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EDITORIAL

End-of-life: assisted dying to active euthanasia – the Kessler Twins Continuum

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On 17 November 2025, twin sisters, Alice and Ellen Kessler, aged 89 years, died in their home in Grunwald, Germany, by a joint assisted suicide [1]. They had both told the Italian news outlet, Corriere della Sera, in 2024, their wish was '*to leave together, on the same day… The idea that one of the two will go first is very difficult to bear*' [1]. They were successful entertainers (singing, dancing and acting) in Europe and the United States between 1947 and 2016 [2]. Ellen Kessler suffered a stroke in October 2025, and their general quality of life was declining due to heart problems. Neither wanted to be dependent on nursing care, and they wanted to die together [2]. There were no mental health issues [1].

Their deaths have fuelled debate in Germany, where active euthanasia is still a criminal offence. However, in 2020, the Federal Constitutional Court established the fundamental right to a self-determined death and decriminalised assisted suicide, provided that the person who ends their life carries full responsibility [3]. The Kessler twins administered the life-ending drugs in the presence of a physician and a lawyer [1]. Their deaths are also bound to feed into the current legislative process on the assisted dying bill in the United Kingdom [4].

The contradictory nature of the German laws means that assisted suicide is unregulated, and therefore not limited to terminal illnesses. This raises the issue of assisted suicide due to the 'pain of living', an existential pessimism, the uneasiness faced with an existence perceived as absurd and meaningless [5]. The author inferred this scenario from the twins' utterances in the year preceding their deaths [1–3, 5]; however, her conclusion was not sound given her premises. There was nothing in the twins' public utterances that revealed their philosophy of life, and they led fulfilling and successful lives. The motive for their action was utilitarian, '*to avoid dependence on nursing care and to die together*' [1–3, 5].

The author went on to invoke the slippery slope fallacy, decried the loss of the sacredness of life and described assisted dying as evil that grips society [5]. This is divine command theory, and its place in a secular society is less relevant. However, the 'pain of living' as a reason for assisted dying should be a cause for concern for society at large.

At 89 years, the actuarial life expectancy for a female in the United Kingdom is 4.99 years [6]. Given the very little that is known about the Kessler twins' health, both seemed to be in decline [2]. However, it is reasonable to assume that they had less than 5% of their lives remaining. Other factors that are worth considering are as follows:

1. They had a successful career spanning 69 years and retired 9 years ago [2].
2. They won awards in their lifetime, including the Bavarian Order of Merit in 2025 [2].
3. They no longer had any relatives [5].
4. They did not want to be dependent on nursing care [2].
5. They wanted to die together [1, 2] and couldn't bear that one went before the other [1].
6. They had a fundamental right to self-determined death [1, 3].
7. They bequeathed their estate to five charitable and social organisations [2].

Before evaluating their actions within the standard ethical framework triangle, it is worth reflecting on the words of the 18th-century Scottish philosopher, David Hume (1711–1776), in his essay 'On Suicide' [7], '*I believe that no man ever threw away life while it was worth keeping. For such is our natural horror of death, that small motives will never be able to reconcile us to it*'.

From publicly available information, one can never infer with certainty how virtuous the twins were. However, they were hardworking, led successful and fulfilling lives, and they contributed positively to their society. They showed courage as their lives slowly came to an end, exploring their options. They were honest about their motives and showed compassion in their bequests. One can infer that the Kessler twins were good moral agents in their life decisions. The second part of the ethical framework concerns guiding principles and rules. Beyond the fundamental right to a self-determined death under German law, which does not equate with ethical rightness, there is no deontological consensus in modern medical practice in these situations.

The third part of the ethical framework concerns outcomes and consequences, on which most medical decisions

are based. Do the positive impacts of the Kessler twins' death predominate over the negative consequences for the greater number of people? The twins had retired for almost a decade before their deaths; thus, their economic impact was negligible, and there were no broken contracts or engagements. Though likely unintended, their bequest to charitable and social organisations and the people they serve came earlier, thereby having a positive impact. They had no family apart from each other, and their friends had known about their intentions through their public utterances, for there to be any significant adverse consequences beyond the normal grief at the loss of a friend. Overall, the positive outcomes of the twins' actions were greater for them, with an inconsequential negative impact on others; denying them their wishes would have caused harm. We can infer that their action was morally right for them and ethical.

While the end-of-life bill currently before the English parliament addresses terminally ill patients [4], many of the reasons in the Kessler twins' case apply but are more urgent. We need to examine current practices of terminating life before its natural end. From the fertilisation of the egg, an irreversible process of life (PoL) begins and continues until natural death in old age [8]. The concept of the PoL simplifies the spectrum of human biology to its basic components. At any stage, this PoL may end prematurely due to natural or human factors. The moral agents for human factors are either external or internal (i.e. self).

After fertilisation, during the zygote-morula stage, as it traverses the fallopian tube, it can get stuck, leading to ectopic pregnancy, and the blastocyte may not implant in the uterine wall. These, and miscarriages from chromosomal, foetal and abnormal maternal health problems, lead to the premature end of the PoL due to nature. Human factors in the premature end of PoL are abortions and selective foetal reduction in multifetal pregnancies, and the moral agents in both cases are external.

