STATEMENT DE197-1

THE EUTHANASIA DEBATE: UNDERSTANDING THE ISSUES
(Part One in a Two-Part Series on Euthanasia)

by J. P. Moreland

In June of 1990, Dr. Jack Kevorkian, a 63-year-old retired pathologist, was charged with first-degree murder after he helped an Oregon woman with Alzheimer's disease commit suicide in June 1990. The charge was dismissed in December 1990. (Michigan has no law against suicide.) In October of 1991, Marjorie Wantz used a suicide machine devised by Kevorkian to take her own life. Kevorkian also assisted Sherry Miller in an act of suicide by pulling a mask over her face so she would inhale carbon monoxide from a tank. Miller's veins were too delicate for a needle involved in Kevorkian's suicide machine. The police found both bodies in a cabin 40 miles north of Detroit. Miller was incapacitated by multiple sclerosis and Wantz suffered from a painful pelvic condition. Neither condition was life threatening.

During 1991, one of the top-selling books in America was *Final Exit* written by Derek Humphry. Humphry, co-founder of the National Hemlock Society (a right-to-die group), wrote the book to advocate the moral appropriateness of suicide and active euthanasia and to instruct people in the practical how-to's of taking their own lives. Based on the book's sales, there is a growing hunger for this type of information.

These cases illustrate the fact that the rise of advanced medical technologies, especially life-sustaining ones, has brought to center stage the various moral issues involved in euthanasia. People can be kept alive against their wishes or in states of pain and other forms of suffering (e.g., loss of control, fatigue, depression, and hopelessness). It is also possible to keep people alive who are in a coma or a persistent vegetative state. The former refers to a condition wherein the eyes are closed, the person cannot be aroused, and there is no sleep/wake cycle. The latter refers to a condition wherein there is no awareness (including awareness of pain and suffering), no rationality or emotionality, the eyes are open, and there is a wake/sleep cycle. In cases like this, the use of medical technologies raises questions about the moral appropriateness of sustaining life versus taking life or allowing someone to die.[1]

The major life-sustaining interventions that are involved in cases such as these are the following:[2]

1. *Cardiopulmonary Resuscitation (CPR).* This refers to a range of interventions that restore heartbeat and maintain blood flow and breathing following a cardiac or respiratory arrest (e.g., mouth-to-mouth resuscitation, electrical shock to restore the heart to its normal pacing).

2. *Mechanical ventilation.* This refers to the use of a machine to assist in breathing and in regulating the exchange of gases in the blood.

3. *Renal dialysis.* This has reference to an artificial method of sustaining the chemical balance of the blood when the kidneys have failed.

4. *Antibiotics.* This designates a number of drugs used to protect a patient from various types of life-threatening infections.

5. *Nutritional support and hydration.* This refers to artificial methods of providing nourishment and fluids. It usually involves the insertion of a feeding tube that delivers nutrition directly into the digestive tract or intravenous feeding that delivers nourishment directly into the bloodstream. Later, in Part Two of this series, I will look at the debate regarding the appropriateness of classifying artificial food and hydration as medical *treatments.*

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The word "euthanasia" comes from the Greek words *eu* and *thanatos* and means "happy death" or "good death." Roughly speaking, there are two major views about euthanasia. The traditional view holds that it is always wrong to intentionally kill an innocent human being, but that given certain circumstances it is permissible to withhold or withdraw treatment and allow a patient to die. A more recent, radical view is embraced by groups such as the Hemlock Society and the Society for the Right to Die. It denies that there is a morally significant distinction between passive and active euthanasia (defined below) that allows the former and forbids the latter. Accordingly, this view argues that mercy killing, assisted suicide, and the like are permissible.

The issues surrounding the euthanasia debate are tips of a much larger iceberg. At stake are crucial world view considerations regarding what it is to be human, what the purpose of life, suffering, and death are, and whether or not life is a gift from God.

In this series I will explore the issues and options that are crucial for developing an informed perspective on euthanasia. In Part One, we will look at important ethical concepts that provide a background for understanding the nuances of the euthanasia controversy and I will state the main features of the traditional and radical views about euthanasia.

In Part Two, the focus will be on critiquing the radical view, defending the traditional view, looking at the issue of artificial food and hydration, and, finally, stating the world view considerations that the euthanasia debate exemplifies.

