1
Defining the Terms

Such is the cultural divide on the issue that neither side will even agree on the terms used. In fact, the words themselves have become a key battleground for the two sides of the debate. The way the language evolves over time indicates a shift in meaning behind the words rather than just increasing use of marketing ploys or politically correct terms. It also gives an important indication of where the debate is headed. Therefore, it is worth analysing in depth the words used by both sides.

However, pinning down such moveable targets is difficult. There has been a shift in the language of assisted suicide over the years, particularly from the campaign for voluntary euthanasia, associated with eugenics, medical efficiency and Malthusian perspectives in the inter-war years, to an emphasis on autonomy and the ‘right to die’ in the 1970s and 1980s, to a new concentration on embedding suicide as a treatment choice. Much as there are some false distinctions made within the literature, there are also many real distinctions cloaked by terminology.

Whereas some of the terms cannot easily be pinned down, others are unknowable. On some levels, the term ‘death’ seems obvious; the animate becomes inanimate, human beings cease being human, subjects come to be objects. We recognize death when we see it. But what does death mean for the individual, for the self? Is it the end of the individual or can an individual’s interests exist after death? Do we ‘experience’ death or is it the end of all experience? Is death a negative to life or simply nothingness? How should we understand our own individual non-existence? It is impossible to avoid these philosophical questions when asking what appears to be a simple question. Within the contested meaning of terms exists what is ultimately behind the entire discussion of assisted suicide – a crisis of human meaning, a confusion of past, present and future, and a misunderstanding of human life.
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Before launching into such deep waters, it is worth attempting to clarify as much as possible the basic terms that provide common grounds for the debate. Even this task is complicated; the terminology used often reflects the attitude expressed towards the issue of legalization.

Definitions

There are several definitions of the terms involved. Nearly twenty years ago, Ezekiel Emanuel usefully provided a basic, working definition of some of the terms current in the early 1990s:

*Voluntary active euthanasia*: Intentionally administering medications or other interventions to cause the patient’s death at the patient’s explicit request and with full informed consent.

*Involuntary active euthanasia*: Intentionally administering medications or other interventions to cause a patient’s death when the patient was competent but without the patient’s explicit request and/or full informed consent (e.g. patient was not asked).

*Nonvoluntary active euthanasia*: Intentionally administering medications or other interventions to cause a patient’s death when the patient was incompetent and mentally incapable of explicitly requesting it (e.g. patient is in a coma).

*Terminating life-sustaining treatments* (passive euthanasia): Withholding or withdrawing life-sustaining medical treatments from the patient to let him or her die.

*Indirect euthanasia*: Administering narcotics or other medications to relieve pain with incidental consequence of causing sufficient respiratory depression to result in a patient’s death.

*Physician-assisted suicide*: A physician providing medications or other interventions to a patient with understanding that the patient intends to use them to commit suicide.¹

Publishing late last year in the UK, the Commission on Assisted Dying used these terms:

*assisted suicide*: providing someone with the means to end his or her own life

*voluntary euthanasia*: ending another person’s life at his or her own request

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¹Note: The definition of physician-assisted suicide may vary depending on the legal framework in different jurisdictions.