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INFANTICIDE: ISSUES AND OPTIONS

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On April 9, 1982, in Bloomington, Indiana, a child was born with Down's syndrome (trisomy 21) complicated by a tracheoesophageal fistula (i.e., an opening between the breathing and swallowing tubes that prevents passage of food to the stomach). The malformation had an even chance of being corrected by surgery, but if left untreated it would lead to the child's death from starvation or pneumonia. The parents declined the surgery; the Indiana Supreme Court upheld the decision, and the child, known as Baby Doe, died at six days of age.

On October 11, 1983, an infant known as Baby Jane Doe was born in New York. Baby Jane Doe suffered from multiple birth defects including spina bifida (a broken and protruding spine), hydrocephaly (excess fluid on the brain), and microencephaly (an abnormally small brain). The parents were informed that without surgery the baby would die within two years; with surgery, she would have an even chance of living into her twenties in a severely mentally retarded and physically impaired state. The parents chose not to authorize surgery. Right-to-life groups successfully petitioned the New York Supreme Court to order the surgery to be performed; higher courts in New York overturned the order, and the executive and legislative branches of the federal government were prompted by the case to formulate various rules and regulations governing the withholding of treatment for defective newborns.

These two famous cases illustrate the growing awareness of important ethical issues surrounding infanticide and defective newborns, as well as the deep division of opinions surfacing in this area of moral debate. In light of the situation, it is crucial that Christians understand how these issues are being argued apart from reference to the biblical text. This article is an attempt to help meet this need by

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offering an update of the current status of the infanticide debate in the broad, intellectual culture.

Infanticide is not new; various cultures throughout history such as China, Greece, and India have permitted it. Historically, a number of reasons have been offered to justify infanticide: 1) the absolute authority of the father over his family, 2) an abnormal child facing little prospect for a happy life, 3) an unwanted female child, 4) economic considerations, 5) social pressures (e.g., the child was conceived and born out of wedlock) and 6) a child not judged fully human (e.g., seen as a subhuman parasite).

While infanticide has been considered morally permissible in various cultures down through history, it still could not be practiced without justification, and there was a general respect for the human life of infants. This is especially true in cultures which were affected by the Judeo-Christian faith. The first century Jewish philosopher Philo was an opponent of infanticide, and the coming of Christianity, with its emphasis on the inherent value of all human beings since they are made in the image of God, moderated much of the infanticide in the cultures it penetrated.

Today, most of the moral dilemmas regarding the treatment of defective newborns occur in the neonatal intensive care units (NICUs) of hospitals. Increased medical technology has heightened our ability to sustain life and increased the need to sharpen our moral focus regarding the withholding or withdrawing of medical treatment from newborns. Some distinguish between "neonaticide" (parental killing of infants within 24 hours of birth) and "filicide" (parental killing of infants older than 24 hours). But this distinction is too sharply drawn and has not gained wide acceptance. Thus, "infanticide" will be used in this article.

Two main issues are involved in the debate about infanticide. First, is it morally permissible to allow a defective newborn to die, and under what conditions is this permissible? Second, if it is morally permissible to permit a defective newborn to die, then is it also morally permissible *actively* to take the life of that newborn?[1]

This second question is not primarily an issue about infanticide, but about active euthanasia. Answering it requires a discussion of the distinction between active and passive euthanasia. I have analyzed these issues elsewhere, and will only briefly examine them here.[2] For

[1] A third area of debate revolves around the question of who should decide when treatment can be withdrawn or withheld. Options include parents, physicians, hospital ethics committees, and the courts.

[2] J. P. Moreland, "James Rachels and the Active Euthanasia Debate," *Journal of the Evangelical Theology Society* 31 (March 1988) 81–90.

our purposes, we can say that passive euthanasia involves allowing someone to die given the presence of certain conditions (e.g., death is not directly caused or intended; the person is terminal and death is imminent; or the treatment withdrawn or withheld is extraordinary and "heroic," not ordinary), and active euthanasia involves the intentional killing of a human being.

