

**Abstract**

*Background:* Euthanasia (which comes from the Greek words for “good death”) may be defined as action which accelerates the death of patient with an incurable, terminal illness in order to alleviate the patient’s suffering and pain. The decision-making process pertaining to terminally ill patients is among the most prominent and long-standing problems in medicine. It is influenced by religious, ethical, and cultural values. The issue concerns not only the patient, but also the patient’s family and the medical staff. Unsurprisingly, there have been extensive ongoing discussions about this subject between medical staff, lawyers, religious figures, and other involved parties.

*Research question:* How do the perceptions and positions of the Christian religion and its denominations influence attitudes about euthanasia and the decision-making process of a terminally ill patient?

*Study aims:* To examine the perceptions and positions regarding end-of-life decisions and euthanasia among adherents of various denominations of the Christian religion in Israel.

*Methodology:* A questionnaire in Arabic, Hebrew, and English was distributed via social networks. The first part related to demographic data. The second part included 36 questions on six topics related to euthanasia: autonomy, knowledge, decision-making, ethics and law, the patient’s family, and social environment. The survey population included 231 Christian adult citizens of Israel. The Christian population comprises approximately 2% of the total population in Israel.

*Findings and Discussion:*

• There was a significant difference (P <0.01) in attitudes towards end-of-life decision making and euthanasia among the various Christian denominations. Orthodox and Catholic respondents were more likely to support euthanasia and to say that patients should have the authority to make decisions.

* Catholic respondents had the lowest levels of knowledge about euthanasia among the Christian denominations included in the study.

• There was a significant difference (P <0.01) in attitudes towards end-of-life decision related to level of religiosity. Secular respondents expressed greater support for patient’s autonomy and acceptance of decisions made by patients and their families, as compared to more religious respondents.

*Conclusions:*

• The study found that among the Christian population in Israel, the Orthodox and Catholic populations were more likely to support the autonomy of the patient to make end-of-life decisions. This contrasts with previous literature in the field, which indicates that Christians completely oppose all types of euthanasia, do not think that the individual is autonomous, and do not accept patients making the decision to end their life. Additionally, in contrast to the findings of the current study, the literature indicates that the Catholic population has significant knowledge about the issue of euthanasia.

• Among the Christian population in Israel, secular respondents were more likely to support the patient’s autonomy in end-of-life decision making, whereas religious and traditional respondents tended to believe that medical professionals and religious clergy should make the decision.

*Summary and recommendations:*

A number of variables influence the decision-making process related to the end of life and euthanasia. In addition to religious denomination, these include age, gender, occupation, level of education, and more. Given that decisions regarding euthanasia or prolonging a patient’s suffering are difficult for any population, we recommend further investigation of these variables in order to deepen our collective understanding of this issue. Recommendations are made for steps which will help clinicians improve care for terminally ill patients.

**Introduction**

The treatment of terminally ill patients is one of the most enduring and prominent problems in the field of medicine. The prolongation of the life of a patient, especially a patient suffering severe anguish, raises serious medical, moral, legal, and economic questions. These questions concern not only the patient, but also the patient’s family and friends, as well as the physicians and medical staff. Unsurprisingly, there are extensive ongoing discussions on this issue among medical staff, religious leaders, lawyers, and the media, who often express their opinions, especially following dramatic events related to this issue (Aviv & Galili-Schachter, 1999).

The concept of euthanasia originated in the classical period of ancient Greece. The term comes from the words ευ (eu) meaning “good” and θάνατος (thanatos), meaning “death”. Some define it as the accelerated death of a patient by the patient or by caretakers. Others define euthanasia as a merciful desire to end the life of person who has a terminal illness in order to end the person’s suffering and pain.

There are several types of euthanasia. Active euthanasia is a deliberate action, such as injection of a drug, which will end the person’s life. Passive euthanasia involves withholding treatment that keeps a patient alive. Voluntary euthanasia refers to a patient’s choice to die. The patient must be mentally capable of making such a choice. Involuntary euthanasia refers to killing a patient without the patient’s consent.

Over the years, euthanasia has assumed a large and significant place in the field of health, making it impossible to ignore. Discussion of this issue covers various factors and areas. Two main areas pertaining to this dilemma are ethical and religious values. It should be noted we may distinguish between the religious values associated with the three main branches of Islam, Judaism, and Christianity. This article will briefly present the perspective of each of these three religions, then focus on perceptions of euthanasia within various denominations of the Christian religion in Israel.

According to the religious worldview of Judaism, a person does not have the authority to choose to die. Life is a gift given by God, and only God can take it away (Steinberg, 1982). People do not own their bodies and cannot end their lives. God gives people their bodies “on deposit” so that they can fulfil the tasks and commandments given in the Torah (Hebrew Bible) and carry out acts of morality. People have no right to harm this deposit in any way.

*“Your blood be on your head, for your own mouth has testified against you, saying, ‘I have killed the LORD’s anointed.’”* (Samuel 1:16).

From this it is understood that killing is murder in all cases.

Islam categorically prohibits all forms of suicide or any action that might help people kill themselves. Islam forbids Muslims from planning or determining the date of their death in advance.

*“Whoever killed a soul, except for a soul slain, or for sedition in the earth, it should be considered as though he had killed all mankind.”* (Table-Al Ma’ida – 5.32).

*“The recompense for he who kills a believer deliberately is Hell, he is eternally there. Allah will be angry with him and will curse him and prepare for him a great punishment.”* (Women-An Nisa’ – 4.93).

The Christian religion agrees with the position that life is a divine gift and no one has the right to dispose of it. Therefore, euthanasia is unacceptable in the Christian view, as shown in the following quotes.

*“Prosperity and adversity, life and death, poverty and riches, come of the Lord.”* (Sirach 11:14)

*“For whether we live, we live unto the Lord; and whether we die, we die unto the Lord: whether we live therefore, or die, we are the Lord’s.”*

*“Why, you do not even know what will happen tomorrow. What is your life? You are a mist that appears for a little while and then vanishes.”* (James 4:14)

The first great division within Christianity began in the year 1054, with the schism between the two main branches of the Western (Catholic) Church and the Eastern (Orthodox) Church. The next division was the Protestant Reformation.

**Literature Review**

**Euthanasia**

Euthanasia is primarily a problem of contemporary society. It has attracted attention around the world. Euthanasia is the deliberate ending of a person’s life for that person’s benefit. The word euthanasia comes from the Greek word ευθανασία, which is built from two root words: ευ (eu, translated as “good”) and θάνατος (thanatos, translated as “death”). It is sometimes called “the merciful extension of death”. It generally refers to voluntary actions undertaken to mercifully end the life of someone who is terminally ill or mortally injured. Due to the progress of medical science, life expectancy has increased. Additionally, lifestyle changes have altered patterns of common diseases. Today, many incurable diseases, such as cancer, are still common and cause great pain and suffering. Euthanasia is an important concept associated with this problem (Mousavi, et al., 2011).

