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The Christian Approach to Cases of Medical Euthanasia

A Thesis Submitted
To the Teacher and Students of Advanced Apologetics

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Introduction

The issue of euthanasia has been a topic of controversy in the medical community since the late 1800s, but in recent times, the media has publicized controversial euthanasia cases such as that of Charlie Gard and has ignited a mass, worldwide debate over this medical practice. While some argue that euthanasia relieves a patient from constant and arduous pain, others have condemned it as murder, and even then there are those who do not find themselves in either definite position for all instances of euthanasia. Because of the many variables involved, it is difficult to establish a single "wrong" or "right" verdict regarding the practice of euthanasia, as each individual case is unique in its circumstances. Consequently, many Christians are left uncertain and troubled about the biblical interpretation of euthanasia as the Bible does not explicitly detail the necessary actions that should be taken. Furthermore, the discussion is additionally convoluted by the misuse and misinterpretation of vital terms and the unnecessary inclusion of issues which do not pertain to the topic of euthanasia. As a result, because of the often moral ambiguity of euthanasia cases, Christians are unable to decide which course of medical treatment, or lack thereof, will be in accordance with God's will.

This thesis will begin with an exploration and clarification of terms that are most commonly utilized and relevant in discussions pertaining to the practice of euthanasia in medicine. In doing so, the different methods of carrying out medical euthanasia will be addressed, and an identification of terms that are often incorrectly associated with medical euthanasia will also be made. Following the analysis of euthanasia-related terminology is a close investigation of commonly-cited Biblical text regarding the topic of euthanasia in which proof is

provided to support the notion that the aforementioned scriptural references are inapplicable to the issue of euthanasia, and an overview of the Orthodox and Catholic Church's respective beliefs and literature on medical euthanasia is presented afterwards.

Taking into account the limitations of humans in terms of their ability to interpret God's will in making euthanasia-related decisions, a presentation of Christian principles is first made in order to affirm humans' authority to make decisions in cases of euthanasia; following that establishment of authority, a method of approaching such situations is presented. The application of the presented methodology is exemplified in the presentation of various case studies.

Terminology

Euthanasia

The term euthanasia originates from the Greek word εὐθανασία, which means "a good death," and refers to an instance in which the death of an ailing individual is caused by another individual, typically in order to cease physical suffering. Modern-day supporters of medical euthanasia favor using the phrase "death with dignity" in lieu of euthanasia in an attempt to distance their beliefs from the controversy of the euthanasia discussion.[1] Regardless, the term is equivalent in meaning to euthanasia and also serves to describe a person making the decision to end the life of a separate and ill person, usually for the purpose of alleviating his pain. However, as the topic of euthanasia has garnered increasing amounts of public attention and debate, its definition has often become muddled and incorrectly associated with similar-- but not synonymous-- terms such as that of physician assisted suicide. Therefore, prior to discussing the morality of euthanasia, it is necessary to distinguish it from any misconceptions and to clearly explain the several variations it does encapsulate-- which differ mostly in their method of execution.

Physician-Assisted Suicide

It is common that during dialogues regarding medical euthanasia, the term physician-assisted suicide[2] has undergone a perversion of its original meaning and lost its distinguishment from that of euthanasia. Physician-assisted suicide describes a situation in which an ailing patient willingly receives medications or other means from a physician

[1] The terms "euthanasia" and "medical euthanasia" are considered synonymous unless otherwise stated, as the euthanizations discussed in this paper are brought about by medical methods and occur in the context of a medical facility or under the purview of a medical professional.
[2] It is also referred to as physician-assisted death and medical aid in dying.

specifically for the purpose of committing suicide.[3] Consequently, physician-assisted suicide is not euthanasia for two main reasons: firstly, it is requested by the patient herself while euthanasia is decided by someone who is not the recipient, and secondly, it is thus self-inflicted and is suicide, as the involved physician does not perform the killing action, so it cannot be considered medical euthanasia. As a result, physician-assisted suicide does not fall under the parameters of non-medical euthanasia, euthanasia carried out by an individual who is not a medical professional, or medical euthanasia and as such should be excluded from conversations regarding the topic.

Voluntary and Involuntary Euthanasia

Euthanasia is typically divided into the two broad subsections of voluntary or involuntary in order to clearly define whether the decision-maker in the situation is the patient himself or a third party. However, the division is both unnecessary and incorrect because the initial and most basic definition of euthanasia explicitly requires that the patient himself is not deciding to end his own life-- rather, someone else is determining his fate. Therefore, euthanasia can only be labelled as involuntary-- in regards to the fact that the patient is not actively involved in the choice-- as voluntary euthanasia is conflicting and inconsistent terminology. Subsequently, voluntary euthanasia should not only be removed from discussions about euthanasia, as physician-assisted suicide should be, but also from any usage at all as it contradicts itself. In addition, the inclusion of the adjective "involuntary" with euthanasia, though technically reasonable in its meaning, is superfluous due to the fact that euthanasia is already, by definition, involuntary.

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[3] Manning, Michael. *Euthanasia and Physician-Assisted Suicide Killing or Caring?* New York, NY: Paulist Press, 1998, 4.

Active Euthanasia

When discussing euthanasia, it is generally divided into three different, major categories-- active, passive, and indirect-- whose variations derive from their methods of causing an individual to die. Death is intentionally caused by deliberate means in cases of active euthanasia; there are five categories of methods used to carry out active euthanasia, and they are inhalant, physical, oral, rectal, and parenteral.

The inhalant method entails the exposure of the patient to an inhalant anesthetic such as chloroform and nitrous oxide or to toxic gases such as hydrogen cyanide and carbon monoxide.[4] Active euthanasia by physical agents involve the application of physical force upon the body of the patient; its methods include that of death by gunshot, electrocution, and cranial disarticulation.[5] While oral, rectal, and parenteral agents are administered by physicians or otherwise qualified medical professionals, physicians are typically not permitted to deliver inhalant agents and are not legally allowed to deliver physical agents to human patients.[6] Oral methods of active euthanasia involve the patient swallowing lethal doses of medication administered by a physician-- a common example of which is a combination of dextropropoxyphene hydrochloride with secobarbital sodium.[7] In the case that the patient is unconscious or otherwise unable to physically swallow medication, rectal or parenteral methods are employed in order to carry out euthanasia. Active euthanasia through rectal methods is

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[4] Shwink, Kay, and E.L. Egger, "Methods of Euthanasia," *Iowa State University Veterinarian*, 8th ser., 42, no. 2, Accessed November 30, 2017, lib.dr.iastate.edu/iowastate_veterinarian/vol42/iss2/8.
[5] Ibid.
[6] Inhalant and physical agents are often used in animal euthanasia as well as mercy killings-- which, although constitute as another form of euthanasia, cannot be accurately defined as medical euthanasia. Mercy killings are defined and explained in further detail in the corresponding paragraph.
[7] "Administration and Compounding of Euthanasic Agents," The Hague: Royal Dutch Society for the Advancement of Pharmacy, 1994.

achieved by administering a suppository-- for example, secobarbital sodium in a fatty base-- into the alimentary canal through the rectum.[8] However, physicians typically prefer parental methods to that of rectal methods as they are more effective and easier to administer; the parenteral method is generally further divided into two subsections: intravenous and intramuscular.[9] Intravenous drugs, such as alcuronium dichloride, are delivered by syringe or catheter directly into the veins while intramuscular parenteral methods deliver muscle relaxers, such as pancuronium dibromide, directly into the muscles.[10] Physicians may opt to use a combination of intravenous and intramuscular methods, such as a combination of sodium thiopental and pancuronium dibromide, in the active euthanization of a patient.[11] All of the aforementioned procedural types, with the exception of inhalants in most cases and physical methods in all cases, are utilized in active, medical euthanasia for the sole purpose of ending the life of a human patient.

