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# EUTHANASIA

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*In the early part of the twenty-first century, euthanasia is destined to become the dominant ethical issue in American culture. It has become better known in the recent past because of several factors: the German euthanasia program, the cases of Karen Ann Quinlan and Nancy Beth Cruzan, and the activities of Dr. Jack Kevorkian. Recent responses to the growing acceptability of euthanasia are the Uniform Health-Care Decisions Act of 1993, the recognition of euthanasia in Holland in 1993, the Oregon Physician-assisted Suicide Initiative in 1994, and the U. S. Supreme Court's upholding of bans on physician-assisted suicide in 1977. A clear understanding of the vocabulary of euthanasia is vital because different sources are attaching differing meanings to the same words. Expressions that are especially significant are "active/passive euthanasia," "voluntary/involuntary/non-voluntary euthanasia," and "direct/indirect euthanasia." The Bible is clear in its condemnation of both homicide and suicide, which cover all types of euthanasia. The Scriptures also present guidelines for dealing with death and euthanasia.*

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That euthanasia will become the dominant ethical issue in American culture in the first decades of the twenty-first century is the conclusion of two leading figures in the contemporary euthanasia debate. In collaboration with Mary Clement, Derek Humphry, founder of the Hemlock Society and an avowed advocate of legalized euthanasia, writes,

> The right to choose an assisted death has swiftly overtaken abortion as America's most contentious social issue. Indeed, activists and the media call it "the ultimate civil liberty." Some 60-75% of the general public supports the right to die. The establishment—government, churches, the American Medical Association, those powerful, exclusive groups that control or influence society—however, is adamantly and vocally opposed. . . . This being an issue everybody—from blue-collar worker to university intellectual—has strong and often fixed views, the next decade in the United States

promises to be a contentious one.[1]

Echoing Humphry's conclusions, C. Everett Koop, former Surgeon General of the United States and a vocal opponent of legalized euthanasia, states, "Suicide, assisted or otherwise, will replace abortion in the headlines as the ethical issue of the next decade."[2] The growing intensification of the debate over euthanasia in American society challenges the contemporary evangelical pastor and church leader to become aware of the issues and the biblical teaching surrounding this debate.

In addition to the public debate, the contemporary pastor/leader also finds himself being confronted continually with end-of-life questions. Some of the questions that the present writer has encountered in pastoral ministry include: "Is it unbiblical for me to ask for 'do not resuscitate' status?"; "May I as a Christian decline being hooked up to this machine since I am soon going to die anyway?"; "May we in good conscience before God ask that our comatose relative's pacemaker be turned off since it is the only thing that is presently keeping him alive?"; and the ultimate question, "What does God allow me to do to deal with the intensifying physical pain that I am experiencing?" These, and similar questions, led Donn Ketcham, M.D., to write,

> Many of you will be called upon to counsel with families and, indeed, you may be called upon to face decisions in your own family which are scripturally and morally determined but so emotionally volatile that maintaining objectivity is most difficult. It is important to have certain guidelines laid down ahead of time—guidelines to which you can cling and hold firmly enough that they weather the storm of emotions in time of crisis. This is a matter in which your convictions must be hammered out on the anvil of scripture and moral principles before it is necessary to apply them in time of stress. They must be settled in the quietness of the study lest the maelstrom of the actual crisis cause you to be swayed and you find yourself with situationally determined standards—a crisis-originated form of situational ethics.[3]

This article will attempt to help the reader hammer out his scriptural and moral principles as he confronts the issue of euthanasia. It will seek to conclude

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[1]Derek Humphry and Mary Clement, *Freedom to Die: People, Politics, and the Right-To-Die Movement* (New York: St. Martin's, 1998) 5-9. This work is the best, most up-to-date introduction of the euthanasia debate in American society from the pro-euthanasia viewpoint. The reader interested in probing the perspective of the proponents of euthanasia should begin by carefully interacting with this monograph.

[2]From C. Everett Koop's commendation of Timothy J. Demy and Gary P. Steward, eds., *Suicide: A Christian Response* (Grand Rapids: Kregel, 1998) 1. Every pastor, and other readers interested in the topic, should secure and work through the articles in this excellent book. The present article, because of space limitations, can give only a broad introduction to the subject of euthanasia; the reader is encouraged to follow up his reading of the present article by using Demy and Steward to further his understanding of euthanasia and be informed of the Christian response.

[3]Donn Ketcham, "A Christian Physician Looks at Euthanasia," *The Baptist Bulletin* (June 1977):8.

with guidelines that can be applied when dealing with end-of-life issues. To accomplish this goal, an introduction to the issue of euthanasia in contemporary society will come first. A clarification of the terminology used in the contemporary discussion of euthanasia will then follow. Next, and most important, will come interaction with the biblical instruction relevant to the contemporary euthanasia debate. Finally, the article will present biblical guidelines applicable to end-of-life issues.

## EUTHANASIA IN CONTEMPORARY AMERICA

In 1947 pollsters began asking Americans about assisted suicide. The question they posed was, "Should doctors be allowed to end the patient's life by some painless means if the patient and his family request it." In 1950 38% of the respondents answered "should" and 55% answered "should not." Twenty-five years later in 1975, the results had been reversed. In that year, 50% answered "should" and 30% answered "should not." The intervening twenty-five years have seen the positive response grow. Today 70% of the respondents answer "should" and only 20% answer "should not."[4]

### The Raising of Public Awareness Concerning Euthanasia

**The German Euthanasia Program.**[5] In the five years after World War II, the American public was exposed to what had happened in the nation of Germany under Hitler. Beginning in 1933 those deemed undesirable, handicapped children and psychiatric patients, were allowed to die by means of starvation. In 1939 active killing replaced this passive killing. Those patients who were judged incurable after a review of their condition were granted "mercy killing." This official euthanasia program came to an end in August 1941. Significantly, it was ended because of public opposition led by parents who opposed the active killing of their children; also significantly, there is no record of any physician protest. However, in the

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[4]These statistics are cited in Brian P. Johnston, *Death as a Salesman: What's Wrong with Assisted Suicide*, 2nd revised ed. (Sacramento: New Regency, 1998) 161. Humphry and Clement (*Freedom to Die: People, Politics, and the Right-To-Life Movement* 14) state their interpretation for the shift in American public opinion. "A number of factors have brought society to the point where a majority favors the voluntary termination of life to avoid unrelenting pain and suffering. Dramatic advances in technology since World War II, the rise of AIDS as a national plague, the decline of the doctor-patient relationship, the economics of health care, and the medical profession's lax attitude toward pain control and comfort care, combined with the expectations of entitlement and autonomy generated by the 'rights culture' of the 1960's, all give rise to the expectation of a quality death with personal input. The right-to-die movement is consistent, furthermore, with the baby boomer's increasingly influential creed: 'I want what I want when I want it, especially if it makes me feel better.'"

[5]This summary is taken from Nigel M. DeS. Cameron, *The New Medicine: Life and Death after Hippocrates* (Wheaton, Ill.: Crossway, 1991) 69-91. For a complete analysis of the German Euthanasia Program, see Robert Lifton, *The Nazi Doctors: Medical Killing and the Psychology of Genocide* (New York: Basic Books, 1986).