IMPORTANT ETHICAL DISTINCTIONS

Natural Moral Law

How should a Christian approach moral issues in a pluralistic culture? Should he or she try to work for a Christian state (one where the state is under Scripture) or should the goal be a just state?[3] Must a believer appeal to Scripture in a moral argument with an unbeliever or is there, in addition, a further source of moral truth and knowledge?

Throughout the history of Christianity, most Christian thinkers have acknowledged that there is something called natural moral law sourced in general revelation (certain knowable truths revealed by God through creation). Simply put, an advocate of natural moral law believes that there are certain moral laws or norms that are true and can be discerned by all men and women *as* men and women. These moral norms do, in fact, come from God, and the existence of such objective moral norms provides strong evidence for the existence of a moral, personal God. But one does not need to believe in God or appeal to Holy Scripture to know that certain moral precepts are genuine moral absolutes.[4]

Again, these basic principles of moral obligation are absolutes that are knowable (at least in principle) by all people everywhere without the aid of Scripture. What is meant by an absolute here? An absolute is an objectively true moral principle that is unchanging and cross-cultural. It is true whether or not anyone believes it to be true. Natural moral law theory implies that we *discover* morality — we do not *invent* it.

Belief in a natural moral law seems to square with the Scriptures themselves. For example, one often finds the Old Testament prophets pronouncing judgments on Gentile nations who did not have the Law of Moses. The pronouncements of judgment often appeal to the fact that these nations have violated fundamental principles of morality which they know to be true — breaking promises, lying, murdering, stealing, oppressing the poor and weak (e.g., Amos 1—2). These nations do not know the God of Israel nor do they possess Holy Scripture, but they are culpable for violating basic moral principles that they should know to be true simply because they are human beings with access to the natural moral law.

In the New Testament, texts such as Romans 1—2 indicate that Paul believed in a natural moral law. In this passage, Paul teaches that there is a universal knowledge of God and His moral law that is available to all men and women apart from the special revelation in the Bible. Humans, he tells us, can sin against nature (Rom. 1:26, 27); that is, against natural obligations that they should know are right because of the way things are in creation.

Furthermore, Paul candidly observes that "when Gentiles, who do not have the law, do by nature things required by the law, they are a law for themselves, even though they do not have the law, since they show that the requirements of the law are written on their hearts" (Rom. 2:14-15 NIV). In other words, Gentiles have a knowledge of right and wrong even though they have no access to Scripture. As C. S. Lewis put it, the great majority of civilizations have acknowledged "the doctrine of objective value, the belief that certain attitudes are really true, and others really false...."[5]

While we should not be naive about moral agreement, nevertheless, natural moral law theory offers the believer this strategy: he

or she should work for a just state; that is, one in which the common good is in keeping with the natural moral law. And we can have confidence that everyone should have access to some basic moral principles which they know deep down are true.

Utilitarianism Vs. Deontological Ethics

There are two major ethical theories that attempt to specify and justify moral rules and principles: utilitarianism and deontological ethics. Utilitarianism (also called consequentialism) is a moral theory developed and refined in the modern world in the writings of Jeremy Bentham (1748-1832) and John Stuart Mill (1806-1873).

There are several varieties of utilitarianism. But basically, a utilitarian approach to morality implies that no moral act (e.g., an act of stealing) or rule (e.g., "Keep your promises") is intrinsically right or wrong. Rather, the rightness or wrongness of an act or rule is solely a matter of the overall nonmoral good (e.g., pleasure, happiness, health, knowledge, or satisfaction of individual desire) produced in the consequences of doing that act or following that rule. In sum, according to utilitarianism, morality is a matter of the nonmoral good produced that results from moral actions and rules, and moral duty is instrumental, not intrinsic. Morality is a means to some other end; it is in no way an end in itself.

Space does not allow for a detailed critique of utilitarianism here. Suffice it to say that the majority of moral philosophers and theologians have found it defective. One main problem is that utilitarianism, if adopted, justifies as morally appropriate things that are clearly immoral. For example, utilitarianism can be used to justify punishing an innocent man or enslaving a small group of people if such acts produce a maximization of consequences. But these acts are clearly immoral regardless of how fruitful they might be for the greatest number.