Passive Euthanasia

Passive euthanasia differs from active and indirect euthanasia in that no external agents are introduced into the patient's body in order to bring about or expediate death; instead euthanasia is considered to be passive when life-prolonging medical treatment is withdrawn or withheld.[12] In other words, passive euthanasia allows for the natural course of life to occur without the intervention of medical support, whether that support comes in the form of drugs and analgesics or in the form of what is considered life support.

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[8] "Administration and Compounding of Euthanasic Agents," The Hague: Royal Dutch Society for the Advancement of Pharmacy, 1994.
[9] Ibid.
[10] Ibid.
[11] Ibid.
[12] Garrard E, Wilkinson, "Passive euthanasia," *Journal of Medical Ethics,* 2005, 31:64-68.

There is no concrete and universally accepted definition of life support or criteria used to determine what is and is not a form of life support. In a general sense, life support includes any apparatus, medication, or treatment that a physician can utilize in order to sustain the life of a patient, but for the purposes of a discussion about medical euthanasia, it is in the best interest of maintaining the focus of the topic to narrow life support forms down to those that are most commonly used for patients who are euthanized or are considering euthanasia. These life support forms, which are withheld or removed in order to carry out passive euthanasia, can be organized into the following categories: artificial nutrition and hydration, organ sustenance, and resuscitation. Artificial nutrition and hydration includes the transfer of food and water into a patient who is no longer able to ingest these vital materials orally, and artificial nutrition can be divided into two categories: enteral nutrition and parenteral nutrition. In the case of enteral nutrition, the appropriate nutrients are delivered through the gastrointestinal (GI) tract via a tube, catheter, or a surgically-created hole into the tract; this is generally referred to as a "feeding tube."[13] Parenteral nutrition, on the other hand, is delivered intravenously, or through the veins of the patient, and its methods include central venous catheters in the upper region of the chest, peripherally inserted central catheters in the upper arm, and ports implanted subcutaneously, usually in the upper area of the chest wall.[14] The category of organ sustenance refers to any apparatus or medical technique that is employed to sustain the function of a vital organ-- usually the lungs and the heart. The most common forms of organ sustenance life support are mechanical ventilation, cardiopulmonary bypass and heart-lung machines, artificial pacemakers, and urinary catheterization. Mechanical ventilation is performed through a ventilator, or what is

[13] Kirby, Donald, and Keely Parisian, "Enteral and Parenteral Nutrition," Enteral and Parenteral Nutrition ACG Patients, Accessed December 05, 2017, http://patients.gi.org/topics/enteral-and-parenteral-nutrition/
[14] Ibid.

commonly referred to as a respirator, and mechanically pumps gas, a combination of air with oxygen, into the patient's lungs through an endotracheal, or ET, tube that is inserted in the mouth or nose and down into the windpipe. The respirator also provides the patient with positive end expiratory pressure, or PEEP, which prevents air sacs in the lungs from collapsing by helping to keep the lungs open, and additionally the endotracheal tube located in the windpipe also makes it easier to remove mucus.[15] Cardiopulmonary bypass, or CPB, is a medical technique which utilizes a cardiopulmonary pump, or heart-lung machine, to essentially replace the function of the heart and lungs during surgery-- by sustaining the circulation of blood and oxygen throughout the body-- in order to allow for a motionless, in that the heart is not beating, and bloodless surgical field.[16] Artificial cardiac pacemakers are medical devices which transmit electrical impulses to contract the muscles in the heart in order to regulate and control the beating of the heart, and urinary catheterization refers to the insertion of a flexible tube into the bladder via the urethra in order to drain urine from the body when the patient himself is either unable to urinate or is suffering from a urinary tract-related impediment. Lastly, the category of resuscitation refers to cardiopulmonary resuscitation, or CPR, which is a series of emergency lifesaving actions following cardiac arrest that often involves a combination of chest compressions with artificial ventilation in an effort to preserve brain function until blood circulation and breathing can be restored in the patient. In addition to cardiopulmonary resuscitation and ventilation, defibrillation, the transmission of an electric shock to the subject's heart, is usually also needed to restore a perfusing heart rhythm.

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[15]Manthous, C., Tobin, MJ. "A Primer on Critical Care for Patients and Their Families," 2001, thoracic.org/assemblies/cc/ccprimer/mainframe2.html.

[16] *Continuing Education in Anaesthesia Critical Care & Pain*, Volume 6, Issue 5, 1 October 2006, 176–181. https://academic.oup.com/bjaed/issue/6/5

The aforementioned life support forms have often been divided by various sources into the labels of either extraordinary means or ordinary means, and these sources have thus used these terms in order to formulate the following definition of passive euthanasia: euthanasia is considered to be passive when extraordinary means are withdrawn or withheld. However, the definitions of extraordinary and ordinary means are not widely accepted or agreed upon because the two terms are fluid in that they are subjective and reliant on the general consensus of the medical community at that particular point in time. In the past, the use of intravenous fluids, a technique that is now extremely common in modern medicine and undoubtedly considered ordinary, was once considered an extraordinary mean of medical treatment. Therefore, the classification of the different types of life support vary as medical and technological advancements increase, and what was originally considered extraordinary often becomes increasingly familiar and ordinary as time progresses and attention shifts to newer gadgets and techniques.

Indirect Euthanasia

The term indirect euthanasia is used to describe a scenario in which a physician administers drugs for the purpose of relieving the patient's pain, but the prescribed drugs have the additional effect of hastening death. Within the medical community, there has been some debate over whether indirect euthanasia should be its own category or whether it should be classified under active or passive euthanasia. However, it is important to emphasize the fact that indirect euthanasia hinges upon the intention in prescribing or opting for a particular medical treatment-- to alleviate pain and not to cause the patient to die. Therefore, indirect euthanasia cannot be accurately classified as active because there is not a deliberate intention or aim to bring

about death through the chosen medical treatment. Furthermore, indirect euthanasia also cannot be properly categorized under passive euthanasia because it involves the introduction of an external agent while passive euthanasia entails the removal or withholding of external treatment measures. Consequently, indirect euthanasia has adequate basis to be separate from that of active and passive because its motivation and purpose stems from a desire to mitigate pain rather than to bring about death. However, this pain-alleviating method can still be considered euthanasia because a person who is not the ailing patient is consenting to the administration of such drugs which will still ultimately cause said patient to die. As a result, indirect euthanasia falls under what is known as the principle, or doctrine, of double effect, which states that in certain circumstances, if the primary intent of a given action is good, then it is permissible and tolerable to take that action even if an unintentional, evil effect is produced.

The principle of double effect is not applicable to all actions, as previously stated, and there are typically four criteria that must be met in order for an action to be accurately classified as an instance of double effect:[17]

1. The action itself must be morally acceptable in that its principal, predicted outcome is intended to be beneficial or otherwise seeks to improve upon a particular situation.
2. Said action cannot be brought about through evil regardless of if the projected outcome of these evil means is good-- in other words, the end does not justify the means.

[17] Beauchamp T, Childress J. *Principles of Biomedical Ethics, 7th Edition*, New York: Oxford University Press, 2013, 207.

3. The evil effect of said action is unintended but is unavoidable, thus the advantageous outcome of the action cannot come about or exist without the added and unwanted evil side effect.
4. Lastly, the benefits of the good effect must outweigh the disadvantages of the bad effect.

Indirect euthanasia has been widely accepted by the majority of the medical community as fulfilling the four requirements in order to be appropriately classified as a valid example of the principle of double effect. The following numbered sequence corresponds with the aforementioned criteria to present the evidence that indicates how indirect euthanasia meets each of the conditions:

1. In the specific case of indirect euthanasia, the action, administering an analgesic in order to reduce physical suffering, is inherently good because it seeks to alleviate the pain of the patient.
2. It also satisfies the second condition because it does not bring about this pain relief through an evil act. If the pain relief could only be brought about through, for example, forging a prescription in order to obtain the drugs then the action would have subsequently been derived from an evil method, and thus, the action does not qualify as morally acceptable because it has violated one of the criteria for the principle of double effect. However, considering that the appropriate channels have been used in order to administer the anaslegic, the action is not intrinsically immoral or a product of immoral means.

