat disease, to reduce suffering and to prolong life, is of course often a blessing. However, these advances have disadvantages too, as when measures to prolong life ultimately result in the pointless drawing out of the process of dying and the imposition of suffering.

2. DECISIONS AT THE END OF LIFE: SOCIAL, CULTURAL AND HISTORICAL CONTEXT

2.1. Preliminary note

This section describes the social, cultural and historical context of decisions that affect the process of dying in the incurably ill. These “decisions at the end of life” usually relate to medical treatment, but sometimes need to be taken in the domestic family environment, too. They extend from the withholding or withdrawal of life-sustaining measures (passive euthanasia), via the treatment of incurably sick and dying people whose possible earlier death as an unintended side-effect must be accepted (indirect euthanasia), to assisted suicide and, finally, to killing on request (active euthanasia).²

Much of the empirical data presented in this section is taken from representative population surveys. Inherent in these are a number of methodological problems, which must be taken into account in interpretation of the findings.

Responses to surveys are expressions of opinion which are not necessarily based on consistent personal convictions and attitudes. Furthermore, expressions of opinion vary according to whether the respondent has personal experience of the subject of the survey. There is even some risk that respondents may, although actually not having an opinion on the subject, be induced to express one as a reaction to the survey – in particular, if there is no allowance for alternative responses in the questionnaire. Again, in surveys of decisions at the end of life, it is uncertain, and also impossible to establish in the context of the survey, whether the respondents have fully understood the explanatory notes defining the various situations.

² See Section 4 below for a discussion and critique of the terminology of euthanasia.

As a general rule, when a particular intention is expressed in a survey, it must be borne in mind that it will not necessarily be reflected in actual behaviour. In addition, there is always a risk that respondents will tailor their answers to socially desirable attitudes and modes of behaviour, thereby distorting the result. Finally, most surveys include only a small number of questions, which do not cover anything like the entire range of issues involved in euthanasia. That is also why surveys of the various aspects of attitudes to death and dying can yield inconsistent or even contradictory responses. For this reason, it is important to ensure, in using the results of surveys, that incommensurable variables are not compared with each other. However, notwithstanding these methodological reservations, representative quantitative surveys remain indispensable for establishing whether one's personal experiences or those derived from specific individual instances reflect a pattern that is widespread in society.

Empirical findings must not be confused with normative demands. Facts can admittedly have normative implications – for instance, if the moral condemnation of an action is based on assumptions about its consequences, such as the risk of harm to the rights of others or to important objects of collective concern. Such assumptions are empirical statements about possible chains of cause and effect. If these are incorrect, the moral condemnation based on them logically no longer holds. However, as a fundamental rule, the fact that something is the case does not mean that it ought to be the case. It is therefore impossible to determine what is ethically correct or acceptable from empirical findings concerning normative attitudes in the population. Even so, the responses do provide an indication of the values actually held in society and of how far the solutions arrived at by political institutions and expert committees agree with them. That is surely not unimportant in a democracy with a properly functioning forum for public debate directed towards the development of social, political and legal solutions – and in particular their enforcement. Yet a normative examina-

tion of whether the actual values held may be deemed consistent with the criteria of law and ethics remains necessary. No one denies that public policy must sometimes oppose the trend of societal attitudes in sensitive political spheres such as the protection of minorities or the treatment of persons of foreign origin. For this reason, with regard to the way society deals with death and dying, it is equally essential to clarify again and again the arguments and historical background in favour of retaining existing provisions or, where appropriate, of demands for them to be changed.

2.2. The right to self-determination

The right to self-determination of the person, as well as its counterpart, the demand that self-determination be exercised, is all-pervasive in the ethos of contemporary life. People can and must decide for themselves how they wish to live. However, the individual depends on the solidarity of the community. No one can live in isolation. The notion that self-determination calls for support through solidarity, on which it is in certain cases conditional in the first place, is surely also not in dispute in our modern civil society.

Self-determination does not mean that decisions can be taken without any constraints. In practice, decisions are always subject to biographical and social conditions which determine perceptions and motives and restrict freedom of action, even beyond the limits set by morality and law. Yet we attribute autonomy to human beings and respect their decisions as an expression of self-determination. Admittedly, this is only the case as long as external conditions do not exert compelling force that precludes voluntary action. And even where people do not feel under pressure, they must usually take decisions – for instance, on the withdrawal of a necessary medical treatment in the here and now – in a situation of great distress. This does not preclude the taking of decisions on the basis of self-determination

in such circumstances. The distress arising in such a case is perhaps comparable with that involved in other existential decisions, such as consent to a critical surgical operation.

The right to self-determination extends to decisions at the end of life. At any rate, there must be good reasons for not complying with the wishes of a dying person. This is the starting point of today's bioethical controversies. From the withdrawal of life-sustaining treatment to killing on request, the debate centres on whether and how people should be able to exercise autonomous control over their own deaths and to what extent they can call upon others to ensure that their wishes are complied with. Another issue on which opinions diverge is that of the binding nature and scope of advance directives (living wills), whereby an individual can specify in advance what medical treatment he wishes to have at the end of life.³

Opinion surveys show that the vast majority of the population favours the recognition of advance directives. It should be possible to decide for oneself whether and how one wishes to undergo medical treatment should one at some future date become incapable of deciding for oneself. In one representative survey,⁴ some 90% of respondents considered that such stipulations should be binding on doctors and nurses. The majority of the population evidently rejects restrictions, on whatever grounds, on the validity of advance directives. The majority also thinks that their validity should not be made conditional on compliance with complicated formal requirements. In addition, 78% of respondents in the same survey did not consider that the validity of an advance directive should be confined to the process of dying. They presumably had in mind situations such as living in a persistent vegetative state or dementia, and wished to be able to decide in advance, in such a case, what was then to happen to them.

The population is much more reticent in its view of whether deliberately putting an end to one's life is an act of legitimate

self-determination. The cultural dominance of self-determination in modern societies has not led to universal acceptance of the notion that decisions about an individual's own life should be a matter solely for the discretion of that individual. Hence suicide, for instance, has by no means been removed from the realm of morality. Representative World Values Surveys conducted between 1981 and 2000 rated various actions on a scale from 1 ("never justifiable") to 10 ("always justifiable"). Respondents in (West) Germany rated suicide at about 3 – that is, well within the negative region. In Spain and the United States, the values were even lower, between 2 and 3, and in Sweden they ranged between 3 and 5.⁵ It follows from these figures that the non-punishability of suicide in law, enacted in Germany by the Penal Code of 1871, is not paralleled by moral approval on the part of the population. In modern societies, too, it is recognized that people have moral obligations towards themselves which set limits to self-determination. These obligations include a person's respect for his own life.

However, if the question is applied to patients suffering from a serious, incurable illness, this respect is qualified by the respondents' recognition of the right to self-determination. In an Allensbach survey dating from 2001, only 12% of respondents insisted on the non-disposability of human life even in such a case, and agreed with the following statement: "Only God, or if you will fate, can decide on life and death. Life is sacred and must remain so. Life must on no account be ended prematurely, even if the patient expressly so requests." On the other hand, 70% considered that a person who was seriously ill should "be able to decide for himself whether he wishes to live or die". This view was shared by the majority of members of a church (over 60%); of those not belonging to a church, 83% were in agreement. However, it is unclear from the wording of the questionnaire whether an individual's own decision that he

³ On this point, see the National Ethics Council's Opinion *The advance directive*.

⁴ Emnid 2004a.

⁵ Level 5 means "tend to disagree" and level 6 "tend to agree".

wished to die could also include the possibility of the longed-for death being brought about by the action of a doctor.⁶ The figures given below are relevant here.

In the predominant opinion of the population, an individual's own decision should be the determining factor even as regards active euthanasia – that is to say, in deciding whether the doctor should help a patient suffering from an incurable condition to die at his (the patient's) request, for instance by giving him a lethal injection. Although active euthanasia for the seriously ill also tends to be rated negatively in the World Values Surveys, the responses are consistently more positive than for suicide in general. Recent values in Germany, the United States and Spain are between 4 and 5, while those in Sweden exceed 6 (on the scale of 1 to 10 mentioned above).

However, these ratings give no indication of the reaction if a graduated response on a scale extending from 1 to 10 is not requested, but instead respondents are asked to express a yes-or-no opinion on the permissibility of active euthanasia. In this case, some two thirds of the German population are inclined to accept euthanasia. The statement "A doctor gives an incurably ill patient lethal poison at his request" was rated, according to ALLBUS surveys between 1990 and 2002, by just under a third of respondents as "very bad/fairly bad", but by two thirds as "less bad/not at all bad". These assessments are confirmed by further data. Agreement with the statement "A seriously ill patient in hospital should have the right to choose death and to request a lethal injection from a doctor" increased in West Germany from 53% in 1973 to 64% in 2001. In East Germany, 80% agreement was recorded in 2001. Rejection fell from 33% to 19% in West Germany; in East Germany it amounted to 6% in 2001.⁷ In a representative survey in 2001, 61.3% of German respondents

answered the following question in the affirmative: "Should active euthanasia for the patients mentioned above [incurably ill and expected to die imminently] form part of a doctor's professional duties?"⁸

These figures do not of course prove that active euthanasia is not a moral problem for three quarters of the population. A question on whether something is acceptable does not necessarily produce the same responses as one asking whether something should be a criminal offence. For instance, many reject the termination of pregnancy for themselves, while at the same time not believing that it should be punishable. Such discrepancies reflect our contemporary pluralism of values. Although people consider certain values and norms to be morally binding on themselves, they would not impose them on others.

Without a detailed knowledge of the motives and reasons underlying the views expressed by the respondents, it is impossible to decide how deeply the opinions recorded in these surveys are rooted in personal convictions. However, the results at least afford an indication of attitudes that are widespread among the population. On the other hand, there are no grounds for supposing that the results of such surveys reflect temporary fluctuations of opinion attributable to the influence of media reports of the day. For most of the findings presented in this section, time series exist as evidence of the stability of attitudes and of growing support for the right of self-determination.

2.3. Hypothetical and actual decision-making

According to the surveys mentioned above, three quarters of the population consider that people should have the right, in the event of a serious disease with no hope of recovery, to have their lives ended on request or to enlist medical assistance for

⁶ The complete wording was as follows: "I consider that, for people who are seriously ill, euthanasia is a good way of ensuring that they do not suffer so much. As long as a person who is seriously ill is still conscious, he should be able to decide for himself whether he wishes to live or die."

⁷ Allensbach 2001: 2.

⁸ Schröder et al. 2003: 337, 339.

suicide if they so wish. The surveys do not show that three quarters actually desire this and would exercise the right should they find themselves in that situation. What a person claims for himself and concedes to others as a right does not necessarily correspond to what he would consider good and appropriate for himself in the specific case. For instance, it is perfectly possible to favour the legal termination of pregnancy even if one would not seriously contemplate it and would reject it for oneself. A similar discrepancy is likely with regard to the attitudes expressed to killing on request. The study by Schröder et al. 2003 reveals a wide gap between approval of active euthanasia in general (61.3%) and the hypothetical likelihood of a given respondent's taking advantage of it for himself (21.1%).⁹

In addition, what is held to be desirable depends substantially on the available alternatives. The surveys mentioned contained questions on attitudes to active euthanasia only. As a result, active euthanasia is as it were made the touchstone of self-determination at the end of life and meets with a high level of agreement for precisely that reason. However, if respondents are confronted with alternative ways of achieving this self-determination below the level of active euthanasia – for instance, forgoing life-sustaining measures in order to avoid what is felt to be unbearable and pointless suffering – active euthanasia is not the first choice. In a representative survey by Emnid in 2004, only 34% of respondents favoured active euthanasia (here, unusually, defined as killing on request, including assisted suicide); 45% preferred the alternative options of passive or indirect euthanasia (defined as the forgoing of life-sustaining measures and the facilitation of dying by pain-killing drugs); 18% rejected euthanasia in all its forms.¹⁰

Alternative options were also provided for in the surveys carried out by Emnid on behalf of the Deutsche Hospiz Stiftung [German Hospice Foundation] since 1997 to deter-

mine the level of approval of active euthanasia and of the use of palliative medicine and hospice care – although the alternatives are inherently not mutually exclusive and it was possible to agree to both.¹¹ According to these surveys, in contrast to all those on active euthanasia alone, the approval of active euthanasia has declined constantly, from 41.2% in 1997 to 35.4% in 2000 and 35% in 2005; during the same period, approval of palliative medicine and hospice care rose from 34.8% in 1997 to 56.6% in 2000, remaining stable at 56.0% in 2005.¹² It is unclear how the results of the other surveys would have differed if they had included an additional question on whether the relevant patients should have the right to choose active euthanasia if palliative treatment had no effect.¹³ Notwithstanding these objections, the results of the studies mentioned can certainly be interpreted as evidence that the perception of alternatives – in this case, increasing familiarity with the potential of palliative medicine and hospice care – can significantly influence the views expressed by respondents and no doubt also their personal intentions.

However, even the lower rate of approval of active euthanasia observed in these surveys does not mean that 35% of the population would actually opt for active euthanasia in the event of a severe incurable disease if they had the right to do so. Statements of hypothetical intentions for specific situations are

¹¹ The statement read as follows (after an explanation of the terms used): "Now that you know this, do you favour the combined use of palliative medicine and hospice care for the most seriously ill, or would you prefer active euthanasia?"

¹² Deutsche Hospiz Stiftung 2005.

¹³ The definition of active euthanasia given in the surveys of the Deutsche Hospiz Stiftung [German Hospice Foundation] (Emnid 2001 and 2005) is also problematical: "Active euthanasia means the killing of a person either at his request or without his consent. Knowing this, do you favour the combined use of palliative medicine and hospice care for the most seriously ill, or do you prefer active euthanasia?" It might be expected from the inclusion of killing without the patient's consent that the proportion of respondents in favour would fall appreciably. However, this widening of the definition was manifestly ignored or overlooked by the respondents: this is evident from a comparison with Emnid 2004, in which "active euthanasia" was confined to cases of killing on request and requests for assisted suicide.

⁹ Schröder et al 2003: 340.

¹⁰ Emnid 2004b.

not necessarily valid predictors of choices made if and when the situation actually arises.