German concentration camps, those deemed undesirable by Hitler—incurable mental patients, homosexuals, and Jews—continued to be put to death. This mass killing was under the supervision of physicians.

When the knowledge of this German euthanasia program and its ultimate results became known in the United States, reaction to the concept of euthanasia was negative. Because the program began with the passive killing of those deemed undesirable, the medical professionals recommitted themselves not to be involved in the taking of life. The doctor's primary responsibility to help the sick and never to injure or wrong them was reaffirmed. With the memory of the German practice so fresh, in 1950 public opinion reacted negatively to any program or movement that had the name *euthanasia*.[6]

**Karen Ann Quinlan.**[7] By 1975 public opinion concerning euthanasia was dramatically reversed as shown by the reaction to the Karen Ann Quinlan situation. Quinlan was a 21-year-old young woman who grew up in a devout Catholic family in New Jersey. She had been on a starvation diet when she went to a party on the evening of April 15, 1975. At the party, she consumed alcohol and a small amount of valium. The combination of alcohol and valium on an empty stomach caused her to stop breathing for two separate periods of approximately 15 minutes each. Quinlan's friends delivered her to the emergency room of a community hospital in an unconscious condition. Doctors immediately placed the young woman on a respiration machine as they sought to save her life. Most patients in her condition would not have survived, but Quinlan was able to be kept alive with the help of the respirator.

Even though Quinlan remained alive, her unconscious condition remained. All the examining physicians agreed that she had suffered irreversible brain damage with no hope of recovery or improvement and that she was now in a persistent vegetative state (PVS).[8] PVS is a condition of upper-brain death. The upper brain

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[6]Humphry and Clement (*Freedom to Die: People, Politics, and the Right-To-Die Movement* 7) assert, "Two decades of debate on the right to die have cleared away most of the general public's concern that legalizing an assisted death resembles Nazi crimes." However, Wesley J. Smith (*Forced Exit: The Slippery Slope from Assisted Suicide to Legalized Murder* [New York: Times Books, 1997] 68-89) warns that there are striking similarities between the German Euthanasia Program and what is being proposed by the contemporary American pro-euthanasia movements. Smith states, "Wicked ideas are hardest to detect in their own time, even when they are variations on a theme that has been tried before. For although there are many substantive differences between the values that drove the earlier German death culture and the ones emerging in our own day, a careful analysis of the *actions* being advocated—rather than just the words used to promote those actions—leads to the uncomfortable inference that the differences are not as profound as many would like to believe" (70).

[7]Information cited here comes from Humphry and Clement, *Freedom to Die: People, Politics, and the Right-To-Die Movement* 82-95.

[8]Mark Blocher (*The Right to Die? Caring Alternatives to Euthanasia* [Chicago: Moody, 1999] 188) argues appropriately for the following clarification: "Due to the fact that the term 'persistent vegetative state' suggests an individual is something less than human (some colloquially refer to such a

supports consciousness, and the brain stem controls certain bodily functions like breathing and heart rate. Upper brain death leads to a permanent loss of consciousness. But it does not always lead to the death of the brain stem. Sometimes a patient whose upper brain is dead will have a brain stem that still supports heart and lung activity. Upper brain death with the brain stem functioning was to be the experience of Quinlan.

After three months, the Quinlans, as devout Roman Catholics, consulted their family priest concerning the possibility of disconnecting the respirator. The priest advised them that they were under no obligation to use "extraordinary means" to prolong life. In this case the use of the respirator was deemed "extraordinary means."[9] Thus, the priest advised the Quinlans that it would be within Catholic practice to ask the doctors to remove the respirator. When the hospital, at the advice of their attorney, refused to turn off the respirator, the Quinlans went to court to seek the removal of their daughter from the respirator. In November 1975, Judge Robert Muir ruled against the Quinlans in New Jersey's trial court. The judge asserted that only physicians or the patient herself could make life and death decisions. He refused to allow the Quinlans the legal authority to make the medical decisions for their comatose daughter. The Quinlans immediately appealed this ruling to the New Jersey Supreme Court. The judges of the Supreme Court overturned the lower court ruling and said the respirator could be disconnected. The court stated that it was affirming the choice Karen herself would have made if she were able to do so. The court recognized the authority of the patient to overrule the physician in end-of-life decisions. On the basis of the court's decision, and after her relocation to another hospital, Karen Ann Quinlan was removed from the respirator in June of 1976. However, she continued to live until July 1985. During these years, Quinlan continued to receive feeding and hydration since these were in accordance with Catholic understanding as "ordinary means" of medical treatment.

A consequence of the Quinlan litigation was the legislative institution of an advanced medical directive (AMD) known as "the living will." This is a legal document in which a person indicates his wishes regarding treatment in order to guide medical personnel in a situation where he is unable to choose treatment. The New Jersey Supreme Court had ruled that the patient had the right to indicate his

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person as a 'vegetable'), I prefer to use the term permanent state of unconsciousness or unawareness. Despite the loss of the higher brain, the part of the brain that controls thought, emotion, and consciousness, such individuals are still human beings to be treated with dignity and respect." Though this present article speaks of PVS, the term is used in the spirit of Blocher's clarification.

[9]Catholic ethicists have long held to the distinction between ordinary and extraordinary medical treatment. Scott B. Rae (*Moral Choice: An Introduction to Ethics* [Grand Rapids: Zondervan, 1995] 164*)* explains the distinction: "The term *ordinary means* refers to the course of treatment for a disease that offers a reasonable hope of benefit to the patient, without being excessively burdensome. Antibiotics for curing an infection is an example of this type of treatment. *Extraordinary means* are those that do not offer such hope and place undue burdens on the patient. For example, placing a patient on a respirator is normally considered extraordinary means. Ordinary means are considered morally obligatory and extraordinary means are morally optional."

wishes regarding medical treatment. In September 1976, the California Natural Death Act was the nation's first statute giving legal status to living wills. In the intervening years, the majority of states have passed legislation authorizing such living wills.

**Nancy Beth Cruzan.**[10] The case of Nancy Cruzan furthered public awareness of euthanasia and legal and legislative determinations concerning end-of-life decisions. Cruzan was a 25-year-old young woman from Missouri who was thrown out of her car as it crashed in January 1983. It was estimated that Cruzan went about 15 minutes without breath or heartbeat before being resuscitated by paramedics. Her lungs and heart began to work again, but she remained in a coma, ultimately descending into a PVS.

In 1987 her parents requested that feeding and hydration be removed, allowing Nancy to die. However, the hospital and attending physicians denied the request. The Cruzans, like the Quinlans before them, petitioned the courts, but they went a step further, asking for the removal of the feeding tube. After the Missouri Supreme Court refused the Cruzans' request to make a medical decision on their daughter's behalf, they appealed to the United States Supreme Court. The Cruzan case was the first end-of-life case to come before the high court. In a 5-4 decision, the court stated that in this case, the U.S. Constitution would grant a competent person a constitutionally protected right to refuse all forms of life-sustaining medical treatment, including artificial hydration and nutrition. The court's statement inferred that competent patients have a constitutional right to refuse medical treatment. However, in the Cruzan case, the court also affirmed that the State of Missouri had to have clear and convincing evidence of a person's expressed decision while competent to have hydration and nutrition withdrawn. Because Nancy had left no such evidence, the Supreme Court sided with the state and returned the case back to Missouri. With the case returned back to the state, several of Nancy's friends suddenly remembered conversations in which she had expressed her wish not to continue in a condition like her then-present situation. Thus both her doctor and the court dropped their opposition to the removal of the tube providing nutrition and hydration to Cruzan. In December 1990, Nancy Cruzan died almost 12 days after her feeding had been withdrawn.[11]

In the aftermath of the Cruzan case, in 1990, Congress passed the Patient Self-Determination Act, which took effect on December 1, 1991. The act requires that all United States hospitals, nursing facilities, health maintenance organizations, and other health care delivery systems receiving federal funds must develop written

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[10]This material is gleaned from Humphry and Clement, *Freedom to Die: People, Politics, and the Right-To-Die Movement* 118-23.