3. Furthermore, the evil effect of the action of indirect euthanasia, death, is not intended because the purpose of the action is to alleviate the patient's pain, but unfortunately, this objective can ultimately only be achieved with the added consequence of the patient's hastened death.
4. Regarding the final condition of the principle of double effect criteria, it is difficult to compare the intangible value of the good effect with that of the evil or unwanted effect and reach a solid conclusion as to which projected outcome is greater in magnitude. Nevertheless, one must consider that in the situation in which indirect euthanasia is even being considered as a method of treatment for a patient, it can generally be inferred that the patient is experiencing not only excruciating but also persistent physical pain due to a condition or disease for which there is little or no chance of definite cure and recovery and will likely, ultimately result in the patient's death. Therefore, it can reasonably be concluded that when faced with a patient for which there is no greatly beneficial treatment option, the principle of double effect would be satisfied, and indirect euthanasia would be justified because it is of greater priority to alleviate the patient's pain rather than to wait indefinitely and improbably for a medical miracle or new cure-- in both cases, the patient is already approaching death at an increased rate due to their illness, but in the second scenario without indirect euthanasia, the patient is left to bear physical distress.

Because the intention and motivation behind deciding to opt for indirect euthanasia stems from a desire to alleviate the present pain of the suffering patient rather than a desire to deliberately cause the death of the patient, the practice, given that it is accomplished through morally

acceptable means, is adequately in accordance with the necessary prerequisites of the principle of double effect.

Mercy Killing

Mercy killing, although it satisfies the requirements in order to be considered a form of euthanasia, cannot be classified as a form of medical euthanasia because it is not carried out by a medical professional. The differentiation between mercy killings and medical euthanasia can be found through an identification of the individual who is performing the operation or processes necessary to end the life of another individual.[18] Those who carry out mercy killings are not physicians or otherwise qualified medical professionals who have been educated in the field; instead, they are regular civilians who are typically close friends or relatives of the patient. Additionally, a distinction must also be made clear between mercy killing and that of physician-assisted suicide because mercy killing is a form of euthanasia while physician-assisted suicide is not, and also, those who perform mercy killings, mercy killers, do not necessarily obtain their resources from physicians as is the case in assisted suicide. In physician-assisted suicide, the patient himself chooses to undergo the necessary processes in order to end his life and voluntarily requests the information and materials for the suicide from the physician. On the other hand, in mercy killings, the mercy killer can either be both the separate party who decides on behalf of the patient to opt for death and the individual who carries out the necessary procedures, or the mercy killer is solely the individual who kills the patient at the request of another individual who is not the patient. In either circumstance, the identity of the mercy killer is not crucial to understanding the fact that the mercy killing comes at the request or decision of

[18]Lavi, Shai Joshua, *Modern Art of Dying: A History of Euthanasia in the United States*, Princeton University Press, 2007.

an individual who is not the patient, ergo mercy killing is a form of euthanasia. Nonetheless, although mercy killing constitutes as a type of euthanasia, it cannot accurately be described as a type of medical euthanasia solely for the reason that it is not performed by a person of the medical profession.

Historical Review

Euthanasia and the Bible

Specific instances of medical euthanasia are not present in the Biblical text, but it is important to address and refute the claim that the cases of suicide in the Bible are relevant to the topic of medical euthanasia. Five suicides are mentioned in the Bible, and they include that of Abimelech in Judges, Saul in 1 and 2 Samuel, Ahithophel in 2 Samuel, Judas Iscariot in Matthew, and Zimri in 1 Kings. In the case of Abimelech and Saul, both men were in an environment of war; consequently, these two occurrences are not relevant to the medical practice of euthanasia on ailing patients. The suicides of Ahithophel, Judas, and Zimri also have no correlation with euthanasia, as the motivation behind their decisions to end their lives stem from non-medical issues.

The story of Abimelech, one of the judge Gideon's sons, is recorded in the book of Judges. Abimelech secures his title as king over the city of Shechem by slaughtering the majority of his brothers, but in the fourth year of his reign, a civil war breaks out in the city. While fighting against his opponents, he is struck in the head by a millstone thrown by a woman in a tower above him. Upon realizing that the collision is fatal, Abimelech orders his armour-bearer to kill him so that he will not have to suffer the disgrace of death at the hands of a woman. In the context of that time period, women were considered inferior to men and often regarded in the same way as property in that their wellbeing and maintenance must be ensured by the men in their lives. Abimelech, who is not only a man but also a king, realizes that he will have a tarnished reputation and legacy post-mortem if it becomes known that he was defeated by a woman. The Old Testament references a woman killing a man of high regard in Judges 4 when

Sisera, an army captain, is deceived and murdered by a woman by the name of Jael. As a result, the death of Sisera, once a great warrior and a fear-inducing leader, is considered to be quite humiliating. Therefore, Abimelech's ordered suicide is not an act of euthanasia or even an attempt to alleviate physical pain and suffering. It is a preventative measure against the tarnishment of his reputation and his reign as king, and it is a decision that would not have seemed unusual in both the social context of that time period and the environment of combat during which it occurred.

Saul's suicide is one that is commonly cited as a Biblical passage that should be consulted in conversations regarding medical euthanasia. However, as in the case of Abimelech, Saul's death must not be removed from the context of war. Prior to his passing, Saul is in the middle of fighting against the Philistines on Mount Gilboa. During the battle, Saul is struck by an archer and is severely wounded. He proceeds to ask his armour-bearer to kill him before he can be discovered by the enemy and die a disgraceful death at the hands of the Philistines. He does not ask to be killed because he can no longer endure the pain of his wounds. Saul is likely aware of the death of Samson after his capture by the Philistines. Consequently, he knows of the degrading treatment Samson is subject to before dying; the Philistines shave his head, gouge out his eyes, force him to work a prison mill, and then parade him around as a source of entertainment for their people. Thus, Saul knew that he, a king, will be forced to endure the same or even greater mutilation, torture, and mortification if he is to be captured by the Philistines. Such degradation will also bring shame to Saul's subjects and tarnish his legacy as king forever. In fact, he is correct in this assumption, as after his dead body is discovered by the Philistines, they decapitate it and display it publicly. Therefore, Saul's decision to commit

suicide comes as a result of his desire to preserve his dignity and to avoid a shameful and likely torturous death by his enemies. His suicide is not an example of medical euthanasia as it did not stem from an intent to end physical ailment. Like Abimelech, Saul's suicide is one that is caused by the circumstances of war, not disease or pain.

Ahithophel's suicide, unlike that of Abimelech and Saul, does not occur in an environment of war, but it is still not applicable to the topic of medical euthanasia. The motivation for his suicide does not have correlation to medical euthanasia, as Ahithophel is not in any physical discomfort or troubled with any sort of disease prior to his death. Ahithophel, renowned for his wisdom and advice, is a counselor to David when he is king. However, upon hearing of Absalom's rebellion against his father and intent to usurp him, Ahithophel begins supporting Absalom and aiding him in his preparations to take David's throne. He supplies Absalom with strategic and pragmatic advice, likely in a hopeful attempt to secure himself a high position of power and prestige under Absalom's reign, but David is soon made aware of Absalom's betrayal and Ahithophel's traitorous participation. As a result, David sends a man by the name of Hushai to swindle Absalom into thinking that he-- Hushai -- is devoted to Absalom and his cause, and Hushai does so successfully. Consequently, Absalom follows his advice instead of that of Ahithophel, and Absalom and all the men of Israel declare that Hushai's advice is greater than Ahithophel's. Upon hearing this and realizing that he no longer has any influence, Ahithophel foresees Absalom's downfall and recognizes that his participation in this failed rebellion will only result in punishment and likely execution, so before these predicted outcomes can take place, Ahithophel quickly arranges his affairs and hangs himself. The biblical text does not include any information that suggests that Ahithophel was suffering from the pain and

discomfort of any illness or physical impairment. As a result, it can be concluded that Ahithophel's suicide is not related to medical euthanasia as it was not motivated by an intent to cease physical agony due to the fact that his choice to end his life is a direct result of Absalom's decision to ignore his advice and the subsequent failure of Absalom's rebellion. Ahithophel is wise enough to understand that Absalom's failure not only indicates that Ahithophel will not be receiving a promotion in rank but also promises David's punishment of Ahithophel. It can thus be inferred that Ahithophel preferred to die on his own terms instead of enduring the undesirable consequences of his betrayal and the uncertainty of David's wrath against him.

