

**EUTHANASIA: THE SILENT REQUEST FOR BECOMING REST IN PEACE****\*<sup>1</sup>Dr. Kishor Dholwani, <sup>2</sup>Kushal Nandi, <sup>2</sup>Amrita Chakraborty, <sup>2</sup>Dr. Dhruvo Jyoti Sen and <sup>3</sup>Dr. Dhananjay Saha**<sup>1</sup>Laxminarayandev College of Pharmacy, Narmada Nagar, Beside Swaminarayan School, Bholav, Bharuch, Gujarat, India.<sup>2</sup>Department of Pharmaceutical Chemistry, School of Pharmacy, Techno India University, Salt Lake City, Sector-V, EM-4, Kolkata-700091, West Bengal, India.<sup>3</sup>Deputy Director, Directorate of Technical Education, Bikash Bhavan, Salt Lake City, Kolkata-700091, West Bengal, India.**\*Corresponding Author: Dr. Kishor Dholwani**

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**ABSTRACT**

Like other terms borrowed from history, "euthanasia" has had different meanings depending on usage. The first apparent usage of the term "euthanasia" belongs to the historian Suetonius, who described how the Emperor Augustus, "dying quickly and without suffering in the arms of his wife, Livia, experienced the 'euthanasia' he had wished for." The word "euthanasia" was first used in a medical context by Francis Bacon in the 17th century, to refer to an easy, painless, happy death, during which it was a "physician's responsibility to alleviate the 'physical sufferings' of the body." Bacon referred to an "outward euthanasia"—the term "outward" he used to distinguish from a spiritual concept—the euthanasia "which regards the preparation of the soul." In current usage, euthanasia has been defined as the "painless inducement of a quick death". However, it is argued that this approach fails to properly define euthanasia, as it leaves open a number of possible actions which would meet the requirements of the definition, but would not be seen as euthanasia. In particular, these include situations where a person kills another, painlessly, but for no reason beyond that of personal gain; or accidental deaths that are quick and painless, but not intentional. Another approach incorporates the notion of suffering into the definition. The definition offered by the Oxford English Dictionary incorporates suffering as a necessary condition, with "the painless killing of a patient suffering from an incurable and painful disease or in an irreversible coma", This approach is included in Marvin Khol and Paul Kurtz's definition of it as "a mode or act of inducing or permitting death painlessly as a relief from suffering". Counterexamples can be given: such definitions may encompass killing a person suffering from an incurable disease for personal gain (such as to claim an inheritance), and commentators such as Tom Beauchamp and Arnold Davidson have argued that doing so would constitute "murder simpliciter" rather than euthanasia. The third element incorporated into many definitions is that of intentionality – the death must be intended, rather than being accidental, and the intent of the action must be a "merciful death". Michael Wreen argued that "the principal thing that distinguishes euthanasia from intentional killing simpliciter is the agent's motive: it must be a good motive insofar as the good of the person killed is concerned." Likewise, James Field argued that euthanasia entails a sense of compassion towards the patient, in contrast to the diverse non-compassionate motives of serial killers who work in health care professions. Similarly, Heather Draper speaks to the importance of motive, arguing that "the motive forms a crucial part of arguments for euthanasia, because it must be in the best interests of the person on the receiving end." Definitions such as that offered by the House of Lords Select committee on Medical Ethics take this path, where euthanasia is defined as "a deliberate intervention undertaken with the express intention of ending a life, to relieve intractable suffering." Beauchamp and Davidson also highlight Baruch Brody's "an act of euthanasia is one in which one person ... (A) kills another person (B) for the benefit of the second person, who actually does benefit from being killed". Draper argued that any definition of euthanasia must incorporate four elements: an agent and a subject; an intention; a causal proximity, such that the actions of the agent lead to the outcome; and an outcome. Based on this, she offered a definition incorporating those elements, stating that euthanasia "must be defined as death that results from the intention of one person to kill another person, using the most gentle and painless means possible, that is motivated solely by the best interests of the person who dies." Prior to Draper, Beauchamp and Davidson had also offered a definition that includes these elements. Their definition specifically discounts fetuses to distinguish between abortions and euthanasia.