After birth, diseases bring a premature end to PoL due to nature. Human factors due to external moral agents include passive euthanasia [9], work-related suicides [10], judicial executions, unfitness for surgery and other medical treatments, withdrawal of treatment due to poor prognosis, end-of-life pathway [11] and best supportive care in incurable cancers. Human factors due to internal moral agents (self) include refusal of treatment ab initio [12], withdrawal of consent for further treatment, advance directives, suicides with no underlying mental illness and active euthanasia.

Many medical decisions by external moral agents lead to the shortening of life expectancy, which may be active, as in selective foetal reduction, or passive in passive euthanasia [9], or patients put on an end-of-life pathway [11], and the shortening may be a matter of hours or days. These, along with advance directives and refusal of treatment ab initio [12], indicate society's acceptance of the shortening of life in appropriate settings. However, various objections are raised when it comes to cases of assisted dying and active euthanasia. The objections include the erosion of the sanctity of life [5], conflict in the traditional roles of doctors in preserving life, slippery slope, divine gift, pressure to die and competition with palliative care. These are the contradictory societal attitudes towards death.

Death occurs naturally, and dying naturally is good; therefore, everyone ought to die naturally. This statement is a philosophical and ethical viewpoint that continues to guide our attitudes towards death. The statement, however, falls foul of David Hume's law that a moral or judgemental conclusion or prescriptive statements cannot be inferred from purely descriptive factual statements [13]. He wrote that the prescriptive statement should have a rationale and be observed and explained. The main reasons for the prescriptive statement that we may infer are the sanctity of life – that is, life is inherently valuable and should not be intentionally ended regardless of suffering – the belief that life is a divine gift that humans should not interfere with natural death. However, these reasons are undermined by Christian theology, in which the crucifixion is central to its beliefs because of its utilitarian consequentialism. Furthermore, modern medicine prolongs life with interventions like chemotherapy, pacemakers, ventilators and home parenteral nutrition, which raises a question about what a natural end of life is.

To address the remaining objections, we need to examine two cases. Baby John Pearson was born on 28 June 1980 in Derby, United Kingdom, with Down's syndrome and some other congenital abnormalities. After speaking to Baby John's parents, who indicated that they did not wish the baby to survive, consultant paediatrician, Dr Leonard Arthur, ordered nursing care only and prescribed DF118 (an opiate) 5 mg four hourly. Baby John died of bronchopneumonia 3 days later. Dr Arthur was charged with attempted murder [9, 14]. The prosecution said it was wrong to kill an innocent disabled human being, and it was wrong to give a strong painkiller to a neonate whose pain and distress could have been alleviated by feeding, comforting and antibiotics [9]. The defence argued that he had a duty to relieve, prevent or minimise pain and suffering, and that infants born with severe physical or mental handicaps, for which medical intervention to increase the baby's survival is not justified. If such lives are preserved, chances of ordinary human flourishing are low. Furthermore, they will impose a significant burden on their parents and community [9]. A jury acquitted Dr Arthur.

Dr Arthur's legal acquittal did not imply that his actions were ethical. Dr Arthur was an external moral agent who made moral decisions on behalf of Baby John. The purported positive consequences of his action was to fulfil the wishes of Baby John's parents, but those wishes were uninformed, given what was known about Down's sydnrome. The negative impacts were many. During his defence, they

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acknowledged that some parents find the additional responsibility of looking after handicapped children enriching, and some handicapped children grow up to have worthwhile lives [9]. Baby John could have had foster or adoptive parents with a similar outlook. If Baby John had lived for only 1 year, his death at 3 days would have deprived him of over 99% of his life. Baby John's parents could have been supported psychologically, and with time, they could have made a different decision. Publicly, Dr Arthur's actions could be seen as an endorsement for parents of newborn severely disabled children who are so inclined to ask for euthanasia.

While Dr Arthur's action was passive euthanasia, his action had the same end point of shortening a non-terminal life expectancy as in the Kessler twins. This makes the distinction between active euthanasia or assisted dying and passive euthanasia a logical fallacy, a distinction without a difference. In this case, it was all negative consequences of passive euthanasia with no positive impact, in contrast to the Kessler twins. This highlights the fact that it is the consequences of active or passive euthanasia that are morally more important to individuals and those around them than the mechanism or means of achieving the shortening of life.

On 25 October 2007, a 22-year-old mother from Telford, United Kingdom, died hours after giving birth to healthy twins. She was a Jehovah's Witness and had declined blood transfusions, which she needed as she had a post-partum haemorrhage [12]. At 22 years, she still had 62 years (74%) of life left [6], two newborn babies without a mother, a devastated family and a 24-year-old distraught widower [12]. The moral agent was internal (self), and the only harm prevented by her death was the spiritual grief she may have had. However, the negative consequences were far greater than the positive impact of her action. In this case, the foundation of the reason is essential. Jehovah's Witnesses are less than 1% of Christians, and these 99% Christians do not believe that the bible prohibits blood transfusion. Since the texts relied upon are from the Old Testament, the Hebrew Bible, Jews accept blood transfusions when necessary. Since nearly all Christians believe in receiving blood transfusions when needed, the actions of Jehovah's Witnesses in this regard cannot be described as a divine command but as a non-cognitive prescriptivism, which is the antithesis of medical reasoning.

