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### **Differentiating Assisted Suicide and Euthanasia**

By Karen Ward, RN

Familiarity with the terms euthanasia and physician assisted suicide (PAS) can save your life, or that of your loved ones. In the world today, there are those who support and those who oppose these practices. Depending on whether you support or oppose the practice is often the result of knowledge in the form of misleading information, or lack of information. Then there are those who feel assisted suicide or euthanasia is your right, your choice, and a compassionate act.

Euthanasia is defined as an act of killing or permitting death. The word comes from the Greek language and means easy death.

Suicide is defined as an act of taking one's own life voluntarily and intentionally. One does not necessarily have to be of sound mind to end their life.

Physician Assisted Suicide (PAS) generally combines the suicide act with physician involvement in the form of prescribing medication lethal enough to kill, offering advice on how to kill, or assisting a person with some type of apparatus that enables him/her to take their own life. In some instances, the physician may assist suicide by other means, such as manually discontinuing a ventilator, dialysis, feeding tubes, antibiotics, or refusing to provide any medical treatment aimed at keeping a person alive.

In 1996, the American Medical Association (AMA) offered a position statement of physician assisted suicide which stated, "Physician-assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide)."

AMA further stated that instead of participating in PAS, they should aggressively treat the needs of the patient and not abandon them, if they have an incurable

disease. The position statement was last updated August 22, 2005.  
<http://www.ama-assn.org/ama/pub/category/8459.html>

In 1999, the AMA voted to support the Pain Relief Promotion Act which would prevent the use of controlled substances in physician assisted suicide, while allowing physicians to aggressively treat pain. AMA President at that time, Thomas R. Reardon, MD, stated, "**The AMA opposes physician-assisted suicide as it is antithetical to the role of the physician as healer. We are committed to providing the best possible end-of-life care. The Pain Relief Promotion Act supports both these goals.**"

The American Nurses Association (ANA) states, "**Participation in assisted suicide entails making a means of suicide (e.g., providing pills or a weapon) available to a patient with knowledge of the patient's intention. The patient, who is physically capable of suicide, subsequently acts to end his or her own life. Assisted suicide is distinguished from active euthanasia. In assisted suicide, someone makes the means of death available, but does not act as the direct agent of death.**"

The ANA also instructs and reassures us that the nurse will not deliberately terminate the life of any person. The rationale is listed and in part "prohibits deliberately terminating the life of any human being; nurse participation in assisted suicide is incongruent with the accepted norms and fundamental attributes of the profession; nurses are not obligated to comply with all patient and family requests; assisted suicide practices has the potential for serious societal and professional consequences and abuses."

<http://www.nursingworld.org/readroom/position/ethics/etsuic.htm>

The American Nurses Association (ANA) believes that the nurse should not participate in assisted suicide. Such an act is in violation of the Code for Nurses with Interpretive Statements (Code for Nurses) and the ethical traditions of the profession. C. Everett Koop, M.D, one of the most distinguished Surgeon Generals of our time in handling the emergence of AIDS, instructs us there is a difference in allowing nature to take its course and actively assisting death. He further states, "**While the terror of state-sponsored euthanasia may never grip America as it once did Germany, it is possible that the terror of the euthanasia ethic - tolerated by medicine and an indifferent public and practiced by a few physicians - may grip many invisible and vulnerable Americans.**" "..... medicine cannot be both our healer and our killer."  
<http://www.euthanasia.com/koop.html>

According to Euthanasia Research Guidance Organization, (ERGO) Derek Humphrey not only has a glossary of terms, he defines assisted suicide and euthanasia, and further breaks those definitions down for further specificity. As we see from his definitions, they are not inclusive.

**Euthanasia:** Help with a good death. (Legally vague but useful as a broad,

descriptive term.) ERGO definition

This definition is so vague, its usefulness is in doubt.

**Assisted suicide:** Providing the means (drugs or other agents) by which a person can take his or her own life. ERGO definition

**Physician-assisted suicide:** A doctor providing the lethal drugs with which a dying person may end their life. ERGO definition

A physician may provide more than drugs to assist suicide.

**Physician aid-in-dying:** Euphemistic term for medical doctor assisting the suicide of a dying patient. ERGO definition

Regardless whether a physician “assists” or “aids” in suicide or dying, the same outcome is achieved; death by proxy.

Other definitions include self deliverance, rational suicide, mercy killing, heroic measures, Nazi euthanasia, and even a vegetable. Silent suicide is defined as starving oneself to death, and generally in extreme old age.