According to Mousavi et al. (2011) there are four types of euthanasia.

1. Active euthanasia: an intentional action causing death, such as a fatal injection of a drug.

2. Passive euthanasia: Withholding treatment that keeps a patient alive.

3. Voluntary euthanasia: Ending the life of a patient who voluntarily chooses to die. The patient must be mentally capable of making this choice or have the ability to undertake the action him or herself.

4. Involuntary euthanasia: Killing a patient without that person’s knowledge or consent.

**Israel’s Terminally Ill Patient Law**

The State of Israel’s *Terminally Ill Patient Law 5762* of 2005 (hereafter: “the Law”) delineates the circumstances and conditions under which a person in Israel is authorized to determine what, if any, medical treatment he or she is willing to receive. The right of the patient to agree to or refuse medical treatment was previously guaranteed under Israel *Patient’s Rights Act* of 1996 (sections regarding the “terminally ill patient” as defined in this law).

The Law ensures the right of a person, even one who is still healthy, to provide written guidelines for refusal of medical treatment that would extend his or her life. This includes times when the terminally ill patient is unable to make decisions regarding the treatment to be provided. The Law asserts that decisions in this matter may be made only according to the will of the patient, and not according to the desires of family members or anyone else. The will of the patient may be determined in several ways. The preferred one is explicit, written guidelines provided by the patient. Another legal option is granting power of attorney to another person, when the patient has previously given a directive for this.

**Legality**

A person at least 17 years of age who has not been determined to be incompetent by a court of law and who is able to make independent decisions has the right to provide prior medical guidelines detailing his or her desires regarding future medical treatment, in case that person becomes terminally ill and is incapacitated. Expression of preferences regarding medical treatment of a terminally ill patient who is incapacitated pertains to a patient is not able to make decisions regarding his or her medical treatment or to understand and to weigh options and preferences regarding medical treatment.

**Christian Position on Euthanasia**

Christianity is the most widespread religion in the world. Like Islam and Judaism, it is a monotheistic religion. These three religions have similar characteristics and are interrelated historically. Religious belief is expressed through love and good deeds. Love is the basis of morality, the universal motive of all virtues and all moral life. The commandment for mutual love requires openness to others. Actions towards other people are the indicators of moral behavior; that is, what is unrelated to people cannot be the purpose of a moral act. It cannot be said that there is consensus regarding end-of-life decisions in the Christian context. Christianity, as a religion, consists of a diversity of denominations including Jehovah’s Witnesses, Lutheranism, Catholicism, the Orthodox Church, and others.

The sacred text of Christianity is the Bible, which includes the Old Testament (Hebrew Bible), together with the New Testament which, according to Christian tradition, renews the previous covenant with God. The place of worship for Christians is the church, where most religious ceremonies are conducted, including prayer, baptism, and marriage ceremonies. The clergy person in charge of church services is the priest, who leads a community of believers. Other clerics on the hierarchy are bishops and cardinals. The symbol of the Christian religion is the cross, symbolizing the crucifixion and sacrifice of Jesus. The sacred day of Christianity is Sunday. It is customary to cease from working and go to church on Sundays and other religious holidays. There are numerous Christian holy sites in Israel such as Bethlehem, Nazareth, Jerusalem, the Church of the Holy Sepulcher where Jesus was buried, the Via Dolorosa (the path Jesus walked to his death), the Jordan River, the Sea of Galilee and other places where Jesus performed miracles according to Christian tradition (Kovaľová, 2016).

The sanctity of human life, as described in the Hebrew Bible, is a central belief of Christianity. Although the Bible teaches that humans should have respect for all God’s creations, including plants and animals, it clearly expresses the special honor people should have for human life. This respect is granted to all people, regardless of sex, race, status, age, sexual orientation, appearance, or mental ability. It is not earned through admirable characteristics or one’s contribution to society, as this would justify attributing greater value to some lives and less to people deemed less worthy. The Bible teaches that God grants each person special respect and sanctity (de Villiers, 2016). In making decisions regarding medically assisted suicide or euthanasia, a Christian response will necessarily consider ethical implications in light of the Bible’s message and the sanctity granted to each person by God. These decisions will also need to take into account the prevailing moral views held by the Christian Church, the society in which the patient lives, the patient’s family, and other Christians (de Villiers, 2016).

**Catholic Position on Euthanasia**

Catholic ethics are rooted in the long Christian tradition and theological and ideological sources including the Bible, teachings of philosophers and theologians, and other religious texts, such as papal encyclicals. Saint Thomas Aquinas first outlined the duties of physicians, which he called the “natural law”. This established a broad moral framework for Catholicism. Since St. Aquinas’ time, confession manuals and theological summaries have asserted that physicians must carry out their duties and activities according to the “natural law”. However, this is no longer interpreted as a series of demands and prohibitions, but rather as a recommendation for physicians to do everything possible in order to behave in a way that shows understanding and respect for the purpose of human life (Kovaľová, 2016).

The most important principles of physicians’ behavior are considered to be those based on the divine privilege accorded to human life, holism, freedom, responsibility, community relations, and mutual assistance. Pope John Paul II expressed the official position of the Catholic Church on these issues in 1995 in the Encyclical letter Evangelium Vitae which was published in the Catechism of the Catholic Church in an abbreviated form. Among other issues, this document expresses a papal opinion that permits discontinuation or non-implementation of medical treatment to keep a person alive when it is painful, dangerous, or has an unexpected effect. Euthanasia is discussed in this document as a worrisome phenomenon indicative of a “culture of death” which is spreading in societies characterized by welfare and a service mentality, according to which society is burdened with too many old and incapacitated people.

Other documents issued by the Vatican, for example, the *Declaration on Euthanasia* (1980), state that it is permissible to end treatment of a dying patient who is suffering and in great pain even if this poses the risk of shortening the person’s life as an unintended secondary effect. The document also notes the role of suffering and the pain of death in the Christian symbol of Jesus on the cross. Active euthanasia is prohibited. Palliative care is required for terminally ill patients with incurable diseases (Kovaľová, 2016).