Whether the patients concerned really do wish to put an end to their lives by refusing life-sustaining measures or requesting active euthanasia depends on circumstances that cannot be fully anticipated at the time of the survey. These include the actual emotional support and care received by the patient, the subjective bearability of the suffering, and the availability of effective palliative treatment and care. Again, experience shows that a wish to die expressed in a situation of suffering is often temporary and unstable.¹⁴

It is therefore not surprising that the number of cases in which active euthanasia is actually desired and practised is much smaller than would correspond to the values found in surveys for a positive attitude and personal intention. A representative study of 3696 deaths in the United Kingdom (family members were surveyed) in 1990 showed that 2.4% of the dying patients had requested active euthanasia.¹⁵ According to a comparative study of statistics from different countries, in 2001 the proportion of all deaths accounted for by assisted suicide in Switzerland and Oregon, where the practice is legal and deemed consistent with medical professional ethics, was 0.36%¹⁶ and 0.1%¹⁷ respectively. If, as seems appropriate, the number of cases of assisted suicide is referred to the figures for non-sudden deaths, the relevant proportion in Switzerland increases to 0.52%.¹⁸ The proportion of permissible and recorded cases of killing on request was 0.30% in Belgium and 2.59% in the Netherlands, or, referred to all non-sudden deaths, 0.46% and 3.89% respectively.¹⁹

Even allowing for recording deficiencies, these figures do not suggest that assisted suicide or killing on request are frequent

options. They are in fact chosen by only a fraction of patients dying from diseases in relation to which the desire to speed up the dying process meets with a wide measure of comprehension. According to studies conducted in Switzerland and Oregon, 0.5% and 0.4% respectively of patients dying of cancer, 3.4% and 2.7% respectively of ALS (motor neurone disease) patients and 4.5% of multiple sclerosis patients (Switzerland only) died by assisted suicide.²⁰

2.4. Frequency of the various end-of-life decisions

End-of-life decisions that influence or may influence the onset of death in one way or another have now become the norm for patients dying of chronic incurable diseases. Comparative studies of approximately 14 000 non-sudden deaths between 2001 and 2004 in seven European countries show that (except in Italy) such decisions were taken in the majority of cases.²¹ Except in the case of Belgium and the Netherlands, almost all these decisions concerned the withdrawal or withholding of life-sustaining measures and the intensification of pain- and symptom-relieving treatments with the possibility or expectation of the shortening of life.

In most countries, 35–45% of end-of-life decisions fall within the category of the withholding or withdrawal of life-sustaining measures. According to estimates by the physicians surveyed, death occurred up to a month earlier in about 90% of the relevant patients.

Pain- and symptom-relieving treatments (palliative measures) with possible life-shortening effects account for about half

¹⁴ Chochinov et al. 1999; Lauter/Helmchen 2006.

¹⁵ Seale 2006: 3.

¹⁶ Van der Heide et al. 2003: 347.

¹⁷ Oregon Department of Human Services 2006: 11.

¹⁸ Seale 2006: 7.

¹⁹ Van der Heide et al. 2003: 347; Seale 2006: 7

²⁰ Bosshard et al. 2003: 312; Oregon Department of Human Services 2006: 22, Table 3.

²¹ The figures for the individual countries are as follows: United Kingdom 70.2%, Belgium 59.0%, Denmark 61.1%, Italy 32.5%, Netherlands 65.4%, Sweden 50.9%, Switzerland 75.0% (Van der Heide et al. 2003: 347; Seale 2006: 7, Table 3).

of all end-of-life decisions; these are reported in nearly a third of the (non-sudden) deaths considered. The doctors surveyed consider that death occurred up to a week earlier in 60–70% of these cases.

A special case of palliative treatment is terminal sedation, when patients in the final stage of their illness are given drugs in order to induce unconsciousness.²² According to a Dutch study, the doctors themselves stated that in 47% of cases they “also” and in 17% “principally” had the intention of hastening the dying process by sedation, often in combination with the withholding of artificial nutrition.²³ It is mainly these findings that have given rise to a debate on whether the use of terminal sedation constitutes a crossing of the threshold of euthanasia.

Doctors who help the incurable terminally ill to die by procuring them a lethal drug or administering it themselves are liable in most countries to professional or criminal sanctions. According to the comparative European studies in which doctors were asked about their medical decisions at the end of life, physician-assisted suicide and killing on request are significant only in countries in which these practices are permitted. The question “Was death caused by the ingestion of a drug prescribed, made available or administered by you or one of your colleagues with a view to hastening the end of life (or to enabling the patient to end his own life)?” was answered in the affirmative in Belgium in the case of 2.78%, in the Netherlands 5.12% and in Switzerland 1.53% of all non-sudden deaths. The corresponding figures for the other countries covered by the study were: United Kingdom 0.54%, Denmark 1.17%, Italy 0.16% and Sweden

0.31%. The respective proportions accounted for by physician-assisted suicide and killing on request were 0.05% of all deaths and 0.46% of non-sudden deaths in Belgium, 0.31% and 3.89% in the Netherlands and 0.52% and 0.39% in Switzerland. There are hardly any reports of physician-assisted suicide in the other countries. Killing on request is reported for 0.17% of the deaths studied in the United Kingdom, 0.10% in Denmark and 0.05% in Italy.²⁴ No studies of this kind have been conducted for Germany.²⁵

2.5. Potential undesirable trends and abuses

An important part in the public debate is played by the issue of the possible consequences if it were permissible for incurably ill patients to enlist medical help to end their lives or for doctors to administer lethal drugs to them at their request. Certain indications exist as to the likelihood of particular future developments, as the discussion of the following three questions shows.

2.5.1. Do exceptions lead to more and more exceptions?

Allowing physician-assisted suicide or killing on request will be contemplated, if at all, only for narrowly defined situations involving incurably ill patients afflicted with unbearable suffering, and would be subject to restrictive procedures. The fear that these situations might not remain the exception must be taken seriously. Exceptional situations can become precedents;

²² According to a survey of members of the Deutsche Gesellschaft für Palliativmedizin [German Association for Palliative Medicine], 94.4% accept terminal sedation for the treatment of otherwise uncontrollable suffering at the end of life (Müller-Busch et al. 2004b: 335). A study of the medical records of 548 patients who died on palliative care wards between 1995 and 2002 showed that 14.6% were sedated in the last 48 hours before death, although many continued to receive nutrition and hydration. Sedation was administered at the express request of the patients in only a third of all cases (Müller-Busch et al. 2004a: 5, 6, Table 3).

²³ Rietjens et al. 2004: 181, Table 4.

²⁴ Referred to the number of non-sudden deaths given in Seale 2006: 7, Table 3. The difference from the aggregate of all assisted-suicide and life-ending actions is due to cases in which patients' lives were ended other than at their express request (see below).

²⁵ In a questionnaire-based survey of 1902 doctors in the USA, 3.3% stated that they had occasionally issued a prescription for a lethal dose of a drug at a patient's request, while 4.7% declared that they had actually administered such a dose (Meier et al. 1998: 1199, Table 6).

they then establish rules that can be applied in cases other than those covered by the exceptions, thus making such cases more likely. For instance, the constitution of the Swiss organization EXIT provides that only patients with a hopeless prognosis, unbearable pain or unacceptable disability are eligible for assistance with suicide. In practice, however, these conditions are not always observed. Assistance with suicide has also been rendered in cases of less severe suffering and of non-lethal diseases – and even where the wish to die was not based on medical grounds.²⁶ In practice, the patient’s wishes legitimize assisted suicide in such instances.

Similar trends are evident with killing on request in the Netherlands. This does not constitute a criminal offence only if the patient is suffering hopelessly and unbearably, as certified by two doctors; in addition, there must be no acceptable alternative treatments available. In practice, the element of hopelessness is indeed determined unequivocally on the basis of medical judgement. On the other hand, to assess whether the suffering is unbearable, doctors usually rely solely on the judgement of the patient. Again, possible alternative treatments may be inapplicable if only because the patient does not want them. For instance, the Regionale Toetsingscommissies Euthanasie [Euthanasia Regional Review Committees] also recognized as unbearable suffering the mental pain of a patient suffering from Alzheimer’s who “was concerned to retain control over his life and was aware that the progress of the disease would deprive him of that control”. It likewise accepted that the intensification of pain-relieving treatment did not qualify as an “acceptable alternative” if patients “were afraid of becoming drowsy or losing consciousness, and on no account wished this to happen”.²⁷ The difficulty of establishing once and for all the limits set in

exceptional situations is illustrated by the debate on whether “feeling tired of life” can be deemed to constitute unbearable suffering. Although this was explicitly denied in the deliberations on the Euthanasia Law, and although the Supreme Court confirmed in the Brongersma judgement of 2002 that suffering must conform to the medical definition of a specific pathology, a committee appointed by the Dutch Medical Association nevertheless placed the question of whether “existential suffering” justified doctors’ participation in the ending of life back on the agenda.

Attempts to qualify the exceptional character of a legal provision so that it can be applied to other situations are therefore likely and some of these attempts will be successful. However, reactions to this fact diverge. Those who reject physician-assisted suicide and killing on request under any circumstances will regard any extension of the field of application as proof that a thoroughly undesirable trend is in the offing. Those who favour it in narrowly defined exceptional circumstances will accept an extension of its application provided that the principles underlying the exception are still observed. This applies not only to assisted suicide and killing on request, but also to other end-of-life decisions. Once the principle is recognized that a life-sustaining measure should be withdrawn if the patient so requests notwithstanding the medical indication, it becomes virtually impossible to avoid the question of whether this should be done on the basis not only of the declared wishes of the patient but also of his presumed wishes.

2.5.2. If killing on request is permissible, will killing other than on request be likely?

In the comparative studies on the practice of medical decisions at the end of life, some of the responding doctors stated that they occasionally administered drugs with the aim of hastening the dying process without an explicit request by the patient to that effect. Figures for the Netherlands presented in these studies

²⁶ In one case, a 72-year-old husband wanted to end his life together with his wife who was dying of cancer, while in another a 91-year-old woman no longer wanted to live because a stroke had left her unable to play the cello (Frei et al. 2001: 378).

²⁷ Regionale Toetsingscommissies Euthanasie 2005.

showed that, in 10% of the 1541 deaths involving assisted suicide or killing on request recorded in 2001, there was no explicit request or otherwise documented wish on the part of the patient; the equivalent rate in 1995 was 7.3%.²⁸ Hence there are a large number of cases in which the strict conditions governing the killing on request of patients with hopeless and unbearable suffering provided for in the relevant Dutch law have been disregarded. These figures are not uncommonly seen as proof that, in societies that open the door to killing on request, the barriers protecting patients from having their lives ended although they have not expressed a wish to that effect, or even against their will, are thereby lowered.²⁹

Without more detailed information on the circumstances underlying the decisions concerned, it is impossible to say whether the figures justify these fears. It is conceivable and indeed probable that the heading “use of a drug with the explicit aim of hastening death” also covers instances in which terminal sedation or the administration of a pain-relieving drug was medically indicated; in certain cases this is permissible in the interests of the patient even in the absence of a declared wish to that effect. Nevertheless, the findings described above can surely be taken as an indication that restrictions deemed necessary are actually flouted and the applicable rules infringed. The comparative studies have revealed instances of medical decisions whereby patients’ lives were ended without their consent, even in countries where active euthanasia is unconditionally prohibited: more such cases are reported in Denmark (1.02%) than in the Netherlands (0.9%).³⁰

The comparative studies of different countries also show that, with regard to the withdrawal or withholding of life-sustaining measures and to potentially life-shortening pain treat-

ment, many doctors take decisions without exhausting all the possibilities of obtaining the patient’s consent or, in the case of an incompetent patient, of consulting family members. In this connection, patient autonomy is no less respected in countries criticized for being in the vanguard of the liberalization of active euthanasia and physician-assisted suicide than in those which maintain strict prohibitions. The contrary is if anything the case. In the Netherlands, 92% of all reported end-of-life decisions were discussed with the patient where competent, and 85% with family members in other cases; the equivalent figures were 67% and 77% respectively in Belgium and 78% and 69% respectively in Switzerland. By comparison, the corresponding figures for Denmark (58% and 52% respectively), Italy (42% and 39% respectively) and Sweden (38% and 39% respectively) were significantly lower.³¹ Time series from the Dutch studies of end-of-life decisions show that the willingness of doctors to end the lives of patients even without an explicit request to that effect is declining. The proportion of medical practitioners stating that they had done this at some time fell by half between 1990 and 2001, from 27% to 13%, while the proportion of those who would never do this rose from 41% to 71%.³²

2.5.3. Is the medical professional ethic harmed?

Bodies representing the medical profession in all countries confirm almost without exception that assisted suicide and killing on request in order to end the lives of hopelessly ill patients exposed to unbearable suffering ought not to form part of a doctor’s professional duties.

However, attempts to examine this position in surveys have in some cases yielded contradictory results. Surveys of doctors have shown that the proportions favouring the legalization of

²⁸ Centraal Bureau voor de Statistiek 2003: 23, 61, Table 4.6.

²⁹ Jochemsen 2001.

³⁰ Although the figures are low, in all these countries they exceed those for active euthanasia (killing on request): the relative proportions are 0.36/0.17% in the United Kingdom, 1.02/0.10% in Denmark, 0.11/0.05% in Italy and 0.31/0.0% in Sweden (Seale 2006: 7, Table 3).

³¹ Van der Heide et al. 2003: 348, Table 4.

³² Ontwuteaka-Philipsen et al. 2003: 397, Table 2.

active euthanasia would be as follows in the countries stated: Sweden 39%, Canada 37%, Denmark 34% and Italy 32%.³³ In France and the United Kingdom, about half the doctors surveyed were in favour of the legalization of assisted suicide.

In Germany, on the other hand, a study conducted in 2004 found that 90% of 251 specialists in palliative medicine rejected the legalization of active euthanasia, while 75% opposed physician-assisted suicide.³⁴ In individual cases, 30% of 282 medical practitioners surveyed could imagine situations in which they would practise active euthanasia for humanitarian reasons.³⁵

More thoroughgoing studies, however, show that results of this kind possess relatively little evidential value except as regards possible basic attitudes. This is partly because the respondents manifestly lack a detailed awareness of the distinction between active and passive euthanasia. For instance, in a study of over 1000 doctors with postgraduate training in palliative medicine, it was found that about half the respondents wrongly considered turning off a ventilator as constituting active euthanasia. The level of misconceptions was even higher for other questions.³⁶

Such figures reveal not only an almost universal rejection of euthanasia but also a high degree of scepticism and uncertainty on the part of the medical profession. This sometimes results in the withholding of appropriate and medically indicated therapeutic measures at the end of life owing to fear of prosecution for active euthanasia.

The general public clearly has fewer problems with regard to the compatibility of medical functions and active euthanasia. In a representative survey dating from 2001, 55.3% of respondents considered that assisted suicide at the request of patients with incurable diseases and facing imminent death should “be included among doctors’ professional functions”; the equivalent figure for active euthanasia was 61.3%.³⁷

³³ Müller-Busch et al. 2004b: 336.

³⁴ Müller-Busch et al. 2004a: 6.

³⁵ Kirschner/Enkeles 1998.

³⁶ Deutsches Ärzteblatt 2001, 48, A 3186.

³⁷ Schröder et al. 2003: 336, 339.

It is difficult to say what individual and societal implications the legalization of active euthanasia would have for the complex doctor-patient relationship. Nor is it possible reliably to predict how and to what extent the ethic of the medical profession would thereby be harmed.