[11]Joe Cruzan, the father of Nancy Beth, hung himself to death on August 17, 1996. The possible cause, remorse, is explored by John M Dolan,"Homicidal Medicine," in *Suicide: A Christian Response*, ed. by Timothy J. Demy and Gary P. Steward (Grand Rapids: Kregel, 1998) 237-38.

policies regarding advance directives. These provider organizations must make available education for the community and staff on advanced directives and documentation in the patient's chart as to the existence of advanced directives. Further, written information must be provided to the patient concerning the policy and philosophy of the medical institution.

**Dr. Jack Kevorkian.** During the 1990s the activities of Dr. Jack Kevorkian continually fanned public awareness on the question of euthanasia.[12] Kevorkian is a self-proclaimed agnostic. This former pathologist has had an interest in the dying process throughout his professional career. Kevorkian is the inventor of his so-called "suicide machine" which allows a patient to push a button when hooked up to the machine and brings death in approximately 6 minutes. The former pathologist advertises the use of his machine for those who want to relieve their suffering. However, it is questionable whether any of the over 40 documented individuals who have taken advantage of Kevorkian's death service were actually terminal cases. Kevorkian defends his practices based upon the principle of patient autonomy. Kevorkian believes that any "rational" person who wants to exercise his right to absolute autonomy can decide to end his own life, whether his medical condition is terminal or not.[13] Even though Kevorkian clearly was illegally assisting in suicides according to the statutes of his home state of Michigan, no jury has been willing to convict him on these charges. It seems as though a significant minority of the American public is willing to support the notion of physician-assisted suicide for any suffering individual whether his condition is terminal or not.

**Recent Responses to the Awareness of Euthanasia**

**Uniform Health-Care Decisions Act.**[14] In 1993 the National Conference of Commissioners on Uniform State Laws combined all the then statutory developments concerning end-of-life decisions into its Uniform Health-Care Decisions Act. This Act is the basis for future state laws in this field. It allows an individual to designate in advance who could make treatment decisions for him if he becomes incapacitated; this is technically called a "durable power of attorney for health care" (DPA). A person can also make a living will which can guide the DPA or, if he designates no DPA, give instructions for health care providers that must be

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[12]Humphry and Clement (*Freedom to Die: People, Politics and the Right-To-Die Movement* 125) state, "The sudden appearance in 1990 on the right-to-die scene of Dr. Jack Kevorkian transformed the issue from polite debate and courteous informational assistance (Hemlock's way) to in-your-face, controversial death-on-request operated by the retired Michigan pathologist." Even fellow-supporters of euthanasia are not necessarily excited by Kevorkian's approach.

[13]For an evaluation of Kevorkian's principle of autonomy, see Francis J. Beckwith, "Absolute Autonomy and Physician-Assisted Suicide: Putting a Bad Idea Out of Its Misery," in *Suicide: A Christian Response*, ed. by Timothy J. Demy and Gary P. Stewart (Grand Rapids: Kregel, 1998) 223-33.

[14]The following information appears in Edward J. Larson and Darrel W. Amundsen, *A Different Death: Euthanasia & the Christian Tradition* (Downers Grove, Ill.: InterVarsity, 1998) 181-82.

followed in the patient's case. Also, these living will instructions can include the options of either receiving or rejecting life-sustaining treatment and offer a choice regarding artificial nutrition and hydration. If a person does not have an advanced treatment directive, the decision-making authority passes to the closest relative—spouse, adult children, parents, and adult siblings, in that order. When no such relative is available, then an adult who has exhibited special care and concern for the patient is to be the designated decision maker. Life-sustaining treatment is no longer automatically provided as previously; medical providers must now make each treatment decision in accordance with the direction of a surrogate who decides in accordance with the patient's instruction and wishes to the extent known to the surrogate or, when not known, in accordance with the surrogate's determination of the patient's best interest.

**Euthanasia in the Netherlands.** Although the penal code of the Netherlands outlaws euthanasia, a series of decisions by various Dutch courts recognized by the Dutch parliament has led to government-sanctioned euthanasia in the Netherlands. In 1973 a lower court ruling in Holland fashioned a general exception to the penal code concerning euthanasia. Since then the practice of euthanasia has rapidly spread across the country. To demonstrate the growth of euthanasia in Holland, Edward J. Larson and Darrel W. Amundsen cite the following data.

> To ascertain more accurate figures, the Dutch government commissioned a survey of deaths for the year 1990. This official survey found that out of 129,000 deaths during the year, 2,300 were requested euthanasia, 400 were physician assisted suicide, and 1,000 were euthanasia without explicit request. Another 1,350 deaths were from pain medication administered with the explicit purpose of ending the patient's life, 450 of which occurred without explicit request. Combining these figures produces a total of about 5,000 cases, or nearly 4% of all deaths in the Netherlands that year. An official task force replicated the study from 1995, finding that the total had jumped by 27% in 5 years to nearly 6,400 cases, which represented nearly 5% of all deaths. Even these figures may understate the total, with some estimates running as high as 20,000 per year, or nearly 1 out of 7 deaths.[15]

In 1993 the Dutch parliament approved guidelines for doctors to report assisted deaths to the coroner, thereby officially recognizing the practice of euthanasia in Holland. The Dutch courts are favorable to physicians who practice euthanasia so long as they meet the following guidelines: "1) The patient must be terminally ill, suffering unbearably and must request it; 2) it must be a case in which no other treatment is possible; 3) the patient must consider the decision at length; and 4) only a physician in consultation with another physician can perform the

[15]Ibid., 234-35.

act."[16] Yet, even with these formal euthanasia guidelines, in some cases Dutch physicians intervene beyond the guidelines to hasten death.[17]

**The Oregon Physician-assisted Suicide Initiative.** In 1994 the voters of Oregon approved a ballot measure allowing physician-assisted suicide by a majority of 51% of the vote. Because of legal challenges, the proposition's provisions did not go into effect immediately. In 1997 state legislators sent the measure back to the voters without change. By a 3-2 margin the voters of Oregon retained their physician–assisted suicide law. By means of this vote, the state of Oregon became the first jurisdiction in the Western world in over 1,500 years to enact a valid statute authorizing a form of euthanasia.[18] Some of the key stipulations of the Oregon law are as follows: (1) the patient must be a resident of Oregon; (2) the patient has to be diagnosed as suffering from a terminal disease as determined by two physicians; (3) the patient must make a written request for medication for the purpose of ending his or her life; (4) there must be a waiting period of at least 15 days from the written request to the actual prescription of the lethal drugs; (5) a physician must write the prescription for the lethal dosage of drugs to be used; and (6) the patient must both voluntarily request and take the drugs so as to precipitate his own death.[19]