This article will focus on the first question.[3] Is it morally permissible to permit a defective newborn to die, and if so, what conditions make such an act morally permissible? There are five major views which present different answers to this question.[4] In what follows, each view will be presented followed by an evaluation of its strengths and weaknesses.

Five Views of Infanticide for Defective Newborns

A. Withhold Treatment in Light of Third-Party Harms

1. *Exposition.* Advocates of this first view do not believe that all non-dying infants should be treated nor do they believe that the issue regarding infants is whether or not they are persons. According to this position, decisions about treating infants should include a benefits/harms consideration to those other than the infant alone. If an infant's continued existence would seriously harm a marriage or adversely affect a family, or if it would require an undue amount of society's resources, then it is morally permissible to allow that infant to die.

The main feature that distinguishes this first position is the moral appropriateness of weighing harms and benefits to those other than the infant. The infant is a moral entity—a human being, a person, or a potential person—and it has a prima facie right to life. But if, on balance, the harms for caring for the defective newborn are greater for all relevant parties than the benefits, then nontreatment is said to be a morally appropriate option.

Advocates of this view differ over the types of harms that are morally relevant to a nontreatment decision as well as over the relevant reference group that is harmed. Regarding types of harms, three main kinds are appealed to. First, one can limit the appropriate harms to emotional and psychological harms, e.g., it can be emotionally stressful to the parents and family to raise a defective newborn. Second, one

[3] For a brief history of attitudes towards active euthanasia and infants, see S. G. Post, "History, Infanticide, and Imperiled Newborns," *Hastings Center Report* 18 (August/September 1988) 14–17.

[4] See R. Weir, *Selective Nontreatment of Handicapped Newborns* (New York: Oxford, 1984) 143–87.

can include financial harms as part of the morally legitimate considerations for deciding what one ought to do. Third, one can focus on what are called moral harms, especially moral harms to the parent. As parents try to cope with the situation of what to do with a defective newborn, they face moral suffering, that is, the tensions brought on by opposing moral forces that are hard to resolve. A decision about infanticide should be made in light of the need to minimize one or a combination of these harms.

Regarding the relevant reference group, some would limit the consideration of harms to the family, especially the parents; others would take into account society as a whole and its resources. The latter approach is sometimes justified by an appeal to a principle of justice: given scarce societal and medical resources, each person should not receive more care than what is due to that person, especially if that care could be more effectively given to someone else.

While they do not agree on all details, two ethicists who can be classified as advocates of this first view are John Fletcher[5] and H. T. Engelhardt, Jr.[6]

2. *Evaluation.* a. Strengths. The strengths of this position are twofold. First, moral decision making is often complex, and all the relevant considerations should be taken into account in justifying a course of action. Specifically, the moral rights, benefits, and harms of all relevant parties, especially parents and family members, are important components of the moral situation. Second, all things being equal, parents do have a moral duty to avoid all unnecessary familial suffering, and this view attempts to specify how that duty can be carried out. However, in spite of these rather modest strengths, this position suffers from severe difficulties.

b. Weaknesses. First, the claim that the harms to third parties outweigh the benefits of continued life for the infant cannot be sustained. There are no clear, objectively rational criteria for balancing these competing claims, and in the absence of such criteria, and in light of the burden of proof on those who would take human life, treatment cannot be withheld from defective newborns on the basis

[5] John C. Fletcher, "Abortion, Euthanasia, and Care of Defective Newborns," *The New England Journal of Medicine* 292 (January 9, 1975) 7578; "Choices of Life or Death in the Care of Defective Newborns," in *Social Responsibility: Journalism, Law, and Medicine* (ed. L. W. Hodges; Lexington, VA: Washington and Lee University Press, 1975).

[6] H. T. Engelhardt, Jr., "Ethical Issues in Aiding the Death of Young Children," in *Beneficent Euthanasia* (ed. M. Kohl; Buffalo, NY: Prometheus, 1975) 180–92; *idem, The Foundations of Bioethics* (New York: Oxford, 1986), especially chapters 4 and 6.

of the third-party harms mentioned in the view under consideration. How can the value of one person's life be measured against the increased quality of another person's life? Terms like "unnecessary suffering" and "burden to the family" are highly subjective, and the use of them in the position under consideration runs the risk of giving parents the right to engage in infanticide whenever they feel like it.