**KEYWORDS:** Euthanasia; end-of-life decision making; physician-assisted dying; mercy killing.

**Euthanasia synonyms:** release from suffering, putting an animal to sleep, mercy-killing, alternative spelling of mercy killing, easy death, non-voluntary, legalisation

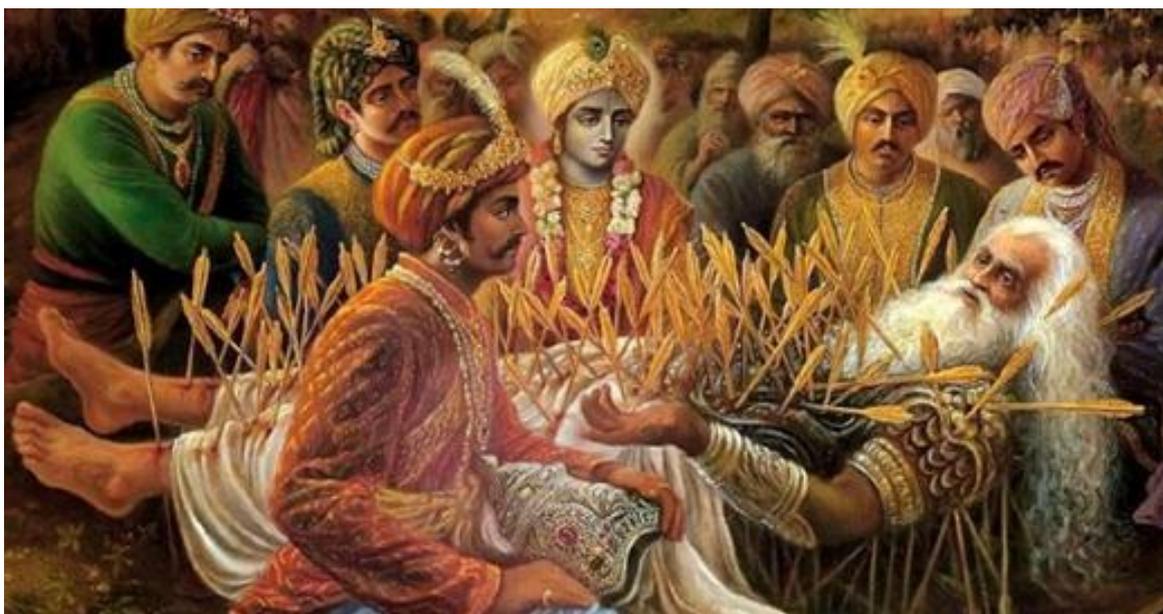
**Murad Jacob "Jack" Kevorkian** (May 26, 1928 – June 3, 2011) was an American pathologist and euthanasia proponent. He publicly championed a terminal patient's right to die by physician-assisted suicide, embodied in his quote, "Dying is not a crime". Kevorkian said that he assisted at least 130 patients to that end. He was convicted of murder in 1999 and was often portrayed in the media with the name of "Dr. Death". There was support for his cause, and he helped set the platform for reform.



**Figure-1: Murad Jacob "Jack" Kevorkian; Euthanasia proponent.**

In 1998, Kevorkian was arrested and tried for his direct role in a case of voluntary euthanasia on a man named Thomas Youk who suffered from Lou Gehrig's disease, or ALS. He was convicted of second-degree murder and served 8 years of a 10-to-25-year prison sentence. He was released on parole on June 1, 2007, on condition he would not offer advice about, participate in, or be present at the act of any type of suicide involving euthanasia to any other person, as well as neither promote nor talk about the procedure of assisted suicide.

**Euthanasia** (from Greek: εὐθανασία 'good death': εὖ, *eu* 'well, good' + θάνατος, *thanatos* 'death') is the practice of intentionally ending life to relieve pain and suffering. A mercy killing is the intentional ending of life of a person who is suffering from a terminal, painful illness. The term—also called “right to die”—is most often used to describe voluntary euthanasia, though it is also used in reference to non-voluntary euthanasia and involuntary euthanasia.