**U.S. Supreme Court Ruling Upholding Bans of Physician-assisted Suicide.** On June 26, 1977, the United States Supreme Court handed down its unanimous decision that bans of assisted suicide enacted by the states of Washington and New York do not violate the 14th Amendment. Demey and Stewart have summarized the decision of the Supreme Court in this way:

> While the opinions were unanimous, there were in both cases concurring opinions that reflected varying views of assisted suicide in certain circumstances that suggested that the decision is a tentative first step rather than a definitive final ruling on the issue. In his opinion in *Washington v. Glucksberg*, Chief Justice Rehnquist concluded by stating that, "throughout the nation Americans are engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society."[20]

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[16]John S. Feinberg and Paul D. Feinberg, *Ethics for a Brave New World* (Wheaton, Ill.: Crossway, 1993) 101. The chapter on euthanasia in this volume has been republished as John S. Feinberg, "Euthanasia: An Overview," in *Suicide: A Christian Response*, ed. by Timothy J. Demy and Gary P. Stewart (Grand Rapids: Kregel, 1998) 149. Further references will be noted from the latter source.

[17]Larson and Amundsen (*A Different Death: Euthanasia & the Christian Tradition* 234-35) note 1,000 cases of euthanasia in 1990 without explicit request, which is contrary to the formal guidelines.

[18]Ibid., 199-202.

[19]The full text of "The Oregon Death with Dignity Act" is found in Humphry and Clement, *Freedom to Die: People, Politics, and the Right-To-Die Movement* 349-56.

[20]Demy and Stewart, *Suicide: A Christian Response* 488.

Thus a great change in the attitude of the American public toward the issue of euthanasia has occurred in the past half century. As the twenty-first century begins, limited forms of euthanasia are being practiced throughout the United States.[21] These practices range from voluntary, passive euthanasia which is legally sanctioned throughout most of the country, physician-assisted suicide in the state of Oregon, and voluntary, active euthanasia implicitly accepted through the lack of conviction of those doctors who are willing to be involved in it. This is the social, legal, and moral condition of the society in which the Christian now finds himself living and ministering.

## THE VOCABULARY OF EUTHANASIA

"Discussions of euthanasia are often unproductive because of confusion over definitions."[22] As one reads the contemporary literature on euthanasia by both advocates and opponents of the practice, he is struck by the fact that the same terms are used with different meanings by differing authors. For instance, the term *euthanasia* has been defined both as "the process by which people's deaths are intentionally brought about by themselves or others"[23] and as "one person, motivated by compassion, intentionally . . . killing another in order to end that person's suffering."[24] Though the first of these definitions includes the act of suicide, the second definition does not. Authors who use the first definition will include physician-assisted suicide as a form of euthanasia, but those who employ the second definition will consistently speak of "physician-assisted suicide and euthanasia."[25] Consequently, the reader must understand how the different terms relating to euthanasia are defined for the purpose of this article. The following are the adopted definitions in this discussion.

### Euthanasia

The term *euthanasia* comes from two Greek words, "good" (εὖ, *eu*) and "death" (θάνατος, *thanatos*), and literally means "good death." In its original context, the term refers to the process by which a person eases into death without unnecessary pain and suffering. The focus is on the manner of dying, and implies that a person meets death with peace of mind and minimal mental and physical

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[21]Dolan ("Homicidal Medicine" 238-44) estimates that between 230,000 and 460,000 deaths by euthanasia in the United States occurred in 1994.

[22]Gary P. Stewart, et al., *Basic Questions on Suicide and Euthanasia: Are They Ever Right?* (Grand Rapids: Kregel, 1998) 23.

[23]Ibid., 22.

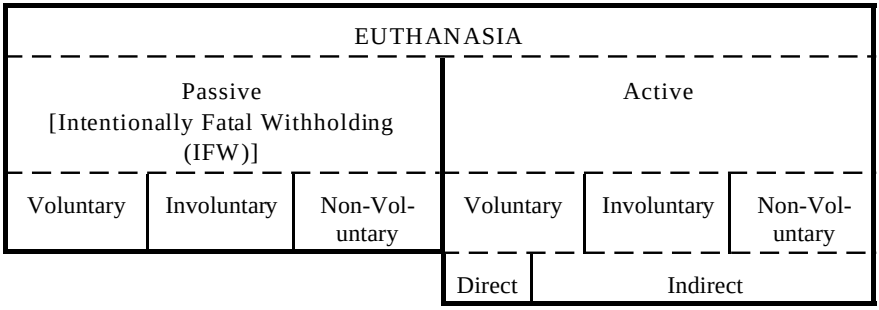
[24]Robert D. Orr, "The Physician-Assisted Suicide: Is It Ever Justified?" in *Suicide: A Christian Response*, ed. by Timothy J. Demy and Gary P. Stewart (Grand Rapids: Kregel, 1998) 62.

[25]Ibid., 65.

pain.[26]

However, the term *euthanasia* assumed a different connotation when used by British intellectual historian W. E. H. Lecky in 1869. Lecky used the term "to signify the act or practice of taking the life of a person who is hopelessly ill and doing so for reasons of mercy."[27] This understanding of the term has continued in contemporary usage. As noted above, some writers continue to use the term exclusively for a killing instigated by a second party. For others, the term has come to stand for a wider variety of practices. This article uses the term *euthanasia* in this latter, broad sense, resulting in the following definition: "Euthanasia is any act or deliberate omission undertaken by oneself and/or others with the specific intention of causing the death of a person and actually causing that death, where the agent(s) acts or deliberately forbears from action on the basis of a conviction that the death being caused will be good for the person who is being killed." Based on this understanding, there are various types of euthanasia as illustrated in Chart 1.[28]

**CHART 1**




**Active/Passive Euthanasia.** "These terms focus on the kind of action taken to bring about death."[29] *Active euthanasia* is "the effort of a person to cause his or her own death or the death of another. . . . The medical cause of death is not disease or injury but the fatal action taken."[30] By contrast *passive euthanasia* is the withholding, withdrawal, or refusal of treatment to sustain life. More precisely,

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[26]Edwin R. Dubose, "Historical Perspectives: Physician Aid-In-Dying (Active Voluntary Euthanasia )," in *Doctor-Assisted Suicide and the Euthanasia Movement,* ed. by Gary E. McCuen (Hudson, Wis.: GEM, 1999) 9.

[27]Robert N. Wennberg, *Terminal Choices: Euthanasia, Suicide, and the Right to Die* (Grand Rapids: Eerdmans, 1989) 3-4.

[28]Chart 1 is adapted from Stewart, et al., *Basic Questions on Suicide and Euthanasia: Are They Ever Right?* 26.

[29]Feinberg, "Euthanasia: An Overview" 152.

[30]Stewart, et al., *Basic Questions on Suicide and Euthanasia: Are They Ever Right?* 23.