The Magistrates of the Catholic Church condemn euthanasia as a type of murder. Their philosophical basis for this is the value and autonomy of life. The values of the sanctity and dignity of human life are necessary condition for goodness. The Magistrates add a theological argument to this philosophical worldview, namely that God is the Creator and master of all life and therefore life is a gift which people cannot choose to reject. Further, the fifth of the Ten Commandments, “Thou shalt not kill,” forbids ending anyone’s life. The Magistrates argue that medicine should be practiced in the service of life not death. They make a strong appeal for palliative care instead of euthanasia in response to unbearable suffering and suggest that palliative care should be available to all terminally ill patients (Liégeois, 2013). According to Benjamin (2015), Christianity in general and the Roman Catholic Church in particular completely oppose all types of voluntary euthanasia.

**Position of the Latin (Western Catholic) Church**

The Latin (Western Catholic) Church is one of the streams within the Catholic Church, and so the perspectives of Catholic Church on all issues including euthanasia apply to the Latin Church as well.

**Position of the Orthodox Church on Euthanasia**

The Orthodox Church is a branch of the Christian Church which is similar to Catholicism in many matters of religion and morality. The identity of this Church is rooted in the Christian Church established in the first millennium, especially with regard to theology. Issues of ethics in general and bioethics in specific are understood in the framework of the personal relationship between believers and God. This ethical position is based on the assumption that God the Creator is incomprehensible and unknowable to humans and that God’s presence can be felt only through a personal mystical experience. This mystical role of God is religious principle, according to which all people, including physicians and other health care workers, are connected to God through their personal moral responsibility for every action. Death is interpreted by the Orthodox Church not only as a biological process, but as a mystery full of hidden religious purpose and blessings. From this, it follows that any death resulting from a human decision is seen as a challenge to God’s authority. Any medical action that is not focused on extending and preserving life is considered immoral. The Bioethics Committee of the Church of Greece points out that there is always a possibility that a diagnosis was made in error or that a disease may take an unexpected course and there is always hope for a miracle. Therefore, the Orthodox Church forbids refusal of treatment, even when a fully conscious patient wishes to stop treatment (this includes treatment that could save the patient’s life). The doctor has a moral duty to persuade patients to agree to treatment. The Orthodox Church permits the use of painkillers, but only to the extent that they will not cause the death of the patient. They forbid the cessation of artificial nutrition even when there is no hope for recovery. Although the term “good death” is a literal translation of the Greek word for euthanasia (as explained above), according to the Orthodox Church, a good death is calm and painless. The contemporary interpretation of active euthanasia as a merciful end of life is totally rejected by the Orthodox Church (Kovaľová, 2016).

According to the theology of the sacred, life and death are communal events. Any discussion of death and life, from the perspective of Christianity as a whole and the Orthodox Church in particular, necessarily includes the concepts of the Holy and of the church. In the Orthodox view, death or a “good death” must be discussed in terms of the theology of the sacred. In this context any death could be a “good death” even if it entails suffering, pain, or loneliness. A good death is not just dying in the hospital numbed by painkillers. One might ask: Did Jesus die a good death? Did the saints and martyrs die good deaths? Of course, most people are not expected to suffer the kind of death endured by Jesus and the saints, but their deaths, despite their pain and suffering, can still be considered “good” since their martyrdom was an expression of their faith, and the value they placed on their Christian communities.

Funeral services and early liturgical traditions in the Orthodox Church clearly show the communal dimension of death. People participate in various ways in the death of a member of their community. The various liturgical formulas and the overall formula of a funeral service presuppose a moral understanding of death (this of course applies to other denominations as well). In the Orthodox theology of the sacred, a human is not only a biological entity, but is a member of a community. A good life, in fact life itself, is not more than just biological material or a living body, and should be considered as such (Ježek, 2014).

On one level, this perspective proposes that human life cannot be separated from the biological being. Therefore, if a person wants to commit suicide because of a decline in quality of life, this is a misinterpretation of the form of a person’s biological characteristics and life experiences. There is no such thing as a life or lifestyle not worth living. As long as a living biological organism is alive, the person’s life continues. If we understand human life from the perspective of the Orthodox theology of the sacred, a person is not an autonomous being who can make decisions about his or her existence. A person is always connected to the divine source of existence. Man as an entity is created in the image and likeness of God, and God exists in the community. A person does not have the autonomy to choose to end his or her life without affecting the community. However, having said this, one does not have to fall into unrealistic idealism. The collapse of an individual’s ability or desire to live is not only the responsibility of the individual. It is a sign that the community has failed. This failure is implied in multiple ways. For example, I find it hypocritical that many Orthodox theologians repeatedly argue against euthanasia for theological reasons (such as that humans being created in the image of God) but fail to acknowledge that their arguments do not alleviate the suffering of a dying patient in any practical way if the community does not follow these principles. In theology, one must say A, but also B. A person can be created in the image and likeness of God, and also represent the image and likeness of the community. A person’s ability and will to live reflects the life of the community and its ability to take care of members. If the community fails in this aspect, it is not morally justified to blame the individual for failure (Ježek, 2014).

**Protestant Position on Euthanasia**

Protestantism is the youngest Christian movement. This movement has raised significant moral questions, which each of the denominations (Lutheran, Baptist, Methodist, Presbyterian, etc.) relates to differently. Unlike Catholicism, Protestantism emphasizes personal knowledge and interpretation of the Bible.9 Given the diversity of denominations and communities, there can be no clear and simple definition of Protestant bioethics and medical ethics or a single set of established principles for dealing with end-of-life questions. Most Protestants make use of modern methods treatments for extending life. Some religious communities support the cessation of treatment when hope for healing no longer exists. There are different opinions on the issue of euthanasia. For example, the German Protestant Church issued detailed principles regarding end-of-life decisions which clearly rejected euthanasia. In contrast, there are members of the Reform tradition in the Netherlands who defend euthanasia (Kovaľová, 2016).

**Ethical View of Euthanasia**

Increasingly, ethical positions enter debates of controversial issues such as euthanasia. The ethical view takes into consideration the idea that a terminally ill patient should make the decisions regarding the final stage of life. Since euthanasia is so controversial, it is fitting to bring into the discussion ethical aspects of making a decision to die in a dignified manner **(**Loredana & Daniel, 2013).

Christian ethics praise the advent of hospice services and palliative care for terminally ill patients. While the goal of medical care and treatment is curing the patient, the goal of palliative care is providing effective relief of physical, psychological and spiritual pain and suffering. It has been suggested that palliative care can now effectively relieve the suffering of 95% of terminally ill patients (de Villiers, 2016).

Ethical advice is based on an assessment of basic values: the privilege of life, autonomy of the patient, and the relationship between caregiver and patient. To incorporate these values, caregivers must clarify that life is a privilege, respect the autonomy of the patient, and provide the best possible care, including counseling on existential questions (Liégeois, 2013).