The story of Judas Iscariot's death is arguably the most famous and well-known suicides of the Bible. It is similar to that of Ahithophel's suicide in that it does not occur in the context of war and it follows the betrayal of a leader. Furthermore, it is also not a biblical example of euthanasia as it is entirely a result of Judas' emotional turmoil and guilt, not a physical affliction. As one of the twelve disciples of Jesus, Judas is the treasurer of the group, and the Bible states in John 12:6 that he frequently pockets money for himself. It is this greed present in Judas that ultimately drives him to betray Jesus. Just prior to Jesus' arrest and subsequent crucifixion, he has great favor amongst the people; this popularity angers the religious leaders, the chief priests and scribes, as they realize that Jesus is diminishing their power over the people, who now hold his teachings in higher regard than theirs. Despite their bitterness and discontentment, the priests and scribes are unable to arrest and kill Jesus without possibly inciting a riot amongst the people. Judas emerges as the answer to their dilemma. He offers to betray Jesus in a moment of solitude and vulnerability and facilitate his arrest in exchange for 30 pieces of silver. However, Judas later regrets his traitorous deal and returns the money to the priests before killing himself. It is

clearly evident that Judas decided to end his own life out of the unbearable shame and immense disdain he felt for what he had done to Jesus. Thus, Judas' suicide cannot be considered a relevant situation when broaching the topic of medical euthanasia. His case is one of emotional turmoil, unlike that of the sickly patients who are confronted with the issue of euthanasia.

The suicide of Zimri differs greatly from the previously mentioned four suicides in that the motivation behind it and circumstances around it are ambiguous. As such, it is still not an appropriate biblical reference to consult regarding the medical practice of euthanasia as its status as an intentional suicide is uncertain. Zimri conspires against his king and kills him while he is drunk; he then proceeds to take his place as king. However, his reign does not last very long as seven days later, the Israelites declare the commander of the army, Omri, to be their king and besiege the city in which Zimri resides. Zimri proceeds to burn his house down while he is still inside of it, but the reasoning behind his actions is not explicitly stated in the Bible. There has been speculation as to whether he intentionally stays in the house he set on fire in order to avoid the likely possibility of either being killed, as he killed his predecessor, or otherwise tortured by Omri and his followers. In which case, Zimri's suicide is a preventative measure against the wrath of his enemies, not an attempt to alleviate physical pain or end the suffering of an illness. Others view Zimri's death as one that came about through an unintentional accident. They argue that it was common for there to be days of celebration following the arrival of a new king on the throne. As a result, Zimri could have been in the midst of one of these celebrations, at which he was likely inebriated, and unwittingly set the house on fire, resulting in his subsequent and accidental death. Regardless of which of the theories is correct, the intent behind Zimri's actions

remains ambiguous, so it would not serve as a suitable source to consult when attempting to address the issue of medical euthanasia.

Although the Bible does not include any other textual instances of suicide[19], three biblical characters-- Elijah, Moses, and Jonah --have asked God to end their lives. However, these examples, like the five cases of actual suicide, are not applicable to medical euthanasia. First and foremost, these three men do not actually attempt to end their own lives themselves. Instead, the distinction must be made that they ask God to kill them and to take their lives away. As a result, the equivalent of this would be an ailing patient asking God to end their lives but making no active decision themselves to go through with euthanasia. Furthermore, all of the men ask for death because of non-medical ailments. Elijah asks God if he may die in 1 King 19:4 because he feels like a failure in his duties as a prophet after receiving Jezebel's death threat. Moses asks God to kill him in Numbers 11:14-15 because he feels he is unable to carry the burden any longer of providing for the people's needs and meeting all of their demands. Jonah asks God to take his life in Jonah 4:3 because he is furious that the Ninevites repented and were able to partake in God's mercy and forgiveness. He was hoping for the destruction, and now that they have been saved, Jonah is so angry that he is unwilling to live with that truth and the fact that he played a pivotal role in catalyzing their repentance. The biblical story of Job is also a commonly cited source in terms of textual support regarding euthanasia. Although Job never explicitly asks God to kill him in the book, he wishes that he had never been born in Job 3:3 and identifies with

[19] Other than the five previously mentioned cases of suicide, there is also the death of Samson. However, Samson's intent was not to end his life but to destroy the pagan temple and its sinful worshippers. His death was ultimately a necessary sacrifice in order to carry out that intended result. Thus, Samson's death would not be rightfully categorized as a suicide. If one were to do so, one would also have to concede that Jesus' death was a suicide in that he sacrificed his own life in order to accomplish his goal. Samson's death is referenced in the paragraph regarding Saul's suicide.

those who long for death but are unable to attain it in Job 3:21-22.[20] However, Job never actively attempts to kill himself to stop the physical and emotional pain he undergoes. He simply feels so depressed that he begins to embrace the option of suicide-- a desire he never acts on. Therefore, the cases of Job as well as those of Elijah, Moses, and Jonah are not relevant in the process of distinguishing the biblical viewpoint on euthanasia.

Euthanasia and the History of the Church

As the topic of euthanasia inevitably intertwines with religion, various churches of different sects of Christianity have sought to provide their members with a clear verdict in regards to their position on the acceptability of euthanasia. The Orthodox Catholic Church[21] and the Roman Catholic Church[22] in particular have extremely similar viewpoints on euthanasia and have made these ideals very widely known to their followers.

The Orthodox Church is generally against the practice of medical euthanasia. The Church defines euthanasia as a direct and active intervention for the purpose of hastening death in a patient that is critically ill or dying.[23] The reasoning behind this verdict lies in the Church's adherence to the Ten Commandments, in which the Sixth Commandment forbids killing. However, the Church recognizes that there is a difference between "killing" and "letting die." In other words, a distinction must be made between the act of purposely taking someone's life-- murder-- and allowing someone to die from natural causes. Consequently, the Church is supportive of passive euthanasia as they believe that it prevents the unnecessary and arduous

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[20] All biblical references originate from the English Standard Version of the Bible unless otherwise stated.
[21] It is also referred to as the Eastern Orthodox Church and the Orthodox Church.
[22] It is also referred to as simply the Catholic Church.
[23] Breck, John, and Lyn Breck, *Stages on Life's Way: Orthodox Thinking on Bioethics,* (Yonkers: St Vladimirs Seminary Pr, 2006), 218-219.

prolonging of suffering while still respecting the life that God has created. However, the Church's definition of the term passive euthanasia refers only to a situation in which the patient himself consents to the ending of his own life by means of a discontinuation of life sustaining devices or treatments.[24] The Church has found that the procedure abides by the principles outlined in the Hippocratic Oath, in Biblical text, and in the history of the Church, as it respects the decision of the patient to cease their own suffering and recognizes the limits of modern medicine. As such, the Church has stated that:

> "...this procedure in fact conforms thoroughly both to the Hippocratic Oath and to the will of God as we know it from Scripture and the tradition of the Church. It respects the patient's need to find relief from his or her suffering, it acknowledges the limits of technology in achieving cures, and it allows the patient to complete his earthly journey with as much peace and dignity as possible...In such situations, passive euthanasia (as regrettable and misleading as that expression happens to be), is morally acceptable, even obligatory."[25]