> Passive euthanasia intends death by withholding (including withdrawing or refusing) available medical treatment or other care that *clearly* could enable a person to live *significantly* longer. Death is intended but not medically caused by the person performing passive euthanasia. Another expression for this practice is "intentionally fatal withholding." Using this expression can be helpful, since it is more explicit about what is in view than is the term *passive euthanasia.* It is important not to confuse intentionally fatal withholding—which is always morally problematic—with legitimately withholding useless treatment, e.g. when death is imminent even with treatment.[31]

**Voluntary/Involuntary/Non-Voluntary Euthanasia.** This distinction focuses on whether or not the patient requests death. *Voluntary euthanasia* occurs when a patient requests death (actively or passively) or grants permission to be put to death, and his desire is honored. *Involuntary euthanasia* occurs when a patient explicitly refuses death, but his request is not honored. Finally, *nonvoluntary euthanasia* occurs when a patient is put to death when the patient's wishes are unknown, either because those wishes are unobtainable or no action is taken to obtain them.[32]

**Direct/Indirect Euthanasia.** These terms denote the role played by the person who dies when his life is taken. In *direct euthanasia* the individual himself carries out the decision to die. In *indirect euthanasia* someone else carries out the decision to die.[33] Chart 2 gives illustrations of the different kinds of euthanasia.[34]

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[31]Ibid., 24. There is a great debate among evangelical writers as to whether the term *passive euthanasia* should be employed because the proponents of *active euthanasia* argue that there is no ethical difference between the two. Orr ("The Physician-Assisted Suicide: Is It Ever Right?" 63) defines *passive euthanasia* as "situations where life-sustaining treatments are withheld or withdrawn from a terminally ill patient, with the expectation that this omission will allow the person to die naturally." On the basis of this definition, Orr concludes, "Thus, *passive* euthanasia is not a necessary or helpful term." However, Wennberg (*Terminal Choices: Euthanasia, Suicide and the Right to Die* 108-56) has an excellent chapter entitled "Passive Euthanasia and the Refusal of Life-Extending Treatment." Wennberg argues that withdrawal of treatment from terminal patients is not passive euthanasia because it is not a form of passive suicide. Passive suicide, and thus a form of passive euthanasia, is when a patient (a) intentionally ends his life (b) by a medical omission (c) when death is not imminent and (d) when it is done to relieve himself of suffering. Wennberg's explanation provides the basis for the definition of *passive euthanasia* given above.

[32]Wennberg, *Terminal Choices* 25.

[33]Feinberg, "Euthanasia: An Overview" 152.

[34]Chart 2 is adapted from Frank Harron, John Burnside, and Tim Beauchamp, *Health and Human Values: A Guide to Making Your Own Decisions* (New Haven, Conn.: Yale University, 1983) 45.

**Chart 2**

<table>
<tr><td></td><td>Voluntary</td><td>Involuntary</td><td>Non-Voluntary</td></tr>
<tr><td rowspan="3">PASSIVE</td><td colspan="3">Mr. A is unconscious from a medical condition that is treatable, but if untreated, will lead to death.<br>Dr. B recommends treatment for Mr. A.</td></tr>
<tr><td>Mr. A refuses treatment (via AMD)</td><td>Mr. A requests treatment (via AMD)</td><td>Mr. A's desire concerning treatment is unknown</td></tr>
<tr><td colspan="3">Dr. B does not treat Mr. A.<br>Mr. A dies from the non-treated medical condition.</td></tr>
<tr><td rowspan="4">ACTIVE</td><td colspan="3">Mr. A has an incurable medical condition.</td></tr>
<tr><td>Mr. A requests a lethal drug.</td><td>Mr. A requests non-lethal pain killers.</td><td>Mr. A's desires are unknown.</td></tr>
<tr><td>Mr. A ingests lethal drugs [direct], or<br>Dr. B administers lethal drugs [indirect].</td><td>Dr. B administers lethal drugs [indirect].</td><td>Dr. B administers lethal drugs [indirect].</td></tr>
<tr><td colspan="3">Mr. A dies from the lethal drugs.</td></tr>
</table>

**Related Terminology**[35]

The contemporary debate over euthanasia has produced many technical terms, some of which are described in what follows. In the legal realm, the principle of *patient autonomy* is the viewpoint that declares that since a person is a self-determining agent, he should be able to make his own evaluations and choices based on his own self-interest when it comes to medical decisions. Therefore, in any medical procedure, there must be *informed consent*, the stipulation that a patient understands treatment options and chooses the course of treatment or withholding of treatment in his personal situation. Since the patient is viewed legally as his own medical decision-maker, he is allowed to put in writing *advanced medical directives* (AMD) in which he declares his preference for medical treatment, in the possible case that future ability to communicate will be impaired. Two such legal documents are the *living will*, in which a person indicates his wishes regarding treatment in order to guide medical personnel in a situation where he is unable to choose treatment, and the *durable power of attorney*, by which a patient designates another to make decisions on his behalf should he become physically or mentally unable to

[35]This section incorporates definitions found in David K. Clark and Robert V. Rakestraw, eds., *Readings in Christian Values*, vol. 2 , "Issues and Applications" (Grand Rapids: Baker, 1994) 133-34.

do so. If no advanced medical documents exist or are not known, there can be *substituted judgment*, a legal declaration by the courts authorizing a person to make treatment decisions for an incapacitated patient. The courts have also recognized a patient's *right-to-die*, a patient's right to refuse unwanted life-sustaining treatment or forcing doctors to drop such treatment if already administered. Advocates of euthanasia seek to expand this "right" to the point where a patient can determine when, where, and how he will die.

In the medical arena, the principle of *beneficence* asserts that doctors are obligated to do good for their patients, while the principle of *nonmaleficence* obligates doctors to avoid harming their patients.[36] Doing good for the patient means that when medical technologies can no longer prevent death, the doctor withholds or withdraws all life-prolonging and life-sustaining technologies as an intentional act to enhance the well-being of the terminally ill patient by avoiding useless prolonging of the dying process; but unlike passive euthanasia, the act of *letting die* does not intend or choose death. When no medical cures exist, the patient is given *palliative care*, medical treatment which is applied to ease the discomfort and symptoms of a terminal illness. Many terminal patients receive *hospice*, a special kind of care designed to provide treatment and support for terminally ill patients, which includes pain management, social interaction, and spiritual care.

Ultimately, in order to apply biblical principles to the euthanasia issue, it is essential to define precisely the reality of euthanasia. Active or passive, involuntary or nonvoluntary, indirect euthanasia is homicide, the killing of one human being by another. As Mark Blocher has pointedly stated,

> To use the word *killing* is technically correct since both action and neglect in particular contexts result in a death that is intended. Euthanasia is allegedly killing for merciful reasons, for reasons of compassion. . . . The absence of malice associated with the acts of euthanasia tends to soften our reaction to it. We are less inclined to label these acts "killing." Yet they are.[37]

Further, active, voluntary, direct euthanasia is a form of *suicide*, the voluntary and intentional killing of oneself. It is vital that "physician-assisted suicide" be clearly recognized for what it is, a form of "suicide." Finally, active, voluntary, indirect euthanasia is a form of both suicide and homicide, suicide on the part of the patient who desires death and homicide on the part of the agent who brings that desire for death to reality through his act of killing.

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[36]The principles of beneficence and nonmaleficence reflect the words of the Hippocratic Oath: "I will use treatment to help the sick according to my ability and judgment, but I will never use it to injure or wrong them." For the words of the Hippocratic Oath, see Cameron, *The New Medicine: Life and Death after Hippocrates* 24-25.

