Dear Editor,

While I laud Abohaimed et al. [1] for taking on the important, challenging, and seldom discussed topic of euthanasia, I am also constrained to point out some deficiencies (i) in definition and typing, (ii) in consistency of “types” of euthanasia (4 in text and 3 in figure), and (iii) in bundling together “types” that has different ethical and legal implications. Admittedly, most of the definitions of euthanasia are descriptive, and there are multiple interpretations in the literature. Therefore, in the interest of clarity the following comments on definition and usage of the term are offered.

The dictionary definition of euthanasia is the act or practice of killing or permitting the death of hopelessly sick or injured individuals (such as persons or domestic animals) in a relatively painless way for reasons of mercy [2].

A studied definition (particularly appropriate for health professionals) incorporates 4 elements: (1) an agent and a subject, (2) an intention, (3) a causal proximity (action of agent led to the outcome), and (4) an outcome. Combining these elements, euthanasia is defined as “death that results from the intention of one person to kill another person, using the most gentle and painless means as possible, that is solely motivated by the best interests of the person who dies” [3]. Consent of the subject (person who dies as a result of the action) is crucial as bioethicists are in general agreement that medicalized killing of a person, irrespective of the intent, without the person’s consent (involuntary) or if the person is unable to give consent (nonvoluntary) cannot be considered euthanasia [4]. Thus, the term euthanasia should be used within the confines of the parameters of these elements.

Passive and indirect “types” are not to be considered euthanasia, and my reasons are stated in comments that follow the authors’ statements. The authors state passive euthanasia is “withholding or withdrawing of life-sustaining treatment either at the request of the patient or when prolonging life is considered futile” [1]. Withholding or withdrawing of life-sustaining treatment at the request of a patient is not euthanasia as it is grounded on “patient autonomy,” one of the basic principles of medical ethics [5]. Besides being ethical it is also legal and practiced in the USA and in other countries. The second element in the statement “or when prolonging life is considered futile” ought to be approached with caution as the definition of futility and who determines it are subjects of contention.

The term indirect euthanasia is used by the authors for “the prescription of pain killers that may be fatal in an attempt to relieve suffering” [1]. Relieving the suffering of a patient is not only the primary mission of palliative care but it is also a core obligation of any physician. Fear of an unintended and untoward outcome should not be a de-
terrent in performing one’s obligation and is ethically supported by the Doctrine of Double Effect [5]. The Doctrine of Double Effect makes a distinction between intended effect and unintended but foreseen effect of an act that has double effects – one good and one harmful – and is justified if the following 4 elements are satisfied: the nature of the act, intention of the doer, distinction between means and ends, and proportionality (the intended good effect is proportionally more than the unintended bad effect). Thus, a physician’s intention to relieve suffering of a patient by appropriate drugs including opioid overrides the possible unintended bad effect or outcome.

I continue to advocate for research and publications on ethical issues in general and end-of-life-care issues in particular from outside of the American and European continents. Most of the publications in these areas are from western countries, and there is a great need to have more information from non-western countries with their rich history and cultures. Respecting local or national culture and patterns, set for decades if not centuries, should not preclude conducting studies (e.g., well-constructed surveys of patients, families, and healthcare providers) that yield objective data that ultimately would improve the care given to patients and their families.

**Disclosure Statement**

The author has no conflicts of interest to disclose.

**References**

1. Abohaimed S, Matar B, Al-Shimali H, Al-Thalji K, Al-Othman O, Zurba Y, et al. Attitudes of physicians towards different types of euthanasia in Kuwait. Med Princ Pract. 2019; 28(3):199–207.
2. Merriam-Webster.com Dictionary. “Euthanasia.” 2020 [accessed 2020 Feb 3]. Available from: https://www.merriam-webster.com/dictionary/euthanasia.
3. Draper H (Chadwick R, editor). Euthanasia. Encyclopedia of Applied Ethics. San Diego: Academic Press; 1998. p. 176.
4. Materstvedt LJ, Clark D, Ellershaw J, Førde R, Gravgaard AM, Müller-Busch HC, et al.; EAPC Ethics Task Force. Euthanasia and physician-assisted suicide: a view from an EAPC Ethics Task Force. Palliat Med. 2003 Mar;17(2):97–101.
5. Beauchamp TL, Childress JF, editors. Principles of Biomedical Ethics. 8th ed. New York: Oxford University Press; 2019. p. 99–303.