For this and other reasons, many thinkers have advocated a second type of moral theory, deontological ethics. Deontological ethics is in keeping with Scripture, natural moral law, and intuitions from common sense. The word "deontological" comes from the Greek word *deon* which means "binding duty."

Deontological ethics has at least three important features. First, duty should be done for duty's sake. The rightness or wrongness of an act or rule is, at least in part, a matter of the intrinsic moral features of that kind of act or rule. For example, acts of lying, promise breaking, or murder are intrinsically wrong and we have a duty not to do these things.

This does not mean that consequences of acts are not relevant for assessing those acts. For example, a doctor may have a duty to benefit a patient, and he or she may need to know what medical consequences would result from various treatments in order to determine what would and would not benefit the patient. But consequences are not what make the act right, as is the case with utilitarianism. Rather, at best, consequences help us determine which action is more in keeping with what is already our duty. Consequences help us find what is our duty, they are not what make something our duty.

Second, humans should be treated as objects of intrinsic moral value; that is, as ends in themselves and never as a mere means to some other end (say, overall happiness or welfare). As we will see in Part Two, this notion is very difficult to justify if one abandons the theological doctrine of man being made in the image of God. Nevertheless, justified or unjustified, deontological ethics imply that humans are ends in themselves with intrinsic value.

Third, a moral principle is a categorical imperative that is *universalizable;* that is, it must be applicable for everyone who is in the same moral situation. Moral statements do not say, "If you want to maximize pleasure vs. pain in this instance, then do such and such." Rather, moral statements are imperatives or commands that hold for all examples of the type of act in consideration, such as truth telling. Moral statements say, "keep your promises," "do not murder," and so forth.

Key Bioethical Principles

There are a number of ethical principles that are deontological in nature, are part of the natural moral law, and relevant to the kinds of dilemmas that occur in euthanasia cases.[6] Four of them are as follows:

1. *The Principle of Autonomy.* A competent person has the right to determine his or her own course of medical action in accordance with a plan he or she chooses. We have a duty to respect the wishes and desires expressed by a competent decision maker.

2. *The Principle of Beneficence.* One should act to further the welfare and benefits of another and to prevent evil or harm to that person. Beneficence requires me to do something for someone.

3. *The Principle of Nonmaleficence.* One should refrain from inflicting harm (or unduly risking the infliction of harm) on another. Nonmaleficence requires me to refrain from doing something to someone.

4. *The Principle of Life Preservation.* We have a moral duty to protect and preserve human life whenever possible. The burden of proof is always on taking human life, not on sustaining it.

Moral dilemmas arise when duties such as these come into conflict. For example, if a competent renal dialysis patient wishes to forego treatments and die, then the principle of autonomy comes into conflict with, say, the principles of beneficence and nonmaleficence.

Cases such as these bring out the importance of seeing absolutes as coming in grades of importance or weight. In Matthew 23:23 Jesus claimed that there are greater and lesser matters of the law. Now, all matters of the law are absolute in the sense that (1) they are objectively true whether anyone believes them or not; and (2) they apply universally to all cases similar in a morally relevant way. But some moral absolutes can be more weighty than others.

A distinction may be helpful. A prima facie duty is an absolute in the sense that it is defined as an objectively true moral duty that can be overridden by a more stringent duty. When two duties conflict and one duty overrides another, the less stringent duty does not disappear completely, but is still present in a morally relevant way. These are examples of *exemptions* of duties, not *exceptions* of duties. An exception would be a case where a duty should apply (say the duty to tell the truth), but for some reason it "goes on holiday," so to speak, and it no longer applies to the case in question in any way. An exemption, on the other hand, is a case where a duty is overridden by a weightier duty, much the same way that a King can trump a Jack in a game of cards, but the prima facie duty still makes its presence felt and does not disappear.