[37]Blocher, *The Right to Die? Caring Alternatives to Euthanasia* 77.

## APPLICABLE BIBLICAL INSTRUCTION

Many fine evangelical works present the arguments for and against euthanasia.[38] The arguments set forth are logical, ethical, historical, social, legal, and medical, in addition to being biblical. However, both the writer and the vast majority of the readers of this present article are committed to the truth that the Bible is the Word of God, and as such, should direct Christian thinking and actions concerning all the questions of life, including euthanasia (2 Tim 3:16-17). Ultimately, the conclusions reached concerning euthanasia must come from and be in accordance with the Scripture. What follows will analyze the biblical passages pertinent to the issue of euthanasia.

### Homicide Is Explicitly Condemned in the Bible

The sixth commandment in the Decalogue is an emphatic negative prohibition, "You shall not kill" (Exod 20:13; Deut 5:17 [personal translation]). The Hebrew root "kill" (רצח, *rāṣaḥ*) occurs 38 times in the OT. It is first used in Exod 20:13. Significantly, the root occurs twenty times in Numbers 35 (vv. 6, 11, 12, 16 [2], 17 [2], 18 [2], 19, 21[2], 25, 26, 27 [2], 28, 30 [2], 31). The usage of the term in this chapter gives insight into the meaning of the prohibition in Exod 20:13.

The context of Numbers 35 is the commandment of the Lord through Moses to the sons of Israel that when they came into the land of Canaan, they were to set aside 48 cities for the possession of the Levites (vv. 1-8). From these cities of the Levites, six were to be set aside as "cities of refuge"[39] (v. 6). These cities of refuge were to function as sanctuaries for anyone who killed another person until their crime could be evaluated and their punishment determined. The LORD then gave instruction through Moses to the sons of Israel concerning the basis for their judgment of the killer, the required punishment, and the reason for this ordinance (vv. 9-34). Two observations concerning the use of *rāṣaḥ* are significant. First, 18 times the term occurs in its participial form to refer both to "the manslayer" (vv. 11, 26, 27, 28) and to "the murderer" (vv. 16, 17, 18, 19, 21, 30, 31). The distinction between the two types of killers is based upon their motivation; the "manslayer" killed unintentionally (what is referred to in English as "manslaughter"), and the "murderer" killed intentionally (what is referred to in English as "murder") (v. 11). The criteria by which intentionality could be determined were (1) the weapon used, (2) the enmity of the killer toward his victim, and (3) premeditation (vv. 16-24). The punishment for the killer judged guilty of murder was death by the hand of "the blood avenger," while the killer guilty of manslaughter was that he remain in his city of refuge until the death of the high priest. Second, *rāṣaḥ* occurs twice in its verbal form (vv. 27,

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[38]For example, see the discussions in Feinberg, "Euthanasia: An Overview" 153-68, and Rae, *Moral Choices: An Introduction to Ethics* 165-80.

[39]All Scripture quotations are taken from the New American Standard Bible unless otherwise indicated.

30). In both cases it refers to acts of killing permitted by the LORD that carry no guilt or punishment. Thus, some acts of killing are outside the boundaries of the prohibition of the sixth commandment. Gordon J. Wenham summarizes the significance of this ordinance:

> This law reaffirms in judicial fashion the sanctity of human life (cf. Gen. 9:5-6; Ex. 20:13). The commandment simply says 'Thou shall not kill.' The Hebrew 'kill' is used in this law both of murder and manslaughter (16, 25). Both incur blood guilt and pollute the land, and both require atonement: murder by the execution of the murderer and manslaughter through the natural demise of the high priest.[40]

The implications of the two observations stated above are twofold. First, the Israelite was aware that even accidental death is an affront to God. Even though the penalty for unintentional killing was less severe than for intentional killing, the loss of contact for a period of time from one's land, community, and, possibly, family was a serious loss. Even more devastating to the sincere Israelite worshiper of the LORD would be his inability to accompany his fellow-servants of the LORD as they went to worship Him at the central sanctuary at the three great annual feasts (see Deut 16:1-17). Thus, the Israelite was conscious of the fact that he was to do everything humanly possible not to cause the death of another person. An example of this commitment to avoid even an accidental death is evident in the law recorded in Deuteronomy 22:8: "When you build a new house, you shall make a parapet for your roof, that you may not bring blood-guilt on your house if anyone falls from it." The OT believer knew human life is a gift from God (Gen 2:7), and he was to preserve it to the best of his ability. He certainly sought not to be a participant in the destruction of life.

Second, the Israelite was aware that there were certain killings allowed by God (Num 35:27, 30). The manslayer who did not obey the LORD by staying in the city of refuge and the murderer were under the judicial judgment of God and could be put to death without violating the sixth commandment. By expansion, all the crimes of the OT that the LORD said were punishable by death were allowable killings.[41] Further, the LORD also commanded Israel to kill their enemies in battle when He directed them to go to war (Deut 7:2; 20:17). By implication, when invasions took place, warfare that was defensive in nature, with the resulting killing, was also allowed by God (Gen 14:2; Judg 11:4-6; 1 Sam 17:1; 2 Kgs 6:8).

Therefore, W. R. Domeris well states the conclusion concerning the meaning of the sixth commandment:

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[40]Gordon J. Wenham, *Numbers: An Introduction and Commentary*, The Tyndale Old Testament Commentaries, ed. D. J. Wiseman (Downers Grove, Ill.: InterVarsity, 1981) 238.

[41]Sixteen crimes that incurred the death penalty in the OT with supporting Scripture, are listed in John MacArthur, *The MacArthur Study Bible* (Nashville: Word, 1997) 270.

> In the wider context of the OT, the prohibition may be defined more narrowly as the taking of life outside of the parameters (as in the case of war or capital punishment), laid down by God. Human life, even more than other forms of life, has unique value in the sight of God. . . . To take a life, outside of the parameters set by God, therefore, requires some sort of restitution.[42]

Furthermore, the NT quotes the sixth commandment extensively (Matt 19:18; Mark 10:19; Luke 18:20; Rom 13:9; Jas 2:11). Thus, the NT believer in Christ is under obligation to obey the commandment, "You shall not kill (outside the parameters allowed by God)." Significantly, Paul in Rom 13:8-10 states that obedience to the commandments, including the sixth, is how a Christian shows love to his neighbor. Christian love is not expressed by taking life, but in preserving life.

The question arises concerning the application of this biblical teaching from the sixth commandment to the modern euthanasia debate. In a seminal article wrestling with this question, Millard J. Erickson and Ines E. Bowers state,

> We must therefore press further the question of whether euthanasia should be classified as murder. The elements in the Biblical concept of murder seem to be:
>
> 1. It is intentional.
> 2. It is premeditated.
> 3. It is malicious.
> 4. It is contrary to the desire or intention of the victim.
> 5. It is against someone who has done nothing deserving of capital punishment.[43]

However, they reason that euthanasia would not be characterized by maliciousness; the person believes he is doing an act of mercy that will be good for the other person. They conclude, "Hence it appears that the attempt to evaluate euthanasia simply by appealing to the teaching regarding murder fails. Guidance in this matter must be found elsewhere."[44] However, as was shown above, the prohibition in the sixth commandment encompasses accidental death, a killing that does not have malicious intent. Therefore, euthanasia is prohibited by the sixth commandment. The Christian cannot be the agent in taking another person's life. The Bible explicitly condemns homicide, malicious or not, except in capital punishment and war.