**Who Supports and Opposes Euthanasia?**

Christians who support voluntary euthanasia have said that choosing a painless death is a “demonstration of love and compassion” when submitted to a parliamentary and Victorian type of inquiry. They argue that voluntary euthanasia for terminally ill people will increase their quality of life by removing the stress of facing a painful death. They also argue that witnessing a patient die slowly or in a medically-induced coma can be extremely difficult for family members and for the medical staff (Benjamin, 2015).

In Belgium, the debate is over. A perfectly healthy person can sign an agreement to end his or her life following a diagnosis of Alzheimer’s or dementia. Children can be killed if they are seriously disabled “in order to alleviate the suffering of the parents” or the children. The current situation there shows how the practice and procedures of euthanasia can become blurred in complex legal proceedings (Ježek, 2014). Euthanasia, under certain conditions, was legalized in Belgium in 2002 for adults. Euthanasia is legal in at least six other localities: the countries of Holland, Luxembourg, Switzerland, and, within the USA, the states of Oregon, Washington and Montana. The rules and conditions require that the patient must be terminally ill and in constant and unbearable physical or mental suffering, as a consequence of an incurable disease or a serious accident (Shah & Mushtaq, 2014).

**Euthanasia Around the World**

Previous surveys indicate that there is a high level of unregulated euthanasia in Belgium and Holland. In Belgium, euthanasia represents close to 32% of all deaths. This indicates that some healthcare professionals are willing to take responsibility for making a judgment regarding whether a person’s quality of life is so poor that death is preferable. Euthanizing people without their request or consent involves mutual reciprocity of the legal “means of defense” in their legislation (Richmond, 2014).

Romania has not yet legally regulated euthanasia. Switzerland grants an individual the right to a dignified death as part of a framework of personal freedoms. Also, in Belgium and the Netherlands euthanasia has been legalized. It is believed that if death is inevitable, alleviating suffering is the humane course of action (Loredana & Daniel, 2013).

The pro-euthanasia position adopted in some developed countries arises from the belief that a person suffering from an incurable and fatal illness should be able to make the decision to end his or her life. However, controversy arises in Third World countries and in countries where religious beliefs have a greater impact on the consciousness of the individual. For medical practitioners in this social context, euthanasia is contrary to religious values, and may be viewed as the same as suicide or murder (Loredana & Daniel, 2013).

In Western liberal democracies, the right to autonomy plays a central role in discussions of the legalization of medically assisted suicide and euthanasia. The moral value of autonomy is seen as being at the core of the right to human dignity, which in turn is perceived as a fundamental human right. Although they are in the minority, it is possible to note there are several Christian ethicists who argue in favor of practices enabled by turning autonomy into a central value (de Villiers, 2016).

The importance of patient autonomy as a moral principle in the Western (Christian) world is not accepted in other ethnic or religious environments. Current medical recommendations and guidelines may be contrary to certain religious views. It is clear that in certain cases, aspects other than religious ones should be taken into account, for example, the existing laws of a society (Kovaľová, 2016).

**Research Question**

How do attitudes and perceptions of the Christian religion and its denominations affect the issue of euthanasia and the decision-making process of a terminally ill patient?

**Research Hypotheses**

1. Difference will be found in positions regarding euthanasia among various Christian denominations.
2. Differences will be found in positions regarding euthanasia according to level of religiosity.
3. No difference will be found in positions regarding euthanasia according to gender.
4. Differences will be found in attitudes regarding euthanasia according to level of education.

**Rationale for the Aims of the Study**

Caregiving professions are a humane calling that requires addressing the needs of every population without regard to race, gender, or religion. People working in caregiving professions must be familiar with all religions and worldviews, and to understand their ethical codes, cultures, and behaviors at different stages of life. Since we, as the researchers and authors of this article, are affiliated with the Muslim religion, we chose to address the topic of euthanasia as seen through the perspective of Christianity and its denominations. Our aim is to investigate and explore how euthanasia is affected by religion, and therefore the perspective of other religions is highly interesting to us.

**Research Methods**

**Research Population**

The research population consists of Christian residents of the State of Israel over the age of 18. The questionnaire was distributed to 240 people, of whom 231 agreed to participate in the study.

It is important to note that the Christian population is the smallest religious minority in Israel, consisting of approximately 170,000 individuals, representing about 2% of the total population in Israel (Central Bureau of Statistics, 2017).

**Research variables**

*Dependent variable:* Positions and perspective on the decision-making process regarding euthanasia.

*Independent variables:* Christian religious denomination and level of religiosity.

**Research tools**

The research tool was a questionnaire designed by the researchers under the guidance of the course lecturer, Dr. Mahdi Tarbiyah. The questionnaire was built using “Qualitirs” and “Google Forms”. It was tested and validated by experts and approved by the Ethics Committee of the Academic College of Tel Aviv-Jaffa. The aim of this tool was to examine the positions regarding euthanasia held by the members of the Christian religion and its denominations in Israeli society. The questionnaire was available in Hebrew, Arabic, and English.

The questionnaire was divided into two parts. The first part dealt with demographic traits such as: age, gender, religion, level of religiosity, education, family status. The second part included 36 questionnaire items pertaining to positions and perspectives on euthanasia. This was divided into six themes: “Autonomy” (items 5, 8, 10, 13, 15, 17); “Knowledge” (items 2, 4, 20, 24, 27); “Law and ethics” (items 3, 7, 9, 25, 28, 29, 30); “Decision-making” (items 1, 6, 11, 12, 26, 31, 34); “Environment “(items 14, 19, 23, 32, 35, 36); and “Patient and family” (items 16, 18, 21, 22, 33). Respondents indicated the degree to which they agreed with the statements according to a scale from 1 (disagree) through 5 (strongly agree).

**Research Procedure**

The questionnaire was distributed to members of the general public in Israel via online social networks using the snowball method. Completing the questionnaire took approximately 10 minutes. Data were collected by the researchers and sent to a statistician for analysis using the SPSS program.

**תוצאות המחקר**

**בניית מדדים:**

מדד מקבל החלטה:

מורכב מ – 7 פריטים (שאלות 1, 6, 11, 12, 26, 31, 34 בשאלון), טווח התשובות נע מ – 1 = לא מסכים כלל ועד 5 = מסכים במידה רבה. היפוך סולם לשאלות 1, 11, 26, **כך שככל שהערך של המדד גבוה יותר קבלת ההחלטה על חייו של החולה נתונה בידי אנשי המקצוע והתתנגדות להמתת חסד גבוהה יותר.** מהימנות פנימית אלפא קרונבך 0.684.

