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Varsha Chiruvella March 26, 2019

A Comparative Reading of Medical Ethics in Late 19th Century German Literature

by

Varsha Chiruvella

Peter Höyng

Advisor

Department of German Studies

Peter Höyng

Advisor

Caroline Schaumann

Committee Member

Gregg Orloff

Committee Member

Jonathan K. Crane

Committee Member

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By

Varsha Chiruvella

Peter Höyng

Adviser

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Abstract

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As a prospective medical student, I am fully aware of the challenges the medical world faces in ethical end-of-life care. With my experience in German culture and language, I wished to combine my interests in medicine and German by examining public discourse on the topic of assisted death in late 19th century German literature. I analyze *Ein Bekenntnis* by Theodor Storm (1887), the first German novella that addressed this modern controversial topic in medicine, and Arthur Schnitzler's play, *Professor Bernhardi* (1912), which also incorporates the theme of ethical end-of-life procedures, particularly the matter of patient non-disclosure.

Ein Bekenntnis presents the confrontation between childhood friends Hans, a present-day lawyer, and Franz Jebe, a physician. Jebe confesses to Hans that he had poisoned and killed his wife with the hopes of fulfilling her wishes to alleviate the pain caused by her stomach cancer. However, protagonist Hans perceives Jebe's act as murder. *Professor Bernhardi* portrays the discourse between a Christian priest and Bernhardi, a Jewish Viennese physician, on the case of a young woman who lay on her deathbed after committing the crime of abortion. While the priest desires to absolve the sins of the patient, Bernhardi is determined to leave his patient undisturbed and ensure her a peaceful, "happy death."

By analyzing the ethical situations in both texts, I discover the ambiguity of the Hippocratic oath in commonly-regarded dilemmas faced in medicine. A contemporary analysis of ethical principles outlined in the Hippocratic oath, in context of these literary works, opens the door to an array of intriguing ethical questions and shows how relevant such a centuries-old text is in the realms of literature and medicine. While certain aspects of medical ethics remain universal and unambiguous, other aspects that handle controversial issues are more arguable, such as physician-assisted death and the obligation to disclose medical information. I examine how ethical concepts illustrated in German literature are applicable to today's medical practice, and explain what has changed regarding end-of-life care from that historical timepoint to now. In discussing both texts, I reveal a deeper complexity to ethical end-of-life care that incorporates elements of religious belief, German Nazi-time history, and medical decision-making.

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Introduction

End-of-life care is a universal term used to describe the emotional, mental, and physical support, as well as medical care or intervention provided during the time surrounding one's death. Often applied to cases of terminal illnesses or the elderly suffering from chronic disease, end-of-life care stretches true time bounds, lasting from days to potentially months before death. Although curative treatments may not always be applicable to such cases, end-of-life care rather emphasizes medical support through palliative means, or care focused on providing alleviation of suffering and relief from the symptoms and stress of a serious illness.

The topic of end-of-life in medicine can, however, transform into controversial debate regarding three concepts essential for consideration when approaching patient death: (a) the ethics of assisted death, (b) the appropriate manner if to disclose relevant medical information, and (c) how to disclose such information to the terminally ill. This discussion on medical ethics is rooted fundamentally in the principles outlined in an oath that physicians globally have vowed to over millennials, and a set of four accepted pillars for moral life, established by contemporary philosophers Tom L. Beauchamp and James F. Childress in 1970: beneficence, non-maleficence, autonomy, and justice. One of the oldest binding documents in medical history, the Hippocratic oath remains an expression of ideal conduct for physicians, detailing principles doctors vow to hold sacred, such as treating the sick to the best of one's ability, or beneficence, and protecting patient privacy, an element of autonomy.

Beauchamp and Childress identify and define the four pillars of ethics as follows. A respect for patient autonomy is the act of acknowledging one's "right to make choices, hold

views, and to take actions based on personal values and beliefs." Under the umbrella idea of autonomy fall specific codes of conduct like medical disclosure and informed consent. Both codes refer to the right patients have to be aware of and fully understand their own medical cases through transparent communication with their medical care providers. Non-maleficence is the main guiding obligation physicians have "not to inflict harm intentionally." Finally, beneficence is the responsibility to "benefit persons and contribute to their welfare." Justice is defined as the equitable and fair distribution of benefits and burdens to patients. To align with the principle of justice, physicians have the obligation to act in a nondiscriminatory way, regardless of patients' social statuses.[1] While my discussion focuses predominantly on the principles of autonomy, non-maleficence, and beneficence, it is important to acknowledge the significance justice plays in the appropriate treatment of a diverse group of patients.

Although one may view these principles as distinct, they are interdependent, often compatible with each other to generate ethical, duty-based action guidelines. Together, they can offer appropriate approaches in clinical medicine and ethical dilemmas that may arise. However, tenets of ethics can often conflict or contradict one another, thus creating an ambiguous and challenging decision-making situation. In such cases, physicians may find themselves in a medical predicament, forced to weigh and balance various principles. Physician-assisted death and patient disclosure are such predicaments.

German literary works written as early as the 1830s introduce highly intricate, and relevant, debates on such ethical issues presented in medicine. At the cusp of modern

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[1] See "Principles — Respect, Justice, Nonmaleficence, Beneficence."

medicine, physicians around the world faced similar ethical questions and situations in medicine. For instance, the issue of truth telling and consent in medicine can be seen in German literature dating back to the early 1800s in the play *Woyzeck*, by Georg Büchner. Set in the 1830s, *Woyzeck* details the life of a poor soldier, Franz Woyzeck, who requests to be a human subject in a doctor's brutal and inhumane experiments in return for money. The anonymously named "Doctor" submits Woyzeck to a diet consisting of nothing but peas and begins to constantly analyze Woyzeck's behaviors, moods, vitals, also noting his adverse symptoms of anorexia, jitters, and hair loss. As time passes, it becomes more apparent that the Doctor's obscure and debatable experimentation causes Woyzeck's mental health to deteriorate, transforming him into a madman as he experiences apocalyptic visions. At first glance, the play presents a clearly black-and-white problem; human experimentation that involves torture under the guise of research or pseudoscientific frameworks is clearly unethical. One may argue that the case portrayed in *Woyzeck* presents an obviously unethical medical practice,[2] in contrast to the ambiguous and contentious ethical debates presented in later works of literature like *Ein Bekenntnis* and *Professor Bernhardi*. However, some contemporary readers may argue that the element of experimentation specifically "auf Verlangen" (upon request) adds a depth of complexity to the ethical question. As such, if human experimentation is particularly requested for, as in the case for money, does this warrant the seemingly unethical means by which the experiment is conducted? Such an openended question is what readers today can discuss in terms of contemporary ethical principles and values. A glimpse into

[2] Büchner portrays this as typical for the time.

past German literature can thus contemporaries understand the complexity and debate surrounding bioethical topics and appreciate how old and universal such discourse in ethics truly is. For one, this can help contemporary bioethicists identify what has changed and/or stayed the same in terms of ethical conduct in end-of-life care and potentially apply certain solutions presented in German literature to the real world. Examining German literature from past centuries also provides a point of comparison and contrast in how we perceive ethical dilemmas like mercy killing and patient disclosure/nondisclosure.

To comprehend a more contemporary application of ethical principles and how they interplay, consider the following ethical dilemma presented in the PBS series, *On Our Own Terms*:

> Jim Wichter is a veterinarian and horse farmer. A high school football player, a collegiate wrestler, a large man with once-strong legs and powerful hands, his wife now must lift him from his bed into a wheelchair. Jim has ALS, gradually losing muscle control from the legs up.
>
> His wife, Suzie, pushes him, bathes him, shaves him, worries for him, loves him. At the same time, she admits frustration, exhaustion, and depression. Her sacrifices, their sacrifices, extend to all aspects of their lives. The family finances and estate have been reduced by half, and the time and energy to care for the caretaker is non-existent. Jim realizes that medical technology - ventilators, feeding tubes, and medications- might keep him alive for years, but as his symptoms progress and loss of function continues, Jim sees a time when, like he once did for his suffering animals, he would want to die

> peacefully with assistance, not prolonging his time bedridden and completely and physically dependent. As he begins to breakdown, he exclaims, “It is a terrible ordeal for me,... and it’s even a more terrible ordeal for my family. And I just need it- I just need to go ahead and finish it.[3]

This case presents an ethical conflict between the principles of beneficence, autonomy, and non-maleficence. While the person who is physically suffering, Jim, wants to do good for his wife, who must cope with overwhelming emotions of frustration, she faces the challenge of respecting his autonomous desire to die and the formidable task of allowing her husband to harm himself. Both parties would want to minimize suffering of the other, as well as oneself, while simultaneously protecting each other and upholding the others’ wishes.

Similar dilemmas to that of Jim and his wife are encountered in the medical field surrounding the topic of mercy killing. For example, a recent news report from 2019 details the case of the “Rogue Doctor” of Mount Carmel, Ohio who provided “significantly excessive and potentially fatal”[4] doses of Fentanyl pain medication to at least 27 terminally ill patients, all of whom had died. The medications were far beyond what was required to provide palliative relief. In this realm, a physician has an obligation to relieve the pain and suffering of patients, thereby promoting the dignity and welfare of terminally ill patients. However, while death may seem a desirable means to achieve such a goal, physicians vow upon an oath not to harm or kill those whom they treat. Ulterior motives, such as money avariciousness in physicians,

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[3] Bill Moyers, “A Death of One’s Own.” *On Our Own Terms*.
[4] Ivy Potter, “A Rogue Doctor of Death in Ohio,” 21 Jan. 2019.

incompetence, and negligence of medical establishments also serve as confounding factors in determining the ethics of mercy killing cases, such as in the aforementioned case. This ethical confrontation is of interest to me, and is my reasoning behind choosing, discussing, and further analyzing the novella *Ein Bekenntnis* by Theodor Storm. Like the story of Jim and his wife, *Ein Bekenntnis* (1887) presents an ethical dilemma when Dr. Franz Jebe confronts the daunting task of fulfilling his ill and suffering wife's wish to end her life. The decisions made by the criminalized "rogue doctor" of Ohio, like Jebe, were based on ending the misery those who are terminally ill.

Storm's novella introduces an interesting and intriguing complexity to the ethics of mercy killing, another term for euthanasia, by sparking arguments like that of Dr. Willard Gaylin, a clinical professor experienced in the discussion of professional and medical ethics. From the viewpoint of Gaylin, if, theoretically, physicians become killers or are granted the right to kill, then a physician will never again be "worthy of trust and respect as a healer and comforter and protector of life in all its frailty."[5] The loaded term "kill" calls into question three variations of its possible meaning. First, one could interpret killing as an act to end another's life. Second, killing could mean letting another die when one could have prevented it. Lastly, and most relevant to *Ein Bekenntnis* and the contemporary ethical debate, is killing in order to *help* another.[6] Such ethical matters, whether originating in the past or in the modern day,

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[5] Hester, *End-of-Life Care and Pragmatic Decision Making: a Bioethical Perspective* (Cambridge University Press, 2010) 75.
[6] Ibid. 79.

force us to confront and assess actions that are deemed “right, good, and acceptable”[7] in the medical field while also taking into consideration the historical location.

Another point of interest in selecting Storm’s *Ein Bekenntnis* for this discussion is the text’s integration of the perspective of the patient, who may be seen as the “victim” of unethical medical conduct, in the determination of what is ethically “right”. While discourse surrounding biomedical ethics is often centered around the obligations and rights of the physician or medical professional, *Ein Bekenntnis* places an additional emphasis on the desires of the terminally ill, which creates a moral dilemma when a medical professional is asked to carry out a wish for death. The consideration of a patient’s autonomous right to selfdetermination and their desire for control over their own dying process adds an additional dimension of meaning to end-of-life care.[8] Furthermore, *Ein Bekenntnis* presents the reader the fascinating ethical question of who has the right, or ought, to die. This centuries-old question in medical ethics has compelling implications in the contemporary discourse on abortion rights as well as 20th century Nazi ideology in creating a supposedly superior race.

