Shared Principles? German Responses to American Bioethics Since the 1970s

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Abstract
Since its inception in the late 1960s and early 1970s, the academic discipline of bioethics has profoundly shaped the professional and public assessments of biomedicine. A universalistic approach preferred by American bioethicists and challenges posed by modern biomedicine created a transatlantic moment for ethical theories and practices. This article will discuss the transfer of bioethical knowledge from the United States to (West) Germany and highlight its immediate reception, its slow adaptation, and its belated implementation at universities, in society, and in the medical profession. Examples from academia, policy and law will provide a narrative focus for explaining the peculiar relationship between institutional ambitions, universalistic theoretical claims, and local professional routines and adjustments. In particular, the article contrasts a general openness towards ethical concepts and practices with the comparably reluctance in adopting American bioethics as it was perceived in Germany, which effectively delayed the implementation of ethics in German medicine for decades. The German responses to American bioethics provide a topical example for boundary work on an international level.

Keywords
Bioethics, Germany, medicine, principlism, transatlantic history, United States

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In February 2002, a programmatic ‘Physician Charter’ was published simultaneously in two of the highest-ranking medical journals, *Lancet* and *Annals of Internal Medicine*.

The text presented the results of a joint project conducted by the European Federation of Internal Medicine, the American College of Physicians and the American Board of Internal Medicine, that centred medical practice around the three guiding principles of ‘primacy of patient welfare’, ‘patient autonomy’ and ‘social justice’. In all but name, that is, without using the term ethics or referring to the underlying ethical concept, the charter iterated what has become impactful and famous as bioethical ‘principlism’, worked out by philosophers Tom Beauchamp and James Childress in their 1979 book *Principles of Biomedical Ethics*: that is, the principles of respect for autonomy, beneficence, non-maleficence, and justice, the balancing and reconciling of which was supposed to provide biomedical researchers and physicians with an applicable ethical framework for professional decision-making.

Four months later, in June 2002, the German federal government renewed its licensing regulations for physicians. One of the changes was that, for the first time, it stipulated ethics not only as a goal of medical education but also as an obligatory examination subject. This acknowledgement of ethics in the required curriculum of physicians’ training was accompanied by the institutionalization of ethics within German medical schools: Until 2002, only two university chairs for medical ethics had existed, established in 1998 at the Universities of Göttingen and Tübingen. The ensuing rapid institutionalization of ethics at German medical schools would be so successful that it virtually replaced the history of medicine as the core of medical humanities in the following years.

Although the publication of the ‘Physician Charter’ can be understood as the culmination of the establishment of bioethics in the United States, the adoption of the licensing regulations represents only the beginning of this process in Germany. As German medical schools were introducing ethics into the curriculum, professional medical associations in the United States had already internalized the founding principles of biomedical ethics to the point that it no longer seemed necessary to acknowledge them as something distinct that, originally, had come from outside the medical profession. That the two events occurred simultaneously in 2002 might lead to the conclusion that

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1 ABIM Foundation, ACP–ASIM Foundation and European Federation of Internal Medicine, ‘Medical Professionalism in the New Millennium: A Physician Charter’, *Lancet*, 359, 9305 (2002), 520–22; idem, ‘Medical Professionalism in the New Millennium: A Physician Charter’, *Annals of Internal Medicine*, 136, (2002), 243–63.

2 Ibid.

3 T. L. Beauchamp and J. F. Childress, *Principles of Biomedical Ethics* (New York, NY 1979).

4 Approbationsordnung für Ärzte vom 27. Juni 2002, *Bundesgesetzblatt*, Teil I, 44 (2002), 2405–35, 2413. All translations of quotes from German are by the author.

5 H. Fangerau and M. Gadebusch Bondio, ‘Spannungen in der jüngeren Medizingeschichte: Legitimationsstrategien und Zielkonflikte – ein Beitrag zur Diskussion’, *NTM* 23, 1–2 (2015), 33–52.

6 In the context of this article, ‘Germany’ always relates to the Federal Republic of Germany. The history of medical ethics in the German Democratic Republic is a matter in its own right that showed only ephemeral overlap with the American and West German developments. Cf. H. Bettin, ‘Eine AG Ethik der DDR als erste zentrale deutsche Ethikkommission. Zum Umgang mit ethischen Fragen bei der Forschung am Menschen in der DDR’, *Zeitschrift für medizinische Ethik*, 56, 3 (2010), 235–50; A. Frewer, R. Erices (eds) *Medizinethik in der DDR. Moraleiche und menschenrechtliche Fragen im Gesundheitswesen* (Stuttgart 2015).
German bioethics developed independently from its American counterpart – an impression that could not be farther from the truth. This article explains the apparent contradiction by looking precisely at the plentiful and manifest relations between the American and German actors in bioethics. In particular, it assesses the reception of some important aspects of American bioethics in the German discourse to highlight the transatlantic relationship and suggest why it still did not produce a corresponding development. After conceptual remarks on the international movement of knowledge, the article discusses five aspects and consequences of this movement with regards to the American–German history of bioethics, each following their own chronology: First, the general contradiction between the early German reception of American bioethics and its late implementation of American bioethical practices like the living will or hospital ethics committees is presented. Second, the extent of the German reception of American bioethics is specified by looking at German participation in bioethics courses hosted by the Kennedy Institute of Ethics at Georgetown University. Third, the delay in the German reception is related to the fate of the aforementioned concept of principlism, which was the centrepiece of the bioethics courses. Fourth, a hypothesis for the delayed acknowledgement of principlism in Germany is presented by explaining the contradictory American and German notions of the term autonomy – pivotal to the concept of principlism – and relating them to the way the German medical profession handled its pre-1945 history. Fifth, a synthesis is drawn by exemplifying German views on the place and function of ethics in medicine.

The history of German bioethics, that is, the formation of ethics in German medicine and the life sciences since the 1970s is still fairly unexplored. Historian Robert Baker, pointing to five major studies on the emergence of American bioethics, noted almost ten years ago that consensus had already been established about the ‘What, When, Who, and How’ of the so-called ‘Bioethics Revolution’ in the United States – a transformation of medical decision-making since the 1960s by physicians and non-physicians like philosophers and lawyers cognizant to the technological, institutional, social and moral changes challenging the legitimacy of medical authorities –, leaving the ‘Why’ to further discussion. In comparison, the state of German historiography is still far

7 Since its inception, bioethics, as both an academic discipline and a professional practice, has dealt with a broad range of problems related to medicine and the life sciences, from clinical care via biomedical research to public health. By highlighting certain aspects of American bioethics in this article – its topics, concepts, and protagonists – I do not intend to suggest that they are best suited to representing the field as a whole, although, for the point in time that is of interest for this historical investigation, one could argue that they were. Rather, this choice rests solely on their reception in Germany and their influence on the German discourse. 8 The history of German medical ethics prior to 1945 has been studied relatively well. Cf. F. Bruns, Medizinethik im Nationalsozialismus. Entwicklungen und Protagonisten in Berlin (1939–1945) (Stuttgart 2009); A. Frewer and J. N. Neumann (eds) Medizingeschichte und Medizinethik. Kontroversen und Begründungsansätze 1900–1950 (Frankfurt am Main 2001); A.-H. Maehle, Doctors, Honour and the Law: Medical Ethics in Imperial Germany (Basingstoke 2009).

9 R. B. Baker, Before Bioethics: A History of American Medical Ethics from the Colonial Period to the Bioethics Revolution (New York, NY 2013), 274f. Baker refers to D. J. Rothman, Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making (New York, NY 1991); A. R. Jonsen, The Birth of Bioethics (New York, NY 1998); M. L. T. Stevens, Bioethics in America. Origins and Cultural Politics (Baltimore, MD 2000); R. C. Fox and J. P. Swazey, with the assistance of
from even mapping out the historical terrain. Therefore, the focus of this investigation is simultaneously wide and narrow: Wide in the sense that it reaches across the Atlantic Ocean, and narrow in the sense that it is confined to the (mostly) German actors and institutions who were involved in this transatlantic bioethical relationship, necessarily neglecting other protagonists and discourses that played an important role in the establishment of American and German bioethics, but were not directly connected to the transatlantic exchange under discussion here. In short, the article presents neither the histories of American and German bioethics nor a comparison of their respective roots in health care economies and policies, professional medical cultures, religious and social stratifications, general attitudes towards science and technology as well as specific perceptions of biomedical and ethical issues arising at the time. Instead, it lays out how the belated and peculiar institutionalization of bioethics in Germany resulted not from ignorance, but rather from the reception of its American precursor.