מדד סביבה:

מורכב מ – 6 פריטים (שאלות 14, 19, 23, 32, 35, 36 בשאלון), טווח התשובות נע מ – 1 = לא מסכים כלל ועד 5 = מסכים במידה רבה. היפוך סולם לשאלה 32, כך שככל שהערך של המדד גבוה יותר כך התמיכה בסביבה מוכרת לחולה הסופני גבוהה יותר. מהימנות פנימית אלפא קרונבך 0.387.

מדד אתיקה וחוק:

מורכב מ – 5 פריטים (שאלות 3, 7, 9, 25, 30 בשאלון), טווח התשובות נע מ – 1 = לא מסכים כלל ועד 5 = מסכים במידה רבה. היפוך סולם לשאלה 25, כך שככל שהערך של המדד גבוה יותר התמיכה בזכות של החולה למות בכבוד גבוהה יותר. מהימנות פנימית אלפא קרונבך 0.579.

מדד אוטונומיה:

מורכב מ – 6 פריטים (שאלות 5, 8, 10, 13, 15, 17 בשאלון), טווח התשובות נע מ – 1 = לא מסכים כלל ועד 5 = מסכים במידה רבה. מהימנות פנימית אלפא קרונבך 0.543, ככל שהערך של המדד גבוה יותר התמיכה באוטונומיה של החולה הסופני בהחלטות על חייו גבוהה יותר.

מדד ידע:

מורכב מ – 4 פריטים (שאלות 2, 4, 20, 27 בשאלון), טווח התשובות נע מ – 1 = לא מסכים כלל ועד 5 = מסכים במידה רבה. ככל שהערך של המדד גבוה יותר הידע לגבי המתות חסד גבוה יותר. מהימנות פנימית אלפא קרונבך 0.681.

מדד משפחת המטופל:

מורכב מ – 5 פריטים (שאלות 16, 18, 21, 22, 33 בשאלון), טווח התשובות נע מ – 1 = לא מסכים כלל ועד 5 = מסכים במידה רבה. מהימנות פנימית אלפא קרונבך 0.560, ככל שהערך של המדד גבוה יותר העמדה היא שיש להתחשב יותר בדעה של הקרובים לחולה.

**מאפייני המדגם**

|  |  |  |
| --- | --- | --- |
|  | **שכיחות** | **באחוזים** |
| **מגדר:**  זכר  נקבה | 81  150 | 35.1%  64.9% |
| **גיל (שנים):**  18-25  26-35  36-45  46-60  מעל 60 | 111  52  36  28  4 | 48.1%  22.5%  15.6%  12.1%  1.7% |
| **מצב משפחתי:**  רווק/ה  נשוי/אה  גרוש/ה  אלמן/ה  פרוד/ה | 128  88  11  2  2 | 55.4%  38.1%  4.8%  0.9%  0.9% |
| **ילדים:**  ללא ילדים  1-3  4-6  7 ומעלה | 139  72  19  1 | 60.2%  31.2%  8.2%  0.4% |
| **מקום מגורים:**  ישראל  ארה"ב | 223  8 | 96.5%  3.5% |
| **מצב סוציו-אקונומי:**  נמוך  בינוני  גבוה | 19  186  26 | 8.2%  80.5%  11.3% |

|  |  |  |
| --- | --- | --- |
|  | **שכיחות** | **באחוזים** |
| **השכלה:**  יסודית  תיכונית  סטודנט  אקדמאית  תואר שני ומעלה | 3  31  77  87  33 | 1.3%  13.4%  33.3%  37.7%  14.3% |
| **עיסוק:**  לא עובד  שכיר  עצמאי | 65  143  23 | 28.1%  61.9%  10% |
| **הכנסה חודשית:**  ללא הכנסה קבועה  הרבה מתחת לממוצע  ממוצעת  מעט מעל הממוצע  הרבה מעל הממוצע | 65  22  95  35  14 | 28.1%  9.5%  41.1%  15.2%  6.1% |
| **מוצא דתי-עדתי:**  קתולי  אורתודוקסי  פרוטסטנטי  לטיני | 88  67  40  36 | 38.1%  29%  17.3%  15.6% |
| **זיקה לדת:**  חילוני  מסורתי  דתי | 53  123  55 | 22.9%  53.2%  23.8% |

**סטטיסטיקה הסקתית**

ממוצעים וסטיות תקן של שני מדדים לפי זרמים בנצרות

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | מדד מקבל החלטה | | מדד ידע | |  |
|  | ממוצע | ס.ת. | ממוצע | ס.ת. | תצפיות |
| קתולי | 3.68 | 0.51 | 4.04 | 0.73 | 88 |
| אורתודוקסי | 3.60 | 0.59 | 4.19 | 0.57 | 67 |
| פרוטוסטנטי | 4.10 | 0.38 | 4.39 | 0.48 | 40 |
| לטיני | 3.92 | 0.73 | 4.45 | 0.70 | 36 |

מבחן F (One-Way ANOVA) לבדיקת ההבדל במדד מקבל החלטה לפי זרמים בנצרות נמצא מובהק (F(3,227) = 8.098, p < 0.01). לפי מבחן post hoc tukey ההבדל מובהק בין קתולי לבין פרוטסטנטי, בין אורתודוקסי לבין פרוטסטנטי, ובין לטיני לבין אורתודוקסי. האורתודוקסים והקתולים הכי תומכים בכך שההחלטה על חייו של החולה נתונה בידי החולה וסביבתו והכי תומכים בהמתת חסד, הפוך מההשערה.

מבחן F (One-Way ANOVA) לבדיקת ההבדל במדד ידע לפי זרמים בנצרות נמצא מובהק (F(3,227) = 4.794, p < 0.01). לפי מבחן post hoc tukey ההבדל מובהק בין קתולי לבין פרוטסטנטי, בין קתולי לבין לטיני. בקרב הקתולים הידע לגבי המתת חסד הכי נמוך.

**השערה 1 אוששה חלקית**: מתוך ששת המדדים של המחקר ההבדל נמצא רק בשני מדדים מדד מקבל החלטה ומדד ידע, ובקבלת החלטה הפוך מהמשוער.

מדד מקבל החלטה: האורתודוקסים והקתולים הכי תומכים בכך שההחלטה על חייו של החולה נתונה בידי החולה וסביבתו והכי תומכים בהמתת חסד, הפוך מהמשוער .

מדד ידע: בקרב הקתולים הידע לגבי המתת חסד הכי נמוך.