In addition to my analysis of Theodor Storm’s 1887 novella *Ein Bekenntnis* is Arthur Schnitzler’s 1912 play, *Professor Bernhardi.* This work is also of interest in my exploration of ethics in German literature because of its particular focus on the intersection between religion, specifically Catholicism and Judaism, and end-of-life medical practices. Prominent in early 20th century Vienna, the Roman Catholic church held a rather restrictive and orthodox view on the

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[7] Hester, 61. [8]
Ibid. 84.

topic of end-of-life care, stating that the intentions of ending life through human manipulation was wrong, regardless of the dying person's desires. The Catholic church adopted the idea that "human life is an unquestionable good,"[8] thus condemning mercy killing. As such, traditional Catholic religious values may reject the suggestion or recommendation for aid measures that may ultimately hasten death for someone who is terminally ill and suffering from pain. This very conflict that *Professor Bernhardi* presents between religious beliefs rooted in nonmaleficence and what may seem as ethical beneficence and respect for autonomy is an intriguing topic which I will discuss later.

Further analysis of *Professor Bernhardi* also introduces us to the contemporary ethical issues of patient disclosure and informed consent. Disclosure is the communication between a health care provider and a patient or family member regarding relevant patient medical information and intervention, thereby serving as an acknowledgement of full awareness and understanding on the patient's behalf of their health status. Related to disclosure, and falling under the ethical concept of autonomy, is informed consent, the process by which a patient "learns about and understands the purpose, benefits, and potential risks of a medical or surgical intervention."[9]

These processes have significant implications in the contemporary issue of HIV/AIDS disclosure policies. Consider the following case studies:

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[8] Hester, 68.

[9] See "Definition of Informed Consent," *MedicineNet*.

- In November 2013 a 52-year-old man living with HIV was charged with reckless conduct after allegedly not disclosing his HIV status to a sexual partner.[10]
- In August 2011, a man living with HIV was charged with reckless conduct by an HIV-infected person after allegedly not disclosing his HIV status to his

girlfriend.[11] According to Georgia law, a person infected with HIV/AIDS is required to disclose their HIV status, prior to engaging in sex, to any and all sexual partners, regardless of intent to transmit HIV or the actual transmission of the virus.[13] In the medical field, physicians often face a moral dilemma when encountering patients living with HIV (PLHIV) who have not disclosed their condition to their partner. In such cases, a conflict between non-maleficence and autonomy arises. On the one hand, a physician has the duty to treat patients as people with free will and the right to make their own decisions or choose the appropriate time and location to disclose their HIV status. On the other hand, the physician may as well be concerned about the health safety of any sexual partners involved due to risk of harm in transmission of the virus. Furthermore, the physician may fear the consequences of disclosing such information themselves, as it may instigate psychiatric, emotional, physical, financial, or social discrimination, dispute, or harm. A similar rationale behind failure of medical disclosure is portrayed in *Professor Bernhardi,* which presents a physician's logic in justifying non-disclosure to a terminally ill patient.

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[10] Evan Bleier, "HIV-Positive Georgia Man Arrested for Having Unprotected Sex," 15 Nov. 2013.
[11] Alaya Boykin, "Douglas County Man Charged with Infecting Girlfriend with HIV," 10 Aug. 2012. [13]
GA. Code Ann. § 16-5-60(c), 2016.

An additional contemporary, and very relevant, biomedical issue handling patient disclosure and informed consent is that of organ donation. Currently, the United States utilizes an "opt-in" system, in which deceased organ donation requires explicit consent by the individual donor, while alive, or by the next of kin post-mortem. The problem exists in the wide discrepancy between the number of organs donated every year and the tremendous number of patients requiring a transplant. As such, many have proposed a shift to an "opt-out" system, currently present in Europe, in which silence on part of the individual, nonregistration as an organ-donor, or dissent is considered as consent.[12] Controversy thus arises whether this is ethically justifiable, as it may undermine autonomy, informed consent and patient understanding of the options they have.

It is significant to note how concerns of assisted death and patient disclosure are at the intersection of contemporary and centuries-past ethics. As shown in German literature from the 19th and 20th centuries and more contemporary issues like HIV transmission, ethical dilemmas faced in medicine are anything but new and are still relevant in today's discussion of bioethics. Literature from past centuries provided space for German authors in particular to discuss highly complex ethical issues in moral terms. Analysis of such German works can thus help contemporary ethicists comprehend and truly internalize ethical situations seen today, as presented in the aforementioned cases of Jim and HIV disclosure laws. Ethics often does not present a clear-cut "right" and "wrong" solution, as cases may be highly subjective, open to

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[12] Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics* 7th ed. (New York: Oxford UP, 2016) 113.

interpretation, and conflict with individuals' personal morals and values. However, examination of ethical dilemmas from past German literature provides useful insight into topics heavily debated in the modern age.

An additional point of interest in discussing medical ethics in context of German literature is how ethical questions have been manipulated through the course of German history. In particular, the Nazi regime serves as a prime example of how questions, such as *who has the right to live,* can be distorted and maliciously exploited in medicine. The concept of "lives unworthy of living" was first coined in the 19th century by Austrian psychologist Adolf Jost (1874-1908) in his 1895 pamphlet *Das Recht auf den Tod*. It not only parallels 20th century Nazi ideology of euthanasia, but also sets the ethical question of who ought to die, or has the right to live, at the forefront. The National Socialist program of Aktion T4, or T4 Euthanasia Program, was a Nazi effort established from 1939 to 1941 to eradicate the physically and mentally ill and disabled, elderly, and emotionally distraught from German society. Run by psychiatrists and other medical experts, T4 served, at that time, as a legal and ethical means for physicians to kill people on the basis of preserving a pure "Aryan" society void of financially and economically burdensome, unproductive bodies. The Third Reich's rationale for euthanasia highly echoes that of Jost from almost half a century later.

From a contemporary lens, these physicians would be considered clearly breaking the centuries-old Hippocratic Oath. In contrast to Dr. Franz Jebe's ambiguous case in Schnitzler's *Ein Bekenntnis*, where a physician is faced with the ethical dilemma of mercy killing when it has the potential to relieve pain and suffering, Nazi physician killings originated from Nazi

ideologies to promote a superior race. The subjectivity of “suffering” in the Third Reich referred not to the physical ailments that victims of “mercy killing” endured, but a suffering of the pure German *Volk* if inferior races and disabled peoples were not exterminated. The Nazis expanded their killing procedures from the terminally ill, to a wide array of the population, including mostly Jews, but also the elderly, the mentally disabled, and children. Euthanasia in the Third Reich was a misnomer because children, deemed “asocial”, disabled, or autistic and “ineducable”, were far from terminally ill and could have led full, meaningful lives, yet were killed because they were labeled genetically “tainted” and unfit for German society.

However, it is interesting to note that, to the Nazis, the Hippocratic Oath seemed to fit with their medical ethics. The extermination of Jewish persons, disabled persons, and patients with hereditary diseases was for them “morally acceptable” and necessary to heal the organism of the German people, or *Volk.* The Nazis emphasized the importance of a healthy *Volkskörper* (“people’s body”) by creating an analogy between the German *Volk* and a sick patient. The only way to cure the *Volk* would be through having its impurities and diseases, or the Jews, disabled, and hereditarily diseased, eliminated. The Nazi misuse and abuse of medical experimentation, research, and euthanasia serves as an example of just how ethical reasoning can be corrupted. Therefore, simply teaching and vowing to an ethical standard may not always guarantee a physician’s moral integrity, as exhibited by Nazi medical crimes. According to Dr. Floridian Bruns and Dr. Tessa Chelouche, present-day scholars in the field of bioethics during the Holocaust, emphasize how ethical criteria are dependent upon the politico-social climate, moral zeitgeist as well as religious belief. Thus, the existence of “eternal” or “universal” values, as outlined in

Hippocratic oath, are not the sole focus of attention when examining ethics in a historical context.[13]

During the 19th century, authors illustrated doctors in their literature as logical and rational beings who "personifiziert die Einheit von Moral und Vernunft, von moderner Naturwissenschaft und schlichter Menschlichkeit" (personified the unity of morality and reason, of modern science and simple humanity).[16] However, as illustrated by Nazi medical practices, morals and bioethical considerations can significantly be influenced by confounding circumstances in society. As such, a physician's ethical reasoning for his/her practice are not always as logical and rational as once thought and are subject to change based on societal circumstances.

When applied to ethical dilemmas like euthanasia or patient disclosure, the Hippocratic oath is ambiguous. Its subjective interpretation may be contingent on multiple variables, of which include socio-political changes, the physician's own moral or religious beliefs, and the complexity of the dilemma itself. The two texts by Theodor Storm and Arthur Schnitzler, which I discuss further in this thesis, detail this uncertainty and ambiguous nature of ethical dilemmas. In Theodor Storm's work *Ein Bekenntnis,* I present the heated two-sided argument for-andagainst physician-assisted death and ending life with the intention to alleviate pain and suffering. I also discuss how the justifiability of mercy killing is distorted in Nazi Germany history. In Arthur Schnitzler's play *Professor Bernhardi,* I detail the intersection of religion and

[13] Florian Bruns and Tessa Chelouche, "Lectures on Inhumanity," Annals of Internal Medicine, 166.8 (2017): 594.
[16] Marcel Reich-Ranicki, *Herz, Arzt Und Literatur: Zwei Aufsätze* (Ammann Verlag AG, 2007) 7.

politics with medical ethics, as anti-Semitism had a significant influence on Schnitzler's literary works. The ethics of patient non-disclosure is a point of relevant discussion and controversy in the play. Both works reveal the fundamental ambiguity and complexity in unraveling medical ethical dilemmas.

Chapter 1

Hans Theodor Woldsen Storm (1817-1888), commonly known as Theodor Storm, was a highly popular German writer and poet of the mid-19th century who wrote many novellas and poems that portrayed everyday life and commonly adopted sensations of nostalgia. Beyond these concepts, Storm's literary works handled a range of topics such as love and the paranormal,[14] both of which were important elements in his 1887 novella *Ein Bekenntnis*. However, *Ein Bekenntnis* is mostly distinct for its handling of the issue of *Sterbehilfe* (assisted death). This novella presents the confrontation between childhood friends Hans, a present-day lawyer, and Franz Jebe, a doctor. During their prolonged interaction, Jebe, ridden with guilt, confesses to Hans that he had poisoned and killed his wife Elsi who was suffering from a perceivably incurable stomach cancer. Jebe had hoped that in doing so, he would alleviate the tremendous physical pain his wife was enduring and fulfill her wish to die. However, after this act of "mercy killing," Jebe ironically stumbles upon a recently published magazine that described how the abdominal disease that his late wife had died of did in fact have the potential to be cured through surgical means. Hans, the protagonist, perceives Jebe's act as murder, rather than humane, posing the question "Wie kommt einer dahin, sein geliebtestes zu todten?"[15] (how can one kill his loved one?). Based on a several year-long letter exchange with another literary scholar of the time, Paul Heyse, it is evident that Storm voices his own views

[14] Inspired by painted works by Henry Fuseli, who depicts the modern concept of psychological guilt through his paintings illustrating the monstrosity of the soul and hauntings of the mind. The fantastical and dreamlike elements portrayed in Fuseli's work *The Nightmare* became Sigmund Freud's focus in unraveling the subconscious in the early 20th century.

[15] Carola Padtberg, "Theodor Storm: Ein Bekenntnis," 26 Apr. 2006.

against mercy killing through his character Hans.

