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Euthanasia as an example of conflict between ethical precepts and entitlement rights. A surgeon's viewpoint (*)

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From right to duty

A *Right* is an ability, a faculty. It is any interest, property or privilege recognised and protected by law. It is the freedom to exercise any power conferred by law and it is also the ambassador of an individual to the different systems of the society (e.g., rights of workers).

An *Offence* (un délit) is committed when the right has not been respected or followed.

A *Duty* implies a moral obligation. This is why Ethics are in the centre place for philosophers like Emmanuel Kant, and why law and policy have to be somewhat moralised. The sense of moral obligation bound to the concept of duty is the justification of the importance of a public space for debates in order to control, to feed and to legitimise the legal and political powers ; keeping in mind that laws and rights are evolving in the wake of Ethics.

A "moral fact"

If a Duty implies a "moral obligation", to understand this concept we have to define first what a "*moral fact*" is.

> One does not know what morality is,
> One only knows that it does exist...

A moral fact is the establishment of the absence of indifference of the human conscience towards our actions ("There are things to be done and things not to be done"). A "moral fact" is the feeling towards human action in consideration of the intentionality of the agent, the liberty of the agent, the responsibility (imputability) of the agent to which is associated the feeling of obligation. In other words: "To be moral, means to deal with his own duties. To be a moralist, means to deal with other people's duties !"

Laws and Rights have not the first place. Duty – as a moral obligation – has the first place.

For instance, Justice is, first of all, the value of equality and equity before being the conformity with laws (jus in latin). Therefore, if Justice is a value it is also a virtue. The most complete virtue, once said Aristote (1). Justice is an active virtue or a virtue that can act, because it gives us the opportunity to fulfil the moral obligation of allowing to preserve the hierarchical harmony of the society by keeping each of us at his place, by attributing to each of us his fair share and function. Law has the second place : law is in the dark shadow of Justice ; it doesn't shine. When law is wrong or unjust, it is our duty to combat it : here we are more in the domain of Morality and Ethics than in the realm of Rights and Laws. Ideally laws should be in harmony with Justice and move together in the same direction. It is our moral duty as citizen to try to reach this goal.

Again, this is also the reason why "Laws and rights are evolving in the wake of Ethics".

However, the evolution is slow, leaving us wondering what right society and government have to make demands on people in end-of-life situations. On the other end, evolution will always be slow because it is our natural fate to be confused by our personal and collective fearof surrendering to death. And even more so in our modern society : death is no longer just a metaphysical scandal. Now, death is sometimes considered as a medical error or even worse : as a medical mistake (i.e., death is medical malpractice !).

A law to put an end to hypocrisy ?

As far as Euthanasia is concerned, do we need a law to put an end to hypocrisy ? No law has ever eradicated hypocrisy. Many of us have been faced and will be faced with decisions concerning terminal or incurable patients. Are all those difficult and dramatic decisions part of the hypocrisy ? To confine the debate about euthanasia to the need to put an end to hypocrisy is quite an insult for caring physicians or surgeons. Practice of surgery is more and more complex ; surgeons are learning fast that hyperindividualism is no more the key of professional success. As one of the Mayo brothers once said (Charles H. Mayo : "The keynote in the progress in the 20th century is system and organisation, in other words, teamwork". In the vast majority of cases, difficult decisions including end-of-life decisions are collegial. To assert the opposite is either wrong or the consequence of being

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unaware of the current clinical reality. Surgeons generally know that common sense alone is hazardous, changeable, unsteady and depending of the context ; that to base judgement only on common sense presents the risk of a decision making process bearing the stamp of uncontrollable affectivity. Therefore, teamwork is inseparable of team decision making process.

To confine the debate to the need to put an end to hypocrisy is also misleading for the population as far as the *sense of responsibility* of surgeons is concerned. Responsibility means *imputability*, which refers to what can be attributable or chargeable to the physician.