Additionally, the Orthodox Church does not believe that the soul resides in the brain, so it does not agree with the commonly accepted scientific criteria of life-- that "whole brain death," including that of the brain stem, is the final indicator that a person has died.[26] However, it does believe that in the case of whole brain death, it is reasonable to surmise that there is no medical treatment excluding a miracle from God that could save the patient, and thus no further efforts should be made to prevent the patient from dying and allowing the soul to separate from the physical body to be with God.[27] Regarding the issue of euthanasia, the Orthodox Church essentially believes that because Jesus Christ has defeated death, death has no true power or

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[24] As defined in the Terminology paragraph of the paper, euthanasia is only regarding when the decision is in the hands of another person, not the patient.
[25] Breck, John, and Lyn Breck, *Stages on Life's Way: Orthodox Thinking on Bioethics,* (Yonkers: St Vladimirs Seminary Pr, 2006), 222-223.
[26] Ibid, 236-237.
[27] Ibid, 237.

significance. Although it dismisses the power of death, it recognizes the intensity of the physical and mental suffering that diseases and trauma cause and in no way seeks to diminish the right of the individual as a patient to acknowledge and declare his pain. Instead, the Church encourages followers to view death without fear and to not allow this misplaced fear of death to justify forcibly preserving a life and a soul that is able to rest with God postmortem.

The Catholic Church's viewpoints resemble that of the Orthodox Church's very closely. The Catholic Church defines euthanasia as an action or omission that intentionally causes death for the purpose of ending suffering.[28] The Church further specifies this definition by stating that specific cases of euthanasia must be viewed in the context of which method has been employed and what intent was behind the decision to utilize it. The Church says, "Euthanasia's terms of reference, therefore, are to be found in the intention of the will and in the methods used."[29] Consequently, the Church has declared that it is firmly against euthanasia. It establishes its basis for this verdict in the presence of God's image in man, which should compel respect for human life-- even feeble life. The Church has declared that it "...firmly believes that human life, even if weak and suffering, is always a splendid gift of God's goodness."[30] Furthermore, it argues that although God did not create death, the power of life and death rests in God's hands alone, and as a result, the Church views euthanasia as a violation of the Sixth Commandment and as a false mercy-- it believes true mercy is sharing in the sufferer's pain, not killing the sufferer.[31] Additionally, the Church seeks to make a clear distinction between euthanasia, which it

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[28] Paul, John, *The Gospel of Life: (Evangelium vitae)*, (New York: Random House, 1995), 117.
[29] Congregation for the Doctrine of the Faith, *Declaration on Euthanasia Iura et Bona* (5 May 1980), II: *AAS* 72 (1980), 546.
[30] Paul, John, *Apostolic Exhortation: The Role of the Christian Family in the Modern World: Familiaris consortio*, (Boston, MA: St. Paul Books & Media, 1993), 48.
[31] Paul, John, *The Gospel of Life: (Evangelium vitae)*, (New York: Random House, 1995), 121.

condemns, and aggressive medical treatment. The Church does not believe that aggressive medical treatment-- which it defines as treatments that would not do anything that would aid in the progressive recovery of the patient-- should be pursued and says that one can "refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted."[32] It justifies the omittance of such treatment by stating that it is the acceptance of the inevitability of death for human beings.[33] The Catholic Church, in making this statement, is affirming an individual's right to decide to refuse medical treatment for themselves. Thus, it is not addressing the issue of euthanasia, which is regarding the right of an individual to decide on the withdrawal or end of another individual's medical treatment. The Church clearly states that it believes that if an individual decides to euthanize a patient without his request or consent, it is murder.[34] The Catholic Church also allows for the use of narcotics to alleviate pain even if there is an additional effect of reduced lucidity and even death.[35]

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[32] Congregation for the Doctrine of the Faith, *Declaration on Euthanasia Iura et Bona* (5 May 1980), II: *AAS* 72 (1980), 546.
[33] Ibid.
[34] Paul, John, *The Gospel of Life: (Evangelium vitae)*, (New York: Random House, 1995), 121.
[35] The allowance of the use of a treatment with a lethal side effect to alleviate pain fits the definition of indirect euthanasia. However, the Catholic Church is again not speaking of euthanasia but of the individual's right to consent to narcotics for his own treatment. This statement is not applicable for the treatment of another other, separate individual-- which would be euthanasia. Pius XII, *Address to an International Group of Physicians* (24 February 1957), III: *AAS* 49 (1957), 147.

Christian View of Euthanasia

Distinctiveness of Human Life

It is well-known among the Christian community that, as recorded in Genesis, on the sixth day of creation God creates Adam, the first human being, to inhabit the world he has created in the days prior. The importance of man and the distinction he holds from the rest of creation can clearly be seen through the reiteration of the Hebrew word *bara'* three times in Genesis 1:27, which not only sets man apart from other created beings such as animals but also indicates his innate superiority over the other creations. In the production of the previous creations prior to man, *bara*' is never used more than once in describing how these beings come into existence; as Christians recognize the truth that nothing in the Bible is unintentional, the repetition of *bara'* in the creation of man only serves as further evidence that God is deliberately seeking to highlight the separation that is present between man and the rest of creation. The most significant aspect, however, of man's creation can ultimately be found in the fact that man was the only creature created in *tselem*, or God's image, which is often referred to by its Latin equivalent, *imago dei*.[36] In revealing that man is created in the very image of God himself, God is providing his reasoning as to why exactly a special separation has been made between man and all other created beings. The logical basis behind the inclusion of the peculiar reiteration of *bara'* is thus explained in the fact that man is not only distinct from every other created being, but he is also of higher-caliber because he is the only being that has been created in the image of the creator himself-- besides whom there is and will forever be, unequivocally, no greater being in existence.

[36] Genesis 1: 26-27

Image of God

The image of God is first mentioned in the Biblical text in Genesis, but a further explanation of the term-- what particular aspects of the human being constitute as the image of God-- is not explicitly included in the surrounding context. As a result, there has been extensive debate over which specific human characteristics make up the image of God, and these varying opinions can ultimately be organized into one of three major viewpoints: the substantive view, the relational view, and the functional view.

Prior to expounding upon the topic of the image of God, it is important to address the misconception that because of the fall of mankind and the subsequent introduction and corruption of sin into the world, humans have lost the image of God. If humans had truly lost their titles as image-bearers, there would be no subsequent mention of human beings bearing the image of God in Biblical passages following the fall of man in Genesis. However, the Bible does indeed make such references to man bearing the image of God during God's covenant with Noah, in which he condemns murder of human beings because God created man in his own image.[37] Furthermore, the New Testament also makes mention of this fact when it warns against cursing against other men because they are made in the likeness of God.[38] Therefore, it can be logically concluded that because God's image in man is cited as a reason to deter men from committing certain immoral acts, humans continue to bear the image of God even after the fall of mankind. Although the presence of the image of God in man has been established, the particular characteristics or qualities that define this image in man have not been clearly addressed and must be done through an explanation of the three most common ways of understanding *imago*

[37] Genesis 9:6
[38] James 3:9

dei followed by an argument against each of the three viewpoints as well as a final conclusion as to the definition of the image of God.