Storm's *Ein Bekenntnis* served as just one piece towards the end of the 19th century that portrayed the rising popularity of and fascination with cancer and introduced the contemporary theme of active euthanasia in 19th century German literature. The late 19th century, also called the "bacteriologische Revolution", was a time in Germany marked with prevalent epidemic diseases such as tuberculosis, childbed fever, and deathly infections.[16] During the final years of Storm's life, discoveries of new forms of cancer became ever more prevalent. Cancer particularly became the root of a developing "kollektive Ängste" (collective fears) in late-19th century German society.[17] During a time marked by disease and fear of acquiring cancer, Storm consolidates an optimistic trust in the inevitability of medical progress and the curability of illnesses no matter how dire. This potential of medical advancement is most obviously illustrated in *Ein Bekenntnis* by the ironic discovery Jebe makes of the actual curability of his late wife's condition, after having considered her cancer untreatable:

> "Ich warf mich mit dem Heft aufs Sofa und begann zu lesen und las immer weiter, bis meine Hände flogen und ein Todesschreck mich einem Beifall gleich getroffen hatte. Der Verfasser schrieb über die Abdominalkrankheiten der Frauen, und bald las ich auf diesen Blättern die Krankheit meines Weibes, Schritt für Schritt, bis zu dem Gipfel, wo ich den zitternden Lebensfaden selbst durchschnitten hatte. Dann kam ein Satz, und wie mit glühenden Lettern hat er sich mir eingebrannt: 'Man hat bisher' -so las ich zwei- und

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[16] Elsaghe, "Krankheit," *Storm-Handbuch: Leben, Werk, Wirkung* (Stuttgart: J.B. Metzler Verlag, 2017) 355.
[17] Ibid.

dreimal wieder- ‘dies Leiden für absolut tödlich gehalten; ich aber bin im Stande, in Nachstehendem ein Verfahren mitzuteilen, wodurch es mir möglich wurde, von fünf Frauen drei dem Leben und ihrer Familie wiederzugeben.”[18]

[I threw myself with the magazine onto the sofa and began to read, letting myself read further until my hands flew and I was immediately struck by shock. The author wrote about the abdominal diseases in women, and I soon read on these pages the disease of my wife, step by step, until I reached the peak where I had cut the trembling thread of life myself. Then came a sentence, and like glowing letters burned me: "One has so far so I read two and three times again- held this suffering as absolutely deathly; I however am capable to share in the following a procedure that was possible for me to save the life of three of five women and return them to their families.]

Further development in the medical field paralleled a change in the attitude towards and conditions that define a terminal illness. On the one hand, the emphasis on hopeful medical progress introduced in *Ein Bekenntnis* was correlated with a rising obsoleteness in perceived incurable medical diagnoses in late 19th century Germany. Storm’s “Glaube an den wissenschaftlichen Fortschritt” (belief in scientific progress) became more widely accepted in the medical community, thus deeming any physical condition as having the potential to be treated and not truly terminal.[22] On the other hand, in 1895 Adolf Jost was the first to openly support the legalization of euthanasia and the right to die on the basis of ridding society of

[18] Storm, *Theodor Storm Sämtliche Werke 1881-1888* (Frankfurt A/M.: Deutscher Klassiker-Verlag, 1987) 618-19.
[22] Elsaghe, 356.

"lebensunwertes Leben" (negative human worth), or those with perceived irreparable, unproductive, and hopeless physical or mental states.[19] Nazi officials of the Third Reich several decades later considered such health conditions justifications for mercy killing, equating them to terminal illnesses like tuberculosis or cancer.

Medical advancements in 19th century Germany and the optimism of medical effectiveness that Storm portrays in his work contributed to a revival of the centuries-old debate on the ethics of mercy killing, which remains to this day a highly complex and controversial topic. Theodor Storm actively participated in this discussion through his novella and an exchange of letters in the late 1860s with Paul Heyse, also a distinguished German author of the 19th century. In fact, Heyse published *Auf Tod und Leben* in 1867, a novella with an unambiguously similar plot to that of *Ein Bekenntnis*, published in 1887. Heyse presents a story of the man Rüdriger who performs assisted death on his terminally ill wife. Although intended to be an act of deep love and compassion for his wife, the mercy killing causes Rüdriger to enter a state of moral reprehensibility, overwhelmed with shame and cowardice. Not only is he faced with the looming guilt of whether he was justified in his act, but also encounters the moral dilemma regarding his right to remarry. Rüdriger's psychological issues are superficially resolved with the appearance of Lucile, Rüdriger's new love interest. Just as Storm voices his views on euthanasia through the character of Hans, Heyse does so through Lucile, who surprisingly responds to Rüdriger's perceived unhonorable act with compassion and warmth. Expressing Heyse's clear stance on the issue, Lucile states:

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[19] Elsaghe, 360.

“Sie sind mir nicht unheimlich geworden durch das, was Sie gethan. Ich gestehe Ihnen, daß ich oft den Kopf geschüttelt habe, wenn ich sah, wie Ärzte es für ihre Pflicht halten, ein verlorenes Leben, das ihnen jammervoll unter den Händen hinschwindet, mit aller Mühe und Kunst noch um Wochen,
Tage und Stunden zurückzuhalten, Qualen zu verlängern, nur um das arme
Dasein, das allen Wert verloren, noch zu fristen; wie mit den letzten
Atemzügen noch gegeizt wird, als wollte man die Galgenfrist eines Verurteilten um jeden Preis verlängern. Ist das nicht eines der grausamsten, gedankenlosesten Vorurteile unserer menschlichen Gesellschaft? Wenn wir ein Tier leiden sehen, beeilen wir uns, seine Qualen zu verkürzen. Einen armen Schmetterling, der sich an einer Kerze halb verbrannt hat, erlösen wir geschwinde von seinem verstümmelten Dasein. Und die, die uns die Liebsten und Nächsten sind, sehen wir nicht nur unthätig sich in Todesschmerzen hinquälen, sondern entfernen aus ihrer Nähe alles, was ihnen in einem Augenblick der Verzweiflung dazu helfen könnte, ein Ende zu machen! Von jedem kleinsten Schmerz suchen wir sie zu befreien, jeden Splitter, den sie sich in die Haut gerißt, ziehen wir sorgsam aus, und mit der größten, unerträglichsten Qual, dem Sterbenwollen und Nichtsterbenkönnen, haben wir kein Erbarmen. Der Arzt mag vielleicht das Recht zu eigenmächtiger Hilfe sich nicht anmaßen dürfen. Wie vielem Mißbrauch wäre da Thor und Tür geöffnet! Aber ein Freund – ein Gatte – der den Mut haben sollte, die Verantwortung für einen solchen Liebesdienst auf sich zu

nehmen – und der wendet den Rücken und versinkt in ein thatloses Mitgefühl, aus feiger Selbstsucht! Ich habe oft darüber nachgegrübelt und mich nur damit getröstet, daß kommende Zeiten, wie mit anderem Aberglauben, auch mit diesem so verhängnisvollen aufräumen werden. Wer aber jetzt schon den Mut hat, in diesem Punkt nur seine Liebe und sein Gewissen zu befragen, sollte ich den nicht bewundern?”[20]

[You have not become scary because of what you have done. Ich admit, that I have often shaken my head when I saw how doctors held it as their obligation, a doomed life, that miserably disappears under their hands, but still with all effort and art for weeks, days, and hours try to keep back and extend its torments, only for the poor being, that has lost all worth, to be skimped on; like what is showed with the last breath, as one wanted to prolong the reprieve of a condemned man at every cost. Is that not one of the cruelest, thoughtless prejudices of our humane society? When we see an animal suffering, we hurry to shorten its agony. A poor butterfly, that has burned half of itself from a candle, we release quickly from its mutilated existence. And those, who are loved ones and nearest to us, we see not only torturing us with the pain of death, but also we remove everything from their vicinity that can ease their despair, to put an end to it! We seek to free them of every small pain, every splinter that has pierced their skin we pull out carefully, but we have no mercy for the biggest, most unbearable agony, the desire to die and those unable to die. The doctor may perhaps like the right to help that

[20] Paul Heyse, *Auf Tod und Leben* (1886) 165.

> he is unauthorized to do. Many abuses would open doors and doors! But my friend, my husband, who should have the courage to take responsibility for such a service of love, but who turns his back and sinks into a meaningless sympathy out of cowardly selfishness. I have often pondered over this and comforted myself, that coming times, like with other superstitions, will also clean up this disaster. Should I not admire who has the courage right now in this point to question his love and conscience?]

As illustrated in the quote above, Heyse openly voices his belief that mercy killing was justified to relieve suffering by means of his character Lucile. Storm, on the other hand, emphasized the "Heiligkeit des Lebens" [21](sanctity of life) and the ethical dilemma of assisted death, as seen in Hans' aghast reaction to Jebe's act of, what was in his eyes, murder. Additionally, Storm's letters during his 1867 *Briefwechsel* (letter exchange) with Paul Heyse were in direct contrast to the viewpoint Heyse held in favor of euthanasia, or what Lucile calls "a service of love." In terms of assisted death, Storm adopted a more restrictive interpretation of the Hippocratic oath. He did not believe that killing was justifiable, regardless of its potential to relieve pain and suffering, as in the case of Franz Jebe and his wife. In the eyes of Storm, *Lebensverlängerung* (life extension) was a physician's absolute duty, even if this required denying *Schmerzlinderung* (pain relief).[26] Although the plot of Storm's 1887 novella *Ein Bekenntnis* had an uncanny resemblance to that of Paul Heyse's novella *Auf Tod und Leben,* published twenty years earlier, the two authors' viewpoints on assisted death could not be more distinct.

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[21] Rudolf Käser and W. Fink, *Arzt, Tod Und Text* (München: Wilhelm Fink Verlag, 1998) 164. [26] Ibid. 165.

Although both authors adopted a similar storyline presenting a man who kills his wife to alleviate her pain from an illness, the difference between the two texts lie in the fact that the man committing the act of killing is a doctor in *Ein Bekenntnis.* Similar to Jebe's case, the protagonist who poisons his wife in Heyse's work did so upon her own request. Heyse held the belief that, because this character was not a doctor and was simply acting out of compliance to his wife, he was free of guilt.[22]

This moral reasoning raises the question if the ethics of mercy killing is directly associated with who commits the act itself. If the killer identifies himself as a physician, does this warrant automatic guilt, and can he handle this psychological distress? In the circumstance that he is not a doctor, is killing out of compliance justified? Heyse created this very distinction, arguing that "Tötung Einwilligender" (consensual killing) fell under a separate category from "ärztliche Euthanasie" (medical euthanasia) performed by a physician.[28] However, this dichotomous distinction cannot be easily applied to the case of Dr. Franz Jebe in Storm's *Ein Bekenntnis*. Using Heyse's reasoning, man could either be a non-physician, killing out of compliance, or a physician performing medical euthanasia. As for Dr. Jebe, the complexity lies in the fact that this character not only is a physician, but also is a caring husband who is faced with a death wish from his wife. He fits both of Heyse's categories of a consensual killer and a physician-euthanizer. Using Paul Heyse's logic in determining the ethical standpoint of this case,

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[22] Rudolf Käser and W. Fink, 174.

[28] Ibid. 175.

one would first ask if Franz Jebe poisoned his wife as a knowledgeable physician, acting on the best interest of his patient, or as a dutiful, loyal husband following the orders of his wife.

Legal thought during the late 19th century was that medical euthanasia administered by a physician was, by all means, unethical and broke the Hippocratic oath, whereas "Tötung Verlangender" (requested death) was justifiable as long as it were not performed by a doctor.[23] In other words, non-physicians would not be bound to the Hippocratic oath. However, as in the case of Dr. Franz Jebe, situations involving mercy killing are evidently not always as black-andwhite as Heyse had previously explained; there exists a gray area in medical ethics between professionalism and humane empathy, or *Mitmenschlichkeit*. It is possible that Jebe performed the deed of mercy killing through rational, professional judgement on behalf of his patient, but it is also likely that he acted out of mere compliance to his suffering beloved.

From a contemporary perspective, the American Medical Association (AMA) Code of Medical Ethics addresses this gray area. The AMA states that physicians should not treat immediate family, for it has the potential to influence, even compromise, medical professionalism, patient autonomy, and informed consent. Resolving the ethics in end-of-life care such as mercy killing thus raises the conflict between civil humanity, or compliance, and medical professionalism.[24] Although no such specific code of ethics existed in the late 19th century, the AMA illustrates through a contemporary lens how Dr. Franz Jebe would be unethical in his actions of treating his own wife, for he could have been influenced by emotions,

[23] Rudolf Käser and W. Fink, 175.

[24] See AMA Council on Ethical and Judicial Affairs, 01 May, 2012.

thus compromising his professional conduct. As *Ein Bekenntnis* presents the conflict Frank Jebe faces between professionalism and emotions, Storm's text provides one example of why the AMA would create such a policy.