In Philosophy, the German word for the latin word *Imputabilitas* is *Schuldfähigkeit.*

The first part of this word is "*Schuld*" which means "*fault*". "Responsibility-Imputability"means in fact : to assume the risk of being charged with a fault, by a legal instance authorised to impute the fault to the defendant. *What else is the surgeon doing all year long ?* Therefore, to confine the debate about euthanasia to the need to put an end to hypocrisy, apart from the fact that it is rather insulting for surgeons, it is also misleading for the *vulnerable* patient who feel profound trust toward his surgeon.

Patient's vulnerability and surgeon's professionalism

"For Surgery to be successful, there must be a relationship of trust and confidence between surgeon and patient. To achieve this, surgeons must be sensitive to the *vulnerability* of patients and respect their human dignity, their ability and right for their own future" (2).

However, lofty phrases generally do not change customary ways of doing things. In fact, medicine in its organised capacity has not properly developed self-regulation and not sufficiently implemented professional standards. To the degree that the profession accepts a commitment to social engagement, the curriculum should teach patient's advocacy skills along with diagnostic skills. This would constitute a startling break with established patterns, for instance, by encouraging and protecting whistle-blowers (3), so that the profession would not be so dependent on outsiders to identify and publicise problems (i.e., journalists and government officials have too often taken the lead for patient's advocacy in uncovering abuses and providing remedies).

It is the complex and sensitive nature of the services required from physicians that justifies professionalism, and morality is a prerequisite for the trust required for its maintenance. Nevertheless, considering the everyday realities of medical practice we run the risk of being left with a word, "professionalim", whose bark remains more powerful than its bite. In other words, how can the medical profession integrate physicians' larger moral imperative with their specific (and increasingly diverse) job demands ? Professionalism today has not only to be restored, it has to be reinvented. Although some authors (4) suggest an archetypal model of medical professionalism entailing three elements, the "devotion, profession, and negotiation", the changing context must be emphasized. Individual physicians can subscribe to these principles, but unless there is organized support, little will change (5). The medical profession needs to reestablish its social contract with society. It must stop viewing public officials as the enemy and develop better ways of responding more broadly to the interest of the public while keeping its own identity (6).

"*Professionalism*, the commitment to subordinate one's self-interest to the interest of one's patients, constitutes the very foundation of trust upon which our social contract rests. And maintaining mutual trust in the doctor-patient relationship is the only way to assure the public that Medicine is fulfilling its sacred obligation. No laws, no regulations, no patients' bill of rights, no fine print in the insurance policy, no watchdog governmental agency, nothing can substitute for trustworthy doctors who care..." (7). Nothing can either substitute for his or her commitment to choose a clear position between the conflicting poles of Ethics.

Polarity of Ethics

On one end is the antique maxim : «Do to anybody else what you would like he would do to you". However, by desiring to do him good, you would be able to justify the fact that you are imposing on him your way to feel what is right and what is wrong. And for this reason to become detrimental to him.

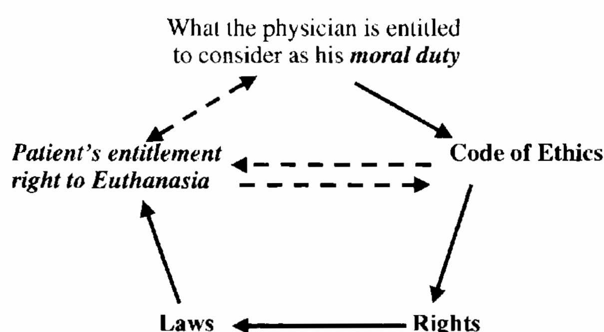
On the other end is the contemporary maxim : "In order not to be detrimental to anybody – particularly when one believes that one does good to him – never try to do anything good, always refrain from any good action!». Such a behaviour leads to hyperindividualism and to the fear of the common good, up to the point to open the way for the worst, that is to say the perversion of the *principle of precaution that becomes, when pushed to its climax, the crime of indifference (the crime of unconcern)* (8).