2.6. The shadow of the National Socialist regime’s crimes of euthanasia

No discussion of active euthanasia in Germany can disregard the fact that, during the period of National Socialist rule, the killing of the incurably sick was a deliberate policy to which nearly 100 000 human beings succumbed between 1939 and 1941. Most of the victims were mentally ill or mentally handicapped inmates of institutions, and the perpetrators were doctors and nurses. The killing programmes were implemented on the basis of secret orders from the Führer. The order underlying the so-called T4 programme empowered selected physicians to grant “mercy killing to those deemed incurable according to the best available judgement of their state of health”.³⁸

Although “mercy killing” certainly meant killing without a request to that effect by the victim, the choice of vocabulary was manifestly intended to convey the impression that what was involved was euthanasia in the sense of assisted dying, and hence an action dependent on the situation and prospects of the individuals concerned. In reality, however, the National Socialists’

³⁸ This is a quotation from the personal authority granted by Adolf Hitler to Reichsleiter Bouhler and Dr Brandt in October 1939, backdated to 1 September 1939. In the course of the “T4” programme, some 70 000 psychiatric patients and inmates of institutions were sacrificed from the end of 1939 on. Most of the killings were concealed by false declarations of the cause of death, and the death notices bore false signatures. Under the earlier “child euthanasia” programme, a start had already been made on the identification and killing of children with disabilities; at least 5000 children were murdered. A further 20 000 disabled inmates fell victim to searches conducted in the concentration camps. The euthanasia programmes were officially terminated in 1941 after their existence had become known and given rise to public protests. See Klee 1985 for the relevant history and documentation.

euthanasia programmes were concerned not with the individual but exclusively with the collective. The annihilation campaigns were the murderous consequence of a late-nineteenth century notion of racial hygiene and eugenics which, while not confined to Germany, was pursued in particularly extreme form by the Nazis. The aim was to protect the “body of the Volk” from what was described as the “burden” of hereditary diseases and consequent “degeneration”. In addition, the collective was to be “spared” the economic “burden” of caring for the sick, whose lives were dismissed as “not worthy to be lived” and as mere “ballast existence”.³⁹

The experience of the National Socialist past, coupled with the resumption of the debate about the worthiness of disabled life to live, has given rise to intense suspicion of any liberalization of the prohibition of killing on request among the disabled and their families, unlike the situation in Belgium, the Netherlands or Switzerland. Such fears are reinforced by indications that a large number of instances in which patients’ lives are ended without express consent go unrecorded.⁴⁰

The memory of the euthanasia crimes of the National Socialist regime is an inevitable concomitant of any political debate on the possible legalization of active euthanasia. However, this should not cause a critical distinction to be overlooked: during the National Socialist period, human beings were killed against their will on the basis of a state-sponsored programme, whereas the discussion today concerns the issue of whether it should be permissible for people to have their lives ended by third parties at their own request, or whether such killing by third parties should remain a criminal offence even if the person concerned makes a serious request for this to be done. Even so, no one can escape the shadow of German history with regard to this subject, whether or not the associated arguments are held to be justified or not.

³⁹ These words are taken from the notorious plea by Binding and Hoche for “permission for the destruction of life not worthy of living” (1920).

⁴⁰ See Section 2.5.3 above.

3. THE PLACES WHERE PEOPLE DIE

Some 850 000 people die in Germany each year. Whereas life expectancy has increased constantly in the last few decades, the causes of death have remained the same in percentage terms: most frequent are diseases of the cardiovascular system (46.8%), malignant neoplasms (cancers) (25.6%), diseases of the respiratory system (6.4%), diseases of the digestive system (5.0%) and non-natural events or acts (e.g. accident or suicide) (4.1%).⁴¹

According to a 2001 survey by the Deutsche Hospiz Stiftung [German Hospice Foundation], 60% of the population would prefer a quick, sudden death for themselves. However, many plainly also wish to bid farewell to their family and friends and to spend their last days in their familiar surroundings.

Notwithstanding the widespread desire to spend the last phase of one’s life at home, about 90% of people in fact die in hospitals or nursing homes. This is partly due to changes in living and family structures and to a reduction in the care provided by family doctors: the emergency doctor nowadays usually summoned in critical life situations will send seriously ill patients to hospital owing to their unknown clinical history and pathology.

3.1. Dying at home

Dying at home used to be the norm. At least the wish to die at home is still widespread today. It is an expression of the need to spend one’s final weeks and days of life in one’s accustomed surroundings together with close family and friends. The reality, however, is very different. In Germany, only about one person in ten dies at home (this proportion is about twice as high in the country as in towns). There are various reasons for this situation. Hospitalization may be necessary for the purposes of medical treatment; quite a few people will have moved into a nursing

⁴¹ Statistisches Bundesamt 2005a.

home long before the terminal phase, or they may be admitted to an inpatient hospice at this time. The circumstances of the patient's life often militate against dying at home, especially if no one close to the patient is on hand or the family members do not feel that they can cope with end-of-life care.

Wherever the appropriate circumstances exist or can be made to exist, a person's wish to die at home should be acceded to. The following factors are relevant:

1. The most important prerequisite for dying at home is the availability of family members who are able and prepared to provide end-of-life care. They must be fully aware of the physical and mental stresses to which they will be exposing themselves and realize that they may find the situation too much for them. However, it is not unusual for the physical and emotional care of the dying to release unimagined inner resources in carers and to be experienced as an enrichment of their lives.
2. Neighbours, friends or church and other religious communities may constitute a network of aid which can appreciably relieve the burden on members of the dying person's family so that they feel supported.
3. When someone dies at home, it may be possible for a family doctor of many years' or even decades' standing to continue to provide care in the terminal phase. The family doctor, having attended and spoken to the patient many times, knows what treatment he wants and which medical measures he would perhaps rather refuse. From the patient's point of view, it is calming and helpful to have a trusted person on hand for medical attendance. Similar considerations apply to spiritual care.
4. For the provision of end-of-life care at home, recourse can additionally be had to the skilled assistance of outpatient nursing services, according to the level of the individual's care

insurance or his own financial resources. Such assistance is often provided by social care units operated by charitable institutions. There are also private-sector nursing services, which have increased substantially in number since the introduction of nursing care insurance in 1995. In addition, outpatient hospice services are available in some places for at-home care of the dying. In 2003, there were 832 registered outpatient hospice services in Germany; this figure does not include small voluntary hospice groups that may not be included in directories. Since 2002, moreover, the Social Law Code (Section 39a of Social Law Code V) has included a framework agreement allowing such services to be assisted by the statutory health insurance scheme subject to certain conditions.⁴²

If a person dies at home, it is easier for family, neighbours and friends to bid farewell to the dying individual or the deceased. Indeed, this may help these individuals too to cope with their loss and mourning. Current law allows a dead person to be laid out in the domestic environment for a reasonable period. However, not everyone is aware of these provisions.

To enable close family to look after a dying individual, the employment legislation should provide for an entitlement to leave, as already exists in some other European countries. The same entitlement to leave should also apply in the case of a close family member who dies in a hospital, nursing home or hospice.

3.2. Dying in old people's and nursing homes

In the last 20 years, the average age of entry into old people's and nursing homes⁴³ has increased greatly – in Bavaria, for instance,

⁴² A nursing home is defined as an institution in which people in need of nursing care live permanently and are nursed and cared for round the clock. The traditional old people's home, in its specific form as an assisted residential unit for older people, is becoming less and less significant.

⁴³ A nursing home is defined as an institution in which people in need of nursing care live permanently and are nursed and cared for round the

from 68 to 86 years. Nowadays, people as a rule move to an old people's or nursing home when home care is no longer possible. Some 75% of residents are discharged from hospital direct to an old people's or nursing home.⁴⁴

About 30% of nursing home residents die within three months of admission. For this reason, great importance attaches to palliative medicine and nursing care in old people's and nursing homes, and many different kinds of institutions and individuals are involved in these activities. This is certainly one of the greatest challenges facing a society characterized by increased life expectancy and ever looser family ties. In a given individual case, it is not always a simple matter, despite all the efforts deployed to that end, fully to satisfy the material requirements, including observance of appropriate standards of nursing care. For instance, a number of studies,⁴⁵ as well as the *Fourth Report on the Situation of the Older Generation*,⁴⁶ draw attention to failings in old people's and nursing homes, such as understaffing or insufficiently skilled staff, poor working conditions, inadequate communication and psychosocial care, lack of time and neglect of individual patients.

Given the expected increase in the number of socially isolated persons in Germany, these problems can surely only get worse.⁴⁷ Accordingly, further action must be taken to improve the conditions of nursing care.

clock. The traditional old people's home, in its specific form as an assisted residential unit for older people, is becoming less and less significant.

⁴⁴ Mautner et al. 1994.

⁴⁵ See for example Becker Meifort 1998.

⁴⁶ Deutscher Bundestag 2002.

⁴⁷ Some 30.5% of home residents are visited by family or friends less than once a month, or not at all, while 28.8% seldom if ever have contact with other residents in their own part of the institution. Other deficiencies and forms of neglect of residents include delayed turning and repositioning in bed, dehydration and undernourishment (Deutscher Bundestag 2002).

3.3. Dying in hospital

Approximately 47% of deaths in the Federal Republic of Germany occur in hospitals. In 2001, the number of such deaths was 392 626 (excluding general and child/adolescent psychiatry). The six specialties with the most deaths are internal medicine (285 348), surgery (67 379), neurology (9152), radiotherapy (4703), neurosurgery (4545) and urology (4379).⁴⁸

The figures show that dying in hospital cannot be equated with death in intensive care: on average, only 2.8% of the total number of patients whose lives end in hospital die in intensive care.⁴⁹ One reason for this low figure is that dying persons are as a rule returned to a general ward for end-of-life care as soon as their health situation is recognized as hopeless.

This is in line with the objectives of intensive care as a medical specialty, which concentrates on ensuring the survival of patients in a crisis situation and on helping them to stabilize both physically and mentally. The patients who die in intensive care are those who are very gravely ill and have often already lost consciousness. End-of-life care in the intensive care ward, in these circumstances, consists mainly of emotional support and spiritual ministering to family members.

Palliative care wards are facilities in which patients with incurable, progressive or already far advanced fatal conditions are treated and cared for to relieve their symptoms – in particular, pain. At present, some 50% of patients (totalling about 7000 people, or 0.8% of all deaths) die while on these special-purpose wards. In the other cases, patients can be discharged after an average treatment period of 15 days. Palliative care ward staff then take charge of the organization of external care for these patients – i.e. contacting family doctors, outpatient nursing units or other nursing facilities such as a care home or hospice. In addition, there are outpatient palliative care services which work together with doctors in private practice and hospice services.

⁴⁸ Statistisches Bundesamt 2005a.

⁴⁹ Statistisches Bundesamt 2005a.

Palliative medicine is already relatively well developed in Germany (in Europe, only the United Kingdom, Switzerland and the Netherlands are better endowed; palliative medicine does not exist in Scandinavia), and palliative care services exist as pilot projects in North Rhine-Westphalia, Lower Saxony and Berlin. However, the reality of this care appears not to match the demand. According to the specialist medical societies, the number of persons in need of palliative care each year is in the range 80 000 to 130 000 (0.1 to 0.16% of the population).

According to the Bundesärztekammer [German Medical Association], there are 75 palliative care wards in German hospitals, providing about seven beds per million inhabitants, whereas the number of beds required per million inhabitants is actually 30. There are also 30 outpatient palliative care services, but the number required is actually 320. A quarter of all patients with tumours need palliative care, but it is available for only 5% of these patients.⁵⁰ Palliative care wards for children, or as facilities in paediatric clinics, do not exist in Germany.

However, adequate medical palliative care must be provided for every incurably ill and dying person. Appropriate provision of beds and skilled staff on palliative care wards is therefore necessary. In addition, the existence of appropriate links between inpatient and outpatient services should be ensured.

To cope with the 80 000 to 130 000 people in need of palliative care, 3000 to 4000 doctors with an appropriate additional qualification would be required, according to the Deutsche Gesellschaft für Palliativmedizin [German Association for Palliative Medicine]. Although the provision of advanced training in palliative medicine for doctors is increasing, only a small number of institutions currently offer this training. The teaching of palliative medicine is integrated in medical studies at some universities. Since 2002, palliative medicine has been provided for in the regulations governing the registration of medical practitioners. Chairs of palliative medicine so far exist

only at the universities of Bonn and Aachen. Palliative medicine societies, academies and associations are currently working on the design of appropriate training, postgraduate and continuing training courses. However, the provision of interdisciplinary training and advance training for medical practitioners and nurses working with seriously ill and suffering patients and with the dying needs to be expanded.

3.4. Dying in a hospice

The concept of a hospice⁵¹ is considerably older than that of palliative medicine. It has its origins in mediaeval Christianity, when the word “hospice” denoted a monastic institution.

Hospices may be organized on an inpatient or outpatient basis. Inpatient hospices are autonomous institutions – that is, they are independent of hospitals or old people’s or nursing homes. They are funded from a combination of sources, including the health insurance funds, care insurance schemes, the institutions themselves, patient contributions or charity. In the case of outpatient hospice services, it is customary for voluntary helpers to assist with individual psychosocial support for the patient, who can then die in his accustomed surroundings; this relieves the burden on family and friends. These services are linked to the care structures of the regional health and social welfare system and are supervised by specialized personnel with experience in palliative medicine.

The various forms of care often complement each other. The actual form of care and support chosen ultimately depends on need, the patient’s pathology, available funds and capacity. This applies to both outpatient and inpatient forms of palliative and hospice care. Family and friends should have access to competent counselling services to advise them on the availability of nursing and other care for the seriously ill.

⁵⁰ Bundesärztekammer 2004.

⁵¹ The word is derived from the Latin *hospitium* [“hospitality”] and literally means a place where guests are received hospitably.

The founder of the modern hospice movement, Dame Cicely Saunders, coined the phrase “high person, low technology” for her approach. Care in a hospice focuses not on medical attention but on care of the body, psychosocial support and ministering to spiritual needs. According to the 2004 statistics of the Bundesarbeitsgemeinschaft Hospiz, there are currently 112 inpatient hospices in Germany (the recorded number of inpatient hospice services has increased by 273% since 1996). This means that there are eleven beds per million inhabitants, although according to the Deutsche Gesellschaft für Palliativmedizin [German Association for Palliative Medicine] 20 are required. Hence the availability of beds and skilled staff in inpatient hospices is still inadequate.

There are at present also seven children’s hospices, which differ substantially from the adult facilities: they often look after children for many years and cater for repeated readmissions.

Those admitted to an inpatient hospice are as a rule patients with advanced cancer, terminal AIDS, diseases of the nervous system accompanied by progressive paralysis, or advanced chronic diseases of the kidneys, heart, digestive tract or lungs. The average length of stay is 27 days; most patients die there. According to the Bundesarbeitsgemeinschaft Hospiz, some 8500 people (1% of all deaths) died as inpatients in a hospice in 2002.

In addition, about 35 000 patients (4%) are cared for by outpatient hospice services. Here again, as in the field of palliative care, the links between inpatient and outpatient care should be improved.

Voluntary activity is an important element of hospice care. With some 50 000 volunteers, the hospice service is one of the fields with the highest intensity of citizen commitment in Germany. This commitment to end-of-life care should continue to receive assistance and support.

3.5. Provision of end-of-life care at the various places where people die

There are many different possible forms of support and care for the dying. If a family doctor has already been providing medical care for some time before the commencement of the terminal phase, he will often continue to look after his patient to the end. Many family doctors report a particularly close relationship with their patients in the final phases of care. Every effort is therefore made to preserve this situation of care even if the dying patient can no longer be looked after at home and is in a nursing home or hospice. However, the aspiration will be to nurse and care for those in need of care individually in their accustomed surroundings (through the provision of nursing on an outpatient or domestic basis), with the involvement of doctors, family and outpatient nursing services.