An obvious explanation for the divergent institutional developments of bioethics in the United States and Germany would be that they occurred independently. In theory, such an explanation could point to the fact that the term ‘bioethics’ itself was not adopted when German medical schools included ethics into their curricula and institutional frameworks. Yet, this terminological peculiarity, far from highlighting an independent German formation, points instead to the specific German relationship with American bioethics: What German medical schools instituted as ‘ethics in medicine’ or ‘medical ethics’ does not differ significantly from American bioethics, least of all in its adoption of the above-mentioned concept of principlism as a source for research and teaching. Accordingly, the argument this article advances is that the German avoidance of American bioethics’ terminology, and indeed of the term itself, while diligently introducing and applying American bioethical concepts, is precisely what enabled ethics to eventually enter into German medical practice and teaching. Such an argument complements the more general understanding that Renée Fox and Judith Swazey presented. As both observers and participants in the rise of bioethics, they highlighted the international impact of principlism, which ‘has been so widely disseminated across national boundaries that it has become a kind of bioethical lingua franca.’ However, another participant-observer of this process, Dutch bioethicist Henk ten Have, emphasized that in Germany, American bioethics, with principlism at its core, was greeted with suspicion if not

J.C. Watkins, Observing Bioethics. A Sociological History (Oxford 2008); J.H. Evans, The History and Future of Bioethics. A Sociological View (Oxford 2012).

10 For some of the first attempts to highlight different aspects of the history of German bioethics, see P. Gehring, ‘Fragliche Expertise. Zur Etablierung der Bioethik in Deutschland’, in M. Hagner (ed.) Wissenschaft und Demokratie (Berlin 2012), 112–39; M. Krischel, ‘The Institutionalization of Research Ethics Committees in Germany – International Integration or in the Shadow of Nuremberg?’, European Journal for the History of Medicine and Health, 78, 2 (2021), 353–76; U. Schlaudraff, ‘“Nun gründen wir mal”. Zur Vor- und Frühgeschichte der Akademie für Ethik in der Medizin’, Ethik in der Medizin, 18, 4 (2006), 294–302.

11 Fox/Swazey, Observing, 216. Cf. J.H. Evans, ‘A Sociological Account of the Growth of Principilism’, Hastings Center Report, 30, 5 (2000), 31–8.
outright opposition. This qualification does not contradict the eventual acceptance of American bioethics and the concept of principlism in Germany. Rather, it points to the fact that bioethical knowledge had to overcome serious obstacles at the local level as it spread internationally – and, thereby, to the more general phenomenon of how knowledge moves and is received beyond borders.

The international movement of knowledge is often investigated in the historical contexts of colonialism, migration and economic globalization. Consequently, it is often associated with an asymmetry of resources and power. Yet, as James Secord put it, ‘to make knowledge move is the most difficult form of power to achieve.’ The international movement of knowledge is not, as it might appear, linear and positive but rather should be understood as a complex process that can range from assimilation via selective adaptation and syncretism to outright rejection of and resistance to foreign influences: International outreach does not necessarily lead to international adjustment; instead it often abets the very notions of particularity that it aims to overcome. The claim of international prevalence regularly generates a counterclaim of particular meaning, an appeal of authenticity, and a corresponding power of local resistance. Ultimately, the international movement of knowledge entails a form of power at both the distributing and the receiving ends; it involves a kind of balancing between both ends that was famously expressed by Bruno Latour:

To convince someone that an experiment has succeeded, that a technique is effective, that a proof is truly decisive, there must be more than one actor. An idea or a practice cannot move from A to B solely by the force that A gives it; B must seize it and move it.

More recently, the historian of science John Krige delineated five major determinants for the international movement of knowledge: ‘the centrality of travel, the role of the regulatory state, the meaning of “borders” and “networks,” the significance of nationality and political allegiance, and the intersection between the local and the global.’ The last determinant, that is, the potential conflict arising from the international ‘standardization of knowledge-producing practices’, on the one hand, and ‘vested local interests and their histories that resist pressure to homogenize and to standardize’, on the other, appears to be particularly useful for understanding the relation between American and German bioethics as a history of extensive exchange as much as of selective appropriation.

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12 H. ten Have, ‘Principlism. A Western European Appraisal’, in E. R. DuBose, R. P. Hamel, L. J. O’Connell (eds) A Matter of Principles? Ferment in U.S. Bioethics (Valley Forge, PA 1994), 101–20, 111.
13 J. A. Secord, ‘Knowledge in Transit’, Isis, 95, 4 (2004), 654–72, 670. Cf. M. G. Ash, ‘Wissens- und Wissenschaftstransfer – Einführende Bemerkungen’, Berichte zur Wissenschaftsgeschichte, 29, 3 (2006), 181–9.
14 R. Robertson, ‘Glocalization: Time-Space and Homogeneity-Heterogeneity’, in M. Featherstone, S. Lash, and R. Robertson (eds) Global Modernities (London 1995), 35–53, 39.
15 B. Latour, The Pasteurization of France (Cambridge, MA 1988), 15 f.
16 J. Krige, ‘Introduction: Writing the Transnational History of Science and Technology’, in J. Krige (ed.) How Knowledge Moves: Writing the Transnational History of Science and Technology (Chicago, IL 2019), 1–31, 4.
17 Ibid., 14, 16.
18 For a comparable approach with regards to the international establishment of research ethics committees, see N. Jacobs and H. Tinnerholm Ljungberg, ‘How Ethics Travels: The International Development of Research
German interest in and contact with American bioethical concepts, scholars and institutions manifested itself early on. During the 1970s, German academics and medical professionals who started to address emerging ethical problems in medicine and healthcare looked to the United States to find tools for approaching them. An early sociological analysis of problems of legitimacy in German medicine that resulted from a changing perception of the doctor–patient relationship, not only drew heavily on the American precursor Talcott Parsons but also on early bioethical scholarship like that of Edmund Pellegrino.\textsuperscript{19} Such references exemplified a growing perception that the differentiation, scientification and technologization of medicine made it exceedingly difficult to define, let alone legitimize, the scope and goals of medical professionals’ interventions. The assertion that the existing physicians’ ethos – based on the Hippocratic tradition, codified in the World Medical Association’s Geneva Declaration from 1948 and figuring prominently in the preamble of the German code of conduct for physicians since 1950\textsuperscript{20} – would sufficiently guide medical practice, was challenged by individual, social and economic considerations: The physician’s assumed knowledge and virtues no longer seemed sufficient to legitimize their practice, which called for a ‘higher system of order’\textsuperscript{21} for medical decision-making. Early protagonists of medical ethics in Germany were convinced that this system could not evolve from traditional, physician-centric ethics, so they turned to other sources of inspiration, and to American bioethics in particular.