The changing context of Ethical Codes of the Medical Profession

Professional ethical codes that have absorbed religious and cultural values over the centuries assume authority when they become law. The list of codes starts with the *Hippocratic oath* (2500 y BC) or even the *Code of Hammurabi* (8 sections and 282 paragraphs are related to physicians and their services, and to the penalties in case of injury and death. The fee scale and penalties were graded according to the social status of the

patient). This *lex talionis*, which basically was a penalty for bad results, was invoked in the German tribes.

The Hippocratic Code, comfortable in the climate of thought before World War II and modernised by the informed consent principle of the Nuremberg Code, has been broadened by legal interpretation of the principle of *self-determination*, which should now be the starting point in medical decision making. For instance, Ameri-an and European laws start with the premise that the person is the master of his or her life. Patients may select their physician and treatment, and may also refuse it. The principle of *self-determination* is not in the ancient religious medical ethics nor in the Hippocratic Corpus. It represents the evolution and the amalgamation of other ethical concepts – human rights and autonomy – into medical ethics and practice. Furthermore, certain ethical concepts, like the principles of equity (fairness as justice) and *entitlement rights*, extend beyond other classical rights in that they include actual health services that are the responsibility of government or state to provide (9).



What is Entitlement Right ?

An entitlement right is the fact of being regarded or treated as having a title to something (e.g. entitlement to health care, employment or unemployment benefit, privacy, respect of autonomy, informed consent, abortion, euthanasia). Entitlements are some kind of fair due or qualified *positive rights* already forged by laws or yet to be forged by laws: " Informatique et Liberté "in France; " Protection de la vie privée "in Belgium.

Laws guarantee rights that may become entitlement. However, entitlement rights, that extend beyond other classical rights, can become controversial and can conflict with precepts from code of ethics. This is exactly what happened in the debate about abortion and now in the debate about euthanasia.

Human rights movement – with its fundamental call for respect of autonomy – is central to late 20th century laws affecting professional values, and have become a dominant influence on practical medical ethics. The human rights guarantees of autonomy and other basic rights have undoubtedly modernised the codes for medical ethics, and have also influenced the Bill of patients' rights. However, the current evolution of the health care industry is a major challenge for the Human rights movement.

Ethical concepts exemplified by the human rights movement – with its fundamental call for respect of autonomy – have profoundly influenced society in general and medical ethics in particular during the past 52 years. The human rights movement began as theory, evolved to inclusion in codes of ethics, and became entitlement (positive rights) as they were passed into law. Much of the influence of Human Rights movement on medical ethics is due to General Telford Taylor, a prosecutor during the Nuremberg trials. In his opening statement, he noted *"This was no mere murder trial, because the defendants were physicians, sworn by the Hippocratic Oath to do no harm"*. In fact, the Nuremberg Code challenges the Hippocratic Ethics, which had traditionally allowed the physician to determine what was in the patient's best interest. By mandating informed consent and autonomy, the Nuremberg Code (and later the Helsinki declaration) entitled (in theory) the patient to as much authority as the physician. Let us remind the first article of the Nuremberg Code : "Voluntary consent of subjects is Essential" (10).

Another example of entitlement right is the evolution of the concept of Confidentiality.

Confidentiality is clearly mentioned in the Hippocratic Code of Ethics. Who would contest that Confidentiality is also a right somewhat protected by law ? A current interpretation of the concept of Confidentiality is, however, more expansive, extending the classical right to confidentiality well beyond the actual laws. The ethical concept of confidentiality after becoming a right is now evolving to an entitlement right (Protection of Privacy).

No one would seriously contest the entitlement right for decent food, shelter, privacy and health care, but the obligation to provide for such needs involves the assumption of responsibility by government or some other entity of the society. However, in this era of "instant gratification" entitlements rights can be interpreted so expansively as to include the right to irresponsible behaviour without obligation or consequence (*...only rights, no duty !*). Furthermore, the legal language on rights is highly developed, but the language of responsibility is meager: "A tendency to frame nearly every social controversy in terms of a clash of rights impedes compromises, mutual understanding and discovery of common ground" (11). The concept of Human Rights can even be diminished by placing each issue, each social ill or need in the context of an entitlement right. For instance, the concept of human rights would be diminished (from the viewpoint of many physicians)

if an issue such as euthanasia – considered as an entitlement right – is progressively associated to the *legal obligation* for the physician to provide it as a *compulsory service.* As rights become laws and laws become entitlements, conflicts can arise (fig. 1).