ממוצעים וסטיות תקן של שני מדדים לפי מידת דתיות בקרב הנוצרים

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | מדד מקבל החלטה | | מדד אוטונומיה | |  |
|  | ממוצע | ס.ת. | ממוצע | ס.ת. | תצפיות |
| חילוני | 3.37 | 0.47 | 3.66 | 0.72 | 53 |
| מסורתי | 3.85 | 0.60 | 3.22 | 0.51 | 123 |
| דתי | 3.96 | 0.44 | 3.14 | 0.60 | 55 |

מבחן F (One-Way ANOVA) לבדיקת ההבדל במדד מקבל החלטה לפי מידת דתיות נמצא מובהק (F(2,228) = 19.076, p < 0.01). לפי מבחן post hoc tukey ההבדל מובהק בין חילוני לדתי, בין חילוני למסורתי. החילונים תומכים יותר בקבלת החלטת שנתונה בידיו של החולה בהשוואה לאחרים ויותר תומכים בהמתת חסד.

מבחן F (One-Way ANOVA) לבדיקת ההבדל במדד אוטונומיה לפי מידת דתיות נמצא מובהק (F(2,228) = 12.907, p < 0.01). לפי מבחן post hoc tukey ההבדל מובהק בין מסורתי לחילוני. בקרב החילוניים הכי גבוה לאחר מכן מסורתיים ולבסוף דתיים. החילוניים הכי תומכים באוטונומיה של החולה בעוד שהמסורתיים הכי פחות.

ממוצעים וסטיות תקן של שני מדדים לפי מידת דתיות בקרב הנוצרים

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | מדד ידע | | מדד משפחת המטופל | |  |
|  | ממוצע | ס.ת. | ממוצע | ס.ת. | תצפיות |
| חילוני | 3.88 | 0.69 | 3.56 | 0.77 | 53 |
| מסורתי | 4.29 | 0.58 | 3.25 | 0.56 | 123 |
| דתי | 4.34 | 0.69 | 3.01 | 0.66 | 55 |

מבחן F (One-Way ANOVA) לבדיקת ההבדל במדד ידע לגבי המתות חסד לפי מידת דתיות נמצא מובהק (F(2,228) = 9.275, p < 0.01). לפי מבחן post hoc tukey ההבדל מובהק בין חילוני לדתי, בין חילוני למסורתי. בקרב הדתיים הכי גבוה לאחר מכן מסורתיים, ולבסוף חילוניים. בקרב החילוניים הידע לגבי המתות חסד הכי נמוך, הפוך מההשערה.

מבחן F (One-Way ANOVA) לבדיקת ההבדל במדד משפחת המטופל לפי מידת דתיות נמצא מובהק (F(2,228) = 9.980, p < 0.01). לפי מבחן post hoc tukey ההבדל מובהק בין חילוני לדתי, בין חילוני למסורתי. החילוני הכי מתחשב בדעה של הקרובים בהשוואה לאחרים.

**השערה 2 אוששה חלקית**: מתוך ששת המדדים של המחקר, בארבעה מדדים נמצא הבדל מובהק.

מדד מקבל החלטה: החילונים תומכים יותר בקבלת החלטת שנתונה בידיו של החולה בהשוואה לאחרים. מדד אוטונומיה: החילוניים הכי תומכים באוטונומיה של החולה בעוד שהמסורתיים. הכי פחות מדד ידע: בקרב החילוניים הידע לגבי המתות חסד הכי נמוך, הפוך מההשערה. מדד משפחת המטופל: החילוני הכי מתחשב בדעה של הקרובים בהשוואה לאחרים.

מבחן T בלתי תלוי (Independent samples T test) לבדיקת ההבדל בששת מדדים לפי מין.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| מובהקות |  | נקבה  (*n* = 150) | |  | זכר  (*n* = 81) | |  |
| *t* |  | *סטיית תקן* | *ממוצע* |  | *סטיית*  *תקן* | *ממוצע* | משתנה |
| 1.741 |  | 0.56 | 3.72 |  | 0.60 | 3.86 | מדד מקבל החלטה |
| 1.778- |  | 0.52 | 3.78 |  | 0.46 | 3.65 | מדד סביבה |
| \*\*4.412 |  | 0.57 | 2.87 |  | 0.40 | 3.16 | מדד אתיקה וחוק |
| 1.322 |  | 0.65 | 3.26 |  | 0.54 | 3.37 | מדד אוטונומיה |
| 0.982 |  | 0.67 | 4.18 |  | 0.64 | 4.27 | מדד ידע |
| 0.374- |  | 0.67 | 3.29 |  | 0.64 | 3.22 | מדד משפחת המטופל |

מובהק ברמה של p < 0.01\*\*, מובהק ברמה של p < 0.05\*

במבחן T בלתי תלוי ההבדל במדד מקבל החלטה נמצא לא מובהק (t(229) = 1.741, n.s.), בין גברים לנשים.

במבחן T בלתי תלוי ההבדל במדד סביבה נמצא מובהק (t(229) = -1.778, n.s.), בין גברים לנשים.

במבחן T בלתי תלוי ההבדל במדד אתיקה וחוק נמצא מובהק (t(213.604) = 4.412, p < 0.01), בין גברים לנשים. גבוה יותר בקרב הגברים, הגברים תומכים יותר מנשים בזכות של החולה למות בכבוד.

במבחן T בלתי תלוי ההבדל במדד אוטונומיה נמצא לא מובהק (t(229) = 1.322, n.s.), בין גברים לנשים.

במבחן T בלתי תלוי ההבדל במדד ידע נמצא לא מובהק (t(229) = 0.982, n.s.), בין גברים לנשים.

במבחן T בלתי תלוי ההבדל במדד משפחת המטופל נמצא לא מובהק (t(229) = -0.734, n.s.), בין גברים לנשים.

**השערה 3 אוששה חלקית:** לא נמצאו הבדלים מובהקים בחמישה מדדים נמצא הבדל מובהק רק במדד אתיקה וחוק.

מדד אתיקה וחוק: הגברים תומכים יותר מנשים בזכות של החולה למות בכבוד.

ממוצעים וסטיות תקן של מדד מקבל החלטה לפי השכלה בקרב הנוצרים

|  |  |  |  |
| --- | --- | --- | --- |
|  | מדד מקבל החלטה | |  |
|  | ממוצע | ס.ת. | תצפיות |
| יסודית | 3.71 | 0.75 | 3 |
| תיכונית | 4.06 | 0.45 | 31 |
| סטודנט | 3.69 | 0.62 | 77 |
| אקדמאית | 3.78 | 0.59 | 87 |
| תואר שני ומעלה | 3.36 | 0.48 | 33 |

מבחן F (One-Way ANOVA) לבדיקת ההבדל במדד מקבל החלטה לפי השכלה נמצא מובהק (F(4,226) = 2.846, p < 0.05). לפי מבחן post hoc tukey ההבדל מובהק בין השכלה תיכונית לבין סטודנטים ובין השכלה תיכונית לבין השכלת תואר שני ומעלה. בקרב בעלי השכלה הערך גבוה יותר במובהק מסטודנטים ובעל תואר שני ומעלה. ככל שההשכלה נמוכה יותר התמיכה היא בכך שקבלת ההחלטה על חייו של החולה נתונה בידי אנשי המקצוע.