**Figure-2: Bhishma Pitamah of Mahabharat going to embrace death.**

Different countries have different euthanasia laws. The British House of Lords select committee on medical ethics defines euthanasia as "a deliberate intervention undertaken with the express intention of ending a life, to relieve intractable suffering". In the Netherlands and Belgium, euthanasia is understood as "termination of life by a doctor at the request of a patient". The Dutch law, however, does not use the term 'euthanasia' but includes the concept under the broader definition of "assisted suicide and termination of life on request".

- Euthanasia is categorized in different ways, which include voluntary, non-voluntary, or involuntary:

- Voluntary euthanasia is legal in a growing number of countries.
- Non-voluntary euthanasia (patient's consent unavailable) is legal in some countries under certain limited conditions, in both active and passive forms.
- Involuntary euthanasia (without asking consent or against the patient's will) is illegal in all countries and is usually considered murder.

As of 2006 euthanasia had become the most active area of research in bioethics. In some countries divisive public controversy occurs over the moral, ethical, and

legal issues associated with euthanasia. Passive euthanasia (known as "pulling the plug") is legal under some circumstances in many countries. Active euthanasia, however, is legal or *de facto* legal in only a handful of countries (for example: Belgium, Canada and Switzerland), which limit it to specific circumstances and require the approval of counselors and doctors or other specialists. In some countries - such as Nigeria, Saudi Arabia and Pakistan - support for active euthanasia is almost non-existent.<sup>[1]</sup>

**History:** Euthanasia was practiced in Ancient Greece and Rome: for example, hemlock was employed as a means of hastening death on the island of Kea, a technique also employed in Marseilles. Euthanasia, in the sense of the deliberate hastening of a person's death, was supported by Socrates, Plato and Seneca the Elder in the ancient world, although Hippocrates appears to have spoken against the practice, writing "I will not prescribe a deadly drug to please someone, nor give advice that may cause his death" (noting there is some debate in the literature about whether or not this was intended to encompass euthanasia).<sup>[2]</sup>

**Early modern period:** Svecchāmṛtyu (Sanskrit: स्वच्छामृत्यु) {Sva (self) + iccha (will) + mṛityu (death)} is an adjective which means - having death at one's own power or dying at one's own will. It is also sometimes called Icchāmṛtyu (इच्छामृत्यु) meaning "self-willed death" but it is not to be confused with immortality or self-inflicted death. Shantanu had granted to his son Gangaputra Devavrata, also known as Bhishma, the supernatural power of Svecchamṛityu. Mahabharata records that Bhishma did choose the time and manner of his own death. In the course of his visit to Amarnath cave, Swami Vivekananda had the vision of Lord Shiva in the cave and was blessed with the boon of death-at-will (iccha-mṛityu). He had predicted that he would not live forty years, he did not. Acquaintances of Mahatma Sisir Kumar and Pandit Dinabandhu Vedantaratra also attest to the fact that they have willed their own death. The Svadhishtana Chakra is the Abode of the Tattva Apas; one conquers death with the awakening of this chakra. As one of the twenty-six siddhis that form part of Kundalini yoga, Iccha-mṛityu siddhi gives the yogi the power to die at will. According to Aurobindo the sadhaka of Integral yoga aims at complete liberation from all attacks of illness, and the power to prolong life at will – Iccha-mṛityu. The term *euthanasia*, in the earlier sense of supporting someone as they died, was used for the first time by Francis Bacon. In his work, *Euthanasia medica*, he chose this ancient Greek word and, in doing so, distinguished between *euthanasia interior*, the preparation of the soul for death, and *euthanasia exterior*, which was intended to make the end of life easier and painless, in exceptional circumstances by shortening life. That the ancient meaning of an easy death came to the fore again in the early modern

period can be seen from its definition in the 18th century *Zedlers Universallexikon*:

Euthanasia: a very gentle and quiet death, which happens without painful convulsions. The word comes from *eu*, *bene*, well, and *θανατος*, *mors*, death.