The thorniest ethical issue is the question of entitlement as a basic (constitutional) right in cases of euthanasia or physician-assisted suicide. If allowed by law, and dealt with as entitlement, a direct conflict with the possible physician's ethical and/or philosophico-religious proscription against causing death can occur. Such a direct conflict arises with what the physician is entitled to consider as his moral duty, with what he is regarded as having the title to consider as his moral duty (fig.1).

"Many opponents of euthanasia point to the Hippocratic Oath and its prohibition on hastening death. But those who turn to the oath in an effort to shape or legitimise their ethical viewpoints must realise that the statement has been embraced over the past 200 years (since 1789), far more as a symbol of professional cohesion than for its content. Its pithy sentences (i.e., *expressed in a clear and direct way*) cannot be used as all-encompassing maxims to avoid the personal responsibility inherent in the practice of medicine [...] Ultimately, a physician's conduct at the bedside is a matter of individual conscience. The wisdom of past years enters into the deliberation, but decision making in the present bears a burden that is unique to the particular transaction between the doctor and the individual patient who has come for help. To seek refuge in ancient aphorism is to turn away from the unique needs of each patient who have entrusted themselves to our care (we here reached what Albert Speer admitted to be *"billigung durch wegsehen"*). [...] Physicians who believe that it is a person's right to choose death when suffering cannot otherwise be relieved must turn to their conscience in deciding whether to provide help in such a situation. Once the decision to intervene has been made, the goal should be to ensure that death is as merciful and serene as possible" (12).

The changing context of Human Rights

The Universal Declaration of Human Rights consists of several tenets.

First, *Human Dignity* is a historical right, which has evolved from many religions, philosophies and traditions, including the Judeo-Christian, the Koran and the Talmud.

Secondly, *Civil and political rights* embodied the liberty to pursue human dignity against the abuse of political authority. These rights are derived from 17th and 18th centuries political thought during the Enlightment (Aufklärung), and are included in the American Declaration of Independence. Condorcet wrote in 1793 : "A society which is not enlightened by its philosophers will be deluted by impostors". These philosophical rights are known as first generation or *negative* rights, because they limit and restrict power of the government (the prince or king) over individuals. A negative right is the ability ***to free oneself of*** a constraint (13).

Thirdly, the *Universal Declaration of Human Rights* : the second generation of rights or *positive* rights (entitlement rights) are those that hold the government responsible for provision of social needs such as health care, employment, protection for the aged and vulnerable populations. These rights, that will be later the foundations of the Welfare state, are mostly an outgrowth of the industrial world of the 19th and 20th centuries. Their first philosophical advocates were Karl Marx and Thomas Paine. The Soviet constitution of 1936 contains provision for the government to protect such positive rights, that influenced also the New Deal policy in the U.S.

The patients' rights movement (e.g., Amsterdam declaration about patients' rights, 28-30 March 1994), that evolved from the informed consent debate and legislation, embodied a *positive* right (i.e., I am entitled to the respect of my autonomy, to equity in allocation of health care resources). However, now the patients' rights movement is more and more a reaction against the current market drift of medicine. It is more akin to *negative* rights (*free oneself* of the constraint of the ultraliberal market place) seeking to proscribe certain acts or practices in the managed care context. This threat has been denounced by President Clinton, in his State of the Union address (January 1998), calling on Congress to enact a national bill of rights in health Care: " You have the right to know all your medical options, not just the cheapest. You have the right to choose the doctor you want for the care you need. You have the right to emergency room care, wherever and whenever you need it. You have the right to keep your medical records confidential" (14). All those positive rights mentioned by B. Clinton are basically becoming negative rights, designed to curb the numerous inadequacies of the current business drift of the health care industry medicine.