Owing to demographic trends and the loosening of family ties, the necessary care can often not be provided by family doctors, family members and outpatient nursing services. The possible alternatives are then admission to a nursing or old people’s home or to a palliative care ward, or recourse to outpatient or inpatient hospice services.

The aim in Germany since the 1980s has been to establish a dual-pillar model based on palliative care wards and hospices. Patients suffering acute pain and other symptoms, who require comprehensive medical care, are treated on palliative care wards, whereas hospice care is directed not towards the relief of symptoms in complex clinical pictures, but instead towards emotional support.

The primordial requirement in the physical and emotional care of an incurably ill and dying person is to respond appropriately to his personal needs. Ideally, he should be cared for by a multidisciplinary team made up of family members, doctors, nurses, therapists of various kinds, psychologists, social workers and providers of pastoral care. The quality of end-of-life care depends on a holistic approach that takes account of physical,

psychological, spiritual and social needs. The prime consideration must always be preservation of the dying person's quality of life. However, involvement of family members both during the terminal phase and after death – to enable them to mourn appropriately – must also form an integral part of this care. For them, as well as for the dying individual himself, the availability of an interlocutor, frankness, reliability and good coordination of care are very important.

4. TERMINOLOGY

4.1. Problems of current usage

The ethical and legal debate concerning decisions and actions that have a direct or indirect bearing on the process of dying and the onset of death is not confined to the issue of what is or can be permitted. It includes the question of the terms to be used to denote the various situations. The choice of vocabulary does not on the surface appear to be a major problem, because it is possible to reach agreement on what is and is not meant. However, words are capricious. They convey not only meanings and associations but also values which cast a light that may be deemed inappropriate or undesirable on what they denote.

For this reason, after 1945 Germans were reluctant to use the German equivalent [*Euthanasie*] of the term “euthanasia” commonly employed in other countries in relation to decisions and actions affecting the end of life. In Germany, the word is indissolubly associated with the murder of the sick and disabled under the National Socialist regime (see Section 2.6 above). Its connotations bear no relation to the structure of the acts forming the subject of this Opinion or to the intentions of the actors. In the public debate on the decisions and actions that ought to be allowed at the end of life, the right to life is an undisputed given.

However, difficulties with the traditional terminology also arise in connection with the word *Sterbehilfe* [literally, “help with dying”], which has substantially supplanted *Euthanasie* in German usage. The word *Hilfe* [“help”] has a positive connotation; it stands for something that is legitimate and desirable. Help is something that everyone surely desires at every phase of one's dying process. Yet this positive tinge becomes problematical in the case of *aktive Sterbehilfe* [“active euthanasia”],⁵²

⁵² The original meaning of the Greek word *euthanasia* – “good death” – has a similarly positive connotation, even though its meaning varies greatly according to the relevant cultural context. [Translator's note: In accordance

which relates to acts deliberately intended to bring about a person's death – with that person's explicit or presumed consent. It is a moot point whether there are cases in which such killing on request can be apostrophized as “help”. It is, however, evident that the use of the word *Sterbehilfe*, as well as that of the phrase “assisted dying”, is felt to be inappropriate and misleading, and indeed positively euphemistic and tending to obscure the true state of affairs.

Objections are also raised to the term *passive Sterbehilfe* [“passive euthanasia”]. This denotes cases in which, where a disease is expected to have a fatal outcome, treatment that is still possible is withheld – that is to say, potentially life-prolonging measures are either not initiated or are withdrawn. The patient is allowed to die. Despite what is suggested by the words used, however, letting a patient die in this way is not necessarily passive – i.e. brought about by simply abstaining from doing something. It can perfectly well involve the active intervention of the attending physician – for example, the removal of a feeding tube so as to discontinue artificial nutrition that has already commenced, or the turning off of a ventilator to end artificial breathing assistance. The term “passive euthanasia” in this context gives rise to confusion, as it is uncertain whether it covers the unequivocally active withdrawal of life-sustaining measures already initiated. Doctors and nurses, too, often consider such measures to fall within the sphere of “active euthanasia” and sometimes of killing on request. However, such a view fails to do justice to the particularities of the various actions and the intentions of the actors. The predominant opinion is that, in assessment of the situation, it makes little difference whether, in the case of artificial feeding, a feeding tube already inserted is removed or whether one was not applied in the first place. In both cases, an unwanted treatment or one that is not medically indicated is omitted. Again, in both cases, the omission permits the disease to progress unhin-

with normal English usage, the word “euthanasia” is used where appropriate throughout this translation.]

dered, so that death supervenes earlier than would have been the case had the relevant measure been adopted. It is perhaps psychologically understandable if the actors (doctors and nurses) are more reluctant to intervene actively – by removing a feeding tube or turning off a ventilator – than simply to do nothing. However, the distinction is not inherently justified. Like doing nothing, the active intervention merely serves the purpose of achieving the omission of medical treatment. In consequence of the omission, the pathological condition takes its natural course and culminates in death. This situation should be described by terms that do not suggest a slippage towards “killing on request”. This will be more readily feasible if the process is described as “letting die”⁵³ instead of “passive euthanasia”.

The critique levelled at the term *indirekte Sterbehilfe* [“indirect euthanasia”] is that it fails to describe the aim of the relevant actions correctly. What is involved is not help with dying but therapies in the terminal phase. Chief among these are pain relief and sedation, in which the risk of the possible side-effect of earlier death is accepted, for instance because the pain-killing drug administered gives rise to hypoventilation. However, given the latest advances in palliative medicine, effective therapy of even extreme pain is usually possible today without causing the premature death of the patient. It seems inappropriate to describe the administering of a drug medically indicated for the purpose of relieving pain in a seriously ill patient as “indirect euthanasia” on the grounds that it may have the unintended ancillary consequence of hastening death. Furthermore, such a description would then also apply to other cases in which the use of drugs whose side-effects include potentially fatal complications is medically justified.⁵⁴ At the same time,

⁵³ This alternative terminology is not new, but has long been favoured by many authors – e.g. Beauchamp/Childress 2001; Steinbock 1994; Spaemann/Fuchs 1997. See also the comprehensive discussion of terminology in President's Commission 1978: 60 ff.

⁵⁴ However, it is only in the case of palliative relief of suffering that even the certainty of an earlier death might be acceptable in extreme situations. For all other treatment measures, this would be seen as an unequivocal contraindication.

it would be an impermissible euphemism to dismiss as “indirect euthanasia” a form of pain therapy that involves an overdose or is otherwise medically inappropriate and therefore leads to the patient’s death. This would in fact constitute an instance of (negligent or deliberate) ending of the patient’s life.

Lastly, the term “terminal sedation” is also problematical. It is used inconsistently and covers a range of measures that must be distinguished from each other in relation to the patients concerned and their wishes, the aim of treatment and the clinical conditions of application. The use of this term suggests that the patient’s death is the intended aim of the sedation itself. However, this would constitute killing, an act that ought not to be described by the euphemism of sedation. Sedation given so as to provide for the refusal of nutrition and hydration in an individual who is not seriously ill but wishes to die also falls within the sphere of killing on request. In another group of patients, “terminal sedation” refers to a situation in palliative care when symptoms such as pain, panic states or extreme agitation cannot be controlled in any other way than by sedation, which is then often only temporary. It would then be more apt to use the term “palliative sedation”, as an element of appropriate therapy at the end of life. Another form of palliative sedation is used in patients in whom the withholding or withdrawal of a treatment is either medically indicated or conforms to the wishes of the individual concerned. In such cases, sedation may be an accompanying measure for the relief of painful or distressing symptoms.

4.2. Suggested terminology

The National Ethics Council proposes that the current terminology of “active euthanasia”, “passive euthanasia” and “indirect euthanasia” be abandoned on the grounds that it is not only open to misunderstanding but also in certain respects misleading. Decisions and actions at the end of life which directly or

indirectly affect the dying process and the onset of death can be appropriately described and distinguished by the use of the following terms: “end-of-life care”, “therapy at the end of life”, “letting die”, “assisted suicide”, and “killing on request”.

4.2.1. End-of-life care

The term “end-of-life care” is proposed to denote measures for the care and nursing of the terminally ill and dying. These include bodily care, the alleviation of feelings of hunger and thirst, the relief of nausea, anxiety and breathing difficulties, as well as emotional support and ministering to the spiritual needs of the dying individual and his family. The aim of end-of-life care must be to maintain the patient’s capacity to exercise volition even in the terminal phase for as long as medically possible, provided that this is bearable for the patient and desired by him.

4.2.2. Therapy at the end of life

Therapy at the end of life comprises all medical measures, including palliative care, adopted in the terminal phase with the aim of prolonging life or at least of relieving suffering. These include measures which may hasten the natural process of dying, whether due to high doses of painkillers or to powerful sedation essential for the control of painful or distressing symptoms. The term “indirect euthanasia” previously used in this connection should be avoided, because the patient’s death is neither the direct nor the indirect aim of the relevant action. If, on the other hand, an overdose of drugs not justified on medical grounds is given in order deliberately to bring about the patient’s death, the term “indirect euthanasia” is in any case inappropriate, because in this instance the patient is being killed.

4.2.3. Letting die

The term “letting die” is used in this Opinion instead of “passive euthanasia” where a life-prolonging medical treatment is withheld, so that the death resulting from the course of the illness occurs earlier than would be expected if this treatment were provided. The withholding may consist simply in the non-initiation of a life-prolonging measure, or, alternatively, of the non-continuation or active termination of a measure already commenced. In some cases it may be appropriate to administer palliative sedation of variable depth in addition.

4.2.4. Assisted suicide

“Assisted suicide” is when doctors or other persons procure someone a lethal drug or support him in any other way in the preparation or commission of suicide on his own responsibility.

4.2.5. Killing on request

“Killing on request” means giving someone, in response to a serious wish on his part, a lethal injection or a drug overdose or taking some other action that is not medically indicated in order to bring about his death before it would otherwise occur in consequence of his illness. Killing on request differs from assisted suicide in that the lethal act is performed not by the subject himself but by someone else.

4.3. Residual terminological difficulties

The National Ethics Council is aware that its favoured terminology does not eliminate all the difficulties involved in the appropriate description of medical measures and decisions at the

end of life. The distinction between “killing on request” and “letting die”, too, may carry connotations of “impermissible” and “permissible”, which may lead to overhasty, ill-founded conclusions. The notion of killing on request loses its negative tinge if it refers to the ending of the lives of incurably ill individuals who wish to die in order to put an end to what they subjectively feel to be unbearable suffering but are unable to bring about their own deaths without help. Conversely, “letting die” is far less innocent than the term suggests. If a doctor withholds a life-sustaining measure from a patient, either by not initiating it or by withdrawing it, he allows the patient to die from the natural course of the disease. This action nevertheless undeniably constitutes the taking of life if the measure was medically indicated and is withheld against the will of the patient. Implicit in the idea of “letting die”, then, is that it is not simply a matter of allowing the patient to die, but of letting him die at his own request or in a hopeless situation where medical measures for further prolonging his life would be inappropriate.

Notwithstanding this reservation, the National Ethics Council believes that its favoured terminology better reflects the characteristics of the actions and the intentions of the actors involved in medical measures and decisions at the end of life than the traditional notion of euthanasia. The distinctions necessary for evaluation must be made in the discussion of each specific situation.

5. THERAPIES AT THE END OF LIFE, LETTING DIE, ASSISTED SUICIDE AND KILLING ON REQUEST: CONSIDERATION IN TERMS OF CONSTITUTIONAL AND CRIMINAL LAW

5.1. Constitutional law

5.1.1. Relevant provisions of the Basic Law

The main constitutional principles applicable to the issues discussed in this Opinion are human dignity, the right to life and the right to free deployment of the personality. The inviolability of human dignity (Article 1(1) of the German Basic Law, or Constitution) requires all state authority to protect the individual, however sick, weak and infirm he may be, from contempt for his subjecthood and hence at the same time to protect his autonomy. The right to a dignified death is not uncommonly seen as falling within the sphere of human dignity; this is usually associated with the notion that human beings must not become the object of third parties' decisions even in matters of life and death and in particular when dying. The right to life and the right to physical integrity (Article 2(2) of the Basic Law) protect the individual, on the one hand, in his biological and physical existence from killing by third parties and, on the other, from impairment of his physical and mental integrity. Since therapeutic actions undertaken without consent also constitute violations of bodily integrity, Article 2(2) of the Basic Law is central to decisions on the shaping of the dying process. Lastly, the right to free deployment of the personality (Article 2(1) of the Basic Law) is understood in the comprehensive sense of a general freedom of action and in practice protects the entire range of possible human activity without the application of qualitative criteria. The prevailing view seems to be that suicide, too, must be assessed on the basis of Article 2(1) of the Basic Law.

5.1.2. The right to life, duties of protection and problems of euthanasia

The right to life (Article 2(2) of the Basic Law) is of paramount importance for the specific issues of therapies at the end of life, letting die, killing and suicide. As a right that can be asserted against acts by the state, it protects the individual from having his life taken against his will. Considered in terms of the constitutionally recognized entity of the duties of protection that flow from fundamental rights, it is in fact directed against not only acts by the state but also encroachments by individuals. This duty of protection is reflected in the penal provisions of Sections 211 ff. of the German Penal Code. The issue in the situations mentioned is the criminalization of killing against the will of the person concerned and is as such unproblematical.

The position is surely much more equivocal where the protection of a human being from himself is concerned. It is sometimes maintained on the basis of ethical or theological considerations that the individual has an obligation to live even if this is contrary to his current wishes, as all forms of "passive and active euthanasia", for instance, are deemed unacceptable. According to this view, the right of self-determination cannot take precedence over life, which is the highest good of all. However, an obligation to continue living even against the individual's own wishes meets with constitutional objections, because it ultimately transforms the subjective fundamental rights, as guarantees of autonomy and freedom, into an objective code of obligations. Such a view is foreign to a liberal constitutional state (as opposed to a totalitarian system).

The right to life does not oblige its individual bearer to remain alive. Nor do the state's duties of protection, based on fundamental rights, which are sometimes adduced against such a view, justify the existence of such an obligation on the part of the individual. As the Federal Constitutional Court has repeatedly emphasized (BVerfGE [Decisions of the Federal Constitutional Court] 39, 1, 42; 46, 160, 164), these duties of protection require

the state “to adopt a protective, supportive stance towards this life – that is, in particular, to protect it also from unlawful acts by others”.

There is of course more to the state’s obligation to protect life. It also includes vigorous attempts to influence the will of a potential suicide with a view to preventing the act, especially where the situation is unclear or suicide is considered likely while a person is in state custody. Nevertheless, neither the state nor others have a right to prevent suicide in all circumstances and thus to impose an obligation on an individual to remain alive.