The basis of the substantive view, also known as the structural view, of *imago dei* is that the image is identified as one or more characteristics that can be found in the makeup of a human being, and the substantive view can further be divided into two subsections based on the type of qualities that are used in the identification of the image: physical or bodily makeup and psychological or spiritual makeup. The first category of the substantive view entails the belief that physical features of the human being-- such as the possession of limbs or a head, for example-- that resemble the features of God are what adequately qualify humans as a bearer of God's image. This physical viewpoint derives from a strict interpretation of the Hebrew word *tselem,* which in its most literal sense translates to mean "statue" or "form."[39] Based on this literal definition of *tselem*, advocates for the physical substantive view find their evidence in the historical context of idols which were constructed by loyal subjects in order to honor and bring glorification to their king. Therefore, the physical substantive view finds humans comparable to these idols, which they believe have been created with certain physical aspects in order to mirror that of God's actual physical appearance. The second category of the substantive view is more common and suggests that the existence of certain intangible qualities in human beings are the presence of the image of God within them. Of the many psychological and spiritual characteristics that could be highlighted in this type of substantive view, humans' ability to reason and process logic has been one of the, if not the most, popular candidates. Regardless of which type of substantive view is held, the main, overarching idea for this particular way of

[39] Smith, Charles Ryder, *The Bible Doctrine of Man*, London: Epworth, 1956, 29-30, 94-95.

understanding *imago dei* is that the image of God is found a human's possession of a particular quality. However, two main issues arise with the substantive view, and the first of which is that there is no scriptural evidence as to what specific qualities within a human equate to the image of God. As a result, any recognition of a certain human quality or set of qualities as the image of God has no legitimate Biblical evidence to support it due to the fact that no human qualities can be found in the surrounding context of the word *tselem* during man's creation.[40] Consequently, because there is no Biblical basis, many attempts to identify specific qualities are derived from non-biblical sources such as the ancient Greeks' notion of reason.[41] The second problem with the substantive view lies specifically in the physical viewpoint in that because God is divine and beyond mortal concepts and the limits of the human world, he is not limited or confined to a physical body as humans are. Thus, because God is not limited to a physical appearance as humans are, it is unlikely that humans, given their lack of divinity, can possess the physical qualities of God. Therefore, a substantive view is an inadequate way of understanding and defining the image of God because it does not possess a solid Biblical basis for determining its criteria.

The relational view contrasts from the substantive view in that it does not base the image of God on certain qualities that comprise a human but on the overall status of the relationship that a human has with God.[42] Therefore, how the image of God is present in a person is dependent upon the type of relationship she has with God. In order for a viewpoint of *imago dei* to be classified as relational it must adhere to the following basic principles:[43]

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[40] In Genesis 1:26-27.
[41] Cairns, David, *The Image of God in Man*, New York: Philosophical Library, 1953, 57.
[42] Ibid.
[43] Ibid.

1. The image of God is not something that can be found in humans alone because it is not a particular characteristic or even set of characteristics within humanity as it is, rather, defined by an individual's relationship with God-- thus, the image of God is the relationship man has with God.
2. The relationship between human and God can be either positive or negative, depending on the status of the relationship between the two parties, and therefore, a human can either be a positive or negative reflection of the image of God.
3. In order for the relationship between man and God to be positive, it must be dynamic in nature, meaning the person must actively seek to gain a deeper understanding of God and to grow closer and closer to him.

The relational view defines the image of God in terms of the relationship that a human holds with God, and it holds that this remains true regardless of whether or not that relationship indicates a positive or negative reflection. The relational view encounters two major problems with its ideology, and the first is regarding its allowance for a negative reflection of the image of God by an individual. Because God is perfect in every aspect and is the ultimate definition of righteousness, thus any evil or acts of immorality are against the nature of God. Ergo, a "negative image of God" is a contradictory concept because it is impossible for someone to bear the image of God while simultaneously acting in rebellion towards him and his nature. Secondly, in order to define the image of God as the relationship between man and God, it is also necessary to delineate the factors that are necessary in order for a man to have the capability to participate in a relationship with God in the first place. As a result, the image of God cannot solely be dependent upon the status of the relationship without a clear definition of the

requirements necessary for the establishment and subsequent existence of the relationship. Because the relational view allows for the presence of the contradictory concept of a negative image of God and is not independently sufficient in its definition of the image of God as a relationship, the conclusion can ultimately be reached that it is not a valid viewpoint of the image of God.

The functional view presents the idea that the image of God is neither dependent upon qualities that can be found within the nature of a human nor reliant upon the type of relationship that a human has with God but is instead related to a certain action or function that a human carries out. While some may confuse the functional view with the psychological substantive view, the two views differ in that although the substantive view defines the image of God in terms of psychological qualities such as the ability to reason, the substantive view is dependent solely on the existence of such qualities and not on the active exercise of them. Therefore, the *ability to* reason can be used to support a substantive view, but the *exercise of* reason-- and not solely the existence of the capacity to reason-- is necessary to support a functional view. Having established the general definition of the functional view, the argument that can be made against it is similar to that which can also be applied against the substantive view. Regarding the fallacies present in the two viewpoints, because the two types both present the image of God solely in a single or collection of quantifiable characteristics, or as is the case in the functional the exercise or application of such attributes, neither of them are able to fully encapsulate the totality of the image of God. The image of God cannot be fully summarized in a list of requirements because its composition entails more than a mere handful of human qualities; rather, the human being is the image of God, a fact that can be derived from the simple truth that God declared it to be so.

The substantive, relational, and functional viewpoints all fail to provide a comprehensive and definitive answer as to what exactly the image of God is because each of the three ways selects only a portion of the image instead of the entirety of it. As a result, the image of God cannot be viewed or understood through the lens of these three interpretations because they present only a partial or incomplete picture by highlighting selected elements of the human being. Therefore, Biblical and logical evidence support the simple conclusion that the existence of the human being is the image of God solely because God, the omnipotent creator of all, ordained for it to be true. It is understood that the creation of the universe, of everything occurred because God declared everything into existence; he issued commands for the heavens to form, for light to be present, for the dry land to appear, and they all came into existence simply because he called for them to exist. In order to gain a better understanding of this concept, God's creation of humankind and the innate presence of the image of God within humankind can be made comparable to the delegation of power by Pharaoh to Joseph. Pharaoh declares that Joseph has been made his regent, the highest-ranking official in Egypt besides Pharaoh himself, and thus has been given immense power to make decisions and issue commands regarding the nation and its citizens, just as Pharaoh does. In Genesis 41:40, Pharaoh says to Joseph, "You shall be over my house, and all my people shall order themselves as you command. Only as regards the throne will I be greater than you" and in verse 44, "...Pharaoh [says] to Joseph, 'I am Pharoah, and without your consent no one shall lift up hand or foot in all the land of Egypt.' It is important to note that in Genesis 41:44, Pharaoh first states, "I am Pharaoh" prior to proceeding to declaring his latest command-- that Joseph is to be made his regent. In doing so, Pharaoh is first establishing that he has the authority, as the king, to issue a command that must be considered as

the truth and must be recognized by his subordinates-- they all must recognize Joseph's Pharaoh-bestowed power. Why is Joseph bestowed this position of power and this freedom to exercise authority? Is it because he possesses the physical attractiveness that would qualify him to be a charming and charismatic public figure, or is it because he has great wisdom that would allow him to be a just and prudent leader? Perhaps Joseph's characteristic traits do indeed qualify him to occupy a position as vital and powerful as that of the regent, but the ultimate reason that Joseph is made regent is because the Pharaoh desired for it to be so, and he has the necessary authority to declare it to be so. In the same way, God declares that humankind has been made in his image, which is to say that humans have been granted the position of God's regents just as Joseph was granted regency by Pharaoh, and like Joseph can exercise powers of authority associated with that of Pharaoh, humans can now exercise powers of authority. Therefore, the image of God cannot be defined through individual attributes because it is intrinsic to the very existence of a human being, in that a human is defined by the fact that he was made in the image of God, and thus, the subsequent conclusion can also be reached that because humans were made in the image of God, they have been granted-- on the principle of God's own desire to do so-- powers of authority in their lives. The aforementioned definition of the image of God differs from that of a functional viewpoint in which the function is identified as the power of authority or dominion because it presents the notion that the image of God exists in humans *because* of humans' ability to exercise authority. However, this is not the case because, as previously mentioned, humans' ability to exercise authority-- which is but one aspect of existing humans-- stems from the fact that humans were made in the image of God. As such, the existence of the image of God is not reliant upon the possession of human qualities or the ability

to utilize them; instead, the image of God is what defines a human as a human, a regent of God, and thus humans have the qualities intrinsic to being humans, or regents, which include that of authority.