The necessity of addressing the increasing moral conflicts of medical practice generated by social and technological progress was especially acute within the German Lutheran Church in relation to questions of reproductive medicine. When the German parliament adopted an amendment of the federal law regulating abortions in 1976, decriminalizing the termination of pregnancies in a narrow range of circumstances, the Council of the Lutheran Church issued a statement calling for increased efforts to counsel not only pregnant women but, even more importantly, health professionals: ‘A key role will devolve upon physicians, their coworkers, and hospitals. They will ultimately decide about the impact of the new law.’\textsuperscript{22} Implicit in this statement was the notion that health professionals confronted with ethical challenges had insufficient intrinsic resources for dealing with them. The Working Group on Medical Ethics, founded under the umbrella of the Lutheran Church in 1977, stated this perception explicitly: Concerning both the questions of abortion and physician-assisted dying, a leading member of the Working Groups claimed that scientific medicine’s ‘awareness of being restricted by nothing but its own will’ had led to an inability to provide ‘inherent

\textsuperscript{19} W. Schluchter, ‘Legitimationsprobleme der Medizin’, Zeitschrift für Soziologie, 3, 4 (1974), 375–96.
\textsuperscript{20} H. Siefert, ‘Ärztliche Gelöbnisse’, in A. Eser, M. von Lutterotti, and P. Sporken (eds) Lexikon Medizin, Ethik, Recht (Freiburg im Breisgau 1989), 114–22, 118.
\textsuperscript{21} H. Schipperges, ‘Motivation und Legitimation des ärztlichen Handelns’, in H. Schipperges, E. Seidler, and Paul U. Unschuld (eds) Krankheit, Heilkunst, Heilung (Freiburg im Breisgau 1978), 447–89, 484.
\textsuperscript{22} Evangelisches Landesarchiv Berlin (ELAB) 36/2659, Wort des Rates der Evangelischen Kirche in Deutschland anlässlich des Inkrafttretens der neuen strafrechtlichen Bestimmungen zum Schwangerschaftsabbruch, 10 July 1976. Cf. S. Mantei, Nein und Ja zur Abtreibung. Die evangelische Kirche in der Reformdebatte um § 218 StGB (1970–1976) (Göttingen 2004).
Another member of the Working Group fortified this claim, again in relation to the ethical challenge of abortion, by noting that the difficulty of distinguishing the ‘truly ethical within a medical–ethical problem’ could not be solved on the basis of medical knowledge and by medical professionals *per se*. Therefore, it was no surprise that the Working Group did not search for answers in the compendia of classical medical deontology but looked beyond the Atlantic Ocean to contributions by religious scholars to the growing field of bioethics: From the very beginning of its activities, the Working Group absorbed and reflected American scholarship, translating articles and inviting U.S. scholars to its conferences, such as Kenneth Vaux from Texas Medical Center in Houston and Harry Yeide from George Washington University in Washington, DC.25

Alongside religious actors like the Protestant Working Group on Medical Ethics, German academics and practitioners from the field of jurisprudence also prompted engagement with American bioethics. In particular, the World Medical Association’s revised Declaration of Helsinki, which called for the establishment of ethical review committees to supervise biomedical research on human subjects in 1975, drew lawyers into the medical realm.26 And just like the religious actors concerned with ethical challenges of modern medicine, German jurists relied on American precursors, as can be shown by the example of end-of-life decision-making. In the United States, this question is most prominently associated with the so-called Quinlan case. In 1975, 21-year-old Karen Ann Quinlan fell into a coma after respiratory failure. As she had been diagnosed with irreversible brain damage and was expected to remain in a persistent vegetative state, her parents asked for her to be detached from the feeding tube and the ventilator that kept her alive. Since the doctors refused to comply, the case ended up before the New Jersey State Supreme Court, which ruled that they were required to adhere to the parents’ wishes, which, in turn, were interpreted as them representing Karen’s own will.27 In the course of this high-profile case, a specific practice of determining one own’s fate, the so-called living will, achieved unprecedented popularity. As early as 1969, lawyer Luis Kutner had introduced the living will as a ‘due process of euthanasia,’ that is, a provision for self-authorizing termination of life-prolonging measures for cases...

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23 J. Schwarz, ‘Wege zu einer therapeutischen Ethik’, *Evangelische Theologie*, 41, 5 (1981), 593–605, 595.
24 D. Ritschl, ‘Die Herausforderung von Kirche und Gesellschaft durch medizinisch-ethische Probleme. Ein Exposé zu einer Landkarte der medizinischen Ethik’, *Evangelische Theologie*, 41, 5 (1981), 483–507, 497.
25 Ibid., 484–6; Evangelisches Zentralarchiv Berlin (EZA) 187/1701, Helmut Schmidt, Evangelische Akademie Hofgeismar, Einladung zur Akademietagung ‘Ethik in der Medizin’, 27–29 January 1979; Kenneth L. Vaux, ‘Medizinische Ethik in den USA’, in W. Becher (ed.) *Medizinische Ethik in der evangelischen Theologie der Ökumene* (Frankfurt am Main 1979), 103–8.
26 As one of the earliest examples, cf. W. Weißauer, ‘Ethikkommissionen und Recht’, *Münchener Medizinische Wochenschrift*, 121, 16 (1979), 551–6. The first research project about bioethical issues to received funding by the DFG (Deutsche Forschungsgemeinschaft – German Research Foundation) was that of Erwin Deutsch, a professor of law at Göttingen University. It dealt with the relationship between ethical review committees and the law. Cf. Deutsche Forschungsgemeinschaft, *Jahresbericht 1982, Bd. 2: Programme und Projekte* (Bonn-Bad Godesberg 1982), 22.
27 Jonsen, *Birth*, 254–6.
exactly like Karen Ann Quinlan’s. From 1969 to 1975, before the Quinlan case came before the courts, the American Euthanasia Education Council had distributed about 750,000 of its templates for living wills; in the eighteen months thereafter, this number almost doubled.

The Quinlan case was prominent well beyond the borders of the United States and also had repercussions in West Germany. There, Judge Wilhelm Uhlenbruck published his own version of a ‘patient’s testament’ in one of the country’s most important law reviews in 1978. Uhlenbruck, in almost Heideggerian fashion, spoke of the ‘living [individual] as the preventive dying [individual]’ who needed to come to terms with their fate and make relevant preparations since the doctor would not be allowed to judge over their life and death. Uhlenbruck cited the English term ‘living will’, albeit without referring to Luis Kutner, and pointed to the New Jersey Supreme Court’s Decisions in the Quinlan case as well as to California’s ‘Natural Death Act,’ which the state had passed in 1977, officially recognizing the living will as a legally binding document. Nevertheless, it took thirty-one more years before Germany came to terms, politically and legally, with the concept of the living will, acknowledging such documents in federal law in 2009. Another belated effect of the Quinlan case was the spread of multidisciplinary hospital ethics committees. In its decision, the New Jersey State Supreme Court had proclaimed the necessity of institutionalizing such committees at hospitals so that they could review ethically challenging cases onsite. Ethical review boards had, in fact, already been introduced much earlier: when kidney dialysis became possible in the early 1960s, such committees were established to decide how the scarce resource should be allocated. The Quinlan case prompted the extensive implementation of such committees to address more widespread and general ethical issues. In Germany, hospital ethics committees were only introduced in 1997, but they still drew their legitimacy from the decades-old American model. In 2003, this relation manifested itself in a German-American initiative that introduced a conference series on clinical ethics consultation to foster transatlantic exchanges.