The first point to be made with regard to the specific situations at issue, in accordance with the above principles, is that the relevant constitutional literature not only raises no objections to the non-punishability of letting a person die at his own request (i.e., in the traditional terminology, passive euthanasia), but actually favours this. Patient autonomy implies the right to refuse life-sustaining measures or to have them terminated – even if they are medically indicated and their refusal or termination could only be deemed unreasonable by “objective” criteria. This protection from unwanted therapeutic actions is also directed against doctors, on whom their profession does not confer a right to treat. Hence the right to life does not give the state or any third party authority to treat the personal bearer of that right against his will and hence to compel him to continue living.

The medically indicated relief of severe suffering by a treatment undertaken with the patient’s consent does not incur penal sanctions even if the treatment has the effect of shortening the patient’s life. Not only are there no constitutional objections to this view, which is almost universally shared in the criminal-law literature, although dogmatically justified on different grounds; it is in fact reinforced by constitutional considerations. In particular, the preference for life-shortening pain relief is held to be supported by the Constitution – for prohibition of this pain relief, involving the shortening of life, notwithstanding the medical indication and the consent of the suffering individual would be tantamount to an obligation to

continue living in intense pain. But this would be not only ethically unjustifiable, but also inconsistent with the premises of our legal order, which sets great store by the self-determination of the individual and, in particular, has made a commitment to humanity by the guarantee of human dignity. It would be contrary to this obligation to subject a suffering patient to a higher-order purpose which he himself no longer shares – namely, the prolongation of life, now experienced as pointless.

In the case both of letting die and of therapies at the end of life, it is thus found that the autonomous will of the patient remains not only the basis but also the limit of medical action.

This view is only seemingly opposed by Section 216 of the Penal Code, which provides that killing on request is a punishable offence. This provision admittedly restricts the individual’s freedom of decision in so far as killing him even at his express, serious request is prohibited. However, this is so not in order to oblige him to continue living against his will, but in order to protect other objects and public interests. The appreciation of these entities and the relative weights to be assigned to them are primarily a matter for legislation. So if the legislature considers it appropriate to criminalize killing on request – for instance to avoid the risk of abuse, to prevent social pressure on doctors and patients or for symbolic endorsement of the prohibition of the taking of life in general – this can be deemed consistent with the Constitution. In this sphere, then, the legislature enjoys considerable freedom, and could indeed perfectly well restrict the application of Section 216 of the Penal Code or even repeal it altogether in its current form.

5.1.3. Suicide

When suicide is considered in terms of fundamental rights, the starting point of some authorities is the right to life enshrined in the first sentence of Article 2(2) of the Basic Law, the act of suicide being seen as a “negative” freedom inherent in the right

to life – so to speak, as the right of termination of life. However, there are good reasons for doubting whether the extinction of the personal bearer of a fundamental right forms a legitimate part of the exercise of such rights. The predominant view seems to be that the suicidal act therefore falls within the purview of the general freedom of action provided for in Article 2(1) of the Basic Law. What is more important than the espousal of one or other of these views is, in particular, the need to understand that the issue is not a positively connoted “right to suicide” in the sense of a competence granted by the state or a form of action which it approves, but solely the fact that any prohibition of suicide would encroach on fundamental rights. For this reason, the contrary view – that any limitation by the state on individual freedom of action must be based on specific formally and substantively correct legal principles – must prevail.

The fact that such a limitation of the freedom to commit suicide, for instance by the introduction of penal sanctions, would probably be devoid of valid constitutional justification stems on the one hand from the guarantee of human dignity enshrined in Article 1(1) of the Basic Law. After all, at least the taking of one’s own life on the basis of a freely made decision to that effect on the responsibility of the person concerned forms part of the freedom, which is a fundamental right, that includes not only the determination of the time of one’s death but also the right to die in dignity. Even if suicide can emphatically not be deemed a “privilege of being human” (Jean Améry), the termination of one’s own life, as a free act of will, does not constitute a violation of the guarantee of human dignity, but is in fact one of its pillars. On the other hand, there is the valid consideration that while a liberal society in a constitutional state imposes obligations on its citizens (such as military service, compulsory schooling or taxation), it does not require the individual to stay alive in that society – nor can it do so, given the principle that the individual takes precedence over the state.

5.2. Criminal law

The criminal law may also be relevant to the conduct of therapies at the end of life, letting a patient die, assisted suicide and killing a patient at his request. This gives rise to considerable uncertainty for family members, medical practitioners and nursing staff – partly because the German Penal Code contains no specific provisions on the situations and issues discussed here. Although killing on request is explicitly dealt with in Section 216 of the Penal Code, this provision makes no direct reference to the situation of the seriously ill or to any other medical context. Recourse must therefore be had to the general norms of the criminal law as interpreted by the courts. Reliable assessment of the present legal position is, in addition, rendered more difficult by the relative dearth of judgements on the relevant specific situations and problems and by the fact that even these decisions have in some cases clarified only individual aspects. Again, the judgements most pertinent to the interpretation of the provisions at issue concerned cases of different and sometimes unusual kinds. Lastly, some of the precedents are based on relatively old judgements of the Federal Court of Justice, so that, having regard to the progress of case law in other courts and the opinion of later authorities, it is doubtful whether the Federal Court of Justice would still interpret the legal situation in the same way today.

5.2.1. Therapies at the end of life

With regard to therapies at the end of life, the right to self-determination over one’s own body is of fundamental importance. This right of self-determination is enjoyed equally by the healthy and the sick. Hence every individual has the right either to permit or to refuse a medical treatment. Any measure adopted against the patient’s will (whether surgery or merely the insertion of a feeding tube) is deemed under current law

(Sections 223 ff. of the Penal Code) to constitute the infliction of bodily harm. Consequently, doctors may be liable to criminal prosecution in situations where a patient is no longer competent and decisions must therefore be made in accordance with his presumed wishes. This risk arises out of the difficulty of determining the patient's presumed wishes with sufficient certainty. The doctor's position is rendered even more difficult by the fact that (see Sections 5.2.2 and 5.2.3 below) the contrary action on his part – the withholding or withdrawal of a treatment – may also be punishable: if a doctor fails to prevent his patient's death because he assumes that the patient has not consented to treatment, he may in certain circumstances be accused of failure to render assistance to the patient or of killing by omission.

The attention of the criminal law is attracted, in particular, by acts involving the administering to a patient of a powerful pain-killing drug, with the associated risk of shortening the patient's life. In such cases, the unanimous view is that a punishable offence pursuant to Sections 211 ff. of the Penal Code has not in fact been committed. Some authors consider that not even the definition of homicide is satisfied in this case, because the drug was administered with a view to making the final days or weeks of life bearable. According to the relevant case law⁵⁵ and much of the literature, although an act of killing has been committed, it is not unlawful. In this connection, some authors hold that the effective (presumed) consent of the patient constitutes sufficient justification. However, the predominant opinion is that facilitating a painless death in accordance with the patient's wishes constitutes a higher-level object of legal protection than “the prospect of having to live a little longer in severe and in particular ‘agonizing’ pain”.⁵⁶ It even follows that the doctor has an obligation to relieve pain as appropriate.

⁵⁵ BGHSt [Decisions of the Federal Court of Justice in Criminal Cases] 42, 301, 305; BGHSt 46, 279, 285.

⁵⁶ As explicitly stated in BGHSt 42, 301, 305.

5.2.2. Letting die

Letting someone die may be relevant to the criminal law in the form of killing by omission (Sections 212 ff. and 13 of the Penal Code) or of failure to render assistance (Section 323c of the Penal Code).

The situations in which it is permissible to let someone die are disputed. For a long time the criterion adduced was that the patient must have already entered the final phase of life. This condition was deemed to be satisfied if, according to medical opinion, the patient's fundamental pathology was irreversible and had taken a course in which death would supervene within a short time.⁵⁷ The implicit basis of this view is the right to a natural and dignified death, which ought not to be prolonged by life-sustaining measures if the patient would thereby be condemned to a lingering death.

However, with regard to the situation where life-sustaining measures are withdrawn, the Federal Court of Justice has ruled that it may be permissible for a patient to be allowed to die if he has not yet entered the terminal phase of his life but desires this withdrawal or if the conditions of a presumed wish are satisfied.⁵⁸ In its decision to this effect, the Federal Court of Justice found that the patient's decision, as an element of his right of self-determination, must be taken into account even in such a situation.⁵⁹ However, according to the Court, in the interests of the protection of human life strict substantive requirements had to be imposed as to the conditions for assuming the patient's presumed consent. The deciding factor was the presumed wishes of the patient, as they appeared after careful consideration of all circumstances. For this purpose, earlier oral or written statements by the patient had to be taken into account, as well as his religious convictions, his other personal values, his likely life expectancy and the pain he was suffering. Objective criteria – in

⁵⁷ BGHSt 32, 367, 380.

⁵⁸ BGHSt 40, 257 (Headnote 1), 262 f. (the Kempten case).

⁵⁹ BGHSt 40, 257, 262.

particular, the view that a measure was commonly held to be “reasonable” or “normal” and in the interests of a sensible patient – had no independent significance, but could merely constitute indications for the purpose of determining the patient’s hypothetical individual wishes.⁶⁰

This decision is predominantly accepted in the literature. This current of opinion implies that the withholding of further treatment even before commencement of the dying process does not incur penal sanctions if the patient refuses continuation of the therapy. In this connection, it is increasingly often pointed out that it is inconsistent with the patient’s right of self-determination (which is also protected by the Constitution) to adopt measures to prolong his life artificially against his will (on this point, see also the National Ethics Council’s Opinion on the advance directive). No one disputes that the right of self-determination includes that of refusing vitally indicated medical measures. Should a doctor nevertheless adopt these, he might be liable to penal sanctions on the grounds of the infliction of bodily harm under Sections 223 ff. of the Penal Code.

The view is further expressed in the literature that a patient’s (actual or presumed) *refusal* of treatment cannot be the sole deciding factor, but that the treatment itself, as well as its continuation, requires the (actual or presumed) consent of the patient. After all, from the point of view of the law a medical treatment involving an action on the body constitutes bodily harm. For this reason, the attending physician must not adopt life-prolonging measures without consent.⁶¹ These principles should also take precedence over the provisions that criminalize omission.

⁶⁰ BGHSt 40, 257, 263.

⁶¹ BGHSt 37, 376, 378; a final conclusion is not reached in BGHSt 32, 367, 378.

5.2.3. Suicide: assistance and the subsequent obligation of rescue

The term “suicide” denotes a situation in which a person kills himself on his own responsibility and, in doing so, actually controls the events that lead to death.⁶² The decisive factor for distinguishing suicide from killing on request (which is dealt with in Section 5.2.4) is the matter of who “controls” the act that directly ends the life of the person concerned: in the case of suicide, this is the individual who is tired of life himself, whereas in that of killing on request, a third party takes the final decision on whether the act is to take place.

Since suicide and attempted suicide are not punishable acts, neither aiders and abettors nor instigators are, according to the principles of the German criminal law, committing a criminal offence.⁶³ A punishable principal offence has not been committed – as Sections 211 ff. of the Penal Code refer to the killing of “another”. For the act not to be punishable, the suicide must be acting on his own responsibility and himself control the final cause that leads to death. With regard to the suicide’s own responsibility, both case law and the prevailing view expressed in the literature are based on a consideration of whether the conditions of effective consent are satisfied. This is not the case if the suicide, by reason of error or lack of capacity for insight, is unable to give effective consent.

However, according to the decisions of the Federal Court of Justice, a person who is present may be liable to prosecution for homicide – specifically, killing on request by omission (Sections 216 and 13 of the Penal Code) – if he occupies the position of a “protector” [*Garant*], as in the case, in particular, of an attending physician or close relatives, and if he is still present when the suicide loses consciousness. This is because “control of the act”

⁶² BGHSt 19, 135, 139.

⁶³ In other countries (e.g. Austria, the Netherlands, Poland and Switzerland), however, aiders and abettors and/or instigators may in certain circumstances be liable to penal sanctions.

is deemed, when unconsciousness supervenes, to pass to the person present, who is then required to render assistance on account of his position as protector.⁶⁴

The imposition of penal sanctions in such cases is criticized in the literature because the intention of the person present is, precisely, to respect the dying individual's wishes and because that individual controls the actual cause of death. The solution reflected in the decisions of the Court, according to this view, systematically undermines the non-punishability of participation in suicide. The literature also criticizes the Court's approach on the grounds that the offence defined in Section 216 of the Penal Code cannot be constituted by omission because that section explicitly refers to the prohibition of active killing of another person. In the view of the relevant authorities, there is no valid precept stipulating that another person must be kept alive against his will if he has, precisely, the intention of dying. The duty of protection arising out of the position of a protector [*Garant*] is limited by the right of self-determination of the person concerned. In addition, there is the contradiction that the "aider and abettor" who is present may render himself liable to penal sanctions once the suicide has lost consciousness, whereas he is not deemed to have committed an offence if he leaves before consciousness has been lost.

If the person who fails to prevent the suicide is not in the position of a protector, he may be liable to prosecution on the grounds of failure to render assistance under Section 323c of the Penal Code. The imposition of penal sanctions in accordance with this provision, too, is disputed. Once again, it is ultimately a matter of the conflict between the right of self-determination and the obligation to render assistance. The point at issue is whether a suicide committed on the responsibility of the person concerned can indeed be deemed to amount to "misadventure" within the meaning of this provision. According to the decisions of the Court, it does constitute misadventure⁶⁵ because suicide often

⁶⁴ BGHSt 32, 367, 374.

⁶⁵ BGHSt 32, 367, 372, 375 f.

constitutes a cry for help or is committed on account of a pathological mental situation. In the short time available, according to this view, it is impossible to undertake a sufficient exploration of the precise circumstances of the suicide attempt and reliably to determine the element of the suicide's own responsibility and the seriousness of the wish to die. In this situation, case law does not require rescue measures to be adopted if the situation can be assumed to be one of "rational suicide", in which the suicide's own responsibility and the seriousness of his wish to die are undisputed. However, the conditions to be satisfied for deeming a case to be one of "rational suicide" are restrictive and disputed.

Again, the obligation to render assistance does not apply in circumstances where it would be unreasonable to expect the person on whom the obligation is incumbent to do so. According to case law, there is also no such obligation if the victim would die within a short time or would survive only with severe consequential impairment. There is no obligation to preserve a life in the process of extinction at all costs, so that a criminal offence according to Sections 216 and 323c of the Penal Code has not been committed.⁶⁶

5.2.4. Killing on request

If a patient is killed and there is no indication that he wanted to die, this constitutes manslaughter (Section 212 of the Penal Code) or murder (Section 211 of the Penal Code – for instance, in the case of greed or base motives). Homicide has been committed even if the perpetrator's motive was to spare the victim suffering. Compassionate killing, or killing because the killer himself could no longer endure the situation, is also subject to penal sanctions under the above provisions. However, mitigation of punishment in accordance with Section 213 of the Penal Code is possible in less serious cases.

⁶⁶ BGHSt 32, 367, 379.

Section 216 of the Penal Code (which provides for the punishability of killing on request) shows in addition that the law does not regard a patient's explicit, serious wish to die as having the effect that this act ceases to be unlawful. In contrast to consent to a therapeutic action, which, as shown, technically constitutes the infliction of bodily harm and is justified by consent, consent does not therefore make killing a lawful act. Nevertheless, the law provides that an explicit wish on the part of the patient to die mitigates the unlawfulness of the relevant act and the associated guilt. After all, the victim wishes to forgo the object of legal protection represented by his life – hence the appreciably lighter penalties provided for in Section 216 of the Penal Code than those for other forms of intentional homicide.