**Suicide Is Implicitly Condemned in the Bible**

Suicide, the act of self-killing, is never directly addressed in the Scripture. Though examples of suicide are recorded in the Bible, the OT legal texts neither directly condemn nor condone the act. It is important to note that a single word for

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[42]W. R. Domeris, "רצח," *New International Dictionary of Old Testament Theology and Exegesis* [*NIDOTTE*], ed. by Willem A. VanGremeren (Grand Rapids: Zondervan, 1997) 3:1189.

[43]Millard J. Erickson and Ines E. Bowers, "Euthanasia and Christian Ethics," *JETS* 19:1 (1976):17.

[44]Ibid.

suicide does not exist in Hebrew or Greek, making it impossible for the Bible to say directly, "You shall not commit suicide." The term "suicide" is a creation of the English language. Robert N. Wennberg explains,

> Interestingly, however, the term "suicide" was introduced into the English language in 1651 by Walter Charleton in order to make available a more neutral and less judgmental term for acts of self-killing which until then had been described as "destroying oneself," "murdering oneself," and "slaughtering oneself"—all phrases that convey firm disapproval. Charleton made his contribution to the English language with this sentence: "To vindicate one's self from extreme and otherwise inevitable calamity by *sui-cide* is not (certainly) a crime." This hyphenated word did not exist in the Latin but was an invention achieved by linking two Latin words, "sui" (self) and "cide" (kill).[45]

However, even though the exact term "suicide" does not occur in the Bible, the condemnation of "self-killing" is usually inferred from the sixth commandment. If to shorten the life of another through killing—except in war or for capital crimes—is wrong, to kill oneself is also wrong. Self-killing is a form of killing, and killing is prohibited.[46]

But today, this understanding of suicide as a biblically prohibited killing has come under intense attack. One of the leading spokesmen for this new assessment of suicide is Arthur J. Droge who has summarized his arguments in an article printed in the influential *Anchor Bible Dictionary*. Droge introduces his article with these words:

> The idea that suicide is both a sin and a crime is a relatively late Christian invention, taking its impetus from Augustine's polemics against the "suicidal mania" of the Donatists in the late 4th and early 5th centuries and acquiring the status of canon law in a series of three church councils of the 6th and 7th centuries. In other words, the act of taking one's own life, which had been accepted, admired, and even sought after as a means of attaining immediate salvation by Greeks and Romans, Jews and Christians throughout antiquity, now became the focus of intense Christian opposition.[47]

Droge advances three biblical arguments in support of his assertion that Scripture permits some suicides.

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[45]Wennberg, *Terminal Choices: Euthanasia, Suicide, and the Right to Die* 17-18.

[46]Eugene H. Merrill ("Suicide and the Concept of Death in the Old Testament," in *Suicide: A Christian Response*, ed. by Timothy J. Demy and Gary P. Stewart [Grand Rapids: Kregel, 1998] 323) states, "Yet suicide is the taking of a human life, and so it clearly falls at least under the rubic of manslaughter."

[47]Arthur J. Droge, "Suicide," *The Anchor Bible Dictionary*, ed. by David Noel Freedman (New York: Doubleday, 1992) 6:225. Droge's assertion that the prohibition of suicide is a late Christian invention is refuted by Larson and Amundsen, *A Different Death: Euthanasia & the Christian Tradition* 103-15. They show that "although suicide is a topic that excited little comment in Christian literature before Augustine, twelve church fathers condemned the act at least in passing" (103).

First, five cases of suicide appear in the OT: (1) Abimelech (Judg 9:54); (2) and (3) Saul and Saul's armor bearer (1 Sam 31:4-5; cf. 1 Chron 10:4-5); (4) Ahithophel (2 Sam 17:23); and (5) Zimri (1 Kgs 16:18).[48] The biblical narrator simply reports each of these self-killings with no statement of either commendation or condemnation. Droge concludes, "The important point is that none of these biblical figures receives censure: indeed, their suicides are scarcely commented on, leading one to conclude that in ancient Israel the act of suicide was regarded as something natural and heroic."[49] However, his conclusion does not follow from his own point: if no evaluation of the suicide is given by the biblical author, how can a positive evaluation be the assured conclusion of the biblical commentator. It is true that OT narrative usually records events with no evaluation. The biblical reader must consider the whole presentation made in order to draw proper conclusions. For example, Saul is presented as a king who was disobedient to the LORD (1 Sam 13:13-14; 15:1-31; 28:3-19); Saul's death was a judgment from the LORD for his disobedience (1 Chron 10:13-14). Saul's suicide was the pathetic act of a rebel against God, not the heroic final act of a faithful servant of the LORD.[50]

The NT records one clear case of suicide, the death of Judas (Matt 27:5; Acts 1:18). Droge states, "It too is recorded without comment, although it is implied that Judas's act of self-destruction was a result of his remorse and repentance, and not an additional crime."[51] While it is true that Judas felt remorse (Matt 27:3), the biblical text contains no statement concerning his repentance. Like Saul in the OT, Judas's suicide was the culmination of a spiritual rebellion that led him to betray Jesus into the hands of His enemies (Matt 26:14-16). Judas's self-destruction was a result of his decision to reject Christ's offer of love and spiritual security (John 13:26). The suicide of Judas was not the result of repentance, but happened because of his lack of repentance. Thus, the six biblical reports of suicide do not convey a sense of acceptance and moral approval; rather, the overall context demonstrates an atmosphere of spiritual disobedience.

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[48]Merrill ("Suicide and the Concept of Death in the Old Testament" 323) points out, "The OT is, among other things, a record of war, bloodshed, murder, and mayhem. Yet, and perhaps amazingly, there are only a handful of instances of suicide, all in narrative texts. Undoubtedly a general reverence for life, fear of death and its aftermath, and the self-evident inability to repent of suicide may be contributing factors in the apparently low incidence of suicide."

[49]Droge, "Suicide" 6:228.

[50]Robert D. Bergen (*1, 2 Samuel*, vol. 7 in *The New American Commentary*, ed. E. Ray Clendenen [Nashville: Broadman and Holman, 1996] 282) observes, "Though the Bible does not explicitly prohibit such actions, each portrayal of this practice is replete with tragic overtones. The Bible seems to suggest that suicide or assisted-suicide is a desperate act by a deeply troubled individual. None of the individuals who resorted to this action is portrayed as a role model for the pious." For a further treatment of the suicide accounts in biblical narrative, see Dónal P. O'Mathúna, "But the Bible Doesn't Say They Were Wrong to Commit Suicide, Does It?" in *Suicide: A Christian Response*, ed. by Timothy J. Demy and Gary P. Stewart (Grand Rapids: Kregel, 1998) 349-66.

[51]Droge, "Suicide" 6:228.

Second, Droge raises the possibility that Jesus' own death could be understood as a form of suicide. He asks the question, "How else are we to make sense of the provocative statement of the Johannine Jesus: 'No one takes my life; I lay it down of my own free will' (John 10:18)?"[52] The answer to Droge's question is found in the deity of Jesus. As the one who has life in Himself (John 1:4; 5:26), no man could take life from Jesus unless He voluntarily surrendered it. But the Bible makes clear that Jesus was put to death at the hands of violent men (Acts 2:23; 3:14-15). Jesus was killed by others; He did not kill Himself.