The foregoing examples of the introduction of bioethical practices such as the living will and the hospital ethics committee in Germany underline the ambiguous impression

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28 L. Kutner, ‘Due Process of Euthanasia: The Living Will, A Proposal’, *Indiana Law Journal*, 44, 4 (1969), 539–54.
29 Stevens, *Bioethics*, 128–9.
30 W. Uhlenbruck, ‘Der Patientenbrief – die privautonome Gestaltung des Rechtes auf einen menschenwürdigen Tod’, *Neue Juristische Wochenschrift*, 31, 12 (1978), 566–70, 569.
31 Jonsen, *Birth*, 269–70; U. Benzenhöfer, G. Hack-Molitor, ‘Die Rolle von Luis Kutner bei der Entwicklung der Patientenverfügung’, *Hessisches Ärzteblatt*, 70, 6 (2009), 411–3; C. Eickhoff, *Patientenwille am Lebensende? Ethische Entscheidungskonflikte im klinischen Kontext* (Frankfurt am Main 2014), 71–80.
32 G. J. Annas, *Standard of Care: The Law of American Bioethics* (New York, NY 1993), 5–9.
33 A. Frewer, ‘Ethikkomitees zur Beratung in der Medizin. Entwicklung und Probleme der Institutionalisierung’, in A. Frewer, U. Fahr, and W. Rascher (eds) *Klinische Ethikkomitees. Chancen, Risiken und Nebenwirkungen* (Würzburg 2008), 47–74; H. Kohlen, *Conflicts of Care: Hospital Ethics in the USA and Germany* (Frankfurt am Main 2009), 92–4.
34 P. Bürkli, ‘Clinical Ethics Consultation – First International Assessment Summit’, *Ethik in der Medizin*, 15, 3 (2003), 250–2; S. Reiter-Theil and G. J. Agich, ‘Research on Clinical Ethics and Consultation: Introduction to the Theme’, *Medicine, Health Care and Philosophy*, 11, 1 (2008), 3–5.
that, although German actors immediately perceived U.S. bioethics’ impulses, those were only implemented very belatedly. It could be argued that the German acknowledgement of American developments was indirect and lacked personal contacts or communication. This argument seems to be supported by an American review of international developments in biomedical ethics published in 1987. Although the report included contributions from all around the world – France, Israel, the Netherlands, Great Britain, Japan, Australia, Poland, Spain, Canada and Italy, – Germany was conspicuously absent.35 Such a lack of international representation becomes all the more conspicuous considering the factual abundance of contacts between Germans and American bioethicists, which are not least visible through German contributions – mostly about the admittedly slow and frustrating development of ethics in German medicine – in the discipline’s journals.36 In fact, such personal transatlantic contacts had been established in the field as early as 1981 when German philosopher Hans-Martin Sass from the University of Bochum came to the Kennedy Institute of Ethics at Georgetown University, one of the first bioethical institutions founded ten years earlier. Sass started his lasting relationship with the Kennedy Institute as a visiting scholar to conduct research on the development of professional ethics in the United States with a special focus on bioethics, funded by the VW Foundation (Stiftung Volkswagenwerk).37 Although having published on neither ethics nor medicine so far – his first scholarly article on the subject did not appear until 198338 – he soon became a central figure in the international transfer of bioethical knowledge due to his activities on both sides of the Atlantic. From the mid-1980s on, Sass, now as a permanent research scholar at the Kennedy Institute, tried to strengthen the transatlantic exchange, first and foremost through his publications. Like his German peers, he contributed to the continuous assessment of the state of ethics in German medicine in international publications, not least those of the Kennedy Institute.39 Additionally, he was just as engaged in bringing American voices – especially the voices of scholars connected to the Kennedy Institute – to Germany, publishing papers, editing a special issue of a medical journal as well as

35 C. Levine, J. Bermel, and P. Homer (eds) ‘Biomedical Ethics: A Multinational View’, Hastings Center Report, 17, 3 (1987), special supplement.
36 E. Seidler, ‘The Teaching of Medical Ethics in the Federal Republic of Germany’, Journal of Medical Ethics, 5, 2 (1979), 76–9; R. Toellner, ‘The Historical Preconditions for the Origin of Medical Ethics Committees in West Germany’, Metamedicine, 2, 3 (1981), 275–82; M. H. Kottow, ‘Letter from Germany’, Journal of Medical Ethics, 8, 1 (1982), 44–7; F. J. Illhardt and E. Seidler, ‘The Federal Republic of Germany: A New Forum for Medical Ethics’, Hastings Center Report, 19, 4 (1989), 26–7; B. Schöne-Seifert and K.-P. Rippe, ‘Silencing the Singer: Antibioethics in Germany’, Hastings Center Report, 21, 6 (1991), 20–7. Cf. F. J. Illhardt, Medizinische Ethik. Ein Arbeitsbuch (Berlin 1985), VII.
37 Stiftung Volkswagenwerk Hannover, Bericht 1981/82 (Göttingen 1982), 176f.
38 H.-M. Sass, ‘Reichs-Rundschreiben 1931: Pre-Nuremberg Regulations Concerning New Therapy and Human Experimentation’, The Journal of Medicine and Philosophy, 8, 2 (1983), 99–111.
39 H.-M. Sass, ‘Bioethics Is Emerging In West Germany, but State of the Debate Is Far Behind the US’, Kennedy Institute of Ethics Newsletter, 1, 12 (1987), 3–4; idem, ‘Biomedical Ethics in the Federal Republic of Germany (F.R.G.)’, Theoretical Medicine, 9, 3 (1988), 287–97; idem, ‘Bioethics in German-Speaking Western European Countries: Austria, Germany, and Switzerland’, Bioethics Yearbook, 2 (1992), 211–31; B. Schöne-Seifert, H.-M. Sass, L. J. Bishop, and A. Bondolf, ‘German-Speaking Countries and Switzerland’, in W. T. Reich (ed.) Encyclopedia of Bioethics 3, rev. ed. (New York 1995), 1579–89.
books with contributions in German by American bioethicists. In addition to bringing German developments to Americans’ attention and vice versa, he actually provided for bringing protagonists from both sides of the Atlantic together in person. In the 1970s, the Kennedy Institute had begun a twofold attempt to spread American bioethical knowledge beyond national and disciplinary boundaries. The Jesuit heritage of the institute’s host institution, Georgetown University, facilitated such international outreach because both traditional and progressive Catholic academics were growing more interested in bioethical issues. Consequently, a network of Catholic scholars from Europe came to be among the first to introduce research and teaching on bioethics in European universities and their medical schools. This exchange fostered the initial professionalization of bioethics in Europe – the foundation of the European Association of Centers of Medical Ethics in 1986. Yet, this European connection left much less of a mark on Germany than its direct contacts with the Kennedy Institute, which expanded its international outreach in the course of the 1980s, when Sass and the Japanese philosopher Rihito Kimura became responsible for scientific exchange with Western Europe and Asia, respectively.

Another, and a much more significant, form of the Kennedy Institute’s outreach beyond the national and disciplinary boundaries of philosophical bioethics in the U.S. began in 1975 with the introduction of an Intensive Bioethics Course, directed especially at medical professionals. This course introduced around two hundred participants to the fundamental ideas of bioethics every summer. In particular, the aforementioned concept of principlism, that is, the four Principles of Biomedical Ethics – respect for autonomy, non-maleficence, beneficence, and justice – formed the basis for the courses and, as a consequence, also became known as the ‘Georgetown mantra’ – their authors, philosophers Tom Beauchamp and James Childress, not only contributed to the theoretical design and the annual teaching load of the Intensive Bioethics Course but had also developed their concept at the Kennedy Institute. In 1986, Sass secured a grant of DM150,000, once again from the VW Foundation, to bring German scholars to Georgetown and enable them to join the Intensive Bioethics Course at the Kennedy Institute together with American participants. Furthermore, Sass, himself an alumnus of the Intensive Bioethics Course of 1983, designed an Extended Course specifically addressing

40 H.-M. Sass, ‘Zehn Jahre Medizinethik in den USA’, Münchener Medizinische Wochenschrift 127, 34 (1985), 799–801; idem, ‘Schwerpunkt: Bioethik. Von der wachsenden Bedeutung ethischer und kultureller Wertfragen in biologischer und medizinischer Wissenschaft und Praxis. Editorial’, Mensch Medizin Gesellschaft, 11, 4 (1986), 229–30; idem (ed.) Bioethik in den USA. Methoden – Themen – Positionen. Mit besonderer Berücksichtigung der Problemstellungen in der BRD (Berlin 1988); idem (ed.) Medizin und Ethik (Stuttgart 1989).

41 J. C. Harvey, ‘André Hellegers, the Kennedy Institute, and the Development of Bioethics: The American-European Connection’, in J. R. Garret, F. Jotterand, D. C. Ralson (eds) The Development of Bioethics in the United States (Dordrecht 2013), 37–54.