The concept of euthanasia in the sense of alleviating the process of death goes back to the medical historian, Karl Friedrich Heinrich Marx, who drew on Bacon's philosophical ideas. According to Marx, a doctor had a moral duty to ease the suffering of death through encouragement, support and mitigation using medication. Such an "alleviation of death" reflected the contemporary *zeitgeist*, but was brought into the medical canon of responsibility for the first time by Marx. Marx also stressed the distinction between the theological care of the soul of sick people from the physical care and medical treatment by doctors.<sup>[3]</sup>

Euthanasia in its modern sense has always been strongly opposed in the Judeo-Christian tradition. Thomas Aquinas opposed both and argued that the practice of euthanasia contradicted our natural human instincts of survival, as did Francois Ranchin (1565–1641), a French physician and professor of medicine, and Michael Boudewijns (1601–1681), a physician and teacher. Other voices argued for euthanasia, such as John Donne in 1624, and euthanasia continued to be practised. In 1678, the publication of Caspar Questel's *De pulvinari morientibus non-subtrahend*, ("On the pillow of which the dying should not be deprived"), initiated debate on the topic. Questel described various customs which were employed at the time to hasten the death of the dying, (including the sudden removal of a pillow, which was believed to accelerate death), and argued against their use, as doing so was "against the laws of God and Nature". This view was shared by others who followed, including Philipp Jakob Spener, Veit Riedlin and Johann Georg Krünitz. Despite opposition, euthanasia continued to be practised, involving techniques such as bleeding, suffocation, and removing people from their beds to be placed on the cold ground.

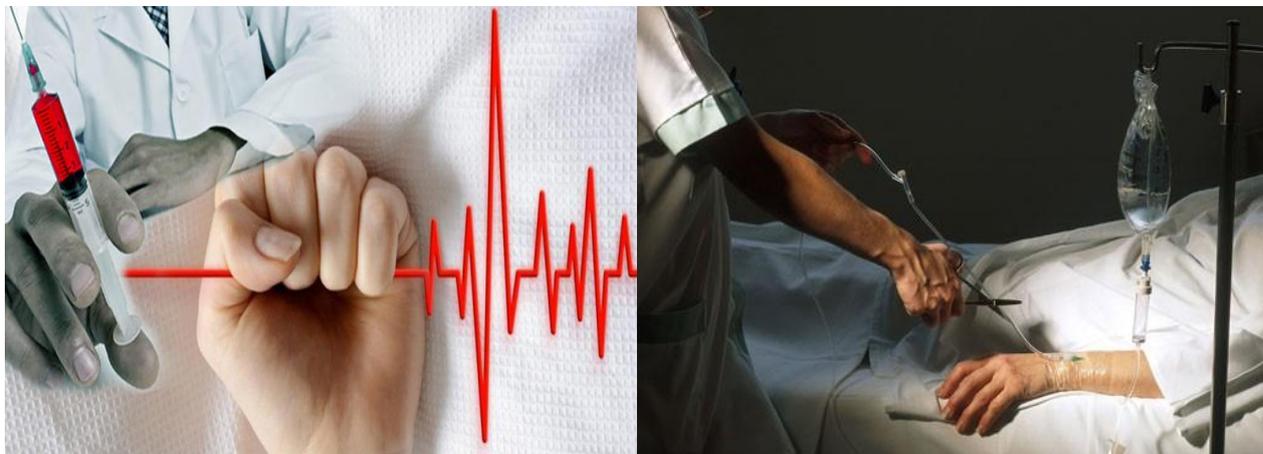
Suicide and euthanasia became more accepted during the Age of Enlightenment. Thomas More wrote of euthanasia in *Utopia*, although it is not clear if More was intending to endorse the practice. Other cultures have taken different approaches: for example, in Japan suicide has not traditionally been viewed as a sin, as it is used in cases of honor, and accordingly, the perceptions of euthanasia are different from those in other parts of the world.<sup>[4]</sup>

**Classification:** Euthanasia may be classified into three types, according to whether a person gives informed consent: voluntary, non-voluntary and involuntary.

There is a debate within the medical and bioethics literature about whether or not the non-voluntary (and by

extension, involuntary) killing of patients can be regarded as euthanasia, irrespective of intent or the patient's circumstances. In the definitions offered by Beauchamp and Davidson and, later, by Wreen, consent

on the part of the patient was not considered one of their criteria, although it may have been required to justify euthanasia. However, others see consent as essential.