However, the serious request that mitigates the unlawfulness must be explicitly declared and also seriously meant. It must therefore be expressed on the unconstrained responsibility of the patient in a manner that cannot be misunderstood and in full awareness of the implications of the decision. This is precluded where the person concerned is influenced by coercion or error.

That said, there is a certain conflict between the prohibition of killing on request and the non-punishability of assisted suicide (which is discussed in Section 5.2.3 above). This is because the prohibition has the effect that no one who is unable to end his life by his own resources can empower someone else to kill him, whereas he would be able to enlist help for the act of committing suicide himself. This problem is also recognized by the courts, which, however, see the possible modification of the protection enjoyed by legal objects as a matter for legislation.⁶⁷

In the criminal-law literature, on the other hand, there is substantial agreement that, in the case of a person wishing to die who is in a state of practically complete helplessness and therefore objectively no longer able to bring about his own death, the prohibition of killing on request loses its justification, because its enforcement would lead to intolerable and hardly justifiable

⁶⁷ BGH [Federal Court of Justice], NJW 2003, 2326, 2327.

hardship.⁶⁸ For such situations, the relevant criminal-law scholars suggest three approaches: that the definition of the offence in Section 216 of the Penal Code be narrowed; that the requirement of an emergency situation as a justification under Section 34 of the Penal Code be deemed satisfied; or at all events that the act should be exempt from punishment on the grounds of an extenuating supra-statutory emergency situation.

In addition, a potential conflict exists between the prohibition of killing on request and acts whereby a patient is given a powerful pain-killing drug even at the risk of shortening his life. As stated in Section 5.2.1, it is generally agreed in the literature that such an act is not punishable under Sections 211 ff. of the Penal Code.

⁶⁸ A good example is the case of Diane Pretty, a British citizen. She was paralysed from the neck down by a disease of the central nervous system. The progressive degeneration of the nerve and muscle tracts put her at risk of suffocation due to failure of the muscles involved in respiration. The Director of Public Prosecutions had refused to grant immunity from prosecution to her husband if he were to kill her at her request. The application against this decision to the European Court of Human Rights was dismissed because the DPP's decision could not be deemed to infringe the European Convention on Human Rights (Pretty v. the United Kingdom, No. 2346/02 (Sect. 4), ECHR 2002-III). The Court did not rule on whether killing on request was or was not punishable under national law.

6. ETHICAL CONSIDERATIONS

6.1. Fundamental criteria

Decisions taken in the particular situation of the incurably ill and dying are governed by fundamental values and norms based on considerations of human dignity and human rights. These values and norms are undisputed within the National Ethics Council. They are also the subject of a wide-ranging consensus in society. Conflict and disagreement arise in the application of these principles to specific practical situations.

The main elements that constantly recur in the debate on end-of-life issues and must be taken into account in any consideration are the protection of life and of bodily integrity, the right to self-determination and the principle of solidarity and care.

In any appraisal of decisions and actions at the end of life, fundamental importance attaches to the protection of life and of bodily integrity. After all, life is the necessary condition of all expressions of the personality. The mere fact that someone is dying or suffering from a fatal illness cannot serve as justification for limiting his medical care or ending his life. This also applies to cases in which third parties invoke the intention of releasing the dying individual from pain and torment. In social, cultural and legal terms, the protection of life is enshrined in the prohibition of killing, which is one of the fundamental rules of any human community. The basis of the protection of bodily integrity is that any violation of it affects the person and may give rise to pain and suffering.

The right to self-determination constitutes an acknowledgement that every individual is unique. One facet of respect for a dying individual as a person is therefore that actions which affect his general condition or prolong the process of dying may be undertaken only with his actual or at least presumed consent. At the same time, self-determination includes the right to refuse offers of help, even if the refusal appears to others to be relatively inexplicable or even unreasonable. In

some situations, admittedly, it is difficult or even impossible for the terminally ill, for physical and mental reasons, to determine what they themselves want and how they wish to live in the time remaining to them. However, such a situation does not justify determination by others; instead, emotional support, assistance and pain relief should be used to ensure that the incurably ill and the dying can as far as possible retain or regain the capacity for volition and self-determination.

Because they are helpless and vulnerable, the dying and the incurably ill have a particular claim on the support of their fellow human beings and the solidarity of society. Family, friends, medical professionals and the community represented by the state are responsible for ensuring that such people are not left alone but obtain the care needed to preserve them as far as possible from pain, fear and despair. The incurably ill and the dying must be assured of the protection that guarantees their rights as persons, as far as possible supports their capacity for self-determination and allows them to die with dignity. The task of relieving pain is an important element of medical care at the end of life.

6.2. The specific situations

A fundamental problem in the ethical appraisal of decisions and actions at the end of life is that the norms and values that are in principle universally accepted may come into conflict with each other in the specific situations, and that there is no consensus on how to reconcile them.

The moral evaluation not only of killing on request and assisted suicide but also of the withdrawal of a medically indicated treatment ultimately depends on one's view of the relative importance of the protection of life, self-determination, social relationships and care. A number of specific questions arise in this connection. Is it morally significant if the dying individual's social environment opposes his wish to die? Can that individual release third parties whose obligations include caring

for him – in particular, family members and attending physicians – from these obligations? Can acceptance of a person’s decision to commit suicide in his particular situation of distress and danger also entail acceptance of the cooperation of others to whom the exceptional existential situation does not apply? Must the person concerned expect to be rescued against his will? What view is to be taken of the situation in which the individual is no longer capable of expressing his wishes, there are no unequivocal indications of his wishes and the other persons concerned must infer the individual’s wishes from his biography and prior statements (see also the National Ethics Council’s Opinion on the advance directive)? What is the significance of the fact that medical decisions sometimes have to be taken under pressure of time and may be subject to diagnostic and prognostic uncertainty? How is one to allow for the fact that the attitudes and expectations not only of patients but also of the members of their family often fluctuate?

6.2.1. Therapies at the end of life

Doctors have a duty to protect the welfare of the patients entrusted to them. In accordance with hallowed ethical and professional tradition, they must pursue the aims of preserving life, restoring health and avoiding disease and suffering. A doctor’s task does not end if the objective of a cure or of significant prolongation of life becomes unattainable. Instead, besides the continuation of basic nurture (the allaying of hunger and thirst, bodily care, appropriate accommodation and emotional support), the focus shifts to palliative treatments, such as the relief of pain, breathing difficulties, nausea and anxiety states. In the advanced stages of a terminal illness, dying must be seen as a part of life and integrated within the field of competence of doctors and nurses. The medical measures indicated in this situation depend on the individual clinical picture. The extent to which they are actually applied is a matter for the patient. The limitation

of therapy may, for example, involve the withdrawal of artificial nutrition begun at an earlier stage. Limitation of therapy must not be misunderstood as necessarily implying inferior therapy.

Powerful sedation of a patient suffering from otherwise untreatable pain or tormenting anxiety states may also be indicated for the purposes of palliative care. Such measures risk shortening the patient’s life because physiological processes, such as independent breathing, are depressed so that, for example, pneumonia is more likely. Such side-effects must on balance be accepted in order to achieve the aim of the treatment – namely, appropriate end-of-life medical and nursing care.

6.2.2. Letting die

As suggested in Section 4, the term “letting die” should be used where the onset of death resulting from the patient’s illness is not prevented by the adoption of possible life-sustaining measures. The withholding of such measures may take the form of their non-initiation, or of the non-continuation or active termination of a measure already commenced. In this case it is accepted that the patient’s death from the disease will occur sooner than would be expected were treatment to be given. If the process of dying is already under way, life-sustaining measures will often be effective for a short time only. If it has not yet commenced, it might be feasible to keep the patient alive for a longer period.

6.2.2.1. Patients who are capable of expressing their wishes

A consensus exists that it is ethically acceptable to let a person die at his current, explicit request, subject to the maintenance of basic nurture, if he is already in the terminal phase of his illness.

Although a doctor has a fundamental duty to preserve life, he may, at a patient’s request, withhold a medical treatment even if the omission brings about the patient’s death, although he could have postponed it with the resources at his disposal; in such a case, he should not be liable to prosecution or charges

of professional misconduct. Indeed, it is incumbent on him to desist from the treatment, as the patient would otherwise be treated against his will – contrary to the universally accepted ethical and legal principles which dictate that no medical treatment can be undertaken without the patient’s consent (see the Opinion on the advance directive).

Even if it is agreed that conscience does not entitle doctors to impose a measure against their patients’ will, opinions diverge on whether they can refuse on grounds of conscience actively to terminate a treatment instead of allowing it, once commenced, to run its course. For example, a doctor may have to decide whether to turn off a ventilator or to remove a feeding tube. Now it is of course not permissible to force an individual to do something inconsistent with the dictates of his conscience, especially in the case of such a fundamental value as the life of a human being. On the other hand, like the commencement of treatment, its continuation too calls for justification. A doctor cannot force his patient to accept a treatment by virtue of a decision based on his – the doctor’s – conscience. Such personal conflicts can sometimes be resolved in the day-to-day clinical situation if another doctor actually terminates the therapy.

For a long time nutrition and hydration were considered an indispensable component of basic palliative care, which a patient could not refuse even in the exercise of his right of self-determination. Death due to the withdrawal of nutrition or hydration was consequently regarded as killing. For some time now, however, a distinction has been made between compliance with subjective demands such as the allaying of hunger and thirst, on the one hand, and life-sustaining medical measures on the other. The allaying of hunger and thirst rightly remains an essential element of the basic nurture of every patient. On the other hand, artificial nutrition and hydration in the absence of the criterion of a subjective sensation of hunger or thirst is a medical measure, which, like all other medical measures, is subject to the patient’s consent.

The crisis in the care of the seriously ill in our society is well known, confirmed by statistics and furthermore illustrated in

dramatic form in the recent literature. Grave deficiencies exist in the provision of long-term medical care and comprehensive nursing for those in need of this assistance. Furthermore, nursing homes and hospices are chronically underfunded. In this situation, the members of the National Ethics Council unanimously consider themselves obliged to make the following statement: it is unacceptable to let a patient die against his will owing to the withholding of available, medically indicated measures. In the determination of what is medically necessary, a patient’s wish to live must be taken into account. Doctors must be able to offer the appropriate medical treatments, and patients are entitled to expect these actually to be available to them. They must in addition have an opportunity of bidding farewell to their family and friends. Self-determination may involve not only the withholding but also the provision of life-sustaining measures, even if, by virtue of the patient’s illness, these are effective only for a limited period.

6.2.2.2. Patients who are not capable of expressing their wishes

Where a patient is unable to express his wishes, recourse must be had to earlier expressions of these wishes. If an advance directive exists, this may constitute an unequivocal and legally valid statement of these wishes. In the absence of an advance directive or in the event of doubts as to its applicability to the current decision situation, the doctor can try to base his actions on the patient’s presumed wishes. However, these will not provide him with a sufficiently reliable basis for decision. For this purpose, additional procedures for consideration and decision-making will instead be necessary.⁶⁹ If all doubts can then still not be overcome, the preservation of life takes precedence. Observance of this principle at all times is also an effective precaution against the dangers of abuse in letting a patient die.

⁶⁹ See Recommendations 8 and 9 of the National Ethics Council’s Opinion on the advance directive.

The fear of abuse applies in particular to patients who have never been able to form wishes of their own and to patients in a persistent vegetative state. The latter show no sign of consciousness and, depending on the cause, duration and extent of brain damage, have virtually no prospect of ever resuming conscious life. The mere impossibility of volition, the fact of being in a persistent vegetative state and the duration of unconsciousness do not in themselves signify that the process of dying has already begun. Life-sustaining measures are always indicated with such patients unless they have refused them by earlier unequivocal expressions of their wishes. However, there should be no question of prosecution or sanctions for professional misconduct if a medical treatment, having regard to its prospects of success, the patient's suffering and his probable life expectancy, is no longer indicated and is therefore withheld, limited or withdrawn. In cases of doubt, the preservation of life takes precedence.

6.3. Suicide, suicide intervention and assisted suicide

6.3.1. General considerations on suicide

Of the approximately 12 000 suicides unfortunately recorded every year in Germany – in addition to those that go unrecorded and to many attempted suicides – most are attributable to mental disturbances, resulting, for example, from pathological conditions such as depression, schizophrenia or chronic alcoholism. Other suicides and attempted suicides are due to situational despair which, although not always clearly distinguishable from depression, causes the person concerned to see his life as acutely unbearable, but could quite probably be overcome. In by far the majority of cases, suicide attempts are in the nature of an appeal. No one would surely deny that these suicides are or would be instances of misadventure that should be prevented. In the

first case, the individual wishing to take his own life would, according to our current ethical notions, be regarded as lacking the capacity for judgement and decision and should – indeed must – be dissuaded from his decision and persuaded to accept therapy. In the second case, death is probably not seriously desired and the attempt should therefore be seen rather as a cry for help. It would be morally unacceptable simply to let suicide happen in such a case. Instead, help must be actively given in order to dissuade the person concerned from putting his intention into effect.

If a mentally competent patient resolves to commit suicide on account of an uncontrollable disease, the problem situation is as a rule different. It is quite possible for the patient to have come to the “well considered” conclusion that on balance he no longer wishes to live and that he would subsequently not be grateful for a successful rescue attempt. Even loving support and comprehensive care will not necessarily induce such a patient to modify his decision that he wishes to die. The suicide of an incurably ill person should be seen as similar to “rational suicide” – that is, as constituting an act whereby, on his own free responsibility and after serious consideration of his prospects, he decides that he no longer wishes to live. Opinions on the ethical permissibility or impermissibility of seriously contemplated suicides have varied greatly from classical antiquity to the present day. Among the ancient Greeks, it was principally Plato and Aristotle who regarded the taking of one's own life as impermissible: Plato thought it contrary to the will of the gods, whereas Aristotle saw it as an unlawful act directed against the polis, from which withdrawal was as it were not allowed. In stark contrast to this view, the Epicurean and Stoic schools, and before them some Sophists, proclaimed the act of “leading oneself out of life” to be a natural freedom that actually conferred distinction and particular status on man. In the Roman Empire, mainly on account of the influence of the Stoics, self-immolation was deemed the natural right of any (free) individual. Christian theology, on the other hand, strongly condemned any form of suicide, which was qualified as

“self-murder”. Augustine saw it as a violation of the Fifth Commandment and hence as a grave sin. St Thomas Aquinas, taking up Aristotle’s political argument of the harmfulness of the act to the community, stressed the contradiction with the natural instinct for self-preservation and added a third, original Christian, consideration – namely, that the individual could not dispose at will of the life that was a gift of God. In consequence, for many centuries the practice of the Christian churches was to impose penances on attempted suicides, while the suicide himself was buried (if at all) “at the crossroads”. To this day, the catechism of the Roman Catholic Church sees both suicide and the voluntary assistance of suicide as a grave violation of the moral law and as contrary to the prohibition of killing.

