Euthanasia

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**Definition**

Euthanasia is the act of putting a person (or animal) to death painlessly, or allowing a person (or animal) to die by withholding medical treatment in cases of incurable (and usually painful) disease. The word “euthanasia” comes from two Greek words that mean “good death.” Euthanasia is sometimes called “mercy killing.”

**Description**

***Terms and categories***

It is important to distinguish euthanasia from “assisted suicide,” which is sometimes used loosely as a synonym for euthanasia. Assisted suicide, which is often called “self-deliverance” in Britain, refers to a person's bringing about his or her own death with the help of another person. Because the other person is often a physician, the act is often called “doctor-assisted suicide.” Assisted suicide is illegal everywhere in the United States except the state of Oregon, while euthanasia is illegal in all fifty states. Euthanasia strictly speaking means that the physician or other person is the one who performs the last act that causes death. For example, if a physician injects a patient with a lethal [**overdose**](https://search-credoreference-com.lopes.idm.oclc.org/content/entry/galegnaah/overdose/0) of a pain-killing medication, he or she is performing euthanasia. If the physician leaves the patient with a loaded syringe and the patient injects himself or herself with it, the act is an assisted suicide.

Euthanasia is usually categorized as either active or passive, and as either voluntary or involuntary. The first set of categories refers to the means of ending life, and the second set of categories refers to the agent of the decision. Active euthanasia involves putting a patient to death for merciful reasons; passive euthanasia involves withholding medical care, or not doing something to prevent death. In voluntary euthanasia, the patient is the one who wishes to die and has usually requested either active or passive euthanasia. In involuntary euthanasia, someone else makes the decision to terminate the patient's life, usually because the patient is in a [**coma**](https://search-credoreference-com.lopes.idm.oclc.org/content/entry/galegnaah/coma/0) or otherwise unable to make an informed request to die.

Another important term to understand is the so-called doctrine of double effect. This is a legal term that has been underscored by the United States Supreme Court in one of its decisions. The doctrine of double effect states that a medical treatment intended to relieve [**pain**](https://search-credoreference-com.lopes.idm.oclc.org/content/entry/galegnaah/pain/0) but that incidentally hastens the patient's death is still appropriate and legally acceptable. In other words, a doctor who gives a dying patient high doses of morphine to prevent pain, knowing that such high doses may shorten the patient's life by a few days, is protected by the doctrine of double effect.

***Historical overview***

Although euthanasia has been practiced in various human societies for centuries, it became a major social issue only in the twentieth century. Some ancient societies allowed infants born with serious [**birth defects**](https://search-credoreference-com.lopes.idm.oclc.org/content/entry/galegnaah/birth_defects/0) to die, and some allowed the elderly to starve themselves to death as a form of voluntary euthanasia. In addition, it was not unusual for soldiers on the battlefield to give a death blow, or coup de grâce, to a mortally wounded comrade to prevent him from being captured by the enemy as well as to end his suffering. The French phrase literally means “stroke of mercy.”

In the nineteenth century, euthanasia became a topic of ethical discussion partly because the discovery of reliable anesthetics and analgesic (pain-killing) medications meant that painless death was now easier to bring about. Prior to this period, the methods of suicide that were available to people were either violent, painful, or uncertain—and sometimes all three. For example, when the heroine of one mid-nineteenth-century French novel commits suicide by taking arsenic, the author describes her agonizing death in clinical detail. But after the discovery of chloroform, ether, [**nitrous oxide**](https://search-credoreference-com.lopes.idm.oclc.org/content/entry/galegnaah/nitrous_oxide/0), and similar anesthetics, people began to consider using them to relieve the suffering of the dying as well as the pain involved in surgical operations.

In the twentieth century, a number of social and technological changes made euthanasia a morally acceptable choice to growing numbers of people. The Euthanasia Society of America (which changed its name to the Society for the Right to Die in 1975) was founded as early as 1938. One important change was the increasing size of the elderly population, a development that resulted from the lengthening of the life span brought about by advances in medical science. A second was the invention of respirators, intravenous feeding, dialysis machines, and other means of prolonging a patient's life even in cases of terminal illness. Discomfort at the thought of ending one's life at the mercy of machinery is frequently mentioned in public opinion polls as a justification for euthanasia or assisted suicide. Another important transition was a change in social attitudes in favor of individual freedom and autonomy, rather than emphasizing a person's membership in a family or community. Many people today feel strongly that they are the best judges of their own well-being, and that they should have the “right to die” if necessary.

In late 2005, the U.S. Supreme Court agreed to again take up the issue of assisted suicide in a challenge to Oregon's *Death with Dignity* law. The justices were to consider whether the U.S. attorney general could use federal drug-control laws to punish physicians who prescribe death-hastening drugs to patients. In October of that year, the U.S. Supreme Court heard arguments and on January 17, 2006, the Court ruled 6–3 in favor of Oregon, upholding the law.

**Viewpoints**

***Medical professionals***

Many North American professional societies in the health care professions have stated their opposition to active euthanasia. The American Medical Association (AMA) sponsored the establishment of an Institute for Ethics in the late 1990s, intended to educate American doctors about pain relief, palliative care at the end of life, and alleviation of patients' fears. The AMA has expressed its concern about the expansion of doctor-assisted suicide in the Netherlands—which became legal in April 2001—to include euthanasia without the patient's knowledge or consent. The American Nurses Association (ANA) signed on to the *amicus curiae* (friend of the court) brief submitted by the AMA to the United States Supreme Court in 1997 opposing doctor-assisted suicide. The ANA also stated that the health care professions should emphasize respectful, compassionate, and ethically responsible care at the end of life, including palliative care, so that patients do not seek assisted suicide as an alternative.

***Religious groups***

In the United States and Canada, most mainstream Christian and Jewish groups remain opposed to active and involuntary euthanasia, though some permit carefully regulated forms of passive euthanasia. Christian and Jewish groups emphasize not only God's ultimate power over death and life, and the value of human beings as creatures made in God's image, but also the relationships that bind humans to one another and to God. From this perspective, these religious traditions stand in contrast to the individualism of much of secular culture.

Contemporary Buddhist thought is divided on the issue of euthanasia. Some Buddhist ethicists believe that euthanasia and assisted suicide are both consistent with Buddhist principles, but others disagree. One reason for the disagreement is the fact that Buddhism encountered Western medicine and its ethical dilemmas only relatively recently.

**Professional implications**

***The goals of medicine and health care***

Euthanasia and assisted suicide compel medical professionals to reexamine their understanding of the purposes and goals of medical treatment. Those who maintain that preserving life and doing no harm are central to the ethical practice of medicine will have a different view of euthanasia from those who regard the relief of suffering as central.

***Professional-patient relationships***

The brief that the AMA submitted to the Supreme Court in 1997 included physician-patient relationships among its reasons for rejecting doctor-assisted suicide. Many American and Canadian physicians believe that acceptance of doctor-assisted suicide would undermine the credibility of the health care professions, and destroy trust between doctors and patients. In addition, others have pointed to the potential abuse of a physician's power to end a patient's life.

***Interprofessional consultation and cooperation***

Euthanasia and assisted suicide are questions that involve public policy, the legal system, and religious institutions as well as the health care professions. The complexity of the social and political considerations, together with the moral concerns, requires better communication among these different groups. One promising development has been the introduction of graduate-level ethics courses that bring together students from law, medical, nursing, and theological schools. Another has been the establishment of research centers and “think tanks” devoted to end-of-life issues.

**KEY TERMS**