An illustration may help to clarify how a moral absolute can function as a prima facie duty. An ambulance nurse told me of a case where a 35-year-old man had suffered a sudden heart attack and they were taking him to the hospital. The patient asked her if he had suffered a heart attack. In this case she knew that she had a duty to disclose information to him because he had a right to informed consent and to know what was happening to him. But she also had a duty to benefit and not harm the patient. And she knew that he was very nervous and vulnerable and the information could easily precipitate a second, perhaps lethal attack. In this case, arguably, the duty to disclose information was overridden by the duty to benefit and not harm. But this does not mean that the duty to disclose information, seen as a prima facie duty here, evaporates entirely. Its presence is still felt and should be overridden as gently as possible so as to honor the weightier duty.

First, she tried to change the subject. He pressed her further. Then, she told him a half truth, assuring him that he was just fine at the moment. He pressed her further, claiming that if she continued to be evasive he would conclude that he had had a heart attack. Finally, she told him a falsehood so as to benefit and not harm him.

The point here is not whether one agrees with her decision. The point is to illustrate that if a duty is prima facie, it still makes its presence felt and must be respected. It does not disappear. It is still objectively true, and it is applicable to the case at hand, even if it is overridden.

The Definition of Euthanasia

There are two different uses of the term "euthanasia." The first is sometimes called the "narrow construal of euthanasia." On this view euthanasia is equivalent to mercy *killing.* Thus, if a physician injects a patient with a drug with the intent to kill the patient, that would be an act of euthanasia, but if the physician allows the patient to die by withholding some excessively burdensome treatment, that does not count as an example of euthanasia. The second view is sometimes called the "broad construal of euthanasia" and includes within its definition of "euthanasia" both killing (*active* euthanasia) and allowing to die (*passive* euthanasia). The broad construal is more widely used, so we will adopt it in this series.

The Active/Passive Distinction

The active/passive distinction amounts to this: Passive euthanasia (also called negative euthanasia) refers to the withholding or withdrawing of a life-sustaining treatment when certain justifiable conditions exist (*see* below) and allowing the patient to die. Active euthanasia (also called mercy killing or positive euthanasia) refers to the intentional and/or direct killing of an innocent human life either by that person (suicide) or by another (assisted suicide).

Withholding Vs. Withdrawing Treatment

The distinction of withholding vs. withdrawing treatment is fairly straightforward. If a treatment is *withheld*, that treatment is not started. If someone *withdraws* a treatment, then that person stops a treatment already begun. The basic difference lies in the mere fact that in the former, one refrains from moving body parts (e.g., I refrain from using my hands to start the respirator), and in the latter, body parts are moved (e.g., I move my hands to turn the respirator off).

Emotionally, some people feel that it is morally preferable to withhold a treatment than it is to withdraw a treatment, perhaps because it seems more dramatic to stop something than it is to not start it in the first place. But ethically speaking, it is hard to see any relevant difference between the two. If it is morally permissible to withdraw a treatment, say, because the treatment is pointless, then it would have been permissible to withhold the treatment for the same reason, and vice versa.

Some have argued that withholding treatment is more justifiable than withdrawing treatment because the latter involves an implicit promise to follow through with the treatment and it creates expectations of care from the treatment. But this argument is not a good one. The issue is not starting or stopping a treatment per se, but whether the treatment — considered in itself — is good or bad. When one begins a treatment, the implicit promise (and thus, patient expectation) only involves using that treatment until a point is reached when it becomes pointless and excessively burdensome.

The Voluntary/Nonvoluntary/Involuntary Distinction

Voluntary euthanasia occurs whenever a competent, informed patient autonomously requests it. Nonvoluntary euthanasia occurs whenever a person is incapable of forming a judgment or expressing a wish in the matter (e.g., a defective newborn or a comatose adult). Involuntary euthanasia occurs when the person expresses a wish to live but is nevertheless killed or allowed to die.

This distinction combines with the active/passive distinction to form six different types of euthanasia: voluntary active, voluntary passive, nonvoluntary active, nonvoluntary passive, involuntary active, and involuntary passive.

The Ordinary/Extraordinary Distinction

Ethicists frequently distinguish ordinary means of treating a disease from extraordinary means. The term "ordinary" is the more basic of the two and "extraordinary" is defined in terms of "ordinary." Ordinary means are all medicines, treatments, and operations that offer a reasonable hope of benefit without placing undue burdens on a patient (e.g., pain or other serious inconvenience). Extraordinary means (sometimes called heroic means) are those that are not ordinary; that is, those that involve excessive burdens on the patient and that do not offer reasonable hope of benefit.