42 P. T. Schotsmans, ‘Integration of Bio-Ethical Principles and Requirements into European Union Statutes, Regulations and Policies’, Acta Bioethica, 11, 1 (2005), 37–46, 38–9.

43 E. D. Pellegrino, ‘Einleitung: Die medizinische Ethik in den USA – Die Situation heute und die Aussichten für morgen’, in Sass (ed.) Bioethik, 1–18, 17.

44 Idem, ‘The Metamorphosis of Medical Ethics: A 30-Year Retrospective’, Journal of the American Medical Association, 269, 9 (1993), 1158–62, 1160; Beauchamp and Childress, Principles, xi–xii.
German participants and adding more practice-oriented aspects – like visits to the National Institutes of Health or grand rounds – to the theoretical focus of the Intensive Courses. With this kind of financial backing, the first two Extended Courses could be held in 1987 and 1988 with 14 and 25 German participants, respectively.\(^45\) Among the first participants was Hans-Bernhard Wuermeling, a professor of forensic medicine as well as the head of the recently founded German professional association of medical ethicists, the AEM (Akademie für Ethik in der Medizin – Academy for Ethics in Medicine) – another early German initiative dealing with ethics in medicine that received support from the VW Foundation, as well as from the Stifterverband (Stifterverband für die Deutsche Wissenschaft – Donors’ Association for German Science).\(^46\) Enthusiasm for the courses was noticeable within the AEM, with plans for a translation of the *Principles of Biomedical Ethics* and a TV documentary about American bioethics being proposed in their immediate aftermath, although neither project appears to have come to fruition.\(^47\) After two funded courses for German participants had been completed, interest had grown to the point that the Extended Courses could be continued, supported by scholarships from the DFG and the Stifterverband.\(^48\) Between 1987 and 1995, German participation in the different bioethics courses offered by the Kennedy Institute amounted to at least 127.\(^49\)

The German participation in the Kennedy Institute’s bioethics courses coincided with the first concerted attempts to integrate ethics into German medical practice and education: A dense sequence of activities in the mid 1980s bore the appointment of commissions dealing with the ethical challenges of reproductive medicine and genetics by the BÄK (Bundesärztekammer – Federal Chamber of Physicians), the German parliament and the federal government. Additionally, the West German ministers of health issued its initial recommendation to integrate ethics into the medical curriculum, and the revised licensing regulations for physicians included a first mentioning of ethics.\(^50\) In this way, the question of whether ethics should be a part of medicine was transformed

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45 *Kennedy Institute of Ethics Newsletter* 1, 5 (1986), 4; *Kennedy Institute of Ethics Newsletter* 1, 11 (1987), 4; *Kennedy Institute of Ethics Newsletter* 2, 4 (1988), 4.
46 Stifterverband für die Deutsche Wissenschaft, *Förderungsprogramm Ethik in der Medizin 1986–1992* (Essen [1992]), 8–9; Schlaudraff, ‘Nun gründen wir mal’, 299.
47 Akademie für Ethik in der Medizin Göttingen (AEM), Ordner Schriftwechsel, Tagesordnungen, Protokolle AEM (1986–1989), Udo Schlaudraff to Helmut Piechowiak, 3 January 1988.
48 Deutsche Forschungsgemeinschaft, *Jahresbericht 1988–1990, Bd. 2: Programme und Projekte* (Bonn-Bad Godesberg 1988–1990); Stifterverband, *Förderungsprogramm*.
49 Bioethics Research Library Archives, Georgetown University, Washington, DC (BRL), 018, Box 25, Folder 38–Box 26, Folder 4. All the following attributions of individual participations in the Kennedy Institute’s bioethics courses stem from these documents.
50 H. P. Wolff, ‘Die «Zentrale Kommission der Bundesärztekammer zur Wahrung ethischer Grundsätze in der Reproduktionsmedizin, Forschung an menschlichen Embryonen und Gentherapie»,’ in R. Toellner (ed.) *Die Ethik-Kommission in der Medizin. Problemgeschichte, Aufgabenstellung, Arbeitsweise, Rechtstellung und Organisationsformen Medizinischer Ethik-Kommissionen* (Stuttgart 1990), 57–63; S. Jasanoff, *Designs on Nature: Science and Democracy in Europe and the United States* (Princeton, NJ 2005), 161f.; C. Fuchs, ‘Erziehung zur Ethikfähigkeit. Verantwortung für die medizinische Ausbildung,’ in U. Schlaudraff (ed.) *Ethik in der Medizin. Tagung der Evangelischen Akademie Loccum vom 13. bis 15. Dezember 1985* (Berlin 1987), 27–33, 33; Approbationsordnung für Ärzte vom 14. Juli 1987, *Bundesgesetzblatt* I, Nr. 36 (1987), S. 1593–1623, 1604.
into the question of how to integrate it. In the course of this process, American bioethics, and particularly the central bioethical concept of principlism, as taught at the Kennedy Institute’s bioethics courses, turned out to be an unavoidable point of reference as well. As two early reports from the bioethics courses show, participants could have the same experience and assess it in completely contradictory ways: In one report, physician Michael Kottow (Extended German Bioethics Course 1987), emphasized the ‘pragmatic’ orientation of American bioethics and its compatibility with the necessities of medical decision-making. Another participant, physician Gebhard Allert (Extended German Bioethics Course 1988, Advanced Bioethics Course 1990) experienced American bioethics as a merely theoretical, non-medical approach that ‘explicitly exceeded the realm of [...] physicians’ ethics,’ and that could not be transplanted into the German context, not least since non-physicians, such as philosophers and theologians, dominated the field.51 These divergent views of the Kennedy Institute’s teaching of bioethical principlism by German participants raise the question of how influential those courses actually were. When philosopher Petra Gehring, with regards to the extensive German involvement in the Kennedy Institute’s courses, speaks about the ‘import of a style of thought,’ such an assessment alludes to the present much more than to the immediate aftermath of this participation.

The prospect of actively exceeding the realm of physicians’ ethics, as American bioethics and its core concept of principlism laid claim to, appeared to face immediate skepticism, if not outright resistance, in Germany, not least by those involved with American bioethics. A more appropriate approach was seen in the subtle reconciliation of German traditions and American concepts. As one German proponent of principlism, Georg Marckmann, highlighted as late as 2000 in one of the first articles that explicitly dealt with the concept, ‘the principles could be brought together with widely shared morals and traditional physicians’ ethics.’53 No less than the actual principles themselves, their compatibility with a given, physician-centric conception of medical ethics needed to be affirmed, and such compatibility would only result from a gradual introduction and adaptation. In 1999/2000 the former managing director of the AEM and contemporary head of the Center of Ethics and Law in Medicine at the University of Freiburg’s medical school, Stella Reiter-Theil (Extended European Bioethics Course 1992, Advanced Bioethics Course 1993), published an identical article on ‘Ethics in Medicine: Demand and Form’ in the professional journals of German internists, pain therapists, ophthalmologists, radiologists, urologists and dermatologists.54 Similar