Storm's *Ein Bekenntnis* portrays the challenging ethical dilemma that Dr. Franz Jebe faces when treating his terminally ill wife, as he attempts to follow both his professional medical and humane intuitions. If Jebe were adhering to his medical expertise, this raises the question of if-and-when a physician truly has full certainty that his patient is at a health status beyond saving. Jebe held the belief that his wife Elsi, suffering from a case of stomach cancer, was at a futile state of incurability after consulting certain medical literature. Though unknowingly overlooking the most valuable piece of medical knowledge, Jebe took the initiative to seek other medical views, all of which expounded on the futile incurability of his wife's case. Thus, his conscience informed him that he was behaving ethically and in accordance with his dying wife. Only after killing his wife does he realize Elsi's illness indeed could have been cured through means of surgical operation after discovering a medical journal that explained the surprisingly strong potential for survival in women with Elsi's condition. Although Jebe was a licensed physician, he was not aware of the curable nature of his wife's disease at the time of treating her. Determining if-and-when a patient has progressed to a health condition considered unable to be saved is a challenge in the medical field. From an ethical standpoint, and the perspective of Theodor Storm, a physician would need to exhaust all medical options and healing alternatives before deeming medical euthanasia an appropriate solution.[25] Because

[25] Rudolf Käser and W. Fink, 164.

Dr. Franz Jebe did not explore many other options in treating his believed-to-be incurable wife, prematurely euthanizing her, one could argue that Jebe acted unethically as a medical professional. Similarly, one could argue that he was justified in his actions because of his utmost compassion and love for his wife, who he struggled to see suffering.

The professional community among German lawyers, politicians and judge in the 19th century debated the highly contentious question of when a physician could justifiably perform medical euthanasia, or mercy killing. Previously against medical euthanasia, the legal opinion on the topic experienced a significant shift between 1885 and 1920 in support of mercy killing, particularly influenced by the emphatic publications by Alfred Jost, who voiced his unambiguous stance in favor of euthanasia in his 1895 publication *Das Recht auf den Tod* (*The Right to Death*). Others in the field argued that euthanasia, or some form of mercy killing, was justifiable, with some also specifying particular conditions under which the act would be wrong. Similar to Jost, the renowned German criminal lawyer Lassa Francis Lawrence Oppenheim (1858-1919) argued that euthanasia was a sensible method to administer anesthesia, and thereby eliminate a patient's pain and suffering, even if death was a following side effect. The psychiatrist Alfred Hoche and jurist Karl Binding opposed this viewpoint in their jointly published book *Die Freigabe der Vernichtung lebensunwerten Lebens* (*Authorization for the Destruction of Lives Unworthy of Living*) in 1920. In short, these men supported the killing of people whose lives were devoid of value and were burdens to society. Hoche and Binding firmly asserted that to protect "higher values," euthanasia must be permitted for physicians to

destroy "unworthy lives.,"[26] a belief like that of Adolf Jost from the late 19th century. Nazi ideology that pervaded German society almost 20 years later also echoes Hoche and Binding's 1920 publication, which states:

> "If one thinks of a battlefield covered with thousands of dead youth ... and contrasts this with our institutions for the feebleminded with their solicitude for their living patientsthen one would be deeply shocked by the glaring disjunction between the sacrifice of the most valuable possession of humanity on one side and on the other the greatest care of beings who are not only worthless but even manifest negative value."[27]

The medical community was thus included in the harsh and abrasive principles of this time that provided doctors the opportunity, and mandate, to abuse their power for mass sterilization and murder. As such, Hoche and Binding's ideals dismissed a physician's obligation to uphold the ancient Hippocratic oath for the sake of upholding racial supremacy.

For others, however, the ethical consideration on the issue of euthanasia in the late 19th and early 20th century was grounded in the "who", rather than the "if"; many professionals believed in the justification of the act of killing, but only if such an act were not performed by a physician. Furthermore, the German Reich government and the criminal code it crafted in 1871 established that killing "auf Verlangen des Getöteten" (upon demand of the dead) was a separate offense, incomparable to murder, and deserved a "Strafmilderungsgrund"

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[26] Binding and Hoche, *Die Freigabe der Vernichtung lebensunwerten Lebens* (Leipzig: Verlag von Felix Meiner, 1920) 27.

[27] Binding and Hoche, *Die Freigabe der Vernichtung lebensunwerten Lebens*, 49-50. [34]
Rudolf Käser and W. Fink, 169.

(mitigation of punishment).[34] With this rationale, it is less astonishing that Franz Jebe was never prosecuted and found guilty by the state after performing a relatively tolerable deed in the eyes of the law at the time.

Theodor Storm, on the contrary, strayed away from this common viewpoint through his strong opposition to euthanasia, illustrated in his novella *Ein Bekenntnis*. “Ein Bekenntnis”, which translates to “A Confession”, presents a double-meaning of the title. For one, Jebe confesses to his childhood friend Hans of his horrendous act performed on his wife. The novella also covertly expresses Theodor Storm’s strong opinions on the ethical issue of mercy killing. Storm believed that euthanasia, regardless if performed by a doctor or someone out of compliance and consent, is still unethical and is still considered an act of murder.

While there are instances where medicine comes into conflict with the law, it also can often conflict with religious belief, as shown in Arthur Schnitzler’s *Professor Bernhardi* (1912). Religion’s impact on medicine raises the question of how religion can shape the ethical decisions of a physician. If a doctor adopts the tenets of Christianity, are they less inclined to perform medical euthanasia, even if it had the potential to alleviate pain and suffering? It could be argued that Franz Jebe of *Ein Bekenntnis* was not “sufficiently” Christian to persuade him not to poison his wife. This very symbiosis, and often conflict between, medical decisions and religious beliefs is also very much debated in German literature and is one of the major themes discussed in the subsequent chapter.

Chapter 2

From the nineteenth, and leading up to the twentieth century, Vienna, the capital of the Austro-Hungarian empire, experienced a period of modern advancement and explosion in medicine, arts, and literature. Such amenities and freedoms were granted during the time of Austrian liberalism, a period in the 1860s the Liberal party assumed political power, in support of Viennese "academic idealism and bourgeois cosmopolitans."[28] Within two decades of rule, liberalism and its values remained confined to the middle class and Jews in urban centers. As a result, liberalism introduced conflict with anti-Semitic nationalists and Catholic social reformers for its religious toleration, equality before the law, and capitalistic ideals.[29] Liberalism and capitalism thus grew to become interchangeable in political thought. Viennese Jews not only became symbols for liberalism and the politically despised concept of capitalism, but also experienced cultural assimilation, social rights, and professional freedoms.

During December of 1867, Jews in the Habsburg Empire experienced, for the first time in centuries, an emancipation that abolished almost all former restrictions placed on them. With "benefits derived from civic and political rights...not dependent on faith and religion," many Jews were thereby able to culturally assimilate into Viennese society and pursue careers in all professions, including law and medicine.[30] Following emancipation, the Jewish community began to fully participate in and, what some would argue, dominate all spheres of cultural and

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[28] Peter G. J. Pulzer, *In New Dimensions in History* (New York: John Wiley and Sons, 1964) 135.
[29] Ibid. 138.
[30] See "Encyclopedia Judaica," *Jewish Virtual Library*.

scientific achievements in the Habsburg Empire. For instance, prominent Jewish physicians like Sigmund Freud and Alfred Adler rose to fame within the medical field, with three out of four Austrian Nobel Peace Prize winners being of Jewish descent. Gustav Mahler and Arnold Schoenberg were two of many rising and highly popular Jewish musicians and composers. The economic, cultural, and political freedom that Jews were granted after emancipation triggered immense growth in the Jewish population in late 19th century Vienna.

However, the period from 1878-1933 was marked with rabid opposition to recognition of Jewish political and social equality in Viennese society. As a result of the immersion of Jews into liberal culture, a rapid backlash of anti-Semitism emerged, placing blame on Jews for the rise of materialistic capitalism, atheism, and liberalism.[31] Outright opposition to Viennese emancipation was evident in publications like the moderate Viennese newspaper, *Wiener Kirchenzeitung*, criticizing:

> …those Israelites who owe their significance in modern society solely to the combination of Jewish disbelief with poisonous hatred against Christian doctrine and Catholic practice.[39]

The 1880s was also marked with several mass group rallies, of which included the anti-Semitic Christians, socialists, and Slavic nationalists, that challenged the presiding liberal hegemony and blamed Jews for all that modernity offered.

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[31] See "Encyclopedia Judaica," *Jewish Virtual Library*. [39]
See *Wiener Kirchenzeitung,* 29 Apr, 1848.

While liberalism focused on rationalism, the rule of law, morals and modern scientific progress, the aforementioned groups "transcended the purely political,"[40] concerning themselves more with social[32]-psychological and aesthetic culture. Carl Schorske (1915-2015), an established American cultural historian, describes Vienna's liberal moral and scientific culture as such:

> Morally it was secure, righteous, and repressive; politically it was concerned for the rule of law, under which both individual rights and social order were subsumed. It was intellectually committed to the rule of the mind over the body and to a latter-day Voltairism: to social progress through science, education, and hard work.[33]

Such prominent values of liberalism contrasts to those that arose from the development of aesthetic culture after the mid-19th century. Out of the aestheticism that predominated the bourgeoisie in this period grew a particular appreciation for art and sensitivity to the psyche. Following the break of Semitic Austrian liberalism in the 1880s and 1890s, the movements of Pan-Germanism and Christian Socialism distorted the once rational and moral liberalism to develop what became known as the "sharper key,"[34] a more abrasive, amoral, and aesthetic political style that emphasized the "life of feeling,"[43] *Gefühlskultur,* or a community of shared feelings that promoted a sense of belonging and nationalism, giving shape to values, behaviors,

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[32] Carl E. Schorske, *Fin-de-Siècle Vienna: Politics and Culture* (New York: Vintage, 1981) 120.
[33] Carl E. Schorske, *The American Historical Review* 66.4 (1961) 933.
[34] Schorske, *Fin-de-Siècle Vienna,* 119. [43]
Ibid. 119.

and perceptions of the *Volk.* It was this newer political outlook that eventually served as an inspiration and a political model for future National Socialist thought under the Nazi regime.

Georg Ritter von Schönerer (1842-1921) was one of Austria's leading authorities of this *Gefühlskultur* model. A key "pacemaker for both nationalism and anti-Semitism,"[35] Schönerer was responsible for organizing radical German nationalists in 1882 and introducing extreme and majorly disruptive anti-Semitic values and behavior into Viennese society. However, Schönerer's anti-Semitic tendencies were initially founded on political and economic thought, rather than racial grounds. In an 1878 speech at the Reichsrat, Schönerer deplored "Jewish capitalism" for its condemnable effects on Austrian peasants and artisans and attacked the government that supported "paid, selfish, and repulsive… Viennese [Jews]."[36] Schönerer also demanded a political union with Germany and preservation of German character in his developing political philosophy. Schönerer's combination of nationalism and semi-socialism could thus be interpreted as an early feature and predecessor of German and Austrian racial anti-Semitism[37], which soon became a major component of Schönerer's 1885 platform:

> The removal of Jewish influence from all sections of public life is indispensable for carrying out the reforms aimed at.[47]

The rise in Jewish emancipation eventually confronted even more popular scientific theories of race, such as eugenics, coined in 1881 by Francis Galton, that opposed the

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[35] Pulzer, 149.

[36] Ibid. 150.

[37] As opposed to political and economic, social, or religious anti-Semitism, racial anti-Semitism was based solely on the belief that Jews were an "inferior race." [47] Pulzer, 153.

absorption of outsiders such as Jews and Gypsies in the late 19th century. Gregor Mendel's findings on heredity and Charles Darwin's discoveries of natural selection and "survival of the fittest" in the animal kingdom were revisited in the early 20th century and applied to the German society and the human race. Such applications contributed to the rise of anti-Semitic sentiments and a supposed "duty to demand the prevention of procreation by 'other inferior races' and by 'inferior individuals' within their own 'race', in order to starve off the decline and ruin of European culture."[38] As such, the pervasiveness of race-theory, racial hygiene, and social biology began as early as 1900.