State sanctions against the taking of one’s own life were dismantled one by one in the age of humanism and the Enlightenment – for instance in Prussia by Frederick the Great in 1751. Whereas Montesquieu, Voltaire, Rousseau and Diderot opposed punishment for suicide, German authors such as Samuel Pufendorf, Christian Wolff or Immanuel Kant took the view that the act should be subject to penal sanctions. Kant regarded “self-immolation” as a violation of the duty of self-preservation, a “crime (murder)”, and indeed an act of destruction of the moral law and one inconsistent with the dignity of man. Notwithstanding these considerations, suicide ceased once and for all to be a punishable offence throughout the German Empire with the introduction of the Penal Code of 1871. This retreat on the part of the law was not paralleled by any reduction in the moral opprobrium attaching to suicide. However, a consensus is lacking on this point.

Two different ethical positions can be distinguished with regard to the suicide of a patient suffering from an incurable illness, each of which is espoused by some members of the National Ethics Council.

A. According to the first view, suicide must always be seen as a deliberate act of contradiction to life and hence as contrary

to the conditions of self-determination. Through suicide, the individual not only contradicts the instinct by which he lives and refutes the intentions that have hitherto guided his actions, but also sets himself up in opposition to everything that has contributed to his existence. For this reason, suicide as such cannot be morally countenanced. However, this view can never be applied unconditionally – that is, without allowing for a person’s individual situation. This is an important consideration particularly in cases where severe, incurable suffering and imminent death have guided or contributed to the decision to take one’s own life. No other person can truly understand and evaluate the reasons that have led to a suicide. It is therefore wrong to condemn suicide in such cases.

This view can also be described in terms of religious or theological categories.⁷⁰ Suicide then appears – for all the human understanding that must be brought to bear in an individual case – as an impermissible attempt to pronounce a definitive judgement on the worth or worthlessness of the person’s own life. By virtue of its irreversibility, it is tantamount to the final abandonment of the hope that man can accept and withstand any life situation while trusting in God’s help and that there is no human suffering that lacks any prospect of relief.

⁷⁰ See the passage on suicide in the joint declaration of the Council of the Evangelical Church in Germany and of the German Bishops’ Conference in 1989: “In suicide, a human being denies himself. Many situations can lead to such a final step. However, whatever the reasons, no other person is entitled to make a judgement. Another person’s motives and grounds for decision, as well as the possible effects of an illness, remain in the last analysis unknown. For a Christian, someone else’s suicide constitutes an enormous challenge: while ultimately unable to understand or approve this act, he at the same time cannot refuse respect for the individual who takes this course. Tolerance of the other over and above the understanding of his act is called for. However, anyone who has understood that man does not live for himself alone is unable to countenance and approve suicide. From this point of view, any suicide attempt can only be seen as an ‘accident’ and a ‘cry for help’” (107).

B. According to the other view, the suicide of a mentally competent, incurably ill individual should not only be understood and respected on the human level, but may also, like any other seriously deliberated suicide, perfectly well be ethically permissible. If self-determination can serve the pursuit of an individual's profoundly held convictions and personal notions of the correct – and good – life, provided that the rights and legitimate demands of others are not infringed, then, in particular, personal conceptions of the right way to die, including suicide as the *ultima ratio*, must also be respected. Of course, this is conditional upon the wish to commit suicide having been seriously deliberated. The care and solidarity to which a seriously ill person is entitled does not only consist in providing him with the help and emotional support he needs to ease the burden of enduring his life. Care and solidarity may also be manifested in understanding and support for an individual's decision that he no longer wishes to endure this life.

The advocates of both views agree that attempts should be made to eliminate the causes of a wish to commit suicide. Friendship and love, active sympathy and practical demonstrations of goodwill should help a person who is tired of life to find the capacity to await his natural end.

6.3.2. Suicide intervention

If a person attempts to take his own life and someone else knows of his intention, arrives on the scene or is present when the attempt is made, to what extent is this other party entitled or obliged to intervene and avert the act? No one denies that a potential suicide whose life situation and motives are unknown should be rescued if possible. This is because the majority of suicides actually embarked upon do not satisfy the criteria of serious deliberation, but are the consequence of mental illness

or unpremeditated impulses in situations of acute despair, and should therefore be seen as a cry for help. For this reason, the maxim *in dubio pro vita* should be applied here.

Whether an obligation exists to save the life of a suicide in the case of a manifestly seriously deliberated decision is a matter of both ethical and legal controversy (see Section 5.2.3 above on the extent of the “duty of the protector”). Notwithstanding their differing fundamental moral assessments of the suicide of an incurably ill individual, the members of the National Ethics Council consider it appropriate to exercise restraint with regard to intervention in the case of a decision to commit suicide taken on the free responsibility of the person concerned following serious deliberation. Such a decision to depart this life taken by someone who is incurably ill should at all events release those close to him from any moral and legal obligation to intervene and prevent him from committing suicide.

However, the members of the National Ethics Council disagree on whether this should also apply to doctors.

A. Some members consider that it is incumbent on doctors, in accordance with their duty to protect life, to frustrate a suicide attempt that is imminent or taking place in their presence or to which they are called for as long as there is any realistic prospect of rescue. Only where a fatally ill or gravely suffering individual himself wishes to put an end to the final phase of his life and cannot be dissuaded from this course by help and argument should a doctor be able to abstain from intervening to save the individual's life, and then solely on the basis of a decision made in accordance with the dictates of his conscience.

B. Others, on the other hand, take the view that a doctor has no general ethical or legal obligation to prevent a seriously deliberated and desired suicide. A doctor called by a third party to an attempted suicide of this kind must be able to abstain from subsequently rescuing his patient without fear

of prosecution. The essential consideration is respect for the suicide's self-determination, which prevents the doctor from acting against the suicide's identifiable wishes.

6.3.3. Assisted suicide

6.3.3.1. Individually assisted suicide

The same view of assisted suicide is usually taken as of suicide itself. If one considers suicide to be acceptable subject to certain conditions or at least abstains from moral condemnation, one will not automatically reject an act whereby its commission is supported, such as the procurement of appropriate drugs. At any rate, the predominant view of the members of the National Ethics Council is that individuals who assist suicide should not be liable to penal sanctions.

However, opinions diverge on the ethical and professional evaluation of physician-assisted suicide.

Doctors can easily find themselves in a situation where they are called upon to assist someone who has resolved to take his own life in the preparation or commission of the act. They are specifically authorized not only to carry out medical treatments but also to prescribe prescription drugs. Hence they can provide access to lethal drugs (e.g. pentobarbital) and thereby facilitate what some patients see as the best available method of committing suicide, which is often the only practicable method for the seriously ill.

A. In the view of the majority of doctors in Germany and also of the Bundesärztekammer [German Medical Association],⁷¹ assistance with suicide is inconsistent with the professional duty of a medical practitioner, who is called upon to combat severe states of physical and mental suffering by all permissible means. The provision of means of committing

suicide or direct participation in such an act, according to this view, is irreconcilable with the medical ethic. Another argument against permitting physician-assisted suicide is that doctors might feel pressured by their patients to provide such assistance.

Another consideration is that, for patients, the barrier to be overcome in arriving at the decision to commit suicide will increasingly be lowered if the act can be carried out with medical assistance. There is in addition the difficulty of ensuring that the patient's wish to commit suicide actually results from a seriously deliberated decision taken on his free responsibility and is not due to a depressive mood swing or temporary mental crisis. Problems of definition also arise in the consideration of whether to accede to the wish of a mentally ill individual for assistance with suicide. Physician-assisted suicide is rejected by many members of the National Ethics Council if only for that reason. In their opinion, there is too great a risk that it will in practice be impossible to monitor the application of the rules established for medical assistance, so that abuse may become widespread.

B. The members of the National Ethics Council who favour physician-assisted suicide do not accept that this help is always and necessarily irreconcilable with the medical ethic.

These members consider that doctors have an obligation to apply their medical skills in the best interests of their patients and to respect their self-determination. As a rule, this entails measures for the prevention and cure of disease, the saving of life and the relief of suffering. However, in the crisis situation of incurable illness, when desperate patients are resolved to take their own lives, assisted suicide too may be consistent with the precept of acting for the benefit of the patient, and hence be consistent with the medical ethic. Doctors are not only able to procure a lethal drug for the patient to enable him to die in the way that he desires; they can also offer skilled support in the dying process and relieve the patient

⁷¹ See Section 4.7.1.

and his family of the concern that the patient might have to suffer more than necessary in committing suicide or that unforeseen difficulties might arise. The patient's trust in his doctor would be strengthened rather than weakened if he knew that his doctor was present for him in this situation, too – although of course any doctor could refuse to accede to a request for assistance with suicide on grounds of conscience.

In addition, doctors are perfectly well able to judge whether a patient is mentally competent; after all, assessment of mental competence is one of the functions of a medical practitioner even where routine medical measures are concerned. Indeed, certain problems of definition and potential abuses may well present less difficulty than in other end-of-life decisions: in the case of assisted suicide, the question does not arise of the merely presumed wishes of the patient and of how these are to be determined, or of the permissibility of rendering this assistance even without the patient's consent. Such issues do, on the other hand, not uncommonly arise in decisions to withhold treatment and in the case of palliative sedation. For this reason, according to this view, appropriate supervision is necessary to ensure, in the case of those decisions as opposed to assisted suicide, that there is no imperceptible slippage from standard medical practice to the killing of patients.

The same applies to the fear that, if such assistance were easily available, sick people might be inclined, or even be put under pressure, to end their lives. This problem also arises in decisions to let patients die by withholding or withdrawing a medical treatment that might still be possible at the end of life. Finally, it is unlikely that permitting physician-assisted suicide would lower the threshold of resistance so that suicide became the method of choice of a large number of patients for dealing with their suffering. In fact, the evidence from countries in which physician-assisted suicide is permitted is that only a fraction of the patients who would legally be able to request such assistance actually take advantage of

this option. It is even conceivable that the knowledge that medical assistance with the commission of suicide is available might give patients the strength to bear their suffering, so that the number of suicides would actually fall.

Those who espouse this position consider that physician-assisted suicide should be allowed by codes of professional practice provided that the patient is suffering from an unbearable and incurable condition and is mentally competent, and that his wish to die – after counselling and an adequate period for reflection – must be deemed final.

- C. A third view is that a doctor's decision for or against assisting a seriously ill and suffering patient to commit suicide is a matter of personal conscience. Notwithstanding the general duty to preserve life, a doctor might conclude, after caring for his patient for a long period, that the patient's wish for help in committing suicide has been seriously contemplated and, while tragic, should be acceded to in the patient's individual situation. In such a case, the doctor can take personal responsibility for assisting his patient's suicide. He should subsequently not be under any obligation, for instance by virtue of his status as a protector [*Garant*], to frustrate the suicide attempt once embarked upon when unconsciousness supervenes. Instead, he should be able to stand by his patient until the onset of death.

From the point of view of professional ethics, such conscience-based decisions should be regarded as permissible in tragic individual instances, and not be deemed to constitute professional misconduct.⁷²

6.3.3.2. Organized assisted suicide

The issue of the acceptability of organized assisted suicide has recently been the subject of vigorous public debate. Examples of organizations whose declared purpose is to offer the incurably

⁷² The Swiss Academy of Medical Science opted for this solution in 2004.

ill an opportunity to commit suicide are EXIT and Dignitas in Switzerland. As provided in their constitutions, they give their members access to a medically prescribed lethal drug to enable them to take their own lives; this is conditional on the mental competence of the person wishing to commit suicide, a wish to die extending over a substantial period and a “hopeless prognosis, unbearable pain or unacceptable disability”.⁷³ Although the doctor and the suicide assistant appointed by the organization must be paid, the organization is not allowed to make a profit. The organizations have mainly long-term members. However, it is also possible to join when one has already decided on suicide. In this case, the suicide assistance provided by the organization may be said to constitute the rendering of a service.

The members of the National Ethics Council have divergent views on the ethics of the organized provision of assisted suicide.

A. The predominant position of the members of the National Ethics Council is that there are fundamental objections to any form of organized provision of assisted suicide, because it confers the appearance of normality on acts directed towards the extinction of an individual’s own life. This would substantially lower the threshold established by society’s taboo on the taking of one’s own life that deters potential suicides from acting in accordance with their mental state. If the public activity of organizations whose sole or principal purpose is to facilitate suicide meets with social and cultural acceptance or is even merely tolerated, society, according to this view, can no longer appropriately perform its function of protecting persons at risk of suicide. Admittedly, in certain circumstances a request for help with suicide made on the basis of clear and free volition and in an unequivocal crisis situation

⁷³ This last condition, as laid down in Article 2 of EXIT’s constitution, is interpreted broadly: the organization itself also claims to provide voluntary assistance with dying for members “who, while not suffering from a disease that will lead to imminent death, are so distressed by the sum of their suffering, pain and disabilities that they are, in the strict sense of the term, tired of life”. See www.exit.ch.

of distress (illness) may mitigate the moral disapproval of such assistance or, in an extreme case, overcome it altogether. However, such assistance should then be rendered at most by close friends or relations, but not by organizations.

B. Some members would be prepared to allow incurably ill people who see suicide as the only course still open to them to enlist the help of organizations. Although the fact that this help is “organized” arouses misgivings because the existential borderline situation represented by involvement in the suicide of another person is then subjected to the rules of an organization and includes the participation of specialized suicide assistants, the transfer of assisted suicide to such organizations cannot be seen in purely negative terms. It can increase the transparency of assisted suicide and facilitate its monitoring, while at the same time ensuring that patients receive appropriate care. Although the prevention of suicide is a high-level public objective, proportionality must be observed in its pursuit. There is no need, and hence no justification, for a blanket prohibition of organized assisted suicide, which would have the effect either of leaving the patients concerned helplessly to their own devices or of requiring friends and family alone, who are as a rule already overstressed, to assist their suicide. An acceptable alternative would be to prohibit organized assisted suicide only where it is deemed illegitimate and to provide for state supervision to ensure compliance with such rules as are considered necessary.

The members of the National Ethics Council who espouse this position do not believe that organized assisted suicide is desirable. A better solution would certainly be for patients to be able to rely on professional assistance with suicide from their attending physicians. However, as long as this option is not available, assistance with suicide from specialized organizations should at any rate not be ruled out as a matter of principle.

6.3.3. Assisted suicide for profit

All members of the National Ethics Council agree that for-profit commercial assistance with suicide, whether rendered individually or in organized form, is ethically unacceptable. If necessary, commercialization of assisted suicide should be made a criminal offence.

6.3.4. Instigation to commit suicide

The members of the National Ethics Council unanimously hold that it is unethical to induce someone by persuasion or incentives to take his own life. This applies even if the motive of the instigator – whether a family member, nurse or doctor – is disinterested, arising, for example, out of the conviction that for reasons of compassion he must “help” a seriously ill patient to find the right path. The decision that a person no longer wishes to live must, if it is to be deemed meaningful in the appraisal of decisions at the end of life, be that of the patient himself, in accordance with all the relevant criteria, and must not be brought about by third parties. Notwithstanding this moral judgement, the vast majority of the members of the National Ethics Council do not consider it necessary at present to make instigation to suicide a criminal offence. However, anyone who, over and above instigation itself, manipulates the wishes of a suicide in such a way as to eliminate that person’s own responsibility for the act is liable under current law to punishment for (indirect) homicide.