**Figure-3: Euthanasia process.**

**Voluntary euthanasia:** Voluntary euthanasia is conducted with the consent of the patient. Active voluntary euthanasia is legal in Belgium, Luxembourg and the Netherlands. Passive voluntary euthanasia is legal throughout the US per *Cruzan v. Director, Missouri Department of Health*. When the patient brings about their own death with the assistance of a physician, the term assisted suicide is often used instead. Assisted suicide is legal in Switzerland and the U.S. states of California, Oregon, Washington, Montana and Vermont.

**Non-voluntary euthanasia:** Non-voluntary euthanasia is conducted when the consent of the patient is unavailable. Examples include child euthanasia, which is illegal worldwide but decriminalised under certain specific circumstances in the Netherlands under the Groningen Protocol. Passive forms of non-voluntary euthanasia (i.e. withholding treatment) are legal in a number of countries under specified conditions.<sup>[5]</sup>

**Involuntary euthanasia:** Involuntary euthanasia is conducted against the will of the patient.

**Passive and active euthanasia:** Voluntary, non-voluntary and involuntary types can be further divided into passive or active variants. Passive euthanasia entails the withholding treatment necessary for the continuance of life. Active euthanasia entails the use of lethal substances or forces (such as administering a lethal injection), and is more controversial. While some authors consider these terms to be misleading and unhelpful, they are nonetheless commonly used. In some cases, such as the administration of increasingly necessary, but toxic doses of painkillers, there is a debate whether or not to regard the practice as active or passive.

**Death drugs:** In 2007 and 2013, physicians were asked to indicate prestructured response categories, which were 1) neuromuscular relaxant (curare or similar drug), 2) barbiturate, 3) benzodiazepine, 4) morphine or other opioid, and 5) other drug, with the possibility to specify the other drug in writing.

**Psychological background behind Euthanasia:** Patients suffering unbearably may wish to hasten their death. Since 2002, the Netherlands has been one of the few countries where euthanasia and assisted suicide (EAS) is allowed under strict conditions. The practice of EAS is restricted to physicians who must adhere to the "statutory due care criteria," i.e., they must (1) be satisfied that the patient's request is voluntary and well-considered; (2) be satisfied that the patient's suffering is unbearable and without prospect of improvement; (3) have informed the patient about his situation and prognosis; (4) have come to the conclusion, together with the patient, that there is no reasonable alternative; (5) consult at least one other, independent physician; and (6) exercise EAS with due medical care and attention.



Figure-4: Death drugs.

Furthermore, the cause of suffering underlying the request must have a medical dimension, either somatic or psychiatric, and physicians must report each case to the Regional Euthanasia Review Committees which review all EAS cases regarding whether the due care criteria were met. In the past decade, the percentage of all deceased patients in the Netherlands who requested EAS prior to their death increased, from 5.2% in 2005, to 6.7% in 2011, and to 8.4% in 2015. Also, the percentage of requests that were carried out increased, from 37% in 2005, to 45% in 2010 and to 55% in 2015. Hence, not only is there a growing demand for EAS, requests are

also more likely to result in EAS. Some evidence, however, suggests that requesting and receiving euthanasia depends, at least to some extent, on the cause of suffering. For instance, patients who have cancer are more likely to request EAS compared to those with cardiovascular diseases. Patients with physical symptoms, cancer, and a short life expectancy are more likely to receive EAS than others, while patients with depressive symptoms are less likely. Also, demographic and care factors have been reported to influence requesting and receiving EAS. Recently, EAS in patients with psychiatric disorders, dementia, or an accumulation

of health problems related to old age (from now, accumulation of health problems) has taken a prominent place in the public debate. In the Dutch Euthanasia Code, this last category, an accumulation of health problems, is referred to as a range of, mostly degenerative, disorders such as visual impairment, hearing impairment, osteoporosis, arthrosis, balance disorders, and cognitive decline. Though the numbers are small, reports of the Euthanasia Review Committees have shown that the absolute number of EAS cases in people whose primary cause of suffering was a psychiatric disorder, dementia, or an accumulation of health problems has increased over the past 5 years.<sup>[6]</sup>