Third, Droge alleges that Paul contemplated suicide according to his words in Phil 1:21-26. He argues,

> Furthermore, full weight must be given to Paul's statement about life and death: "which *I shall choose* I cannot tell" (1:22). In other words, the question of life or death is a matter of Paul's *own* volition, not a fate to be imposed on him by others. If it is a matter of Paul's own choosing, then it seems clear that his internal struggle concerns the possibility of suicide. . . . While the option of death was considered and, indeed, personally desirable, it was ultimately rejected because it contravened his understanding of the *present* will of God, namely, that Paul continue his earthly mission. It is not the case, however, that Paul rejected suicide *per se*, only that it was not *yet* the appropriate time for such an act.[53]

However, the choice mentioned in Phil 1:22 is between the "gain" of death (1:21) and the "fruitful labor" of life (1:22), not between death and life *per se*. Between these two beneficial choices, Paul is hard pressed in knowing which to prefer. But the choice in this case is not his to make. The Lord through his execution or release will make known to Paul what His will is.[54] Paul's reflections here show his heart to the Philippian church, a heart that is willing equally to live or to die. What they do not show is a man contemplating suicide.[55]

Therefore, the Bible does not condone suicide. The sixth commandment includes the act of self-killing. Any act of voluntary passive or active euthanasia is an act of disobedience against God because suicide is implicitly condemned in the

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[52]Ibid.

[53]Ibid., 6:228-29.

[54]Gordon D. Fee (*Paul's Letter to the Philippians*, NICNT, ed. by Gordon D. Fee [Grand Rapids: Eerdmans, 1995] 147) answers, "*Contra* A. J. Droge . . . who argues that to take 1:22 seriously must allow that Paul was contemplating suicide. But that seems methodologically in reverse, since the rest of passage, and the letter as a whole, hardly allows such a view. This fails to take seriously Paul's understanding of apostleship—and of discipleship in general—in which one's longing to know Christ includes 'participation in his sufferings' because of one's certainty of the resurrection."

[55]See further, Dónal P. O'Mathúna, "Did Paul Condone Suicide? Implications for Assisted Suicide and Active Euthanasia," in *Suicide: A Christian Response* 387-97.

Bible.[56] Thus, for those who build their ethical standards and behavior on the Scripture, any act of euthanasia is to be rejected as direct disobedience to the Word of God.

## BIBLICAL GUIDELINES APPLICABLE TO END-OF-LIFE ISSUES

The Bible clearly asserts that God has sovereign control over life and death (Deut 32:39; 1 Sam 2:6; Pss 31:15; 139:16). As the master over death, the Lord declares, "It is appointed for men to die once . . ." (Heb 9:27). Until the return of the Lord, each person must experience death. Death for the Christian is the gateway into the presence of Christ (2 Cor 5:8; Phil 1:21); but for the non-Christian it is the entrance into Hades and ultimately the second death (Rev 20:13-15). The Bible gives truth about death that provides guidance for end-of-life decisions.

### Biblical Guidelines for Death

First, death is inevitable (Eccl 3:2). Therefore, each person should make preparations for death. With the present legal climate, it is imperative that each believer have an advanced medical directive.[57] A durable power of attorney is better than a living will.[58] The surrogate chosen should have the same Christian perspective as the believer.

Second, death is an enemy (1 Cor 15:26). Therefore, when the hope of recovery through medical treatment remains a possibility, the believer should take advantage of every opportunity to forestall death so that he can continue to serve the Lord.

Third, dying is a process (Heb 11:21, 22). Therefore, when it is reasonably certain that a patient's disease is incurable and terminal, measures designed to control physical pain, to provide food and water, to give regular hygienic care, and to ensure personal interaction and mental/spiritual stimulation should be instituted. "Letting die" is not to be equated with "passive euthanasia."[59]

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[56]Erickson and Bowers ("Euthanasia and Christian Ethics" 17-24) argue that one cannot prove that voluntary active euthanasia is an instance of suicide (they make a distinction between suicide, euthanasia, and martyrdom), and one cannot demonstrate the wrongness of suicide. Rather, they object to euthanasia on the basis of six broad principles: (1) the sanctity of life, (2) the finality of euthanasia, (3) the spiritual benefit of suffering, (4) the possibility of recovery, (5) the danger of euthanasia being abused as under Hitler, and (6) the alternative of pain management instead of euthanasia.

[57]An excellent explanation of living wills and durable powers of attorney is found in Beth Spring and Ed Larson, *Euthanasia: Spiritual, Medical & Legal Issues in Terminal Health Care* (Portland, Ore.: Multnomah, 1988) 137-71.

[58]John Frame (*Medical Ethics: Principles, Persons, and Problems* [Phillipsburg, N.J.: Presbyterian and Reformed, 1988] 72) declares, "The durable power of attorney also has legal advantages over the living will. A living person is more flexible, more responsive to circumstances, than is a paper document. He can interpret his own words, while a document must be interpreted by others."

[59]See note 31 above.

Fourth, suffering is a part of present earthly life and death (Rom 8:18; 2 Cor 4:17-18; 1 Pet 5:9-10). Therefore, the Christian will patiently endure any pain, especially at the end of life. Pain will not become the reason to commit the unbiblical act of euthanasia.[60]

**Biblical Guidelines for Dealing with Euthanasia**

The Christian finds himself in a society that is quickly succumbing to the allure of euthanasia. There is a growing demand for the legalization and greater practice of euthanasia. Mark Blocher gives some insightful words concerning the response:

> In fact, focusing all our effort on the debate whether or not we should legalize the practice misses the most important issue, how to improve care for dying individuals. . . . My concern is that too much of our effort will be invested in public policy and courtroom litigation, leaving us with little time, energy, and financial resources to improve care for the dying. If we can effectively resist the efforts to plunge society into the darkness of state-sanctioned medical killing, . . . it will be because we have shown that there is no disgrace in human mortality, that human dignity can be cared for and respected in the midst of life's worst experiences.[61]

Therefore, first, it is imperative that we show compassion to the dying. The advocates of euthanasia assert that they wish to show mercy by killing those in pain or by allowing them to kill themselves. But this supposed expression of mercy defies the instruction of the God of all mercies (Ps 119:156)! Instead of mercy killing, Christians need to exhibit mercy living as we pray for, visit, and care for the dying among us. Second, to die well, believers must trust God. It is not euthanasia that is the good death! Rather, it is the Christian who maintains his faith strong in the Lord even unto death and leaves this life with joy who truly dies well.[62]

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[60]An excellent discussion of end-of-life issues is found in Gary P. Stewart, et al., *Basic Questions on End of Life Decisions: How Do We Know What is Right?* (Grand Rapids: Kregel, 1998).

[61]Blocher, *The Right to Die? Caring Alternatives to Euthanasia* 13.

[62]The reader who would like to stay abreast of the latest evangelical information concerning euthanasia should contact: The Center for Bioethics and Human Dignity, 2065 Half Day Road, Bannockburn, IL 60015. Phone (847) 317-8180. Fax (847) 317-8153. Email: <cbhd@banninst.edu>.