The patient's right to choose his death is related to human dignity. But when one deals with legalisation of Euthanasia, one enters in the domain of positive right (i.e., respect of autonomy). Nevertheless, in the changing context of health care resources allocation, the *right to choose* death could become rather easily the duty to choose death.

If the *right to choose* my death is progressively replaced by the *duty to choose* death, then, what is socially desirable and humanely valuable would come down to what is economicallyprofitable. At this stage, we will have lost positive right and negative right, but above all we will have lost human dignity.

Are physician-assisted suicide or active euthanasia to be considered as constitutional right ?

The fundamental question is : *Do patients have a constitutional right to have physician-assisted suicide or active euthanasia ?*

We have already mentioned that it is an act proscribed by the Hippocratic Oath.

However, in the Netherlands, euthanasia and physician-assisted suicide represent 2.7% of all deaths. In 1998, the US. Supreme Court rejected the constitutional right to physician-assisted suicide (*Washington v. Glucksburg* and *Vacco v. Quill*). Cited in the *Amicus Curiae* briefs were concerns of linking physician-assisted death to the effort to reduce the high cost ofterminal care. The Supreme Court noted the cost-saving potential: "If physicians-assistedsuicide were permitted many might resort to it to spare their families the substantial financial burden of end-of-life care cost". The *Amicus Curiae* ("friends of the court") are, in fact, the counsels who assist the court by putting arguments in support of an interest that might not be adequately represented by the parties to the proceedings (such as public interest) or by arguing on behalf of a party who is otherwise unrepresented. The philosophers who participated to the redaction were Thomas Nagel, Thomas Scanlon, Judith Jarvis Thomson, Ronald Dworkin, Robert Nozick and John Rawls (15). Those people represent the best theoreticians of the XXth century concepts of justice.

Are there objective data about the potential cost savings from legalising physician-assisted suicide ?

Drawing on data from the Netherlands on the use of euthanasia and physician-assisted suicide and on available U.S. data on costs at end of life, the most reasonable estimate is a savings of $ 627 million, less than 0.07 percent of total health care expenditures. This is not likely to save substantial amounts of money in absolute or relative terms, either for particular institutions, managed-care plans or for the nation as a whole (16).

Four types of confusion and misunderstanding yet disturbing the Euthanasia debate

1. *Responsibility Ethics versus Conviction Ethics*

Responsibility ethics is non-perfectionist, of compromises and of multiple considerations.

Conviction ethics is perfectionist, of categorical and abstracted principles. Medicine has to find its own way between these two types of ethics. In this aspect, there are some analogies between Medicine and Law considered as attempt to mediate between cynical policies and angelical ethics.

The categorical imperative of conviction ethics is *categorical* because it admits of no exceptions and is absolutely binding. It is imperative because it gives instruction about how one morally must act, like the first formulation of the categorical imperative of Emmanuel Kant : "To be universal a maxim must be capable of being conceived and willed, without contradiction, as valid for everyone... The maxim should be capable of becoming a universal law !". Practically, it is unworkable for medical ethics. Nevertheless, the second formulation of the categorical imperative is more challenging for any physician : "*Take action so as to treat mankind in thy person, as well as in any other person, not merely as means but as an ultimate end*".

If the patient is the ultimate end, his liberty has also an instrumental value because the patient remains a human whose autonomy represent altogether an essential factor for his care (*the patient is the first agent for his own treatment... and his own death !*), and the ultimate "Court of Appeal" to decide which decision to take. Those are the reasons why information and disclosure and a sense of responsibility of the actors are so important in clinical practice.

2. *Uncertainty and probabilistic nature of medicine*

"I would not treat a patient if I knew the chance of success was zero ; the converse would hold true if the chance of success was 100 %. In the clinical arena, the odds often lie between those numbers and are tinged with uncertainty. Does a 20 % likelihood of success warrant vigorous therapeutic intervention, what about 8 % ? Where do we draw the line, and why ?