**Debate:** Historically, the euthanasia debate has tended to focus on a number of key concerns. According to euthanasia opponent Ezekiel Emanuel, proponents of euthanasia have presented four main arguments: a) that people have a right to self-determination, and thus should be allowed to choose their own fate; b) assisting a subject to die might be a better choice than requiring that they continue to suffer; c) the distinction between passive euthanasia, which is often permitted, and active euthanasia, which is not substantive (or that the underlying principle—the doctrine of double effect—is unreasonable or unsound); and d) permitting euthanasia will not necessarily lead to unacceptable consequences. Pro-euthanasia activists often point to countries like the Netherlands and Belgium, and states like Oregon, where euthanasia has been legalized, to argue that it is mostly unproblematic.<sup>[7]</sup>

Similarly, Emanuel argues that there are four major arguments presented by opponents of euthanasia: a) not all deaths are painful; b) alternatives, such as cessation of active treatment, combined with the use of effective pain relief, are available; c) the distinction between active and passive euthanasia is morally significant; and d) legalising euthanasia will place society on a slippery slope, which will lead to unacceptable consequences. In fact, in Oregon, in 2013, pain wasn't one of the top five reasons people sought euthanasia. Top reasons were a loss of dignity, and a fear of burdening others.

In the United States in 2013, 47% nationwide supported doctor-assisted suicide. This included 32% of Latinos, 29% of African-Americans, and almost nobody with disabilities.

A 2015 Populus poll in the United Kingdom found broad public support for assisted dying. 82% of people supported the introduction of assisted dying laws, including 86% of people with disabilities.

An alternative approach to the question is seen in the hospice movement which promotes palliative care for the dying and terminally ill. This has pioneered the use of pain-relieving drugs in a holistic atmosphere in which the patient's spiritual care ranks alongside physical care. It 'intends neither to hasten nor postpone death'.<sup>[8]</sup>

One concern is that euthanasia might undermine filial responsibility. In some countries, adult children of impoverished parents are legally entitled to support payments under filial responsibility laws. Thirty out of the fifty United States as well as France, Germany, Singapore, and Taiwan have filial responsibility laws.

### Religious views

#### Christianity

**Broadly against:** The Roman Catholic Church condemns euthanasia and assisted suicide as morally wrong. It states that, "intentional euthanasia, whatever its forms or motives, is murder. It is gravely contrary to the dignity of the human person and to the respect due to the living God, his Creator". Because of this, the practice is unacceptable within the Church. The Orthodox Church in America, along with other Eastern Orthodox Churches, also opposes euthanasia stating that "euthanasia is the deliberate cessation of human life, and, as such, must be condemned as murder." Many non-Catholic churches in the United States take a stance against euthanasia. Among Protestant denominations, the Episcopal Church passed a resolution in 1991 opposing euthanasia and assisted suicide stating that it is "morally wrong and unacceptable to take a human life to relieve the suffering caused by incurable illnesses." Protestant and other non-Catholic churches which oppose euthanasia include:

- Assemblies of God
- The Church of Jesus Christ of Latter-day Saints
- Church of the Nazarene
- Evangelical Lutheran Church in America
- Presbyterian Church in America
- Lutheran Church–Missouri Synod
- Reformed Church in America
- Salvation Army
- Seventh-day Adventist Church
- Southern Baptist Convention
- United Methodist Church
- Partially in favour of

The Church of England accepts passive euthanasia under some circumstances, but is strongly against active euthanasia, and has led opposition against recent attempts to legalise it. The United Church of Canada accepts passive euthanasia under some circumstances, but is in general against active euthanasia, with growing acceptance now that active euthanasia has been partly legalised in Canada.<sup>[6]</sup>

**Islam:** Euthanasia is a complex issue in Islamic theology; however, in general it is considered contrary to Islamic law and holy texts. Among interpretations of the Qur'an and Hadith, the early termination of life is a crime, be it by suicide or helping one commit suicide. The various positions on the cessation of medical treatment are mixed and considered a different class of action than direct termination of life, especially if the

patient is suffering. Suicide and euthanasia are both crimes in almost all Muslim majority countries.<sup>[9]</sup>

**Judaism:** There is much debate on the topic of euthanasia in Judaic theology, ethics, and general opinion (especially in Israel and the United States).