6.4. Killing on request

The ethical acceptability or otherwise of killing an incurably ill and unbearably suffering individual at that individual’s request raises particularly grave and conflictual end-of-life issues. Opinions differ widely, both among the public at large and within

the National Ethics Council, on whether such a request may be acceded to subject to certain conditions.

Notwithstanding the divergent positions, however, the members of the National Ethics Council agree on certain aspects of the definition of the conflict. All members concede that patients may find themselves in situations of hopeless, uncontrollable suffering in which they desperately long for death and in which, if they cannot bring it about themselves, they see killing on request as the only way out and as a final act of compassion.

All members are ultimately agreed on the recommendation that provision for exceptional situations expressly permitting the killing of the incurably ill on request should not currently be introduced into the German criminal law. However, this shared conclusion is based on a diversity of arguments, which are set out below.

- A1. As is logical, those who already regard assisted suicide as ethically unacceptable hold killing on request to be unacceptable for the same reasons.
- A2. However, the majority of those who at least do not reject assisted suicide in all circumstances take the view that killing on request must be assessed differently.

They adduce, firstly, the existence of a categorial difference between suicide and homicide. Whereas a suicide himself controls the actions that directly lead to death, the perpetrator in the case of killing on request is another person, who takes much more responsibility for the act than would be involved in its mere assistance and who must overcome the taboo on killing another human being. According to this view, this is inconsistent with the medical professional ethic.

Furthermore, since the resistance to having oneself killed by another is lower than that to killing oneself, it is feared that the legalization of killing on request would make people particularly susceptible to yielding to social pressure to die. At the same time, the avoidance involved in choosing death could become the normal way of dealing

with intense suffering and detract from the general value placed on life. Finally, there is a high risk of imperceptible slippage towards killing other than on explicit request.

A.3 The point is also made that killing on request is a fundamentally different kind of act from letting someone die, and as such must be assessed differently in ethical terms. While killing on request constitutes a direct means of ending another person's life, where an individual is allowed to die the other's death is accepted as being the outcome of a pathological process that is permitted to take its course without intervention. From the point of view of the overall situation, a doctor who lets his patient die withdraws as an actor, even if he must at first actively terminate a therapy previously commenced. In so doing, he does not necessarily intend to bring about the death of his patient, even if he perhaps regards it as a good end to the patient's severe suffering. Conversely, a doctor who kills his patient on request intentionally brings about the patient's death, and is therefore solely responsible for it. Any blurring of these distinctions would be tantamount to disregarding the ethical relevance of intentions and complex reasons for an actor's acts, to one-sidedly considering the result alone, and to deeming the self-determination of the person to whom the act is directed to be the sole deciding factor.

B. Others, however, invoke the consideration that, whereas a doctor is obliged to act in accordance with his patient's best interests, these are not always synonymous with the preservation of life. In certain cases it may be precisely in the patient's best interests if his life is ended at his request under medical supervision, thus allowing him to die because he sees this as the only way out of intense suffering. This, it is held, applies a fortiori to patients who are incapable of an act of suicide (e.g. owing to severe paralysis) and who also do not regard being simply allowed to die as a tolerable course. Although a categorial difference admittedly exists between

the act of killing on the one hand and assisted suicide and letting die on the other, this does not necessarily entail a fundamental distinction in the relative ethical assessments.

With regard to the intended result – the bringing about of death – and in terms of causal responsibility, there is no significant difference between the situation in which someone procures a lethal drug for an incurably ill patient at his request and places it beside him so that he can take it himself, and that in which the person additionally administers the drug to the patient because he is no longer capable of taking it himself. In both cases, the patient's wish to put an end to a hopeless state of suffering justifies the third party's contribution to the act that is necessary to put his wishes into effect. By the same token, the act of a doctor in turning off the ventilator of a hopelessly ill and gravely suffering patient should be judged no differently from the giving of a lethal injection.

Nevertheless, the members of the National Ethics Council who, as stated above, consider killing on request to be ethically acceptable subject to certain conditions deem it undesirable for this to be explicitly permitted by law, for two different reasons.

B.1 In the view of some members, the risk of gradual slackening of the applicable conditions and of abuse is excessive, particularly as the number of potential cases would probably be too small.

B.2 Others, by contrast, consider there to be no justification for the fear of adverse social consequences. In their view, society has learned to live with limited exceptions to the prohibition of homicide (e.g. self-defence or supra-statutory emergencies) without slippage into abuse. Again, the number of reported cases of killing other than on request in countries which permit killing on request subject to certain conditions is not consistently higher than in those which maintain a strict ban on the termination of life in such circumstances (see Section 2). Supervision to prevent abuse

in the form of the killing of incurably ill patients is necessary in regard to all decisions at the end of life. The risk of abuse is less with killing on request than in the case of the very frequent decisions to withhold treatment at the end of life; in those instances too, doctors rather than the patients themselves are the actors. The reason why the members of the National Ethics Council who espouse the above arguments nevertheless support the recommendation that the prohibition of killing on request should be maintained is political consideration of the German history of criminal euthanasia under the Nazi regime.

Ultimately, then, all members of the National Ethics Council take the view that the prohibition of killing on request should remain and that Section 216 of the Penal Code should not be amended. If someone kills another person at the latter's request in a situation of extreme suffering where no alternative remedy is available, he must be prepared to accept the sanctions imposed on him by a community governed by the rule of law. However, this does not preclude eschewing punishment in certain individual cases.

7. RECOMMENDATIONS

7.1. Fields of action and terminology

The National Ethics Council considers the terms “active euthanasia”, “passive euthanasia” and “indirect euthanasia” to be open to misunderstanding and to be misleading. Decisions and acts at the end of life that have direct or indirect effects on the process of dying and the onset of death can be appropriately described and distinguished by use of the following terminology:

- » The term “end-of-life care” denotes measures for the nursing and care of individuals in whom the process of dying has already begun. “End-of-life care” includes, for example, bodily care, the allaying of feelings of hunger and thirst and the relief of nausea, anxiety and breathing difficulties. It also involves emotional and spiritual support for the dying patient and his family.
- » “Therapies at the end of life” comprise all medical measures – which thus include palliative care – adopted in the final phase of life with the aim of prolonging life or at least of relieving suffering. They include measures that may have the incidental effect of hastening the natural process of dying, whether on account of high doses of pain-killing drugs or of powerful sedation, without which grave symptoms cannot be controlled. The term “indirect euthanasia” previously used in this connection is inappropriate, because the relevant actions are intended neither directly nor indirectly to bring about the patient's death.
- » The term “letting die” should be used instead of “passive euthanasia” where a life-sustaining medical treatment is withheld, so that the death resulting from the course of the disease occurs earlier than might be anticipated with the treatment. The withholding may involve not initiating a life-prolonging measure in the first place, or alternatively

not continuing a measure already begun or actively withdrawing it.

- » “Assisted suicide” denotes the situation where doctors or other persons procure a lethal drug for someone or otherwise assist him in the preparation or commission of suicide undertaken on his own responsibility.
- » “Killing on request” refers to acts whereby a person’s death is actively brought about in response to a serious request by that person. Such acts may comprise, for example, the administering of a drug not indicated therapeutically or an overdose of indicated drugs.

7.2. End-of-life care and therapies at the end of life

1. Every incurably ill and dying individual is entitled to be treated, nursed and cared for with dignity.
2. The wishes of the person concerned must be respected in all end-of-life measures and therapies at the end of life.
3. Every incurably ill and dying individual must be provided with adequate palliative care. For this purpose, doctors should be able without fear of prosecution to accord priority to the patient’s quality of life over maximizing the length of his life.
4. Adequate inpatient and outpatient care in nursing homes, palliative wards and hospices is urgently necessary.
5. The provision of interdisciplinary training and advanced training for doctors and nurses treating seriously ill and suffering patients and the dying should be increased.
6. Voluntary commitment to end-of-life care should be promoted and supported.

7. Family members should have access to skilled counselling on the availability of nursing and other care for the seriously ill.
8. The labour laws should provide for an entitlement to leave, so as to allow those close to a dying person to care for him, as is already the case in some other European countries.

7.3. Letting die

1. Every patient has the right to decline a medical measure. This applies even if the medical measure might prolong his life.
2. For this reason, doctors, nurses and family members should be able to withhold, limit or withdraw life-sustaining measures in accordance with the patient’s wishes without fear of penal or professional sanctions.
3. The same applies if the patient is incapable of giving expression to his wishes but his rejection can be inferred with sufficient certainty from an advance directive or other reliable indication (see the National Ethics Council’s Opinion on the advance directive).
4. Where there are no reliable indications of the patient’s wishes or no such wishes can be formed, criminal and professional sanctions should not be imposed if medical treatment is no longer indicated having regard to the prospects of its success, the suffering of the patient and his likely life expectancy and the treatment is therefore withheld, limited or withdrawn.
5. The preservation of life must take precedence in cases of doubt.

7.4. Suicide, suicide intervention and assisted suicide

1. Both the law and the practice of society should continue to be directed towards dissuading even the seriously ill from taking their own lives and towards offering them prospects for living.
2. If there are clear indications that a suicide attempt by a seriously ill person was made on the basis of a seriously deliberated decision and that the person concerned would refuse any measure to save his life, then, in the view of the majority of the members of the National Ethics Council, persons such as doctors or family members who have particular responsibility for the individual concerned should be able to abstain from intervening without fear of prosecution. Some members of the National Ethics Council consider it necessary to restrict this possibility to situations where the serious illness is expected to lead to imminent death.
3. Attempted and assisted suicide do not incur criminal sanctions in Germany. This should continue to be the case, although assisted suicide should be subject to the following restrictions:
 - 3.1 Opinions within the National Ethics Council diverge on the permissibility of physician-assisted suicide:

A number of members hold that physician-assisted suicide is inconsistent with the medical ethic and therefore hold that it should not be permitted by the relevant professional code.

Other members, however, believe that doctors should be able to help a patient to commit suicide if his suffering is unbearable and incurable, he is mentally competent, and his wish to die – after counselling and a sufficient period for reflection – must be deemed final.

- 3.2 The members of the National Ethics Council also differ on the permissibility of organized assisted suicide:

The majority reject the introduction of any organized provision of assisted suicide in Germany. They consider that, depending on the circumstances, this should be made a criminal offence.

A few members hold that organized assisted suicide should be permissible in Germany as in some other countries provided that certain conditions, such as counselling and a period for reflection, are satisfied. In the opinion of a small number of members, this should at least be the case as long as doctors are prohibited by professional ethics or their professional code from assisting suicide.

- 3.3 The National Ethics Council unanimously favours a ban, backed by penal sanctions, on assisting suicide for profit.
4. The National Ethics Council considers instigation to suicide to be ethically repugnant.

7.5. Killing on request

Killing on request should remain a criminal offence (cf. Section 216 of the Penal Code).

To allow for cases where a person, acting in accordance with the dictates of conscience, kills another at the latter's request, an explicit statutory exception to the prohibition should not be made, but no punishment should be imposed, in view of the balancing by the person concerned of the preservation of life against the ending of suffering.

SUPPLEMENTARY POSITION STATEMENT

Although we agree in part with the recommendations of the National Ethics Council, some of the ethical and legal justifications set out before them in this Opinion are in our view insufficiently clear. The image of man they present is based unilaterally on the ideals of self-determination, autonomy and independence. Respect for the self-determination of the seriously ill and the dying is of course a fundamental precept of the medical ethic. However, respect for the dignity of an individual who is seriously ill and dying calls for more than mere respect for an allegedly uninfluenced self-determination. To help them cope with the final phase of their lives, the seriously ill and the dying are dependent on care and assistance, on adequate medical attention and nursing, and on the emotional support and closeness of other people. Hence respect for the person of a seriously ill and dying individual calls for a willingness to be reliably available to him in the last phase of his life, which in turn entails waiting for death together and being constantly present so that the dying person is not abandoned to loneliness and distress.

The legal order and the healthcare system are expressions of the high value placed by a democratic state on the lives of its citizens.

In our opinion, the prohibition of killing on request should be maintained, and not only for historical reasons associated with Germany's particular responsibility for the "euthanasia" crimes of the Nazi period. There is in fact an important moral distinction between letting someone whose medical condition is hopeless die and killing a person on request: the two acts differ fundamentally in terms both of the intention of the relevant medical act and of causation, involving in the latter case the direct inducing of death. Whereas the withholding of further life-sustaining measures is permitted and may in certain circumstances even be appropriate if such measures would merely prolong unnecessarily the suffering of a patient who is seriously ill and dying, the deliberate inducing of death is irreconcilable

with the high value placed by our legal order on life – a value we expect to be shared, precisely, by doctors and nurses. If killing on request were legal, or tolerated subject to certain rules in exceptional cases, this would still further increase the pressure to which the seriously ill and the dying might be exposed on the part of the healthcare system and its scarce nursing and medical resources; at the same time, the seriously ill and the dying would be liable to fear and self-doubt due to concerns about whether it was permissible for them to continue to be a burden on others. Categorical observance of the prohibition of killing by all concerned, on the other hand, gives the dying the freedom necessary to accept their own deaths.

Helping a seriously ill or dying patient to commit suicide is also contrary to a doctor's professional duty. Doctors have an obligation to combat severe physical and mental suffering with the means allowed by their medical ethic; for this purpose, they must exhaust all the possibilities of effective relief of suffering by means of palliative-care measures. However, the provision of means to facilitate suicide, as well as direct participation in such an act, is inconsistent with the medical ethic. That said, there may be situations at an advanced stage of a serious illness when a doctor should no longer oppose a patient's attempt to commit suicide; an individual decision not to prevent a suicide attempt need not contradict the doctor's position as a protector. But if physician-assisted suicide were permitted by medical ethics or professional codes, this would fuel the erroneous impression that such assistance formed part of a doctor's normal duties, which he could avoid at most by invoking conscientious objections.

The high value placed on life in our legal order likewise precludes the public toleration or promotion of institutionalized suicide counselling and assistance as a service. Both the law and our spontaneous behaviour towards those wishing to commit suicide must remain oriented towards dissuading them from the wish to take their lives and towards providing them anew with prospects for staying alive. If organized assistance with

suicide were available as a public service, this would give acts directed towards the extinction of a person's own life the appearance of normality and social acceptability. Such a situation would appreciably lower the resistance presented by the social taboo on the taking of one's own life that often deters a person at risk of suicide from actually carrying out an act consistent with his mental disposition. If the public activity of organizations whose sole or main purpose is to facilitate suicide comes to be socially, culturally and legally accepted or even only to be tolerated, society can no longer appropriately discharge its duty of protection vis-à-vis those at risk of suicide. In our view, actively assisting another to commit suicide can be tolerated by the law only as an individual conscience-based decision of someone close to the person intending to commit this act. On the other hand, the impression must on no account be conveyed that, by the provision and promotion of possibilities of assisted suicide, society is suggesting to the seriously ill and the dying that they might wish voluntarily to take their leave of the living if they are at risk of becoming a burden on them.

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