This critical change in social climate that threatened liberal Jewish culture and fostered nationalistic thoughts in the early 20th century had an impact on young adults at that time. Growing up to become literary scholars, they wrote works that addressed the rising problem of anti-Semitism. One such young adult was Arthur Schnitzler (1862-1931), a Jewish Viennese author who, in the crisis of liberalism of the late 19th century, turned his attention to the political crisis at hand: anti-Semitism. In several of his works, Schnitzler portrays the disintegration of Austrian liberal society under anti-Semitism. The liberal dynamic of emancipation and its anti-Semitic backlash could comfortably be observed in the Schnitzler family. Arthur Schnitzler's father, Johann Schnitzler, was a prominent Austrian physician who originally anticipated a similarly medical-oriented career for his son. However, even as a medical student, Arthur was immensely drawn to the field of art and psychology, eventually

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[38] Benno Müller-Hill, *Murderous Science* (Oxford: Oxford U, 1998) 7.

serving as a clinical assistant to Sigmund Freud's mentor, Theodor Meynert. Arthur Schnitzler eventually became an author of drama and prose whose works often addressed controversial issues, such as anti-Semitism and sensuality, that were relevant to his life. For example, several of Schnitzler's literary works, such as *Reigen* and *Fräulein Else*, are branded with Freudian concepts of instinctual sexuality and were perceived as pornographic in nature.[39] Pieces such as the novel *Der Weg ins Freie* and the play *Professor Bernhardi* portray Schnitzler's stark views against anti-Semitism.

Professor Bernhardi, published in 1912, is Arthur Schnitzler's most famous Semitic play, the plot of which portrays the job experiences and anti-Semitic tensions that Arthur's father and physician Johann Schnitzler faced as director of the Vienna General Policlinic. The work presents the discourse between a Catholic priest, Franz Reder, and a Jewish Viennese physician, Professor Bernhardi, on the case of an 18-year-old patient, Philomena Beier, who lay on her deathbed from sepsis after committing the crime of abortion. The priest desires to absolve the sins of the young woman, but Bernhardi, the director of a private Viennese clinic, refuses the priest's entry with the intention of ensuring a peaceful "glückliches Sterben" ("happy death") for his youthful patient.[40] Bernhardi feared that the mere sight of the priest and knowledge of her incurable medical condition would unnecessarily provoke imminent death of his patient.

The play presents the contemporary reader the ethics of end-of-life care, specifically addressing the argument of patient non-disclosure with the purpose of prolonging life and

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[39] Jürgensen, Lukas, and Scheffel, *Schnitzler-Handbuch* (Stuttgart: Verlag J.B. Metzler, 2014) 92-96.

[40] Arthur Schnitzler, *Professor Bernhardi: A Comedy in Five Acts* (New York: Simon and Schuster, 1928) 31.

relieving suffering of a patient. Furthermore, it also poses the question of what accuracy physicians have in determining the futility of cases, and how religion and politics influence crucial medical decisions. This debate is held between two significant parties of the late 19th century: the Catholic church and the scientific community. The play presents a clear confrontation between the ethical end-of-life care in medicine and the religious beliefs and practices in the prominent religion of Christianity. *Professor Bernhardi* also serves as an example of how an ethical dilemma between two moral entities can spiral out of control and enter the religious and political arena.

All too often do medical professionals encounter a dilemma in which they discover that their, otherwise healthy, patient has a terminal illness. In this instance, the physician is faced with the challenge of balancing telling patients the truth about their diagnoses and/or prognoses and upholding the tenets of “do not harm,” as outlined by the principle of nonmaleficence. It is a critical not only to decide whether to disclose relevant information, but also to determine how much information to withhold from patients. To make matters even more complicated, the patient may be young, or may present a physical state beyond saving. This is the very dilemma that the protagonist Professor Bernhardi confronts in Schnitzler's 1912 play, *Professor Bernhardi,* with a young patient dying from a case of sepsis. Worried about the adverse emotional and mental impact on his patient from disclosing her irreparable health condition, Bernhardi not only refuses entry of the Catholic priest who desires to administer the patient’s last rites, but also injects his patient with camphor to induce a feeling of euphoria.

Despite the desperate circumstances he encounters, Bernhardi tells the priest that she would soon be rescued by her savior and taken home, healthy:

> Wie ich schon bemerkte, Hochwürden, die Kranke ist völlig ahnungslos. Und sie erwartet alles andere eher als diesen Besuch. Sie ist velmehr in dem glücklichen Wahn befangen, dass in der nächsten Stunde jemand, der ihr nahe steht, erscheinen wird, um sie abzuholen, und sie wieder mit sich zu nehmen, -ins Leben un ins Glück. Ich glaube, Hochwürden, es wäre kein gutes, fast möchte ich zu behaupten wagen, kein gottgefälliges Werk, wenn wir sie aus diesem letzten Traum erweckten wollten (…) Und zu meinen Pflichten gehört es, wenn nichts anderes mehr in meinen Kräften steht, meinen Kranken, wenigstens soweit als möglich, ein glückliches Sterben zu verschaffen.[41]
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> [As I remarked before, your Reverence, the patient is absolutely unconscious of the nearness of the end. She expects anything rather than this visit. On the contrary, she is under the happy illusion that, within the next hour, some one dear to her will appear to fetch her away and take her back to life and happiness. I think, your Reverence, it would be no good, I might even say, no God-given deed, to waken her from this last dream(…) She is beyond all earthly hope, there can be no doubt about that (…) my duties when nothing else remains to me, is to ensure as far as possible a happy death for my patient.][42]

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[41] Arthur Schnitzler, *Gesammelte Werke* (S. Fischer Verlag, 1961) 356.

[42] Schnitzler, *Professor Bernhardi,* 31.

When, if ever, is it ethical and justifiable for a physician not to disclose significant medical information to a patient? In the eyes of Professor Bernhardi, it is believed that the terminally sick should be protected from more harm through non-disclosure of medical information.[43] On the one hand, receiving a diagnosis of a terminal illness like cancer could leave a sense of hopelessness and be interpreted as a diagnosis of death. On the other hand, not receiving this information and living without appropriate treatment could also pose a great danger to life. For example, medical recommendations for lifestyle changes or the best treatment plan may only be attained with information specific to the patient. This information, however, may only be obtained by disclosing the disease to the patient. In the case of Bernhardi's 18-year-old patient, he had determined that, due to her dire medical status, she would not have a chance of survival, and medical or religious intervention would be futile. In this instance, the adverse effects in diagnosing and disclosing the patient's true poor prognosis and physical condition outweigh the unlikely potential of treatment benefits.

The practice of nondisclosure raises the question of whether withholding the truth from patients is unethical and equivalent to lying in the medical field. As outlined in the Hippocratic oath, it is without a doubt unethical for a physician to lie. It is, however, prevalent in the medical field and deemed more appropriate for physicians not to state the whole truth with patients.[44] Unlike the latter case, Professor Bernhardi lies to his sepsis patient, claiming that she will be returning safely home, and distorts her perception of reality through the use of shortacting euphoric drugs. Both respecting a patient's autonomy and behaving in accordance

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[43] Farzaneh Zahedi, *Journal of Medical Ethics and History of Medicine* 4.11 (2011): 6.
[44] Zahedi, 7.

with beneficence and non-maleficence is the ethical dilemma that Professor Bernhardi confronts. For Bernhardi, allowing his suffering patient to die a "happy death" was allegedly his ultimate goal, and thereby placed a greater emphasis on "do no harm," considering his patient's physical, emotional, and mental well-being before her inevitable death. "Harm", however, is subjective to what the patient perceives as "harmful." From the perspective of the Catholic priest, harm would be the consequence of not absolving the patient's sins of abortion and abandoning her sinful soul. On the contrary, Doctor Bernhardi perceives harm as putting his patient through more tangible physical agony and emotional distress, warranting his camphor injections to alleviate suffering and refusal of the priest's entry.

When a patient's autonomy is upheld by a physician, he/she provides informed consent and has the right to make medical decisions regarding their treatment options and disclosure of information. However, because Professor Bernhardi drugged the girl and thereby altered her mental state, Bernhardi did not obtain with certainty the consent or desires of his patient. On the one hand, his patient may not have wanted to know about her true prognosis and terminal condition, in which case Bernhardi would have presumably acted accordingly. Alternatively, she may have sought the Catholic priest, who Bernhardi had controversially banned from the patient room, to set her soul free and be brought to salvation because of her unlawful abortion. From a contemporary perspective, Bernhardi failed to uphold his patient's autonomy[45] by

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[45] The original Hippocratic oath includes ethical principles of beneficence and non-maleficence. Autonomy, however, is a newer addition to the modern Declaration of Geneva oath and is a current emphasis in medical ethics.

drugging her without consent and withholding the truth about her deathly illness and her dire chance of survival.

The association between truth telling in medicine and patient autonomy can also vary among cultures. For instance, patients originating from Western cultures such as the United States typically demand a greater degree of medical information regarding their case, especially those involving terminal illnesses, when compared to patients from Eastern regions like China or Japan.[46] Whether or not a patient wants to know the status of their medical condition is confounded by several variables, of which include age, religious "locus of control", gender, ethnicity, and level of education.[47] Religious beliefs and cultural values influence end-of-life care practices and emphasis on the tenets of medical ethics in general, whose weight are distributed differently in different regions of the world. For example, in collective societies like Muslim and Asian cultures, beneficence or "do not harm" outweighs a patient's individual autonomy. On the contrary, Western cultures such as in the United States and Europe tend to respect the individual rights of patient autonomy and place a greater emphasis on disclosure of medical information. In Western countries, approximately 80–90% of cancer patients are given the complete truth about their diagnosis, whereas in other cultures, these figures can range from 0 to 50%.[48] Disclosure of diagnoses and prognoses, and discussions regarding termination of treatment "reflect mainstream liberal Western cultural values, and are not even necessarily

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[46] Zahedi, 2.

[47] Ibid. 4.

[48] M. Gold, *Internal Medicine Journal* 34.9-10 (2004): 578-80.

supported everywhere in Europe."[49] Italy, for example, provides physicians the opportunity not to disclose or "mitigate a serious or lethal prognosis."[60] Applying these facts and figures to the early 20th century, one may argue that Bernhardi, originating from Western culture, chose not to truthfully disclose information to his patient out of cultural standards. However, due to his emphasis on his role as a physician first and foremost, and duties as a physician, Bernhardi more likely behaved in accordance with medical responsibilities or humane purposes.

Given the fact that Bernhardi represents the quintessential liberal Jew of the emancipation, it is essential to understand the traditional Jewish viewpoints on end-of-life care. In the Jewish religion, the phrase "terminally ill" can be interpreted in two ways. First, and supported within the medical community, it means that a patient has 72 hours left to live, placing them in the category of *goses* in Jewish belief. Second, according to Jewish thought, being terminally ill is "analogous, but not equivalent, to a dead person," or *terefah.*[50] This connotation lessens the ethical inhibitions or reluctance surrounding assisted death and allows physicians a greater moral approval when terminating or withdrawing treatment. Thus, although the Jewish religion forbids suicide, removing life support systems from terminally ill patient is not considered the same as committing suicide. Furthermore, Judaism in the realm of medical end-of-life care is centralized around respecting patient autonomy and permitting and advising for advance medical directives. According to Jewish belief, a patient's right to choosing their physician and refusing treatments considered "unbearable" should always be valued.[62]

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[49] Ingrid Hanssen, *Medicine, Health Care and Philosophy* 7.3 (2005): 274.
[60] Zahedi, 2.
[50] Patrick T. Hill and David A. Shirley, *A Good Death* (Reading, MA: Addison-Wesley Pub., 1992) 126. [62] Ibid. 127.

Although a Jew himself, Bernhardi, rather than following the Jewish tenets of patient autonomy and pursuing medical intervention, abided to the ethical tenet of "do no harm," prohibiting his patient to even see the Catholic priest, the sight of whom he worried would trigger his patient's imminent distress and death. This decision speaks volumes to the character of Bernhardi as a Jewish physician; he is an assimilated Jew who appears to embody medical professional standards, still relevant in modern medicine, but does not conform to traditionally Jewish values in terms of end-of-life practices.