Passive euthanasia was declared legal by Israel's highest court under certain conditions and has reached some level of acceptance. Active euthanasia remains illegal; however, the topic is actively under debate with no clear consensus through legal, ethical, theological and spiritual perspectives.



**Figure-5: Euthanasia and end of life.**

**Health professionals' sentiment:** A 2010 survey in the United States of more than 10,000 physicians found that 16.3% of physicians would consider halting life-sustaining therapy because the family demanded it, even if they believed that it was premature. Approximately 54.5% would not, and the remaining 29.2% responded "it depends". The study also found that 45.8% of physicians agreed that physician-assisted suicide should be allowed in some cases; 40.7% did not, and the remaining 13.5% felt it depended. In the United Kingdom, the assisted dying campaign group Dignity in Dying cites research in which 54% of general practitioners support or are neutral towards a law change on assisted dying. Similarly, a 2017 Doctors.net.uk poll reported in the British Medical Journal stated that 55% of doctors believe assisted dying, in defined circumstances, should be legalised in the UK.<sup>[10]</sup>

One concern among healthcare professionals is the possibility of being asked to participate in euthanasia in a situation where they personally believe it to be wrong. In a 1996 study of 852 nurses in adult ICUs, 19% admitted to participating in euthanasia. 30% of those who admitted to it also believed that euthanasia is unethical.

## CONCLUSION

A 24 July 1939 killing of a severely disabled infant in Nazi Germany was described in a BBC "Genocide Under the Nazis Timeline" as the first "state-sponsored euthanasia". Parties that consented to the killing included Hitler's office, the parents, and the Reich Committee for the Scientific Registration of Serious and Congenitally Based Illnesses. The Telegraph noted that the killing of the disabled infant—whose name was Gerhard Kretschmar, born blind, with missing limbs, subject to

convulsions, and reportedly "an idiot"—provided "the rationale for a secret Nazi decree that led to 'mercy killings' of almost 300,000 mentally and physically handicapped people". While Kretschmar's killing received parental consent, most of the 5,000 to 8,000 children killed afterwards were forcibly taken from their parents.

The "euthanasia campaign" of mass murder gathered momentum on 14 January 1940 when the "handicapped" were killed with gas vans and killing centres, eventually leading to the deaths of 70,000 adult Germans. Professor Robert Jay Lifton, author of *The Nazi Doctors* and a leading authority on the T4 program, contrasts this program with what he considers to be a genuine euthanasia. He explains that the Nazi version of "euthanasia" was based on the work of Adolf Jost, who published *The Right to Death (Das Recht auf den Tod)* in 1895. Lifton writes:

Jost argued that control over the death of the individual must ultimately belong to the social organism, the state. This concept is in direct opposition to the Anglo-American concept of euthanasia, which emphasizes the individual's 'right to die' or 'right to death' or 'right to his or her own death,' as the ultimate human claim. In contrast, Jost was pointing to the state's right to kill. ... Ultimately the argument was biological: 'The rights to death [are] the key to the fitness of life.' The state must own death—must kill—in order to keep the social organism alive and healthy. In modern terms, the use of "euthanasia" in the context of Action T4 is seen to be a euphemism to disguise a program of genocide, in which people were killed on the grounds of "disabilities, religious beliefs, and discordant individual values". Compared to the discussions of euthanasia that emerged

post-war, the Nazi program may have been worded in terms that appear similar to the modern use of "euthanasia", but there was no "mercy" and the patients were not necessarily terminally ill. Despite these differences, historian and euthanasia opponent Ian Dowbiggin writes that "the origins of Nazi euthanasia, like those of the American euthanasia movement, predate the Third Reich and were intertwined with the history of eugenics and Social Darwinism, and with efforts to discredit traditional morality and ethics.

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