51 M. Kottow, ‘Medizinethik in den USA: Ganz pragmatisch’, Deutsches Ärzteblatt, 84, 47 (1987), A-3214; G. Allert, ‘Medizinische Ethik lernen und lehren. Ein Bericht über Aus- und Weiterbildungsprogramme in medizinischer Ethik – bioethics – in den USA’, Ärzteblatt Baden-Württemberg, 44, 1 (1989), Sonderbeilage 1.
52 P. Gehring, ‘Operation Ethik. Import eines Denkstils’, Zeitschrift für Ideengeschichte, 11, 4 (2017), 44–51.
53 G. Marckmann, ‘Was ist eigentlich prinzipienorientierte Medizinethik’, Ärzteblatt Baden-Württemberg, 55, 12 (2000), 499–502, 502. Cf. M. Quante and A. Vieth, ‘Angewandte Ethik oder Ethik in der Anwendung? Überlegungen zur Weiterentwicklung des principlism’, Jahrbuch für Wissenschaft und Ethik, 5 (2000), 5–34.
54 S. Reiter-Theil and W. Hiddemann, ‘Ethik in der Medizin: Bedarf und Form’, Der Internist, 40, 3 (1999), 246–54; idem, ‘Ethik in der Medizin: Bedarf und Form’, Der Schmerz, 13, 5 (1999), 349–60; idem, ‘Ethik in der Medizin: Bedarf und Form’, Der Ophthalmologe, 97, 1 (2000), 66–77; idem, ‘Ethik in der Medizin: Bedarf und
papers appeared in the German oncologists’ journal as well as in the European Journal of Health Economics, and Reiter-Theil also wrote the editorial ‘Ethics in Medicine’ for the journal of German anesthesiologists.\textsuperscript{55} Just as Marckmann pointed to the necessity of reconciling the American bioethical concept of principlism with the German tradition of physicians’ ethics, these publications can be understood as an attempt to cautiously introduce ethical concepts into the German medical profession while rather subtly invoking principlism. Although Reiter-Theil, in her original contribution, mentioned the four principles and ascribed a growing significance to them in German ethical discourse – albeit without any reference to their source and its authors – she also differentiated between allegedly ‘eccentric’ bioethics and the ‘integrated everyday ethics in medicine’\textsuperscript{56} that dealt with practical questions instead of fancy theories. Only in Reiter-Theil’s very brief editorial for the anesthesiologists did she actually present the ‘central principles of medical ethics’ and their authors as the decisive point of reference for ethics in German medicine.\textsuperscript{57}

Such cautious attempts from the late 1990s and early 2000s to link German medical ethics to the American bioethical concept of principlism prompt the question of why an immediate referencing did not appear prudent already ten years earlier. The answer may be deduced from the fact that most of the German participants of the Kennedy Institute’s bioethics courses stemmed from the medical realm – academics and clinicians from medical schools, biomedical researchers, representatives of professional organizations, private practitioners. An incompatibility appeared to persist between what these participants learned in the United States and how they construed their practice back home, just as Allert pointed out immediately after the courses, and Marckmann and Reiter-Theil acknowledged in their attempts to reconcile the concept of principlism with the physicians’ mindset. This perceived contradiction can be exemplified by looking at the core of bioethical principlism, the principle of autonomy – or rather, of respecting the patient’s autonomy in ultimately making their own decisions about any medical interventions. Discussing the principle of autonomy in their book, Beauchamp and Childress highlighted that this kind of respect had to be claimed since it contradicted the physician’s professional standing: ‘The authority assumed by medical professionals presents many of the difficulties about autonomy and consent that arise in the medical setting.’\textsuperscript{58} What was true for the American medical profession,\textsuperscript{59} turned out to be even more problematic within the German context due to the very understanding of what the term autonomy actually represented and to whom it referred. The BÄK’s journal

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\item Form’, Der Radiologe, 40, 2 (2000), 190–201; idem, ‘Ethik in der Medizin: Bedarf und Form’, Der Urologe, A 39, 2 (2000), 182–93; idem, ‘Ethik in der Medizin: Bedarf und Form’, Der Hautarzt, 52, 12 (2001), 1119–34.
\item S. Reiter-Theil and W. Hiddemann, “Patientenautonomie statt Paternalismus”. Ein Paradigmenwechsel in der klinischen Ethik?’ Der Onkologe, 6, 3 (2000), 190–7; S. Reiter-Theil and W. Hiddemann, ‘Ethics in Medicine’, The European Journal of Health Economics, 2, 1 (2000), 18–25; S. Reiter-Theil, ‘Ethik in der Medizin’, Der Anaesthesist, 49, 11 (2000), 927.
\item Reiter-Theil and Hiddemann, ‘Ethik’, 247.
\item Reiter-Theil, ‘Ethik’, 927.
\item Beauchamp and Childress, Principles, 62.
\item T. M. Olszewski, ‘Between Bench and Bedside: Building Clinical Consensus at the NIH, 1977–2013’, Journal of the History of Medicine and Allied Sciences, 73, 4 (2018), 464–500, 484.
\end{itemize}
during the 1980s occasionally mentioned autonomy in the relation to patients’ choices.\textsuperscript{60} An understanding of the term in relation to professional autonomy was, however, much more prominent, as the head of the BÄK, Karsten Vilmar, repeatedly highlighted.\textsuperscript{61} In the first decades of the Federal Republic, the German medical profession had been overly successful in exerting its professional autonomy against administrative interventions and fiscal limitations.\textsuperscript{62} As a result, German physicians were especially slow to associate the term with patients’ self-determination.\textsuperscript{63} This uncompromising stance in the matter of professional autonomy resulted not least from an image the profession conveyed about its own role during National Socialism: The medical crimes that took place during that era, if acknowledged at all, were understood to have been caused by careerist and pseudo-scientific actors falling prey to the materialist Nazi state’s seduction and subjugation of German physicians. If deviations from the profession’s collective moral integrity had to be acknowledged at all, those were understood as having resulted from the dismantling of the profession’s autonomy.\textsuperscript{64}

As one particularly blunt official claimed in 1979, the Holocaust had been a direct result of the ‘dismantling of the so-called privileges of the liberal professions,’ which destroyed established principles not only of the medical profession’s organization but also of its professional conscience and conduct.\textsuperscript{65} Such rationalizations of the profession’s involvement in and responsibility for crimes against humanity came under scrutiny in the course of the 1970s and 1980s, when the public became increasingly aware of the

\textsuperscript{60} P. Lawin and H. Huth, ‘Grenzen der ärztlichen Aufklärungs- und Behandlungspflicht aus medizinischer und rechtlicher Sicht. Teil I: In Konflikt mit Umwelt und Zeitgeist’, \textit{Deutsches Ärzteblatt}, 79, 12 (1982), A/ B-58–A/B-66; K.-E. Bühler, ‘Aggression und Autonomie’, \textit{Deutsches Ärzteblatt}, 86, 31-32 (1989), A-2236; G. Allert, ‘Das Selbstbestimmungsrecht und der Schutz der Betroffenen sind das Maß: Bioethik in den USA – eine kurzgefaßte Übersicht’, \textit{Deutsches Ärzteblatt}, 86, 49 (1989), A-3780–A-3784.

\textsuperscript{61} K. Vilmar, ‘Selbstverwaltung in Freiheit und Verantwortung. Entwicklung und aktuelle Herausforderung der ärztlichen Körperschaft’ \textit{Deutsches Ärzteblatt}, 75, 39 (1978), A-2169–A-2176; idem, ‘Bericht zur gesundheits-, sozial- und berufspolitischen Lage’, \textit{Deutsches Ärzteblatt}, 79, 21 (1982), A/B-47–A/B-68; idem, ‘Gesundheitspolitik 1985 – ohne Wende?’ \textit{Deutsches Ärzteblatt}, 82, 22 (1985), A-1670–A-1680.

\textsuperscript{62} T. Gerst, ‘Neuaufbau und Konsolidierung. Ärztliche Selbstverwaltung und Interessenvertretung in den drei Westzonen und der Bundesrepublik Deutschland 1945–1995’, in R. Jütte (ed.) \textit{Geschichte der deutschen Ärzteschaft. Organisierte Berufs- und Gesundheitspolitik im 19. und 20. Jahrhundert} (Köln 1997), 195–242; W. Süß, ‘Gesundheitspolitik’, in H.-J. Hockerts (ed.) \textit{Drei Wege deutscher Sozialstaatlichkeit. NS-Diktatur, Bundesrepublik und DDR im Vergleich} (München 1998), 55–100.

\textsuperscript{63} The most important textbook on medical law did not refer to ‘patient autonomy’ until its 7th edition, published in 2014. The first six editions, which appeared between 1983 and 2008, only included the term autonomy as related to the medical profession. E. Deutsch, A. Spickhoff, \textit{Medizinrecht. Arztrecht, Arzneimittelrecht, Medizinproduktrecht und Transfusionsrecht} (7th edn, Heidelberg 2014), 16.