These questions have no generally accepted answers, and physicians and families are often left to agonise over therapeutic decisions that present as ethical dilemmas" (17).

In other words, we are practising surgery in shades of grey : nothing is completely white or completely black. Many of the decisions we have to make are not simply technical or medical judgements ; often they also require the *negotiation* of *conflicting values* and *trade-off* between three levels of *traders* : 1st order" trader : the health care *technocrat* who controls the allocation of scarce resources ; 2d order" trader : the health *professional* with his competence and his high technology ; 3d order" trader : the *vulnerable patient* disposing of almost no power.

The shades of grey is extending. If therapeutic decisions could present as ethical dilemmas, in the current business environment physicians are also at legal and financial risk for treatment decisions that blend other *probability risks* (the likelihood of medical events based on the characteristics of patients populations in a given

pool) with *efficiency risks* (how completely and efficiently the care are rendered). The probability risks have been the traditional responsibility of insurance, now it is ours too !

3. *Instrumental value of the " necessary atmosphere "of privacy*

"Privacy is a necessary condition – *"the necessary atmosphere"* – for intimate relationships. It is my thesis that privacy is not just one possible means among others to insure some other value, but that it is necessarily related to ends and relations of the most fundamental sort : respect, love, friendship and trust... Privacy is not merely a good technique for furthering these fundamental relations; rather without privacy they are simply inconceivable. There can be little doubt that privacy has an instrumental value. We grant others access to ourselves in order to have and maintain such relationships as love, friendship, trust, and the variety of intimate social relationships with other that we desire. For example, we allow physicians to gain access to some aspect of our lives in order to protect our health" (18) ... or assisted our death! This does not preclude the individual physician to seek advice or to use all the benefits of sound medical confraternity before making a final decision.

4. *Erratic use of metaphors in Medicine !* (19)

Metaphors are figurative expressions that interpret one thing in terms of something else. Metaphors are often associated with *models.* For instance, in the doctor-patient relationship : the physician may be viewed through the metaphor of *father* and the patient through the metaphor of *child,* and their relationship may be interpreted through the model of *paternalism.*

The metaphor of paternalism has progressively been replaced by the metaphor of *Warfare* to describe Medicine. This metaphor illuminates much our conception of what is, or should be, done in day-to-day medicine: the physician is the *captain* who leads the battle against disease ; he orders a battery of tests, develops a plan of *attack,* calls on the *arsenal* of medicine and directs *allied* health personnel ; he treats *aggressively* and expects compliance ; he has faith in *magic bullet* allowing surgical strikes and unfortunately causing also...*collateral damages.* The metaphor of Medicine as Warfare reaches the level of a real analogy when the physician in British hospitals is designated as the House Officer and the higher member of the U.S. Health Care Federal Administration as the U.S. Surgeon General. After the Kosovo's electronic War, one can even compare the last resort chemotherapy course for terminal cancer as "humanitarian bombing".

Medicine as Warfare explains also the expression ***"High tech - low touch"*** coined by the former Wimbledon winner tennis champion Arthur Ashe (who got Aids from a blood transfusion during coronary bypass surgery) addressing young physicians at the Commencement ceremony at Harvard Medical School in June 1992 : "This label means that as : technology races ahead of any solid consensus on how to use or regulate it, people like you will be evermore tempted to seek solutions through machines rather than personal contact" (20).

From Medicine as Warfare, we are moving now to the metaphor of Medicine as *business on the market place.* The business metaphor highlights and hides various features of contemporary health care : the language of efficiency replace the language of care and compassion for the sick, and equity in distribution. The doctor is a provider ; the patient is a consumer ; the goal of Medicine is a "healthy bottom line" and a good doctor save the money of his Health Maintenance Organisation (HMO), i.e., he does not take care of many patients.