**השערה 4 אוששה חלקית**: מתוך ששת המדדים של המחקר, רק במדד מקבל החלטה נמצא הבדל מובהק.

מדד מקבל החלטה: ככל שהאדם יותר משכיל קבלת ההחלטה על חייו של החולה יותר נתונה בידיו.

**Discussion and Conclusions**

Over time, a wide range of opinions regarding treatment terminally ill patients have been expressed. This issue is considered particularly problematic due to the various dilemmas such as prejudice, religion, and social norms. The issue concerns not only the patient, but other concerned parties including physicians, family, and friends. Consequently, there are extensive discussions on this topic among medical professionals, judges and lawyers, clergy and more.

We chose to investigate this issue reflecting our interest in the varied opinions on euthanasia held by various populations in the State of Israel. Even before we started the research process, we expected to encounter challenges, and thought we might encounter a fundamental change in the ways of thinking about it.

The specific research questions were: What are the positions of the Christian religion on euthanasia? How do these positions influence the decision-making process regarding terminally ill patients? We examined the subject in various fields and with multiple of variables in order to cover the phenomenon as thoroughly as possible.

The research hypotheses propose connections between the principles and positions of religions and the corresponding attitudes of members of each religious stream regarding euthanasia. The first hypothesis predicts that there will be differences in attitudes towards euthanasia among the various denominations in Christianity. The results indicate that subpopulations of the Orthodox and Catholics support the idea that decisions regarding a patient’s life should be made by the patient and those in the patient’s immediate social environment. Most respondents in this group supported euthanasia. However, our findings pertaining to this hypothesis are not supported by previous literature, which indicates that the Catholic and Orthodox populations are completely opposed to all forms of euthanasia According to Liégeois (2013), the Catholic Church condemns euthanasia as murder based on the belief that life is a gift from God and humans cannot choose death. The argument is made that medicine is in the service of life rather than of death, and there is a strong appeal for palliative care instead of euthanasia. In addition, according to Benjamin (2015) Christianity in general and the Roman Catholic Church in particular totally opposes all types of voluntary euthanasia.

Similarly, according to Kovaľová (2016), Orthodox Christians do not accept any decision to undertake euthanasia and think that physicians must convince patients of what that they see as the correct attitude, namely that a patient cannot refuse medical treatment. Every patient should accept the medical guidelines as if they were sacred and cannot be ignored. According to Ježek (2014), in the Orthodox Christian theology of the sacred, humans are not autonomous beings who can make decisions regarding their existence. Rather, this position asserts that people are always connected to the divine source of their existence and are created in the image and likeness of God. Since God is a communal God, people do not have the autonomy to choose to end their or life without affecting the whole community. According to the scientific literature, Orthodox Christians are absolutely opposed to euthanasia. Finally, we can say that this hypothesis was partially confirmed by the fact that they acknowledge the doctor’s significant role but are unwilling to accept his decision on euthanasia.

Another measure examined in this hypothesis is the knowledge index. Analysis of the data indicates is that the level of knowledge about euthanasia is lowest among the Catholic population. It can be noted that this contradicts previous literature such as Kovaľová (2016), which finds that the Bible, the holy book of Christianity, clearly opposes euthanasia and presents other options to terminally ill Catholics who are experiencing pain, suffering and hopelessness. It is therefore possible to argue that the Catholic population is knowledgeable about euthanasia.

The second hypothesis predicts that there will be differences in attitudes toward euthanasia according to degree of religiosity. The results obtained in the four indices did show a significant difference. Data on the two measures of patient decision-making and autonomy indicate that the secular population is more willing to allow the patient to express opinions that contradict traditional religious positions that limit the patient’s choices. Kovaľová (2016) finds that traditional clerics assert that human life is a sacred value and there is no place for euthanasia even in response to a patient’s request.

Our findings related to the according to the autonomy index, the secular population supports the autonomy of the patient while the traditional and the religious are less willing to support this idea. This hypothesis is supported by the literature and especially de Villiers (2016), which show that in the liberal Western viewpoint, the right to autonomy plays a central role in attitudes regarding medical treatment and euthanasia.

According to Kovaľová (2016), the importance of patient autonomy is accepted as a moral principle in the Western Christian world but is not accepted in culturally and religiously traditional social environments. This further supports the hypothesis. Finally, according to the scientific literature and our statistical analysis, secular or religiously alienated respondents are more likely to support autonomy in end-of-life decision making. In contrast, religious people see their choices and autonomy as limited.

Analysis of data pertaining to the knowledge index indicates that knowledge about euthanasia is lowest among the secular population. This is supported by Kovaľová (2016) who found that Catholic bioethics are based on ideological sources such as the Bible, the teachings of philosophers and theologians, and other religious texts. Religious Catholics rely on these as sources of knowledge regarding end-of-life decisions. In contrast, knowledge among the secular population regarding euthanasia and end-of-life decisions is limited. The study indicates that the position of the secular population supporting a patient’s right to choose euthanasia stems from a lack of awareness and not from understanding and knowledge.

Another measure examined pertains to the patient’s family. The findings indicate that the secular population is more likely to take into account the opinion of family members, as compared with the other groups. This contradicts the scientific literature and especially de Villiers (2016), who argues that according to the Bible and the belief that personal destiny is determined by God, Christians are obligated to consult with family members and other Christians. This indicates that religious people are more likely to consult with their family members and their community regarding in decisions related to the end of life, as compared with secular people.

The third hypothesis predicts there will be no difference in views on euthanasia between the genders. It may be noted that de Villiers (2016) found no difference according to this variable. Analysis of the data collected in this study shows a difference between the genders on the index of law and ethics. This difference may primarily be attributed to the fact that women are more sensitive to the subject, and it is difficult for them to make a fateful decision in general compared with men who are tougher, coarse and also more used to making independent decisions.

The fourth hypothesis pertains to differences in opinion according to level of education. It was found that people with higher levels of education were more likely to say that patients should be permitted to make individual decisions about their life. These results seem to uphold a general assumption that educated people are better able to cope with stress, but it is important to note that we have not found support in the literature for this interpretation, so we present only the results of our study.