\textsuperscript{64} H.-P. Kröner, ‘Die Bedeutung der NS-Geschichte für die medizinische Ethik’, in R. Toellner and U. Wiesing (eds) \textit{Geschichte und Ethik in der Medizin – von den Schwierigkeiten einer Kooperation} (Stuttgart 1997), 155–72; S. Westermann, ‘Die deutsche Ärzteschaft und ihre Standesvertretung will auch heute mit solchen Personen nichts zu tun haben.’ Die NS-Medizin im Spiegel des “Deutschen Ärzteblattes”’, in R. Kühl, T. Ohnhäuser, and G. Schäfer (eds) Verfolger und Verfolgte. “Bilder” ärztlichen Handelns im Nationalsozialismus (Berlin 2010), 241–60; S. Schleiermacher and U. Schagen, ‘Medizinische Forschung als Pseudowissenschaft. Selbstreinigungsrituale der Medizin nach dem Nürnberger Ärzteprozess’, in D. Rupnow, V. Lipphardt, J. Thiel, and C. Wessely (eds) \textit{Pseudowissenschaft. Konzeptionen von Nichtwissenschaftlichkeit in der Wissenschaftsgeschichte} (Frankfurt am Main 2008), 251–78.

\textsuperscript{65} FR, ‘Holocaust und die Ärzte’, \textit{Frankfurter Rundschau} (10 May 1979).
cruelties of Nazi medicine, accompanied by, and often combined with, criticism of current health care policies and the conduct of health professionals.66 Yet, the ensuing criticism of the medical profession was not linked to contemporary ethical debates: In 1982, the Protestant Academy in Bad Boll, host of the aforementioned Protestant Working Group on Medical Ethics, organized one of the earliest German conferences dedicated to ‘Medicine during National Socialism’ without referring in any way to said working group or establishing any connection between Nazi medicine and medical ethics.67 Although the BÄK supported attempts to implement ethics in medical practice early on, it persistently fended off attempts to problematize its history or connect this history with its ethical engagement, even when explicitly adverted to such a connection: In the early 1990s, it was discovered that some specimen in German anatomical and neuropathological collections stemmed from Nazi victims, fueling yet another discussion about historic responsibility. Canadian physician and medical ethicist William Seidelman, who had helped bring the existence of those specimens to light,68 complained about the general state of ethics in German medicine and the conspicuous absence of German ethicists from the investigation of the specimen collections. He proposed that German medical students undergo a more intensive and obligatory training in ethics, adding that ‘[t]he importance of this subject at German universities does not need to be restated.’69 The BÄK, in its reply, which took a year to be finalized, almost exclusively addressed the progress in establishing ethics at German medical schools while ignoring any connection to the legacy of Nazi medicine.70

Also with regards to connecting ethics and history, the German–American contrast is startling: American bioethicists had addressed purported connections between contemporary bioethical issues and Nazi medical crimes early on while German medical historian and ethicist Richard Toellner decried German medical ethics ‘impotent silence’ regarding Nazi medicine as late as 1997.71 Only around that time did publications appear that drew connections between history and ethics with special attention to Nazi medicine, stemming from Toellner himself as well as some of his former students like

66 H. Tümmers, Anerkennungskämpfe. Die Nachgeschichte der nationalsozialistischen Zwangssterilisationen in der Bundesrepublik (Göttingen 2011); S. Topp, Geschichte als Argument in der deutschen Nachkriegsmedizin. Formen der Vergegenwärtigung der nationalsozialistischen Euthanasie zwischen Politisierung und Historiographie (Göttingen 2013); V. Roelke, ‘Between Professional Honor and Self-Reflection: The German Medical Association’s Reluctance to Address Medical Malpractice during the National Socialist Era, ca. 1985–2012’, in V. Roelke, S. Topp and E. Lepicard (eds) Silence, Scapegoats, Self-Reflection. The Shadow of Nazi Medical Crimes on Medicine and Bioethics (Göttingen 2014), 243–78; C. Kemper, Medicin gegen den Kalten Krieg. Ärzte in der anti-atomaren Friedensbewegung der 1980er Jahre (Göttingen 2016).
67 Evangelische Akademie Bad Boll (ed.) Medicin im Nationalsozialismus. Tagung vom 30. April bis 2. Mai 1982 in Bad Boll (Bad Boll 1982).
68 W. E. Seidelman, ‘Dissecting the history of anatomy in the Third Reich 1989–2010: A personal account’, Annals of Anatomy, 194, 3 (2012), 228–36.
69 Bundesarchiv Koblenz (BArch), B 417/2019, William Seidelman to Berthold Witte, 25 September 1991.
70 Ibid., Bundesärztekammer to Auswärtiges Amt, 5 October 1992.
71 P. Steinfels and C. Levine (eds) ‘Biomedical Ethics and the Shadow of Nazism. A Conference on the Proper Use of the Nazi Analogy in Ethical Debate’, Hastings Center Report, 6, 4 (1976), special supplement; R. Toellner, ‘Das unbußfertige Schweigen. Historische Erfahrung und ethischer Diskurs – Medizinethik in Deutschland nach 1945’, in Ruprecht-Karls-Universität Heidelberg (ed.) Moderne Medicin – Wunsch und Wirklichkeit (Heidelberg 1997), 145–61.
Urban Wiesing (Intensive Bioethics Course 1988, Advanced Bioethics Course 1990) and Claudia Wiesemann (Extended European Bioethics Course 1990, Advanced Bioethics Course 1992), but also from scholars close to the AEM, like Ulrich Tröhler (Extended European Bioethics Course 1990) and the aforementioned Stella Reiter-Theil.72 The occasion that prompted these short-lived attempts to relate medical ethics to medical history was not only the fiftieth anniversary of the end of World War II and of the Nuremberg Code. Additionally, in the late 1980s, a rather combative trans-ideological movement had begun to form in West Germany that openly associated bioethical scholars and institutions – especially Australian philosopher Peter Singer and the Council of Europe’s bioethics convention – with Nazi medicine for allegedly legitimizing inhumane biomedical concepts and practices. By claiming that the field of bioethics itself aided in the reemergence of eugenics and unfettered human experimentation, the movement tainted not only those bioethical proxies but the very term bioethics in the public eye.73 The German medical profession, and not least proponents of medical ethics, had long disregarded the general historicity of ethical questions and the particular historicity of ethics in German medicine. Due to its lacking distance – or, as it could be put, its lack of autonomy – from the medical profession’s unprocessed past, the bioethical discourse in Germany became guilty by association.74

There is a common denominator that binds together the different phenomena discussed in this article: The delayed implementation of bioethical practices like the living will and hospital ethics committees, the contradictory German perception of the bioethics courses at the Kennedy Institute, the reception of the bioethical concept of principism and the disassociation of autonomy from the will of the patient, as well as the disassociation of history and ethics. All of them derived from the perception that it was necessary to reconcile traditional (German) understandings with emerging (American) concepts in order to define the appropriate place and function of ethics in German medicine. The contentious, selective, and adaptive relationship of German medical ethics with American bioethics resulted from the different protagonists’ insight that, eventually, ethics would only take up its place and function if this place was within the realm of medicine and this function aimed to complement medical decision-making. The discussions and proclamations on the place and function of ethics in German medicine, which continued throughout the 1980s and 1990s, highlight

72 U. Wiesing, ‘Zum Verhältnis von Geschichte und Ethik in der Medizin’, NTM, 3, 1 (1995), 129–44; C. Wiesemann and A. Frewer (eds) Medizin und Ethik im Zeichen von Auschwitz. 50 Jahre Nürnberger Ärzteprozesse (Erlangen 1996); R. Toellner and U. Wiesing (eds) Geschichte und Ethik in der Medizin – von den Schwierigkeiten einer Kooperation (Stuttgart 1997); U. Tröhler and S. Reiter-Theil (eds) Ethik und Medizin 1947–1997. Was leistet die Kodifizierung von Ethik (Göttingen 1997).