Second, even if someone came up with such criteria, they would most likely be based on 1) quality-of-life judgments, 2) viewing the infant as a nonperson or as a potential person, or 3) utilitarian views of what gives a person, the infant in this case, value. The first two options will be considered later as different approaches to the morality of infanticide. Option three suffers from problems with utilitarian views of morality and persons in general. Specifically, this option views the infant as a means to an end (e.g., the removal of parental suffering) and, thus, fails to treat the infant as an intrinsically valuable end in himself or herself.

Third, while this can be overstated, suffering can play a helpful role in familial and individual growth. A morally appropriate conception of the good life does not dictate that we avoid financial, psychological, and moral suffering at all costs. True, we should avoid "unnecessary" suffering, but the moral point of view demands that we not avoid suffering by doing what is morally wrong. Thus, if a certain course of action is morally correct, then we are morally obligated to do it and try to learn from our suffering if it comes. We should not do what is wrong just to avoid suffering. So suffering can be beneficial in human growth, and even though we should avoid unnecessary suffering, we should not do moral harm to others in the process.

Fourth, while it is true in a certain sense that parents "own" their children, Christian theists argue that children are really "owned" by God. Life is ultimately a gift from Him, and parents do not have the right to withdraw treatment from a defective newborn simply because they are harmed. Such an act fails to respect the fact that children do not merely exist in a family system or in a culture, but in the kingdom of ends created by God.

Fifth, this view has an inappropriate view of family and runs the risk of causing a breakdown in how families are understood. A family is, among other things, a moral unit within which relations of care, concern, respect, and sacrifice among family members constitute the very essence of the family unit. But the view under consideration tends to view the family as a heap of individual members with individual rights who relate to one another in a harms/benefits way. Such a system is not a true unity, and members relate to one another as

means to ends. This view of the family violates the nature of persons, the nature of the family itself, and if such a view gained currency in a culture, it would have bad effects on the moral, psychological, and spiritual health of the community at large.

Sixth, this view fails to consider the distinction between immediate care and long-term custody. Just because a person cannot maintain long-term custody over another person, that is not in itself grounds for failing to provide immediate care. If a defective newborn is allowed to die because it "harms" the parents, this fails to allow others to adopt the child who *would* wish to care for it.

Finally, cost factors are dehumanizing and wrong when they are used to evaluate the moral worth of sustaining the life of a specific individual. In this regard, it is important to distinguish between microallocation issues and macroallocation issues. The former focus on distributing resources to specific individuals (e.g., given only one heart and three patients, who gets the transplant and why) and patient advocacy is the appropriate posture. The latter focus on distributing society's medical and financial resources to specific types of individuals, diseases, and research programs. Here cost/benefits analysis is an appropriate posture.

In macroallocation deliberations, cost analyses constitute an appropriate part of decision making because one (and only one) of our moral responsibilities to distribute our resources justly is the duty to make efficient use of them. But when it comes to assessing the treatment of a specific individual, a cost/benefits analysis is not morally appropriate for at least two reasons.

First, an individual human has intrinsic value and a monetary price cannot be put on that individual. Second, such a cost/benefits analysis uses a business model and distorts the very practice of medicine (and the family as mentioned earlier) from a morally and professionally skillful, caring vocation to a job in which a group of individuals contracts an exchange of goods and services for a price.

B. Withhold Treatment in Light of Quality-of-life Judgments

1. *Exposition.* According to the quality-of-life view, modern medicine forces us to make treatment decisions in cases where the ordinary/extraordinary distinction regarding terminal patients facing imminent death is not applicable. In cases like these, we must recognize at least three things.

First, life is a relative good not an absolute good. There is no moral duty to keep on living at all costs and in spite of all circumstances. Life is a relative good; that is, life is good because it is a precondition for other goods, e.g., having friendships, and pursuing personal goals.

Second, because life is a fundamental, presuppositional good, we have a prima facie duty to preserve life and benefit another person. The burden of proof is on the one withholding treatment from a defective newborn, and life should be preserved unless the quality of the infant is such that continued existence would be less appropriate than death itself.