Two important points should be made regarding this distinction. First, it utilizes terms such as "reasonable hope" and "excessive" which change as medicine changes. What was excessive in medicine fifty years ago may be ordinary and routine today. Thus, the distinction between ordinary and extraordinary is relative to the current state of medical science; but this relativity is factual, not moral. Normally, we are obligated to offer ordinary treatment but not extraordinary treatment. Factually, what counts as ordinary or extraordinary depends on our medicine and technology.

Second, the distinction between ordinary and extraordinary should not be made abstractly for *kinds* of treatments, but should be made in terms of kinds of treatments for specific persons in specific situations. The idea here is that what is excessively burdensome and offers little hope for one patient may be less burdensome and more hopeful for a second patient in a different state of health.

The terms "ordinary" and "extraordinary" have been given different interpretations by different philosophers. For example, some take it to be the distinction between natural means of sustaining life (e.g., air, food, and water) and artificial means (e.g., respirators, artificial organs). A second, less adequate view treats the distinction as one between a (statistically) common versus

an unusual means of care.

Despite minor interpretive differences, the main point is this: the terms "ordinary" and "extraordinary" attempt to express moral intuitions as to when a treatment can be withheld or withdrawn from a person in a state of irreversible disease where death is imminent. The line between ordinary and extraordinary treatment is not always easy to draw, and such judgments should be made on a case by case basis and should involve the patient, the family, and the attending physician.[7]

Intentional Action and the Principle of Double Effect

When we evaluate the morality of someone's action, we take into account the intention of the person who acted. If a person drives recklessly through a residential area and accidentally kills someone, that person is guilty of manslaughter. But if a person intentionally runs over someone, we consider that person even more culpable — namely, guilty of murder. Morally speaking, our intentions or lack thereof make a difference.

When we evaluate the morality of someone's action, we also take into account whether or not that person uses an immoral means to accomplish some end that may be either morally good or neutral. If a husband confronts his alcoholic wife with her problem in public, but he does so because he hates her and wants to embarrass her, then he may accomplish a good end (reformed behavior) by an evil means (a malicious act). But if he confronts her in public because he loves her and wants to help, he accomplishes that same good end by means of a good act.

These two moral insights — the importance of intentions and the avoidance of using a bad means to accomplish a good or neutral end — have been expressed in what is called the principle of double effect. The principle states that when an action has good and bad consequences, then the action may be performed under the following circumstances:

1. The act is good or at least indifferent regarding the end that one directly intends.

2. The good and evil effects follow immediately from the act; that is, the good effect is not obtained by means of the evil effect.

3. One only *intends* the good effect and merely *tolerates* the bad effect, even if that bad effect was foreseen prior to the act.

4. There is a proportion between the good and bad effects; that is, the good must be at least equal to the bad.

The principle of double effect expresses the importance of intentions and means to ends in moral actions. This is in keeping with a traditional understanding of the nature of a human moral action that treats intentions, motives, and means to ends as parts of actions. Since intentions, means to ends, and the nature of moral actions are all central to debates about euthanasia, it is important to be clear about how they are analyzed in the principle of double effect.

An example may be helpful. Suppose that Patty, Sally, and Beth each have a grandmother who will leave behind a large inheritance. Each visits her grandmother on a Saturday afternoon and brings a cherry pie to her. Patty, motivated by respect for a relative, intends to love her grandmother by means of being with her for the afternoon and by giving her a cherry pie. Sally, motivated by greed, intends to secure a place in the will by means of being with her grandmother for the afternoon and by giving her a cherry pie. Beth, motivated by hate for her grandmother, intends to secure a place in the will by means of giving her grandmother a cherry pie with poison in it.