A possible argument that could arise against the proposed definition of the image of God is regarding those who have mental disabilities that prevent them from fully exercising their authority as regents of God. In addressing this argument, it is important to consider the fall of humanity, in that although it did not eradicate the existence of the image of God in humans, it did affect humans' ability to fully encapsulate the image of God. The fall of humanity introduced sin and flaws such as mental disabilities into the world resulting in the presence of imperfections in all humans; therefore, even those without mental or physical disabilities are still incapable of fully and accurately epitomizing God's image because they sin each and every day of their lives. However, the shortcomings of human beings do not mean that they are no longer allowed to exercise authority because God created man in such a way that this power of authority is innately present in the very nature of their being, and while the unfortunate consequences of the fall have resulted in the existence of mental disabilities, those humans still still continue to possess the right to authority and are not required to exercise that power in the same fashion that any other human being does-- there is no one, singular way to exercise the authority given to humans by God.

Application of Christian Principles

Because it is impossible to account for every possible variable and variation involved in cases relating to euthanasia, there is no universally formulaic or definitive solution that can be applied to all circumstances of euthanasia. However, after a careful investigation of the Biblical

definition of the image of God, it can accurately concluded that humans do indeed have the authority as regents of God to make earthly decisions such as those regarding human life and death. In regards to the fact that humans have no indisputable means by which they can interpret God's will in each and every specific euthanasia case, Christians' honest desire and efforts to make a decision that is in accordance with God's will places them in a position where they are acting with respect to God's will. In other words, the fact that the decision-making person in question has the true intention of carefully consulting all provided resources in order to make the "right" decision in accordance with Christian principles indicates that that person is indeed already acting in God's will. The resources that such a person can use in order to assist them in the process of arriving upon a decision include that of an overarching theme, an intent for goodwill, trust in the Holy Spirit, and a utilization of available medical assets.

In approaching these often complex and morally ambiguous crossroads, Christians should ultimately adhere to an overarching theme that they will always be able to refer back to when making any end-of-life or medical decisions regarding euthanasia. As Christians' duty on earth has been defined by the spreading of the Gospel-- in scriptural passages such as the Great Commision in Matthew 28:16-20-- and thus, the overall advancement of the kingdom of God, it is logical to construct the thematic criteria around that vital concept of the Christian religion. Therefore, an overarching theme that is relevant in cases of euthanasia is the following: Will the continuation of this life contribute to the betterment of the kingdom? This thematic question can provide great aid to Christians struggling to determine if their actions and choices are in accordance with God's will. Due to the fact that humans have no infallible means of determining the outcome of their decisions beforehand and no access to Biblical text that

explicitly details which end-of-life and medical treatment decisions are in accordance with God's will and which are not, the existence of the aforementioned thematic question allows Christians a Biblically-founded principle by which they are then able to make a decision based on their answer.

As mentioned before, the decision-maker's intent and mindset is vital in determining whether or not that person is acting in accordance with God's will. Because humans have no way of determining what precisely God's will is in every tribulation in life, they must approach these perplexing situations with an honest mindset and the genuine intention to make the decision that is most pleasing to God. A person who takes into account the value of the patient's life, as a bearer of the image of God, and is focused on making a decision that first and foremost takes into account the overarching theme is acting within God's will.

It cannot be assumed that because humans cannot interpret God's will at all times and in all circumstances that God has left humans to suffer through the emotional and ethical turmoil of having to make life and death decisions by themselves. The gift of the Holy Spirit to humankind is God's means of providing a constant and powerful aid to Christians when they are faced with circumstances in which they are not otherwise equipped to adequately determine which decision they must make in order be in within God's will. The Holy Spirit's purpose is to guide Christians towards acting and living in a manner that pleases God, and Christians must trust in the power of the Holy Spirit to have influence over their lives by guiding them towards right decisions and preventing them from mistakenly choosing the wrong course action despite good intentions. If Christians do not view the presence of the Holy Spirit within them as an adequate

means of leading them toward the correct decision, then they are in fact wrongly diminishing the power of the Holy Spirit and its role in the Holy Trinity.

In addition to the consultation of Christian theology based resources, decision-makers should also take full advantage of the available assets of medicine and physicians' professional opinions. As God has allowed for humans throughout history to continue to gain a better understanding of the anatomy and physiology of the human body and subsequently increase medical advancements in terms of medication, treatment methods, and technology, people who must make judgement calls in cases of euthanasia should utilize this knowledge. Nevertheless, Christians must approach this scientific, non-religious knowledge under the influence of the Holy Spirit and expect that the Holy Spirit will reveal or guide them towards selecting the medication or treatment plan which is most suitable for the given situation.

Case Studies

Case A

Presentation of the Case:

"A young Iraqi patient presented to the Balad Air Force Theater Hospital on day 9 of the Battle of Fallujah. The patient was intubated, with a systolic blood pressure of 75, and with blood pouring from a high-velocity wound between his eyebrows and no exit wound. Physical examination showed profuse bleeding from the entrance wound with obvious brain tissue extruding from the wound site; profuse bleeding from both nares; a Glasgow Coma Scale score of 3; and bilateral, fixed nonreactive pupils. Advanced Trauma Life Support was initiated, fluids/transfusions were begun, and the HNI surgeon could not stop the profuse bleeding with a head dressing and nasal packing. All six operating beds were occupied with several American and Iraqi patients triaged as immediate who were waiting for the next available OR bed. In addition, the emergency room was notified that a Boeing Ch-47 Chinook helicopter was en route with 10 wounded Americans, several of whom were deemed as critically injured." [44]

Operation:

"None. The HNI surgeon designated the patient as expectant. The neurosurgeon was asked for a second opinion, and he also designated this patient as expectant. Both surgical subspecialists believed that this patient had suffered a devastating brain and cavernous sinus penetrating injury with very little chance for survival. In addition, this patient would have required a large amount of resources (eg, operating room services, blood, etc) that may have

[44] Salinas NL, Faulkner JA, Facial trauma in Operation Iraqi Freedom casualties: an outcomes study of patients treated from April 2006 through October 2006, *J Craniofac Trauma*, 2010;21:967–970.

compromised the care for other immediate patients with more survivable injuries. Therefore, the patient was triaged as expectant, moved to a quiet area of the surgical intensive care unit where comfort measures were instituted, and expired shortly thereafter." [45]

Analysis:

In this particular case of military triage, I believe that the use of indirect euthanasia was justified firstly because the both surgical specialists on the case designated the patient as having a low chance of survival, and they had to take into consideration the expectant arrival of an additional ten critically wounded patients to the six that had already been triaged. As a result, the surgeons practiced a form of utilitarianism in which the benefit of the majority is considered over the benefit of a single individual. In exercising this theory, the surgeons surmised that due to the patient's low chance of survival and the limited amount of supplies, the supplies should be retained for use in the sixteen other patients, of which there exists at least one that retains a higher survival probability than the patient in question. Thus, the surgeons must consider the supply of available resources and the condition of the patients in order to make decisions that maximize the saving of lives. Overall, the surgeons considered two main points of reference: the effect of time on the patient's condition and the effectiveness of the treatment. In other words, the surgeons had to take into account how long the patient would be able to sustain life without treatment and how long the patient's treatment would take to complete-- would the patient be able to wait until supplies were restocked? Would treating this patient prevent the surgeons from treating another patient who would require less time and less supplies? They would also have to

[45] Salinas NL, Faulkner JA, Facial trauma in Operation Iraqi Freedom casualties: an outcomes study of patients treated from April 2006 through October 2006, *J Craniofac Trauma*, 2010;21:967–970.

consider whether or not the treatment would benefit the patient's condition-- would it be futile to squander supplies on a patient who has little chance of survival rather than to save the supplies for a patient with a higher probability of survival? The surgeons ultimately decided that the patient, though in critical condition, would not benefit greatly from medical intervention, and the use of already-scarce supplies and the attention of medical personnel on this patient still would likely not save him from death but would better benefit one of the other injured soldiers. From a Christian standpoint, because these surgeons do not know the religious status or personal information of the patients, they are unable to adequately determine which patients should be prioritized on the basis of who could benefit the kingdom to a greater degree. Therefore, the utilitarian approach is justified in that a logical assumption can be made that the greater number of lives saved, the greater the possibility that at least one of those saved will further kingdom. The surgeons, however, did utilize indirect euthanasia in order to ease the pain of the patient, thus also practicing a form of palliative care.