Compared to Judaism, Roman Catholicism traditionally plays a game of cost versus benefits regarding medical procedures. Costs in this case not only include physical, but also emotional and economic burdens.[51] According to Catholic belief, when certain costs outweigh the benefits, there is no obligation for a physician to provide a patient medical care. With an aim to protect life, Catholicism, unlike Judaism, does not always endorse medical intervention due to the threat technology could pose to life. Bernhardi did not intend to put his patient through futile treatment, and rather focused more on promoting the "happiest hour of her life,"[52] as he describes to his colleague:

> Sie vergessen nur das eine, Lieber Herr Hofrat, wie die meisten übrigen Leute, dass ich ja nicht im entferntesten daran gedacht habe, irgendeine Frage lösen zu wollen. Ich habe einfach in einem ganz speziellen Fall getan, was ich für das Richtige hielt.[53]

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[51] Hill and Shirley, 117.

[52] Schnitzler, *Professor Bernhardi,* 16.

[53] Schnitzler, *Gesammelte Werke*, 462.

[You forget only one thing, my dear Mr. Hofrat, as everyone else seems to- that I had not the remotest intention of solving any problem whatever. I simply did what I held to be right in one specific instance.][54]

Ironically, Professor Bernhardi demonstrates these values and practices of Catholicism more so than that of Judaism. Humanitarian in his outlook, Bernhardi is determined to foster a "happy," or "good" death by prohibiting the Catholic priest from entering and performing salvation, as well as opting out of providing futile treatment for his dying sepsis patient:

Bernhardi [mit seinem ironischen Laecheln]: Sind wir nicht allzumal Suender, Hochwuerden?

Pfarrer: Das gehoert wohl nicht hierher, Herr Professor. Sie koenne nicht wissen, ob nicht irgendwo in der Tiefe ihrer Seele, die Gott allein sieht, gerade in diesen letzten Augenblicken, die ihr nocht vergoennt sind, die Sehnsucht wach ist, durch eine letzte Beichte aller Suenden sich zu entlasten.

Bernhardi: Muss ich es nochmals wiederholen, Hochwuerden? Die Kranke Weiss nicht, dass sie verloren ist. Sie ist heiter, gluecklich und -reuelos.

Pfarrer: Eine um so schwerere Schuld naehme ich auf mich, wenn ich von dieser Schwelle wiche, ohne der Sterbenden die Troestungen unserer heiligen Religion verabreicht zu haben.

[54] Schnitzler, *Professor Bernhardi,* 160.

Bernhardi: Von dieser Schuld, Hochwuerden, wird Sie Gott und jeder irdische Richte freisprechen. *Aus seine Bewegung* Jawohl, Hochwuerden. Denn ich als Arzt darf Ihnen nicht gestatten, an das Bett dieser Kranken zu treten.[55]

[*Bernhardi* (*with an ironic smile)*: Are we not all sinners, your Reverence?

Priest: This is hardly the place to discuss that, Professor. Who knows but that, at the bottom of her soul, which God alone can see, just in these last moments, there is the longing to free herself from sin by a death-bed confession.

Bernhardi: Must I repeat it once more, your Reverence? The patient does not know that the end is near. She is gay, happy, and unrepentant.

Priest: All the greater would be my sin if I moved from this threshold without having ministered to the dying woman the consolations of our holy religion.

Bernhardi: From this sin God and every human judge would declare you absolved. [*In answer to the Priest's movement of impatience.*] Yes, your Reverence. For I, as physician, cannot permit you to approach the bed of this patient.[56]]

This discourse between the priest and Bernhardi directly takes place directly outside the door of the patient's room. The unbudgingly consistently back-and-forth nature of this discussion

[55] Schnitzler, *Gesammelte Werke*, 357.
[56] Schnitzler, *Professor Bernhardi*, 32.

sheds light on the comical nature of the play, which Schnitzler himself calls a Kömodie (comedy). Rather than intervening directly with the dying patient, who is in an induced euphoric state, the two are stuck in a confrontation between religious Catholic tradition and medical practice. This scene especially contributes to the element of comedy in an otherwise tragic play.

Although *Professor Bernhardi* depicts a strong conflict between religion and science, modern medicine began to detach from the prominent religious belief system, diminishing the role of the Catholic church a certain degree, as science grew more advanced in early 20thcentury Western Europe. Therefore, a significant backlash that Arthur Schnitzler received in the early 20th century for his character Professor Bernhardi originated from the Christian, and often anti-Semitic, Viennese community. Several believed that *Professor Bernhardi* was a way for Schnitzler to start a controversy between Catholicism and Judaism. Although it was indeed not his intention, Schnitzler's drama *Professor Bernhardi* was labeled as a "flagranter Akt von Religionsstörung" (a flagrant act of religious disturbance) for its disrespect towards the Catholic church and powerful Semitic elements.[57] In addition to unintentionally provoking religious disorder, *Professor Bernhardi* presents the overlap and conflicting ethical duties between the Catholic church institution and the medical field. While the church foregrounded the absolution of a patient's sins post-abortion, Bernhardi, as the leader of his medical community, focused on alleviating the suffering and emotional burden of his patient. The character of Professor Bernhardi also, quite literally, stands between medicine, represented by

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[57] Rolf-Peter Janz, *Akten des internationalen Symposiums* (Bern: P. Lang, 1985) 109.

the patient, and religion, embodied by the priest. As a doctor, Bernhardi serves as the mediator and gatekeeper to the ill. Schnitzler may have presented such a confrontation in his literature for several reasons. For one, he may have desired to present a Jewish figure like Bernhardi in a position of authority and power in an otherwise anti-Semitic society. Schnitzler may have also personally experienced the impact of religious tension on his family's medical practice and wished to illustrate this through fictional characters.

Although *Professor Bernhardi*'s ethical dilemma enters the realm of politics and religion, the play still presents and majorly focuses on the medical ethical issue at hand. Rather than creating a contentious political or religious statement, Schnitzler emphasizes the ethical confrontation between a physician and society. This viewpoint is most evident in the setting where most of the play takes place: outside the door of the sepsis patient's room. The confrontation between Bernhardi and his staff and the Catholic priest transpires almost entirely in front of the patient's room. As such, the audience does not obtain a clear view of the dying young woman herself and thus will not be influenced by emotions or other confounding variables when judging the ethical dilemma in plain sight. Furthermore, the audience lacks any knowledge about the abortion the patient underwent before suffering from terminal sepsis. Schnitzler avoids elaboration of the contentious issue of abortion, so the audience does not have enough evidence or details to debate the unethical nature of the circumstances. Consequently, viewers remain unbiased when gauging the ethical confrontation merely between Bernhardi and the priest:

Hoch: Was werden wir den eigentlich als Todesursache angeben?

Oskar: Na, Sepsis natürlich.

Hoch: Und Ursache der Sepsis? Weil's ja doch wahrscheinlich ein verbotener Eingriff war-

Bernhardi [der unterdessen am Tisch einige Schriftstücke unterzeichnet hat, die ihm die Schwester vorlegte]: Das konnten wir nicht nachweisen. Eine Verletzung war nicht zu konstatieren. Die Anzeige ist erstattet, damit ist für uns die Sache erledigt.[58] [*Hoch*: And, what shall we give as the cause of death?

Oskar: Blood-poisoning, of course.

Hoch: And the cause of the blood-poisoning? Because there was undoubtedly an illegal operation-

Bernhardi [*who has meanwhile signed some papers which the Sister placed in front of him*]: We couldn't prove it. No injury could be definitely traced. The case has been notified, and that ends the matter, for us.][71]

Although the patient may have had an abortion, an illegal operation in 20th century Vienna, Bernhardi views this information as unproven and irrelevant for his care of the patient. Though the play involves medical ethics, it has larger implications that intersect ethics with religion and politics such as law-making. Because abortion was criminalized in Vienna in the

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[58] Schnitzler, *Gesammelte Werke*, 341. [71]
Schnitzler, *Professor Bernhardi*, 12.

early 1900s, women were forced to undergo secret, contraband, and potentially botched abortion procedures that put lives at stake such as in the case of Philomena Beier. Such connections raise the question that if abortion was in fact legal in early 20th century Vienna, then Beier could have had a safer and professionally-performed abortion with a small likelihood of sepsis occurring in the first place.

The field of medicine further integrates ethics and the law. For instance, when a physician receives a case of a patient who had previously carried out an illegal procedure, does and should this affect the physician’s role in treating the patient? The ethical tenet of “justice” requires physicians to treat all patients equitably, independently and regardless of prior illicit activities, distributing the benefits and burdens of treatment equally among all. A contemporary analogy to medical professionals acting in accordance with justice is first responders treating overdose (OD) cases in which people had abused illicit drugs. Similarly, Professor Bernhardi cares for his sepsis patient although he knows that she had illegally gotten an abortion. The spheres of medicine, ethics, and politics become less and less distinct disciplines as physicians may involve themselves in policy-making to resolve pressing issues in healthcare that may conflict with their ethical values. *Professor Bernhardi* addresses to readers how it may not always be possible for medical ethics to detach from the realm of religion and politics.

Chapter 3

The Hippocratic oath, vowed to by medical students at a ceremony before they start their medical practice, is a promise for future physicians to prolong the life and lessen the suffering of their patients. It is a code that embodies universal ethical guidelines (i.e., beneficence, non-maleficence, autonomy, and justice) while outlining a physician's exemplary duty to his/her pupils. Clinically, physicians have an ethical responsibility to respect the patientphysician relationship, such as upholding a patient's right to autonomy. Socially, the ethical standards for physicians include using proper judgement and technique to benefit the ill and avoiding harm and injustice. These tenets of medicine present the ethical duties physicians face in both clinical and societal settings.

Though the medical field has been advancing at an exponential pace over the past century, the millennial-old Hippocratic oath is still, for the most part, upheld. As medicine is one of the fastest-progressing fields, it is reasonably logical to wonder why such an old oath would still be considered relevant to contemporary medical practice. One may argue that since certain ethical dilemmas or questions faced in medicine are rather general and universal, that a centuries-old vow is still applicable to conduct modern medicine appropriately and ethically. One may also add that certain symbolic traditions such as the Hippocratic oath are hard to stray away from; vowing to the oath has become a norm in the practice of medicine.

While the oath is still pledged and relevant today, the ethical guidelines and standards of practice outlined in the oath have adapted to changing times in medicine. The classical oath,

for instance, emphasized beneficence and non-maleficence, clearly disapproved of assisted death, and incorporated elements of religion:

> I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.
> I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect. Similarly, I will not give to a woman an abortive remedy. In purity and holiness, I will guard my life and my art.[59]

Although it similarly emphasizes universal principles of beneficence and non-maleficence, the modern oath, with recent changes as late as 2017, places greater focus on a physician's obligation to practice with compassion, empathy, and humility, emphasizing the significance of patient confidentiality. Unlike the classical oath, which wholly dismisses the idea of killing, the contemporary adaptation acknowledges a physician's potential for taking another's life:

> I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug. I will not be ashamed to say "I know not," nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.
> I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a

[59] Tyson Peter, "The Hippocratic Oath Today," 21 Mar. 2001.

> life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God. I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.[60]

These excerpts from old and new versions of the Hippocratic oath illustrate how, while certain ethical principles have been universally accepted for many years, others are more ambiguous. While a physician should act on a patient's best accord has always been a universal principle in medical ethics, other provisions, such as end-of-life care, in particular physician-assisted death, and patient disclosure have grown to be more debatable. For example, the question of whether a physician has the duty to tell a patient that he/she has contracted a terminal disease is relatively new to the Western culture and the code of medical conduct.[61] Such ethical scenarios produce a more ambiguous view of the Hippocratic oath, as such dilemmas are rather delicate and not always discernible as black and white, or a "right" versus "wrong" dichotomous outcome.

Such changes to the century-old Hippocratic oath illustrate how it is not the end-all-beall in medical conduct. Previously mentioned ethical dilemmas of physician-assisted death and disclosure are subject to different interpretations and various emphases on ethical

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[60] Peter, "The Hippocratic Oath Today."