Each woman had a motive, an intent, and a means to accomplish that intent. A motive is *why* one acts; an intent is *what* one is intending to do; and a means is *how* one acts — that is, the steps one takes to accomplish one's intent. Patty had a good motive (respect for a relative), a good intent (to love her grandmother), and a good means to accomplish that intent (spending time with her and giving her a pie). Sally had a bad motive (greed), a bad intent (selfishly securing a place in the will), and a good means to that end (the same means Patty used). Beth had a bad motive (hate), a bad intent (the same as Sally's), and a bad means to that end (killing her grandmother by giving her poisoned pie). This example shows that motives, intents, and means to ends are relevant in assessing the moral worth of an action, and the principle of double effect tries to capture these and other important issues. The principle of double effect also expresses the priority of intention for determining the nature and morality of an action.[8]

These distinctions are important in understanding the current debate about euthanasia. As was mentioned earlier, there are two major views. The most common one is usually called the traditional or standard view. A second, more recent position is called the

radical or libertarian view. Let us begin our investigation of the euthanasia debate by examining the libertarian view.

TWO VIEWS ABOUT THE MORALITY OF EUTHANASIA

The Libertarian View

The libertarian view is a minority position among current moral philosophers and theologians, but it nevertheless has a strong, articulate group of supporters. The clearest, most forceful statement of the view can be found in the writings of philosopher James Rachels.[9] In what follows, therefore, I will focus on his position as a way of analyzing the libertarian view of euthanasia.

According to Rachels, the distinctions used in the traditional view are inadequate. There is nothing sacred or morally significant about being a human being with biological life. Nor is there any moral difference between killing someone and letting him die. Thus, if passive euthanasia is permissible in a given case, so is active euthanasia. Two distinctions are central for Rachels's libertarian position.

Biological Life Versus Biographical Life

The mere fact that something has *biological* life, says Rachels, whether human or nonhuman, is relatively unimportant from an ethical point of view. What is important is that someone has *biographical* life. One's biographical life is "the sum of one's aspirations, decisions, activities, projects, and human relationships."[10] The facts of a person's biographical life are those of that person's history and character. They are the interests that are important and worthwhile from the point of view of the person himself or herself. The value of one's biographical life is the value it has for that person, and something has value if its loss would harm that person.[11]

Two implications follow from Rachels's view: (1) Certain infants without a prospect for biographical life, and certain patients (e.g., comatose patients or those in a persistent vegetative state) are of little intrinsic concern, morally speaking. Though they may be alive in the biological sense, they are not alive in the biographical sense. And the latter is what is relevant to morality. (2) Higher forms of animals do have lives in the biographical sense because they have thoughts, emotions, goals, cares, and so forth. They should be given moral respect because of this. In fact, a chimpanzee with a biographical life has more value than a human who only has biological life.

Killing and Letting Die

Rachels argues that there is no morally relevant distinction between killing someone intentionally and letting someone die. The active and passive dichotomy is a distinction without a difference. He calls this the "equivalence" thesis, and the main argument for it is called the "bare difference argument." Rachels sets up two cases that are supposed to be exactly alike except that one involves killing and the other involves letting die:

> Smith stands to gain a large inheritance if anything should happen to his six-year-old cousin. One evening while the child is taking his bath, Smith sneaks into the bathroom and drowns the child, and then arranges things so that it will look like an accident. No one is the wiser, and Smith gets his inheritance. Jones also stands to gain if anything should happen to his six-year-old cousin. Like Smith, Jones sneaks in planning to drown the child in his bath. However, just as he enters the bathroom Jones sees the child slip, hit his head, and fall face-down in the water. Jones is delighted; he stands by, ready to push the child's head back under if necessary, but it is not necessary. With only a little thrashing about, the child drowns all by himself, "accidentally," as Jones watches and does nothing. No one is the wiser, and Jones gets his inheritance.[12]

According to Rachels, neither man behaved better even though Smith killed the child and Jones merely let the child die. Both acted from the same motive (personal gain) and the results were identical (death). Thus the only difference between the two cases is killing versus letting die, and since the cases are morally equivalent, this distinction is morally irrelevant.

Two implications follow from the equivalence thesis: (1) Cases where passive euthanasia is permissible are also cases where active euthanasia is permissible. (2) Situations where we let people die — for example, when we let people starve in famine

situations — are morally equivalent to killing them.

The Traditional View

Since I have already hinted at the essence of the traditional view, it may be stated briefly here by focusing on three main points.