Third, it is morally permissible, and some would argue obligatory, to withdraw or withhold treatment from a defective newborn and let the newborn die if its qualify of life drops below a certain threshold. Different phrases are used by different advocates in stating this quality-of-life idea: the infant's life is "a life not worth living"; it is not "meaningful life" nor does it have potential to be; it is not an "acceptable life"; or it is a "poor quality of life." However, more important than the language used to express the idea of quality of life is the interpretation given to it.

There are different ways in which "quality of life" is understood. First, it can be interpreted to mean the present or future value or social utility the individual has for others, e.g., the family or society. So understood, this would represent a position which should be classified under the first view listed above.

A second way to interpret "quality of life" is to define it as the subjective satisfaction experienced or expressed by an individual in his or her mental, physical, or social situation. Since an infant obviously cannot express its own experiences of satisfaction, this interpretation requires a substituted judgment—a judgment where a person attempts to express what another is thinking and feeling.

A third way to interpret "quality of life" is to define it in terms of an evaluational set of criteria used by an onlooker. This is the most important understanding of "quality of life" as it is used by advocates of the position.

Unfortunately, those advocates differ significantly in the different criteria they use in judging when someone no longer has a life they deem worth living: the lack of the ability to have a self concept, use language, have meaningful relationships with God and other humans, pursue autonomously chosen goals and ambitions, or the presence of gross physical anomalies. The key to all of these criteria is that they rest on the assumption that the traditional understanding of the sanctity-of-life view is inadequate—the value of life in itself is not the issue but, rather, the degree of human functioning.

In sum, because life is a relative good, there is a prima facie duty to preserve life, but treatment can be withdrawn or withheld from a defective newborn if it lacks the quality of life needed to make its life

meaningful, appropriate, and worthwhile as judged by one or more appropriate criteria. Advocates of this view are R. McCormick,[7] Joseph Fletcher,[8] and G. Williams.[9]

2. *Evaluation.* a. Strengths. Advocates of the quality-of-life view argue that there are at least three strengths to their view, none of which is adequate to justify the position. First, they hold that it is clearly the case that we do not have an absolute obligation to preserve human life at all costs irrespective of the state of the person whose life we are preserving. The mere presence of biological life does not signal a life worth living. Appropriately understood, this observation appears to be correct, and even advocates of the sanctity-of-life view (see below) would agree that we are not always obligated to continue treatment regardless of the condition of the patient. What is at issue, however, is whether or not the quality of life of the patient is the morally relevant factor which justifies allowing that patient to die.

Second, this view correctly makes the factual observation that there is a relationship between the quality of a person's life and the satisfaction enjoyed by that person. However, what that relationship is, who should decide the minimum threshold level of satisfaction, and whether or not one should be allowed to die simply because life is not "satisfying" are altogether different questions.

Third, quality-of-life advocates argue that most people would prefer to die rather than live, given that life would entail a certain low-level quality of life, and that in such cases, death is preferable to life. Thus, allowing an infant to die does not unfairly deprive that infant of anything because life itself is wrongful; that is, life itself can present a greater harm than death. This claim will be evaluated below.

b. Weaknesses. There are several major weaknesses with the quality-of-life view which make it inadequate as a moral way to view the selective treatment of defective newborns. First, the terms and criteria used in the quality-of-life view are inherently vague and subjective. Terms like "worthwhile life" and "relational capacity" are

[7] R. A. McCormick, "To Save or Let Die: The Dilemma of Modern Medicine," *Journal of the American Medical Association* 229 (July 8, 1974) 176; "The Quality of Life, the Sanctity of Life," *Hastings Center Report* 8 (February 1978).

[8] Joseph Fletcher, "Indicators of Humanhood—A Tentative Profile of Man," *Hastings Center Report* 2 (November 1972) 1–4; *idem*, "Medicine and the Nature of Man," in *The Teaching of Medical Ethics* (ed. R. Veatch, W. Gaylin, and C. Morgan; New York: Institute of Society, Ethics, and the Life Sciences, 1973).