In conclusion, there are numerous variables that significantly affect attitudes regarding euthanasia in addition to religious denomination, such as age, education, and gender. Decisions regarding euthanasia, death, and prolongation of suffering are difficult for people in any population, regardless of the demographic traits of the decision-maker. These decisions are difficult to make and difficult to uphold and implement following the decision.

**Recommendation**

We make the following recommendations:

1. Establishment of advisory groups in hospital departments that deal with terminally ill patients, which will be composed of clerics and medical staff, in order to increase awareness of cultural and religious issues related to euthanasia and end-of-life decisions. According to the findings of this study, discussion of euthanasia always raises ethical, medical and social issues. The essence of this debate is the sanctity of life versus the desire to relieve the suffering of a patient suffering from a terminal illness. There are various reasons behind these respective views, including religion, beliefs, and social norms. There is a wide spectrum of populations in Israel, each characterized by blood relations, traditions, social norms, and more. In addition, there are also sub-populations that differ in their beliefs and ways of thinking. Advisory groups in hospital departments that deal with terminally ill patients, which include clerics and medical staff belonging to the same religion and population as the patient and who understand the social environment and values of patients and their family would raise awareness among the professional staff about religious and cultural aspects of end-of-life decision-making. These groups may help offer solutions for terminally ill patients and their families, thus facilitating end-of-life decisions.
2. Establishment of workshops and lectures in the Christian community to explain the options available to terminally ill patients. These workshops could be led by doctors, social workers, monks, and nuns. These would contribute to raising awareness among the population about various treatment options, such as hospices and palliative care for patients with terminal diseases in order to alleviate their suffering and support them during critical stages of the illness.
3. Passage of bill that allows terminally ill patients to choose the way in which they want to end their lives. Israeli law does not allow active euthanasia. However, the *Terminally Ill Patient Law* allows, under certain circumstances, cessation of life-prolonging treatment. For example, in some cases a patient may be taken off a respirator, not given medication, or not given an artificially assisted supply of food and liquids. The *Terminally Ill Patient Law* allows the decision not to extend the life of a terminally ill patient if that patient has previously given appropriate instructions in this matter. However, the law expressly states in section 19: “The provisions of this Law shall not permit any action, including medical treatments, which are intended to cause death, or the result of which is probable also the cause of death, whether performed out of mercy or compassion or not, and whether the request is made by the terminally ill patient or any other person.”

There exists a relatively large number of terminally ill patients who wish to undergo voluntary euthanasia in order to end their own pain and suffering. This decision is based on knowledge and understanding of their medical condition. It is therefore necessary to consider this and to implement a law that allows passive or active euthanasia under certain and specific conditions, in order to give patients all possible autonomy regarding the end of their lives.

**Summary**

The treatment of a terminally ill patient is one of the most prominent ongoing problems in medicine around the world and in Israel. The prolongation of the life of a patient, especially a patient suffering severe anguish, raises serious medical, moral, legal and economic problems. The problem concerns not only the patient, but also the patient’s family, friends and acquaintances, physicians and medical staff. The topic of euthanasia is the topic of wide-ranging discussions on ethical and religious values. When euthanasia is defined as the acceleration of death by the caregivers then any passive or active action with the intention of causing a painless death to a patient can be considered euthanasia.

The findings of this study seem distinctive to the Christian population in Israel. On the one hand, we learned that the attitudes and perceptions of the religious Christian groups in Israel indicate they are totally opposed to all types of voluntary euthanasia. They believe that life is a gift from God, people are not autonomous and cannot decide to die, and medicine is in the service of life and not of death. In contrast, the secular Christian group was more likely to support autonomy, allowing patients to express their wishes and make decisions regarding end of life and euthanasia.

Finally, it is important to note that this study to some extent helps us understand certain points more clearly and effectively. It could serve as the basis for further research on the subject of euthanasia and religion. It is reasonable to assume that eventually Israel will follow the path of other countries in the West and will enact a law that permits active voluntary euthanasia. Currently, any person who helps a relative die may be charged with murder. This often leads to heartrending tragic deaths and suicide. Therefore, it seems inevitable that there will be a need for such a law to prevent partisan actions of inappropriate euthanasia that are still considered murder.

‏ **References**

Aviv, A., & Galili-Schachter, I. (1999). *And You Shall Choose Life*. Jerusalem, Israel: Ministry of Education, Culture and Sport. Retrieved from: http://school.kotar.cet.ac.il/KotarApp/Viewer.aspx?nBookID=95894370#234.0.6.fitwidth

de Villiers, D. E. (2016). May Christians request medically assisted suicide and euthanasia?. *HTS Theological Studies*, *72*(4), 1-9. ‏

Israel Central Bureau of Statistics. (24 November 2017). *The Christian population of Israel: Data on Christmas holiday pilgrimage. Christians in Israel: Christmas 2017.* Jerusalem, Israel.

Ježek, V. (2014). Euthanasia and Orthodox theology of Communion. *Review of Ecumenical Studies Sibiu*, *6*(2), 214-226. ‏

Kovaľová, D. (2016). Certain cultural-religious specifics of health care “in the end of life” in the context of (white) bioethics and religious studies. *Zeszyty Naukowe. Organizacja I Zarządzanie/Politechnika Śląska*.

Liégeois, A. (2013). Euthanasia and mental suffering: An ethical advice for Catholic mental health services. *Christian Bioethics*, *19*(1), 72-81.‏

Mousavi, S. M., Akbari, A., Kashani, F. L., Akbari, M. E., & Sepas, H. N. (2011). Euthanasia in cancer patients: Islamic point of view. *Iranian Journal of cancer prevention*, *4*(2), 78-81. ‏

Preiss, B., & Beazer, M. (2015). Media watch: Christian group backs euthanasia. *Legaldate*, *27*(4), 8.‏

Richmond, D. (2014). How should Christians respond to proposals to legalise euthanasia and assisted suicide?. *Stimulus: The New Zealand Journal of Christian Thought and Practice*, *21*(1), 20.

Shah, A., & Mushtaq, A. (2014). The right to live or die? A perspective on voluntary euthanasia. *Pakistan Journal of Medical Sciences*, *30*(5), 1159.‏

Steinberg, A. (1982). Mercy killing in the light of Jewish law. *ASSIA, 3,* 242-257. Retrieved from: http://98.131.138.124/articles/ASSIA/ASSIA3/R0031424.asp

Terec-Vlad, L., & Terek-Vlad, D. (2013). Euthanasia: The right to a dignified death. *Postmodern Openings/Deschideri Postmodern*, *4*(4). ‏