The Distinction Between Active and Passive Euthanasia

Two main reasons have been offered for the distinction between active and passive euthanasia. (1) The direct cause of death is different. In the former it is the doctor or another human agent. In the latter it is the disease itself. (2) The intent of the act is different. In active euthanasia it is the death of the patient, either as an ultimate end or as a direct means to some other end (e.g., a pain-free state). In passive euthanasia death is a foreseen consequence of an otherwise legitimate action whose intent may be to alleviate suffering, respect patient autonomy, cease interfering with the dying process, and so forth.

The Permissibility of Passive Euthanasia

The traditional view allows for withholding or withdrawing treatment in some cases where certain circumstances exist; for example, cases where the patient is terminal, death is imminent, treatment is judged extraordinary, and death is not directly intended.

Active Euthanasia Is Morally Forbidden

The traditional view forbids active euthanasia regardless of whether it is done directly by the physician (mercy killing) or by the patient himself with the help of the physician (assisted suicide).

In this article, I have focused on two things. First, a number of important ethical distinctions have been surveyed in order to give the background necessary for stating and assessing the main contours of the euthanasia debate. Second, the central features of the radical and traditional views of euthanasia have been outlined and clarified. In Part Two I will critique the radical view, defend the traditional position, discuss the special features relevant to the issue of foregoing artificial nutrition and hydration, and place the euthanasia debate in the context of broader world view issues which that debate surfaces.

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NOTES

[1] For a survey of death and dying cases, see R. M. Veatch, *Case Studies in Medical Ethics* (Cambridge: Harvard University Press, 1977), 317-47. *See* also, Tim Smick, James Duncan, J. P. Moreland, Jeff Watson, *Eldercare for the Christian Family* (Dallas: Word, 1990); and J. P. Moreland and Norman L. Geisler, *The Life and Death Debate* (Westport, CT: Praeger Books, 1990).
[2] For more on the medical and ethical aspects of these interventions, *see Life-Sustaining Technologies and the Elderly* (Washington, D.C.: Congress of the United States, 1987), 166-354.
[3] *See* Norman L. Geisler, "A Premillennial View of Law and Government," *Bibliotheca Sacra* 142 (July-September 1985): 250-66.
[4] For more on natural law theories, *see* Alan J. Johnson, "Is There a Biblical Warrant for Natural-Law Theories?" *Journal of the Evangelical Theological Society* 25 (June 1982):185-99; A. P. d'Entreves, *Natural Law,* 2d. ed. (London: Hutchinson, 1970); Martin D. O'Keefe, *Known from the Things that Are* (Houston: Center for Thomistic Studies, 1987); John Finnis, *Natural Law*

and Natural Rights (Oxford: Clarendon, 1980).
[5] C. S. Lewis, *The Abolition of Man* (New York: Macmillan Publishing Co., 1947), 29. Cf. John Warwick Montgomery, *Human Rights and Human Dignity* (Grand Rapids: Zondervan Publishing House, 1986).
[6] For a fuller treatment of these and other principles, *see* Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics* (Oxford: Oxford University Press, 1979).
[7] For a discussion that modifies the ordinary/extraordinary distinction but retains its substance, *see* the President's Commission report entitled *Deciding to Forego Life-Sustaining Treatment* (Washington: U. S. Government Printing Office, 1983), 82-89.
[8] Brief analyses of a traditional understanding of human moral action are R. M. Gula, *What Are They Saying about Moral Norms?* (New York: Paulist Press, 1982), 61-74; John Finnis, *Fundamentals of Ethics* (Washington: Georgetown University Press, 1983), 37-48, 112-20; R. M. Chisholm, *Brentano and Intrinsic Value* (Cambridge: Cambridge University Press, 1986), 17-32. For a more extended treatment, *see* Robert Sokolowski, *Moral Action* (Bloomington: Indiana University Press, 1985).
[9] Cf. James Rachels, "Active and Passive Euthanasia," *The New England Journal of Medicine* no. 292 (9 January 1975):78-80; "Euthanasia," in *Matters of Life and Death*, ed. Tom Regan (New York: Random House, 1980), 28-66; *The End of Life* (Oxford: Oxford University Press, 1986); *Created From Animals* (Oxford: Oxford University Press, 1990).
[10] Rachels, *The End of Life*, 5. *See* also 26, 33, 35, 38, 47, 49-59, 65, 76, 85.
[11] *Ibid.*, 38.
[12] *Ibid.*, 112.