<http://www.finalexit.org/more-glossary.html>

The Christian Medical and Dental Association (CMDA) states, “**Practitioners have adopted the role of healer with the goals of healing when possible, and relief of suffering. While there have doubtless been individual physicians and dentists over the centuries who have occasionally helped their patients to die, this activity has clearly remained outside the boundaries of acceptable medical treatment.**”

“**There is professional concern that acceptance of physician involvement in either direct or indirect induced death would seriously undermine the trust that is a necessary component of the physician-patient relationship. If euthanasia becomes accepted, a physician might be tempted to end a patient s life without a request, either out of compassion, or out of self-interest (e.g. when the care of a patient becomes too difficult or burdensome). In addition, there is concern that there might be less impetus to continue work on the significant gains made in good palliative care in the past 20 years.**”

<http://www.cmdahome.org/index.cgiBISKIT=3273571711&CONTEXT=art&art=345>

CMDA offers a glossary of End of Life Terms on assisted suicide and the types of euthanasia, along with examples of each. Utilization of these definitions is far more accurate emanating from a medical professional organization rather than an organization lobbying for changes, such as [MoveOn.org](http://www.MoveOn.org).

**Physician-Assisted Suicide:** Helping a person to kill himself. In physician-assisted suicide (PAS), the doctor prescribes a lethal dose of one or more medications.

**Example:** doctor prescribing a lethal dose of barbiturates which the patient takes himself.

**Euthanasia (Active Euthanasia):** From Greek meaning "good death" - The act or practice of ending the life of an individual suffering from a terminal illness or an incurable condition.

**Example:** Can be passive or active. If active, it can be voluntary, non-voluntary or involuntary. Physician-assisted suicide is a form of euthanasia.

**Passive Euthanasia:** Withholding or withdrawing medical interventions without patient's consent; the intent is to cause death. The patient is not dying but the withdrawal of nutrition/medication will cause death.

**Example:** Not giving insulin to a Type I diabetic; withdrawal of food from a patient with Alzheimer's when they are not dying, with the intent of causing their death. Terri Schiavo is a classic example.

**Voluntary Euthanasia:** Patient consents to doctor's lethal injection.

**Example:** Patient asks doctor for lethal injection; doctor complies.

**Non-voluntary Euthanasia:** Patient's consent not possible due to unconsciousness, mental incompetence or other medical reason.

**Example:** Patient is comatose or demented. Terri Schiavo applies here as well.

**Involuntary Euthanasia:** Patient's consent possible but not sought.

**Example:** Doctor euthanizes patient without his or her consent.

**Medical Futility:** When treatment will have no benefit or is outside accepted medical practice, the clinician may be justified in withholding or withdrawing treatment.

**Example:** "Pulling the Plug"; discontinuing a ventilator or other life support measures in a dying patient.

Do a comparison of Final Exit's definitions with CMDA's definitions as a common sense approach to formulate your opinion.

Terri Schiavo was assisted to die via passive, non-voluntary euthanasia. She was unable to voice her decisions due to her brain injury, and her feeding tube was pulled to commit the act of euthanasia.

Kenneth Stevens Jr., M.D., vice president of Physicians for Compassionate Care Education Foundation concluded Oregon's assisted suicide program is being poorly conducted and managed. The basic Oregon assisted suicide data for the early years has been destroyed. In a personal communication from Darcy Niemeyer of the Oregon Department of Human Services to Dr. Stevens on February 17, 2004, she confirms loss of data. Darcy states, "**Unfortunately, we are unable to provide any additional information than is currently available in our Annual Reports. Prior to 2001, we did collect the names of physicians**

**who were participating. However, because of concerns about maintaining the confidentiality of participating physicians, we began using a numeric coding system in 2001. When we implemented this coding system, we destroyed the identifying data from the earlier years."** Dr Stevens asks, "How can we learn from the "Oregon Experiment" when critical data has been destroyed?"

<http://www.pccef.org/articles/art42UofO.htm>

In conclusion, the definitions you choose to believe are irrelevant, as they all define the same basic acts and leave little doubt in the readers mind in terms of patient examples. The disparities are with the organizations who define these terms, their word choices, and whether they support or oppose assisted suicide and euthanasia. Do you choose medical professionals affiliated with medical organizations when seeking medical clarifications, or those people and organizations that hold an ideological or philosophical belief with a specific agenda?

Assisting suicide is not a merciful or compassionate act. There is nothing dignified in killing yourself or assisting another in killing themselves. Assisting suicide is more abandonment of the ill when they lay dying at the neediest time of their lives. This may be what occurred in New Orleans, if in fact the allegations of euthanasia are found to be factual.

In spite of media portrayals and reports, legislative comments and votes, and unlawful judicial rulings, medical professionals and organizations as a majority voice do not support or approve of assisted suicide. So we must ask this question, why are so many states in this country attempting to pass assisted suicide laws? Why are state and federal lawmakers deaf to the voices of medical professionals when our daily duties are permeated with this ethical issue? 3-1-06

*Karen is a registered nurse with a specialty in obstetrics and currently holds licenses in Ohio and Florida*

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