[61] Steven H. Miles, *The Hippocratic Oath and the Ethics of Medicine* (New York: Oxford UP, 2013) 50.

principles. Examination of texts by Storm and Schnitzler help us understand this very ambiguity and two-
sided nature of ethical dilemmas.

Although certain tenets of medical ethics, like the treatment of all patients equally and fairly, are unambiguous and universally acknowledged, the debate regarding physician-assisted euthanasia and nondisclosure rights was and still are highly contested issues in medicine. The literary works of Storm and Schnitzler reveal ethical questions and dilemmas of 19th and 20th century end-of-life care that are also relevant to the contemporary practice of medicine. For example, it could be argued that the character of Bernhardi in Schnitzler's *Professor Bernhardi* broke the Hippocratic oath by breaking the patient's autonomy through not disclosing her true medical status or prohibiting the entry of the priest. On the contrary, he could be upholding the pillars of beneficence and non-maleficence by acting on the best wishes of the patient and allowing her to die peacefully and without harm. In Theodor Storm's *Ein Bekenntnis,* one may say that Franz Jebe upheld the principle of patient autonomy by respecting his wife's desire to die and fulfilling her wishes on her deathbed. Contrarily, Jebe could be accused of breaking the Hippocratic oath by not exploring alternative possibilities of prolonging his wife's life. Essentially, these texts present subjectivity in medical ethics. While it may be easy to judge an ethical situation as purely black-and-white, the confrontations I present within 19th and 20th century German literature portray a higher level of complexity within the sphere of end-of-life care.

Rather than physician-assisted death, Socrates (470 BCE-399 BCE), a contemporary of Hippocrates (450 BCE-380 BCE) argued that physicians should withhold from providing continuous, aggressive treatment to sustain the life of an incurably ill person who is "incapable of living in the established round and order of life . . . of no use either to himself or to the state."[62] On the issue of who has the right to live, Socrates voiced a similar rhetoric as individuals like Adolf Jost from the 20th century, who believed that those who do not contribute to society and the economy should be considered differently. However, unlike Jost's radicalized beliefs of eliminating "lives unworthy of living," the Hippocratic oath states that physicians, rather than killing with deadly drugs, should rather avoid spending treatment and resources on futile medical cases. Similarly, Professor Bernhardi neither attempted life-saving treatment for his severely ill sepsis patient, nor performed physician-assisted death, letting her die a peaceful "happy death." While the oath unmistakably states that physicians utilizing lethal drugs to kill is dishonorable and unethical, it rather overlooks medical cases in which "mercy killing" may be a more appropriate alternative to alleviate a patient's pain and suffering, such as the dilemma presented in *Ein Bekenntnis.*

Coined around a century after the Hippocratic oath was written, the term "euthanasia" literally translates to "good death" in Greek. Initially, euthanasia did not refer to the concept of assisted death, but to "natural death without agony."[76] Primarily over the 19th century, however, the meaning of euthanasia transitioned from fostering painless, natural death to

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[62] Plato, *Republic III, 405a-410a.* [76]
Miles, 68.

ending life to prevent suffering from a disease. As death is a key topic of interest in the discussion of end-of-life care, both ancient Greek and contemporary medical ethicists debate whether to help treat incurably ill patients. The following excerpt from *The Art,* a highly respected Greek medical text voices the opinion that treatment of the terminally ill is futile, and it is essentially foolish and ignorant to think that medical science is always effective at treatment:

> I would define medicine as the complete removal of the distress of the sick, the alleviation of the more violent diseases, and the refusal to undertake to cure cases in which the disease has already won the mastery, knowing that everything is not possible to medicine. . . A man who thinks that a science can perform what is outside its province, or that nature can accomplish unnatural things is guilty of ignorance more akin to madness than to lack of learning.[63]

Other ancient Greek thinkers, such as Hippocrates himself, described how caring for and treating the terminally ill mostly leads to death and unnecessarily prolongs dying, stating "It is better not to treat those who have internal cancers since if not treated, they die quickly: but if treated they last a long time."[78] While the traditional Hippocratic oath appears to blatantly disapprove of physician-assisted death through use of "deadly drugs", other medical guidelines and codes of ethics outlined in the oath create further dimensions to this complex issue. The topic of assisted death is so fundamentally and philosophically relevant to the medical practice

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[63] *The Art 1:8* (Trans from Chadwick who calls it "The Science of Medicine"). [78] *Aphorisms 6:38* (Hippocrates [1950]).

and patient end-of-life care that, despite significant medical progress over the past centuries, the Hippocratic oath is still relevant to the discussion of medical ethics.

In addition to the debated topic of euthanasia, patient disclosure and informed consent serve as further elements to the examination of ethical end-of-life care. From a contemporary perspective, patient education, the frank disclosure of diagnoses, and informed consent to treatment are the prerequisites for a good physician-patient relationship and are ways to effectively engage patients as partners in treatment.[64] Cases in which these conditions are not met often reflect medical paternalism, or the attitudes and practices exhibited by physicians in which they determine a patient's autonomy should not be upheld. A common example seen in the medical field, as well in Storm's *Ein Bekenntnis,* is the non-disclosure of information with the mistaken belief that bad news will psychologically harm the patient. Traditionally, the physician-patient relationship established in the Hippocratic oath condoned paternalistic medicine. Written around the same time as the oath in ancient Greece, *Decorum* advocates for paternalistic behavior as an essential guideline of medical ethics. The following excerpt from this ancient text reveals how central and old ethical debates in medicine are:

> Perform these duties calmly and adroitly, concealing most things from the patient while you are attending to him. Give necessary orders with cheerfulness and serenity, turning his attention away from what is being done to him; sometimes reprove sharply and emphatically . . . revealing nothing of the patient's future or present condition.[65]

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[64] Miles, 125.

[65] Hippocrates. *Decorum: XVI.* (This passage about the time of Jesus).

The case of Professor Bernhardi is an almost exact resemblance to this argument from centuries past, for Bernhardi did not reveal his patient's true medical condition, concealed her from the Catholic priest and from her own health status, and acted calmly to ensure his patient's unperturbed "happy death."

For other ancient Greeks, disclosure of medical information was beneficial to both the physician, enhancing his or her reputation, and the patient, fostering communication and securing cooperation for further treatment.[66] This rationale, however, becomes complicated when examining cases such as Professor Bernhardi because his sepsis patient was so terminally ill and beyond saving that disclosure may not have been as beneficial as ideally thought. The Hippocratic oath is not only ambiguous on its stance on mercy killing, but also open to interpretation regarding medical disclosure and silent on the topic of truth telling in medicine.[67] Although the original Hippocratic oath condoned paternalistic behavior, the mid-20th century saw a transition to and current emphasis on respecting patient autonomy with a new clause created in 2017, stating that medical professionals will "respect the autonomy and dignity" of patients at all times.[68]

Respecting autonomy is to acknowledge a patient's input, values, beliefs, and their right to make choices.[69] As an element under the concept of autonomy in medical ethics, informed consent pushes the idea of obtaining patient consent further to include acquiring patient

[66] Miles, 126.
[67] Ibid. 135.
[68] Ga Ogunbanjo and Knapp D Van Bogaert, *South African Family Practice* 51.1 (2009): 30-31.
[69] Beauchamp and Childress, 106.
[85] Ibid. 122.

understanding and *authorization* of medical procedures and information relating to their medical case.[85] Disclosure is an important component of informed consent, also falling under the ethical principle of autonomy. Although the specifications for disclosure constitute an expanding list in medical ethics, Beauchamp and Childress address "facts or descriptions that patients or subjects consider material when deciding whether to refuse or consent to a proposed intervention" and physician-deemed relevant information are required to be disclosed.[70]

However, intentional non-disclosure in medicine is quite common in cases similar to that presented in Schnitzler's drama *Professor Bernhardi.* To justify not revealing medical information and surrounding events to his sepsis patient, Bernhardi makes the claim that nondisclosure is beneficial to the patient and would save her from imminent death. From a contemporary lens, Bernhardi utilizes "therapeutic privilege" as a medical professional in which he withholds information due to the, what Beauchamp and Childress would argue as mistaken, belief that this information could potentially harm a "depressed, emotionally drained or unstable patient" and cause irrational decisions, anxiety, or stress.[87] Professor Bernhardi believed that his patient suffered from such severe angst, that the mere knowledge of her dire physical condition, or the visit of a priest to absolve her sins, would provoke so much fear and anxiety that it would lead to sudden death. As opposed to the Catholic priest, whose main concern is to perform the patient's dying sacraments and forgive her sins of abortion, Professor

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[70] Beauchamp and Childress, 125.
[87] Ibid. 127.

Bernhardi vows to ensure "ein glückliches Sterben" (a happy death) for his patient by leaving her undisturbed and in a euphoric trance. However, Bernhardi did not know for sure how and if revealing the priests visit or the true state of his patient's health would jeopardize her health so detrimentally as to actually trigger immediate death. With the argument of uncertainty, nondisclosure seems less justifiable and serves as one example of not upholding patient autonomy and breaking the modern Hippocratic oath.

In addition to respecting patient autonomy, ethical principles outlined in the Hippocratic oath emphasize non-maleficence, incorporating an obligation for physicians to use treatment to help the sick according to their best ability and judgement, but never to use it to injure or harm them. With regards to approaching end-of-life care and death appropriately in the medical field, non-maleficence introduces a distinction between mercy killing, or physician-assisted death, and "letting die," or the act of forgoing treatment and fostering natural death.[71] Although the classic oath that physicians swear by states that they should uphold nonmaleficence, and by no means harm their patient, is it ethically wrong for a physician to kill a patient in order to alleviate their overwhelming pain? In other words, would a physician be upholding nonmaleficence if he or she extends the life of a patient, but prolongs their suffering from a terminal illness? These questions create and have for centuries created an ambiguous and contentious debate on the ethical issue of mercy killing. One widely acknowledged perspective, however, is that of Beauchamp and Childress, who state that one can take the life

[71] Beauchamp and Childress, 174.
[89] Ibid.

of another while still upholding nonmaleficence, as there are certain measures that need to be met in order to qualify physician-assisted death as justified or unjustified.[89] For instance, if the means of death inflict pain or suffering on the patient, then one would consider such a circumstance unjustifiable and unethical.

In fact, ethical guidelines assert that health professionals are obligated to respect a patient's autonomous decision to refuse life-prolonging care, but are not obligated to honor a request for aid-in dying.[72] Such requests are legally bound by documents like *advanced directives*, including Do Not Resuscitate (DNR) orders, that outline specifically how physicians should approach a patient's end-of-life care to ensure their wishes are carried out, should the patient be incapacitated or unable to communicate with the physician. The accepted rule in medical ethics is that if a patient makes the autonomous call that the benefits of alleviating their pain and suffering through death outweighs the setback of future ambitions, then assisted death is a justifiable form of end-of-life care. For example, Franz Jebe as a physician was not coerced into killing his wife, but rather had a choice; he valued his wife's seemingly autonomous decision to die and poisoned her, fulfilling her wish for an effortless, painless death. In this way, although his actions ultimately resulted in another's death, they caused minimal harm or pain as well as respected her autonomy. However, one could also raise the counterargument that autonomy was in fact not upheld, as it was confounded by variables such as influence. Elements that can affect a true autonomous decision in medicine, such as

[72] Beauchamp and Childress, 182.
[91] Ibid. 138.

persuasion, include, but are not limited to, "acts of love, threats, manipulative suggestions, and emotional appeals."[91] For instance, emotional appeals can be a form of persuasion. Originally, Jebe's wife Elsi wanted to hide her serious illness from her husband to protect his health and happiness, thus appealing to emotion, and feared being a burden. In this case, did Elsi truly make an autonomous decision or was she influenced by the sight of her husband's emotional impact from her physically damaging condition?