A further extension of the general military context of this case can be made in proposing the hypothetical that two patients requiring the same critical level of care were brought into the same hospital and were of different ranking-- one was a major and the other was a private. The hospital and surgeons only have the resources necessary to save one individual. While some may argue that the major should be given the care rather than the private due to his higher ranking, and thus, in terms of military value, a Christian viewpoint indicates that because the surgeon has no knowledge of which individual would benefit the kingdom more, the decision would be left to "chance." However, considering the surgeon is a Christian who has considered the overarching theme, the surgeon's decision cannot be considered a consequence of chance but

as an instance in which an educated professional is making a choice based on limited information and trusting that the Holy Spirit is guiding him toward the right choice. Furthermore, regarding the general topic of warfare, it must be addressed that humans have no certain way of knowing, without a doubt, that they are on the correct side of the war-- that they are the ones whose victory is in accordance with God's will. As a result, if the surgeon's decision, which stems from the theme and from an obedience to the Holy Spirit within him, results in the death of the major, the private, or both individuals, the surgeon has not failed per say in making the correct decision; instead, it is reasonable and logical to conclude that this outcome may very well be apart of God's plan.

Another variation of the previous hypothetical, military-centered case could again involve two patients who require the same level of care, but in this instance, one of the individuals is the chaplain while the other is a private who is known by his fellow soldiers to be a strong spiritual leader. This case presents a different dilemma in that both individuals have and will likely continue to benefit the kingdom, so how exactly is the doctor, or other medical personnel, to determine who should be treated with the limited supplies first? In an emergency situation like this, a quick decision must be made in order to expedite and maximize the treatment and flow of patients; therefore, the doctor must utilize her medical knowledge in order to determine which patient she believes-- on account of age, medical history, family history, possible drug use, and other relevant factors-- has a higher chance of survival, and she must rely on the steadfastness of the Holy Spirit to guide her in the correct direction. If the doctor has indeed overlooked some vital detail that could sway the decision, the doctor must trust that God will reveal this information to her if it is within his will to do so. It is vital that whatever choice

the doctor opts for, she carries it out to completion and without hesitation, in that she does not change her mind halfway through treatment and switch patients, thus providing both patients with inadequate care.

Case B

Presentation of the Case:

"The terrorist bombings in London on July 7, 2005, produced the largest mass casualty event in the UK since World War II...The Royal London Hospital received 194 casualties, 27 arrived as seriously injured. Maximum surge rate was 18 seriously injured patients per hour and resuscitation room capacity was reached within 15 minutes. 17 patients needed surgery and 264 units of blood products were used in the first 15 h, close to the hospital's routine daily blood use...At 0850 h on Thursday July 7, 2005, three bombs exploded on trains at three different locations on the London Underground system. A fourth bomb exploded on a double-decker bus at 0947 h. Edgware Road station was the first site to be declared a major incident at 0912 h followed by King's Cross station at 0919 h, Aldgate station at 0924 h, and Tavistock Square at 0957 h. Initial reports were confused as to the nature and number of explosions, not least because of casualties emerging from stations at either end of a tunnel, and in total there were eight separate incident scenes declared, all requiring a full emergency response. A London-wide major incident was declared at 0923 h." [46]

A 23-year old male arrived at the Royal London Hospital who was unresponsive initially at the scene but then increased to a Glasgow Coma Scale of 13 and a heart rate of 120. The patient had several facial abrasions and lacerations as well as a minor proximal tibia fracture and chest tenderness on left with decreased breath sounds. It was determined that the patient had a pulmonary contusion and was at high risk of acute respiratory distress syndrome; thus, he required the use of a ventilator. A 17 year old female arrived at the hospital at approximately the

[46] Aylwin CJ, Konig TC, Brennan NW, et al: Reduction in critical mortality in urban mass casualty incidents: Analysis of triage, surge, and resource use after the London bombings on July 7, 2005, Lancet 368:2219–2225, 2006.

same time as the male patient. She was presented with a Glasgow Coma Scale of 13, a heart rate of 128, and a minor sternal fracture. She also had decreased breath sounds and chest tenderness which ultimately indicated that she too had a pulmonary contusion that required immediate application of a ventilator. Both patients are in dire need of the ventilator, and the arrival of additional ventilators is unlikely to be timely due to the widespread confusion and lack of comprehensive information, as indicated by the initial reports, and traffic chaos. It is highly likely that if either of the patients does not receive the ventilator, he or she will die.

Analysis:

Mass casualty situations include not only terrorist attacks but also pandemics, vehicle collisions, building collapses, and natural disasters such as earthquakes and fires; as a result, the following analysis can also be applicable to such incidents.

As the conditions of both patients are relatively equal in terms of severity, the doctor is unable to determine who to allocate the ventilator to on the basis of who is in more critical condition. As a result, this situation can be approached similarly to the last variation of Case A, in which the doctor must be able to promptly land on and execute a decision based on his professional knowledge and an evaluation of medical conditions. Regarding this specific case, the doctor may, for example, choose to give the ventilator to the female patient because she is younger and thus has a greater chance of survival; on the other hand, by the same logic, he may believe that the younger female patient has a greater chance of surviving until ventilators are restocked and thus give the ventilator to the male patient. However, age would only be one of several factors considered in making this decision, as the doctor would also have to consider

pre-existing medical conditions-- for example, if one of the patients suffered from ailments such as asthma that would already impede their breathing abilities and decrease their chances of survival without the ventilator. In a mass casualty incident, it is critical that the doctor is able to continually make educated choices in terms of resource allocation because of the large and often sudden influx of patients and a rapidly depleting supply of medicine and other necessary provisions. In addition, the doctor must act with confidence and resolutely carry out whatever course of action he has opted for because he has complete faith in the power of the Holy Spirit to guide him. In the case that the doctor, in his efforts to make a swift decision, has made an uninformed decision, the doctor has not failed in executing God's will because if it was within God's will for the doctor to have made a different choice, he would have revealed the necessary information to the doctor.

Conclusion

This thesis has sought to clarify the terminology and Biblical evidence regarding the topic of medical euthanasia in an attempt to bring elucidation to a discussion that is often disorganized and for which there are little to no comprehensive sources available for Christians to consult. Furthermore, a proposed methodology for approaching decisions regarding euthanasia has been presented in this thesis to provide Christians with a suggested set of criteria to consult and to hopefully establish, at the very least, a basis for further attempts to create comprehensive Christian criteria in regards to end-of-life decisions. The criteria is summarized in the following list:

1. The decision-maker consults an overarching thematic question to which every decision stems back to: will the continuation of this life contribute to the betterment of the kingdom?
2. The decision-maker possesses an honest mindset and well-meaning intentions by maintaining focus on the overarching theme.
3. The decision-maker trusts in the power of the Holy Spirit to guide him toward making the right decision, in accordance with God's will
4. The decision-maker utilizes available medical assets under the influence and continual guidance of the Holy Spirit.

This thesis is in no way claiming that the methodology presented within it is the definitive approach that should be applied by every Christian who is faced with a decision regarding euthanasia. However, its aim is to provide a thorough source which can be consulted in order to

make a personal and informed decision when encountering a case of medical euthanasia in which the conditions appear to be morally ambiguous, and the solution is uncertain.

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