A great surgeon, Francis D. Moore, once said : "Corporate standards for social behaviour and community responsibility should not be confounded with clinical and ethical guidelines". So much for the corporate values and the professional (i.e., of the Medical profession) values (21) illustrated in Table I.

Table I

VALUES	
Corporate	**Professional**
Profit	Service
Competition	Advocacy of the patient
Responsibility to stock holders	Altruism
Market driven	Services of specialised knowledge
Standards set externally	Standards set internally
Consumerism	Humanism
Short-term goals	Long-term goals

SWICK H. M., Academic medicine must deal with the clash of business and professional values. *Acad Med,* 1998 ;**73** : 751-755.

There are consequences for the patient when metaphors are used to describe Medicine.
Medicine as warfare, in which the physician treats aggressively and has faith in surgical strikes – forgetting the potential...collateral damages –, leads the patient to fear *overtreatment.*

Medicine as business on the market place, where the primary concerns are efficiency and savings instead of care and equity in distribution, leads the patient to fear *undertreatment.*

This double and paradoxical fear is actually in the middle of the current debate about euthanasia.

Features of clinical relevance

In the current era, the first step for a medical act to be ethical as well would be to replace the expression "sta-

tistically significant" by *"clinically relevant"*. Euthanasia can be an ethical act so heavily loaded with the burden of the challenge of reconciliation between our desire to combat death and yet find a way to accept it when the fight is lost. Neither doctors nor patients are quite sure what stance to take toward death – they are torn between fighting and acquiescing. It may well be that this schism in unavoidable.

The director of NHS Health Technology, Sir Miles IRVING, proposed at the third annual meeting of the European Society of Surgery, held in Berlin in December 1999, the following features that have to be met for a guideline to be considered as "clinically relevant" : Validity, Reliability, Charity, Clinical applicability, Patient and user involvement, Linked to audit, Reproducibility, Clinical flexibility, Scheduled review date, Meticulous documentation, Cost-effectiveness. It is worthnoting that charity is in third position and cost-effectiveness in last position. Indeed, several of those features for a guideline to be considered as "clinically relevant" could be also applied to any clinical decision relative to Euthanasia.

We want both to combat death and yet find a way to accept it when the fight is lost. That is easy to imagine, but it is increasingly difficult to draw the line in practice. No perfect reconciliation may ever be possible, unless we turn to ... *charity* (compassion). Charity is with *Prudence* (wisdom), *Fortitude* (moral courage) and *Temperance* one of the four cardinal virtues of the Antiquity and Middle Ages. Each of these virtues need to be combined to the remaining three.

Is it absolutely indispensable to impose the combination of virtues – like Charity, Prudence, Fortitude, Temerance – by legal text to the Medical profession ? Or would it be more rational and reasonable – even if reasonable is not the same as achievable – to expect and to keep some degree of confidence in the civic, social and moral sense of obligation from members of the medical profession ?

Conclusion

Montesquieu once said : "When it is not necessary to legislate, it is necessary not to legislate".

It is not according to the concept of human dignity, to the concept of justice or of kindness that is accomplished an ethical act. An ethical act is in fact its concrete achievement, which is the privilege of ***caring*** people. And "the secret of patient care is in caring for the patient" (22).

For the last fifty years and up to the current national debate about Euthanasia, never has a Belgian physician been prosecuted and condemned for euthanasia as a crime ; except for the puzzling case that happened very recently in Liège – amazingly enough – in the middle of the public debate on Euthanasia. So far, judges were able to refer to the legal concept of *"State of necessity"* that was rather helpful to reach wisdom in their judgement, as well as to pronounce a judgement of wisdom.

Is it indispensable to further extend the legal language on entitlement rights and to open the way for the frenzy of legal changes ? This question is still unresolved, but we have to be cautious because this frenzy could backfire by undermining the confidence of the public not only in the medical profession but above all in the political and legal institutions.