73 D. Herzog, Unlearning Eugenics. Sexuality, Reproduction, and Disability in Post-Nazi Europe (Madison, WI 2018), 42–69; Lars Klinnert, Der Streit um die europäische Bioethik-Konvention. Zur kirchlichen und gesellschaftlichen Auseinandersetzung um eine menschenwürdige Biomedizin (Göttingen 2009). Cf. Regine Kollek and Günter Feuerstein, ‘Bioethics and Antibioethics in Germany: A Sociological Approach’, Journal International de Bioéthique, 10, 3 (1999), 11–20.

74 Contemporary observers were startled by the state of political-ethical discourse in Germany. See ten Have, ‘Principlism,’ 111; M. A. M. de Wachter, ‘The European Convention on Bioethics’, Hastings Center Report, 27, 1 (1997), 13–23.
this perception: Already in 1982, when a Working Group of Medical Ethics Committees was being founded to coordinate regulations and counseling on research ethics, the participants thought it prudent to explicitly distance their narrow task from ‘American conventions, including the English/American term “Medical ethics’.’75 Eduard Seidler (Extended German Bioethics Course 1987, Extended European Bioethics Course 1990), another medical historian and early proponent of medical ethics, claimed that no ‘“ ethicist’’ would establish ethics in German medicine since it was not perceived as a ‘special subject, but a practical and theoretical task running across disciplines.’ Consequently, he argued against the denomination of this task as bioethics and preferred the more inclusive formulation ‘ethics of the healing professions.’76 The AEM, which Seidler helped found and presided over from 1988 to 1992, adopted this viewpoint, also highlighting in the first issue of its journal, published in 1989, that ethics was not and should not be ‘a discipline separated from other subjects of medicine’ but a ‘challenge and a duty’ of all healthcare professionals.77

The effort to differentiate German medical ethics from American bioethics was especially noticeable when, in 1988, the AEM discussed recommendations for ethics in medical education: The members with the strongest ties to American bioethics and, in particular, the Kennedy Institute, Hans-Martin Sass and Bettina Schöne-Seiffert (Intensive Bioethics Course 1983, Extended European Bioethics Course 1990), a physician who also held a Master’s degree in philosophy from Georgetown University, strongly disagreed with the very idea of publishing such a proposal. Both felt that the field was not yet able to provide qualified staff, and Schöne-Seiffert even characterized the draft as a ‘project of prematurely instituting “medical ethics”’ by physicians for physicians.78 Nevertheless, the AEM published its recommendations, clarifying that training in ethics was an interdisciplinary obligation and did not require some ‘independent discipline of “medical ethics”’.79 To compensate for the undeniable lack of qualified teachers, the AEM established a ‘Teachers’ Training Course’ in 1992, which addressed an interprofessional group of medical practitioners and students.80 In this way, the AEM tackled the lack of ethical reflection during both medical education and medical practice not by trying to impose the standardized approach of American bioethics but by slowly developing inroads, providing encounters, and, thereby, increasing the

75 BArch, B 189/16569, Heinz Lothar Jelen, Bundesministerium für Jugend, Familie und Gesundheit, Rundschreiben, 18 November 1982. The term ‘Medical ethics’ was rendered in English and in quotation marks in the original German text.
76 E. Seidler, ‘Bioethik oder Ethik der Heilberufe?’ Medizin Mensch Gesellschaft, 11, 4 (1986), 258–63, 261. ‘Ethicist’ was rendered on quotation marks in the original text.
77 F. Anschütz, D. Ritschl, and E. Seidler, ‘Editorial’, Ethis in der Medizin, 1, 1 (1989), 1–2, 1.
78 AEM, Ordner Schriftwechsel, Tagesordnungen, Protokolle AEM (1986–1989), Bettina Schöne-Seiffert to Helmut Piechowiak, 9 February 1988. ‘Medical ethics’ was rendered in quotation marks in the original text.
79 Akademie für Ethik in der Medizin, ‘Empfehlungen für die Weiterentwicklung des Unterrichtsangebotes zu Fragen der Ethik in der Medizin’, Ethis in der Medizin, 1, 1 (1989), 59–62, 60. ‘Medical ethics’ was rendered in quotation marks in the original text.
80 S. Reiter-Theil, W. Kahlke, and R. Dressel, ‘Teachers’ Training Course. Ein Projekt der Akademie für Ethik in der Medizin’, Diskussionsforum Medizinische Ethik, 9/10 (1993), XLIX–LI. Supplement to Wiener medizinische Wochenschrift 144, 3 (1994).
acceptance of ethical training within German medicine. It was no accident that, in the first textbook on medical ethics, published by the AEM in 1995, its president, surgeon Hans-Konrat Wellmer, still highlighted that ‘ethics is not a medical subject’. This statement pointed to the lasting lack of acknowledgment and representation of ethics in German medicine at the time. Simultaneously, the aforementioned Claudia Wiesemann straightforwardly pointed out that the ‘greatest obstacle’ to this task was by no means political – since the public demand for ethical considerations was steadily growing – but professional: It were the physicians who objected to ethical constraints in their autonomous decision-making, so ethics needed to be repackaged not as a limitation but as an amplification of their authority. In 1998, Wiesemann became one of the first German chairholders for medical ethics at the medical school of Göttingen University.

This last example, in particular, provides insight into why the movement of bioethical knowledge from the United States to Germany proceeded with such difficulty and so belatedly despite the abundance of intellectual and personal contacts between the two countries. Still in the 1990s, proponents of this movement, such as Claudia Wiesemann, were well aware that implementing ethics in German medicine required a humble demeanor and an emphasis on the fact that it bore a close relationship to the medical profession. Nothing highlights the reservation those advocates felt more than the fact that some of the most ardent among them not only completely abandoned the term bioethics but even put the term medical ethics in quotation marks as if to suggest that it lacked earnestness or authenticity in the German context. When one compares this approach to one of the earliest programmatic texts of American bioethics from 1973, in which philosopher Daniel Callahan proclaimed ‘bioethics as a discipline’, that is, as a legitimate form of non-medical expertise with the authority to engage in and provide effective advice on the most controversial issues of biomedical research and practice, the contrast could hardly be any starker. American bioethics had not only set out to form a new discipline but also understood itself as a mode of exhibiting ethical discipline over professional medicine and biomedical research. The implementation of ethics in German medicine, on the other hand, could be interpreted rather as a form of professionalization, that is, a specification and modernization of the physician’s conduct towards the patient or of the scientist’s research practice – not as an external constraint. This does not mean that the two approaches necessarily contradicted each other, or aimed at different outcomes. It means that different approaches were necessary to achieve comparable outcomes, just as different strategies were needed to legitimize the implementation of new concepts and practices that, in the end, turned out to be quite similar in both settings. The belated implementation of manifestly American-inspired ethical practices and concepts in German medicine appears to have been the product not of ignorance but of strategic reservation. The beginning and early development of

81 H.-K. Wellmer, ‘Geleitwort’, in W. Kahlke and S. Reiter-Theil (eds) Ethik in der Medizin (Stuttgart 1995), V.
82 C. Wiesemann, ‘Das Erlanger Modell. Urteilskraft und Handlungskompetenz als Lernziele des Ethikunterrichts’, Ethik in der Medizin, 6, 2 (1994), 93–8, 94.
83 D. Callahan, ‘Bioethics as a Discipline’, Hastings Center Studies, 1, 1 (1973), 66–73.
ethics in German medicine reflected the advanced American bioethical context as a point of reference for legitimizing a general idea, and simultaneously regarded American bioethics as something it had to differentiate itself from in order to legitimize the independent development of ethical considerations that would be better adapted to the German context of scientific and professional medicine – a process of legitimization, differentiation and adaptation that, in the end, would result in a long delay of actual implementation and institutional representation. It could be argued that this was the predictable outcome of the continuous downplay of the fields own disciplinary ambitions, as much as it was the only outcome that appeared attainable.

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