Considering the ethics of physician-assisted death requires further examination of several conditions. Justified euthanasia requires factors including a voluntary request by a competent patient, an ongoing patient-physician relationship, unacceptable suffering by the patient, and use of a painless and comfortable means of death. Franz Jebe's case fits these criteria. However, other essential prerequisites for justifiable physician-assisted death involve a considered rejection of alternatives and a structured consultation with other parties in medicine, neither of which Franz Jebe fulfilled.[73] Having only discovered a research article entailing a possible treatment for his wife's condition *after* euthanizing her, Jebe did not seek medical advice from other professionals. As such, Jebe's seemingly humanitarian act of assisted death could be interpreted as medically unethical.

In the sphere of medical ethics, paternalism can often introduce a conflict between beneficence and autonomy, questioning which ethical principle should have priority in medical dilemmas. In Storm's *Ein Bekenntnis,* Franz Jebe does not want to harm his wife, but also desires to fulfill her dying wishes. Similarly, in Schnitzler's *Professor Bernhardi*, Bernhardi

[73] Beauchamp and Childress, 184.

believes that his patient's knowledge of the Catholic priest or of her poor physical condition would pose detrimental effects, and thus refrains from pertinent disclosure. To uphold beneficence, the ethical principle of acting on a patient's best interests and refraining from harmful acts, a physician may need to deny a patient's right to autonomy. Common examples in medicine include performing resuscitation even when patient requests for DNR (Do Not Resuscitate) or withholding potentially harmful medical information that a patient has requested by means of deception, manipulation, nondisclosure, or lying.[74] Determining if such aforementioned acts of paternalism are ethically justified entails weighing autonomy with the patient's benefit. As the benefits increase but autonomous interest decreases, justification for paternalism becomes more appropriate. However, preventing minor harm or providing trivial benefits to the patient while greatly dishonoring patient autonomy lacks paternalistic justification.[94] In considering Professor Bernhardi and Franz Jebe's paternalistic behaviors, it is the contemporary reader's role to determine if: first, the patient would truly be harmed by disclosure of pertinent information, and, second, if the rationale behind therapeutic privilege, which values non-maleficence and beneficence, outweighs autonomy.

It is essential, however, to acknowledge that "autonomy" was not legally or formally recognized in the Hippocratic oath until around the 1960s. As a relatively newer addition to the ethical principles outlined in the modern oath, is it appropriate for contemporary bioethicists to hold the authors of German literature from the 19th and early 20th century accountable for their omission of patient autonomy? It is arguable that Storm and Schnitzler in particular are

[74] Beauchamp and Childress, 215.
[94] Ibid. 221.

responsible for breaking rules of autonomy even in 1912 due to the already-present, widespread discourse on consent in medical experimentation beginning in the 1850s. Across the United States and Europe, including Germany was a discussion on proper medical ethics when human subjects are involved. By the 1880s, German legal academics were debating the basis of consent to treatment, particularly of an experimental nature.

The sudden rise of concern for consent, an extension of now-formulized patient autonomy, can be explained by the post-1850 advancement in medicine and testing of new drugs and treatments which ultimately turned patients into objects of experimentation.[75] Georg Büchner's *Woyzeck* (1879) is one piece of German literature that captures the essence of the debate. Cases of German physicians bargaining with the poor to trade in their bodies for research purposes, as illustrated in *Woyzeck*, was a topic of heavy debate. By the early 1890s, state of Prussia had identified the ethics of consent and human use in experimentation as an issue. One widely known case that exacerbated the situation was German physician Albert Neisser's syphilis experimentation on humans in 1892. After the discovery that Neisser did not obtain consent from his patients, legal scholars expressed the importance of consent in medicine. Experimentation that involved minor risks would only be justifiable if subjects must be fully informed about all likely hazards. Furthmore, authorization from superiors was a requirement as well as documentation of all patient details.[96] Although the term "autonomy" never appeared in texts such as the Hippocratic oath until the late 20th century, its concept with

[75] Dingwall and Rozelle, "The Ethical Governance of German Physicians," *Journal of Policy History* 23.1 (2011): 32.
[96] Ibid. 36.

respect to obtaining consent was widely known within the sphere of German bioethics and literature. It thus follows that, with reasonable limits, it is appropriate for contemporary scholars to hold works by authors like Storm and Schnitzler to the same ethical standard of autonomy.

Conclusion

As illustrated in the texts *Ein Bekenntnis* (1887) and *Professor Bernhardi* (1912), the medical field has, for centuries, faced ethical conflicts in end-of-life care in accordance with the universal ethical principles of autonomy, beneficence, and non-maleficence. Elisabeth KüblerRoss, a pioneer in the field of the death psychiatry, poses the question whether medicine is to remain a respected humanitarian profession or become a depersonalized, robotic science focused on prolonging life rather than diminishing human suffering.[76] Additionally, the ambiguity of medical ethics, in particular terminal procedures like death postponement through automated ventilators, can often blur the lines in determining when curative treatments are appropriate and when the actual process of dying begins.[77] Both curative and palliative measures are necessary in medicine, but as expressed by Cohen et al., palliative treatment should be at the forefront in patient care in order to alleviate suffering, an ethical tenet medical professionals vow to in the Hippocratic oath:

> The recent inclusion of quality of life measurement in oncologic clinical trials research has arisen in response to a recognized need to adopt a broader mandate, that is, the alleviation of suffering, rather than the narrower goal of fighting disease. Patients, rather than diseases, are treated.[99]

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[76] Elisabeth Kübler-Ross, *On Death and Dying* (New York: Quality Paperback Book Club, 2002) 10.
[77] Peggy S. Gordon, *Psychosocial Interventions in End-of-life Care* (London: Routledge, 2017) 23-24. [99]
Robin S. Cohen et al., *Cancer* 77.3 (1996): 576.

However, the emphasis on palliative care to diminish patient suffering is a relatively contemporary model for medical intervention. Originally, religious thought centered in Catholicism stated that suffering on Earth would be rewarded in Heaven. However, this religious thought confronted the rise of 20th century drugs to combat pain and suffering. With the decline of religious prominence and rise of scientific advancement, the significance and religious backing of "suffering" has thus been lost through time.[78] From an ethical standpoint, palliative end-of-life care may be viewed as a justified means of treatment, upholding values like "do no harm" and minimizing physical and emotional agony. It can, however, also be an inappropriate and futile means of prolonging a dying life. Palliative care opens an additional dimension to this complex debate, setting the question of whether assisted death is an ethically justified measure of palliative medicine.

Patient autonomy and the topic of patient disclosure are also rather new concepts in medical ethics, an addition to the modern Hippocratic oath. The conflict that medical professionals face in today, and in years past, is one between upholding patients' right to medical information and acting in accordance with nonmaleficence and beneficence. KüblerRoss claims that the question in biomedical ethics should not be whether to disclose information to a patient, but should be rephrased to "how do I share this knowledge" with examination one's own professional attitudes towards terminal care and patient cues on willingness to face reality.[101]

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[78] Kübler-Ross, 13. [101]
Ibid. 32.

By definition, end-of-life care is the component of medical care that practices how to "diminish the suffering and improve the quality of the remaining life of terminally ill patients," with quality care focused on controlling patient symptoms rather than simply prolonging life.[79] According to Kübler-Ross, the appropriate attitude medical professionals should hold regarding end-of-life care is one oriented towards preserving and equally valuing interpersonal human relationships. As such, promoting a "good death" in medical care is a priority in Western medicine, supported by Western governments through strategization and resource allocation towards proper end-of-life care.[80]

A "good death", or "glückliches Sterben" as Storm describes, is often a physician's hope when alleviating a patient's pain and suffering in cases where life-saving or prolonging measures are deemed futile or unfavorable. A terminally ill person may also possess the desire for hastened death (DHD) in circumstances where the dying process evokes physical and/or psychosocial suffering. A study performed in 2007 identified four critical stages of the dying process that could cause the terminally ill elderly population to desire DHD, of which includes "perceived, insensitive communication of a terminal diagnosis, experiencing unbearable physical pain, dying in a distressing environment, and unacknowledged feelings regarding undergoing chemotherapy or radiation treatment."[81] In Storm's *Ein Bekenntnis,* the first few events listed applies to Franz Jebe's wife, who increasingly suffers from a perceived incurable

[79] Gordon, *Psychosocial Interventions in End-of-life Care*, 32.
[80] Kübler-Ross, 10.
[81] Tracy A. Schroepfer, *Journal of Palliative Medicine* 10.1 (2007): 139-40.

and dire case of stomach *carcinoma* and ultimately asks her husband to assist in her death. The view of the Institute of Medicine (IOM) describes a "good death" as follows:

> People should be able to expect and achieve a decent or good death-one that is free from avoidable distress and suffering for patients, families, and caregivers; in general accord with patients and families wishes; and reasonably consistent with clinical, cultural, and ethical standards.[82]

Another study from 2000 presents empirical evidence identifying what patients, family members, and medical professionals believed are essential for quality end-of-life care and to provide a good death. Results revealed "pain and symptom management" and control of future symptoms as the most prioritized consideration to promote a safe, painless death.[83] Although the texts *Ein Bekenntnis* and *Professor Bernhardi* present dilemmas in which certain tenets of medical ethics, such as autonomy, informed consent, and beneficence are not fully upheld, both emphasize the importance of fostering a good death for the terminally ill, thereby placing utmost value on patient wellbeing and alleviation of suffering- a central principle in ancient and contemporary codes of medical ethics.

The concepts of medical disclosure and requested patient death in end-of-life care ethics, previously discussed in context of 19th and 20th century German literature, also present implications in contemporary medicine. For instance, in cases of terminally ill and those on life

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[82] IOM. Committee on Approaching Death (Washington, DC: The National Academies Press, 1997) 5.

[83] Karen E. Steinhauser et al., *Annals of Internal Medicine* 132.10 (2000): 827.

support, particularly elderly patients, a similar question arises today whether assisted death should be the most viable medical option. Ethical end-of-life care, however, is dependent by the time frame at hand. The factors and complications that must be considered regarding endof-life now are different than those from centuries prior. For instance, the types of terminal diseases that are prevalent in society now, like Alzheimer's, are different than the ones that characterized 19th century Europe, such as tuberculosis and typhus. The quality of care for such a condition like Alzheimer's in the 21st century is also highly complex and unlike that of 19th century typhus. For the terminal illness typhus, the course of treatment was relatively simply, entailing administration of antibiotics and hospitalized attention with either a positive or negative chance of survival. Now, however, when a loved-one is diagnosed with terminal Alzheimer's, family members are faced with a difficult decision. Caretakers must decide whether to place the individual in hospice care, to permit the risk of surgery at an old age, to follow a course of treatments, or to face the challenge of providing constant personal support for the individual.

Other changes to end-of-life care from the 19th century to today include, but are not limited to, longer life spans, increased cost of medical treatment, and highly advanced medical technology. Contemporary medicine's greater emphasis on patient autonomy also complicates the dilemma of end-of-life care, as individuals with terminal altered mental states cannot make medical decisions for themselves. These changes and additions to the discussion of contemporary end-of-life care impact the appropriate ethical approach to patient cases. Today, for example, the elderly must choose whether to face the abundant cost of a surgery to remove

a tumor, or, to live the rest of their short lives happy and without limitations. Such questions were not as significant in past centuries due to different factors associated with end-of-life.

Throughout this paper I have presented specific ethical dilemmas exhibited in two German texts from the 19th to 20th century. These dilemmas are not, however, to be considered irrelevant to today's discussion of bioethics. They provide the contemporary reader a glimpse into contemporary medical ethics and problems that arise today. As illustrated in the texts, ethical dilemmas are not simply black-and-white issues that have a clear "right" and "wrong." They are often ambiguous and complex, needing further evaluations in context of legal policies, human instincts, and written codes of ethics. By looking at bioethical situations relating to euthanasia, or physician-assisted death, and patient disclosure through a contemporary perspective, one can achieve a more holistic understanding of issues faced in modern medicine and compare-and-contrast viewpoints on the best courses of action. It is essential, however, to acknowledge the influence time frame, socio-political circumstances, and religious views have on bioethical discourse. Examination of ethical dilemmas illustrated in 19th century German literature can help contemporaries in the bioethics gain new perspectives on end-of-life practices, identify how end-of-life care has evolved over time, and find answers to similar dilemmas faced today.

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