Actually the French National Advisory Committee on Ethics recently proposed the *"exception d'euthanasie"* which is a concept quite close to the decades old Belgian *"State of necessity"*. It has been already widely criticised in France. Therefore, it is worth mentioning the recent answer from some executive members of the French National Advisory Committee on Ethics :

"An ethical opinion originates less from a peremptory certainty than from the tension and refusal to definitely end the questioning about recurrent and haunting matters related to one of the foundations of human condition... To hear a last request gasping for transgression is perhaps the only remaining way for our society to answer the last existential distress. Such an answer, short of hypocrisy and secrecy, could be the ultimate opportunity for a person who is facing the last moment of his life, his family circle and friends, and for those people who are caring for him to share confidence; were they eventually obliged to account for their conduct before the law" (23).

**"There is a time for departure
even when there's no certain place to go ..."
Tennessee Williams - *Camino Real* - 1953.**

References

1. ARISTOTE. Ethique à Nicomaque. V, 3, 1129 b 25-31. Trad. Tricot, Vrin, 1979 : 218-219.
2. A.G. JOHNSON. The Surgeon's Duty of Care. The Senate of Surgery of Great Britain and Ireland. London, October 1997.
3. ROTHMAN D. J. Medical professionalism - Focusing on the real issues. *New Engl J Med*, 2000 ; **342** : 1284-1286.
4. WYNIA M. K., LATHAM S. R., KAO A. C., BERG J. W., EMANUEL L. L. Medical professionalism in society. *New Engl J Med*, 1999 ; **341** : 1612-1616.
5. CRUESS R. L., CRUESS S. R. Teaching medicine as a profession in the service of healing. *Acad Med*, 1997 ; **72** : 941-952.
6. CRUESS R. L., CRUESS S. R. (Letter). *New Engl J Med*, 2000 ; **342** : 1288-1289.
7. COHEN J. J. People want their doctor back. *Acad Med*, 1998 ; **73** : 72.
8. MICHEL L. Les défis de la répartition des ressources en soins de santé. *La Revue Nouvelle*, 2000 ; **111** (2) : 32-53.
9. SHELTON G. F. Professionalism, managed care and human right movement. *Bulletin of the American College of Surgeons*, 1998 ; **83** (12) : 13-34.

10. Trials of War criminals - Nüremberg, October 1946 - April 1949. Washington : U.S. Gov. Printing Office, vol. 2, pp. 181-182.
11. GLENDON M. A. Right talk. *Time*, August 12, 1991.
12. NULAND S. B. Physician-Assisted suicide and Euthanasia in practice. *New Engl J Med,* 2000 ; **342** : 583-84.
13. McCULLOUGH L. B. Bioethics in the Twenty-First Century : Why we should pay attention to Eighteenth Century medical ethics. *Kennedy Institute of Ethics Journal,* 1996 ; **6** : 329-333.
14. ANNAS G. J. A National bill of patient's rights. *New Engl J Med,* 1998 ; **338** : 695-699.
15. Editorial. The New York Review of Books, March 27, 1997.
16. E. J. EMANUEL, M. P. BATTIN. What are the potential cost savings from legalizing physician-assisted suicide ? *New Engl J Med,* 1998 ; **339** : 167-172.
17. STEINBERG D. Doctor's dilemna ; *Harvard Medical Alumni Bulletin,* 2000 ; **73** : 20-27.
18. Charles FRIED C. FRIED, "Privacy" : A Rational Context. *Yale Law Journal,* 1968 ; **77** : 475-493.
19. MICHEL L. Du bon usage de la métaphore. *La Libre Belgique,* March 20, 2000.
20. ASHE A. Tremendous task ahead. *Harvard Medical Alumni Bulletin,* 1992 ; **66** : 14-16.
21. Swick HM, Academic medicine must deal with the clash of business and professional values. *Acad Med,* 1998 ; 77 : 751-755.
22. PEABODY F. W. Editorial. *JAMA,* 1927 ; **88** : 877
23. COLLANGE J. F., PELLERIN D., SICARD D. Euthanasie: oser le dire. *Le Monde,* March 20, 2000.