The three cases above illustrate the complexity of premature termination of life. Is the loss of less than 5% of life lost by the Kessler twins less ethical than the 99% lost by Baby John or the 74% lost by the Jehovah's Witness, because the Kessler twins' deaths were assisted? Are the reasons given by the Kessler twins of not wanting to be dependent on nursing care and dying together less logical than the JW's reasons that are not shared by over 99.5% of Christians and Jews, just because their deaths were assisted? Is the prevention of temporal harm to the Kessler sisters any less significant than the prevention of spiritual harm to the Jehovah's Witness, when the associated costs were 5 and 62 years lost, respectively, just because their deaths were assisted? Clearly, the means of achieving the same premature death, passive or active, cannot and should not continue to be society's moral compass; because they do not reflect the degree of harm caused.

By combining moral agency (external or internal), virtue (honest appraisal of decisions), laws and ethical guidelines (cognitivist), and consequences (lesser harm to the dying, long-term loss, harm to others) in people without mental infirmity, one can establish a hierarchy of ethical premature deaths. Among the three cases above, the Kessler twins serve as a benchmark for non-terminally ill elderly patients. The cohort of people being discussed in the end-of-life bill in the British parliament [4] are terminally sick, within six months of their lives. At the ages of 18 and 60, they would have already lived 97% and 99% of their lives, respectively.

The Kessler Twins and Baby John's cases are at the polar ends of the ethical spectrum of premature termination of life. They could represent a continuum to assess many ethical decisions in clinical reasoning (Table 1). The first quartile concerns decisions made in the last years of life, whether due to chronological age or disease. Active euthanasia in the terminally ill and assisted dying in failing health in old age are included in this group because the tide is turning towards these in many societies. In societies where these are controversial or unacceptable, then they would be in the third and fourth quartiles, respectively. The second quartile consists of other age groups, and in many cases, before reaching the end, there might have been counselling or psychological support. In many cases, external factors are involved. Again, depending on the society, they may be in the third or fourth quartiles. Each quartile is arranged in a hierarchy, and the lower down in the quartile, the greater the likelihood of falling into the next lower quartile.

The third quartile represents controversial ethical decisions. Many would argue that the Jehovah's Witness case is about religious freedom and, therefore, divine command, but it is not. It is an interpretation of the bible not shared by the vast majority of Christians, a controversial one that leads to harm to those left behind. In work-related suicides, a court ruled in the United States that a person may be held responsible for the suicide of another [10]. In the United Kingdom, the House of Lords (now the Supreme Court) ruled that a workplace can be held accountable for the suicide of its employee [10]. However, in the United Kingdom, suicides are the only work-related injuries that are not subject to statutory investigations [10], and the ethics of this need to be examined. The fourth quartile represents ethical practices that should be discouraged.

Conclusion

A paradigm shift is necessary in the discourse about assisted dying and euthanasia. By recognising the supremacy of outcome over means, it will be easier to address some of the

Table 1. The Kessler Twin Continuum. EMA – External moral agent, IMA – Internal moral agent (self). In parentheses are, in order, the presumed reason for premature death, the moral agent and the mode of death

First Quartile	[1] Best supportive care (incurable disease, EMA, nature)
	[2] Withdrawal of treatment (futility, EMA, passive euthanasia)
	[3] Revoking treatment consent (exhaustion, IMA, passive euthanasia)
	[4] Terminally ill (imminent death, IMA, active euthanasia)
	[5] The Kessler twins (planned end, IMA, assisted dying)
Second Quartile	[1] Selective foetal reduction (improving outcome, EMA, active euthanasia)
	[2] Suicide in a non-depressed person (exhaustion, IMA, suicide)
	[3] Unfitness for emergency surgery (co-morbidity, EMA, passive euthanasia)
	Caution
Third Quartile	[1] Jehovah's Witness's death (non-cognitivist, IMA, passive euthanasia)
	[2] Suicide due to mental illness (systemic failure, EMA, suicide)
	[3] Work-related suicide (external causation, EMA, suicide)
Fourth Quartile	[1] Paediatric treatment refusal (external causation, EMA, passive euthanasia)
	[2] Baby John Pearson (options not explored, EMA, passive euthanasia)

moral and ethical dilemmas that arise in individual cases, and a better framework will emerge to assist in decision-making. As shown above, the issues around premature end of lives pertain more to motives, reasoning processes, and the resulting harm. The moral agent making the decision is an important consideration, especially external moral agents, because of issues such as clinical reasoning, cognitive biases and systems failure. Whether a doctor gives the medication that could lead to death to the nurse to administer (passive euthanasia), or to the patient to use (assisted dying), or gives it himself (active euthanasia), these distinctions without a difference are immaterial to outcomes and consequences.

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