[9] G. Williams, "Euthanasia Legislation: A Rejoinder to the Nonreligious Objections," *Minnesota Law Review* 43 (1958), repr. in *Biomedical Ethics* (2d ed.; ed. T. Mappes and J. Zembaty; New York: McGraw-Hill, 1986) 423–27; *idem*, *Sanctity of Life and the Criminal Law* (New York: Knopf, 1957).

vague, and different advocates use different, competing, and equally vague criteria to specify them. How can "quality of life" be adequately applied to an infant with absolutely no track record of achievements, failures, life-style, education, or family relationships?

The problem here is not primarily that ethical issues are often hard to settle and that ethical terms are hard to formulate so as to cover all problem cases whatever. Rather, the problem is that the quality-of-life argument suffers from a vagueness and subjectivity which makes it an inadequate moral position. There are a number of reasons why evaluations of quality of life are vague and subjective.

First, different people mean different things by quality of life, including lack of pain, loss of mobility, loss of a certain level of mental achievement, and loss of relational abilities. Not only do these differ from each other, but different people will weigh each one differently. Second, even individual evaluations of quality of life change throughout a person's life. What is often acceptable at one period of life is not judged acceptable at another. This problem is especially acute in infanticide cases because an adult is projecting his or her own criteria on an infant. Third, quality-of-life judgments easily reflect cultural and socioeconomic bias and prejudice.

The subjectivity of quality-of-life judgments contributes to differences of opinion as to what medical conditions fall below the minimum threshold of acceptable life: some would limit such decisions to infants with anencephaly, Tay-Sachs disease, and Lesch-Nyhan disease; some would include infants with spina bifida cystica, others would not; some would include extremely premature infants and infants with Down's syndrome and other complications, others would not. Again, the point is that differences arise not merely because ethical judgments are often difficult, but because of the inherent vagueness and subjectivity in the quality-of-life view itself. Quality-of-life advocates simply assume that some lives are better off not lived and that there is a rational way to decide among conflicting interests and which criteria should be most important. But these assumptions have not been justified.

A second, related objection is this: quality-of-life advocates must show that some infants are better off dead than alive. But merely showing that they are in bad shape does not prove that they are better off dead than alive. The fact is that there is no way of comparing a life with defects to a state of death and showing that the former is inferior to the latter because there is no clear, common basis of comparison between the two.

Third, the quality-of-life view has a defective view of persons and suffering. Regarding persons, the view fails to treat persons as

entities with intrinsic value simply as human beings made in the image of God, and it tends to reduce the value of human beings to their social utility or to a view of humans as bundles of pleasant mental and physical states or capacities. But humans are substances which have both mental and physical states; they are not merely a bundle of states themselves, and judgments of value are grounded on humans as substances with inherent moral worth, not on the presence or absence of certain states or capacities. Our focus should not be on the quality of patients, but on the quality of treatments for patients which are dying and for whom death is imminent.

Suffering can have meaning for one's own life or the life of others. This observation can be abused, but the mere presence of suffering is not in itself sufficient to signal the presence of a morally inappropriate situation. In fact, if life is a gift from God, then a life of suffering can be objectively meaningful and valuable because 1) that life reflects the image of God and has intrinsic value; 2) suffering can cause moral growth; and 3) suffering can help teach others to face life's difficulties and cause a person's family and community to grow as well.

Fourth, if people embrace the quality-of-life view, this would most likely have morally bad implications. If infanticide is allowed for quality-of-life reasons, it would lead to unacceptable results in at least three areas. First, it could easily change the perceptions of society toward the infant himself or herself and contribute to a lessening of palliative care and concern for that infant. Second, it could contribute to a change of our view of what constitutes medicine as a vocation. Part of the traditional view of medicine is that it is a moral vocation wherein physicians commit themselves to being present to those who are vulnerable. Part of that commitment involves preserving life and providing care even when a patient is suffering and will not be henceforth totally healed or "normal." The quality-of-life view threatens to distort this view of medicine and replace it with a view in which health care professionals judge some vulnerable patients as no longer worthy of beneficence.

Finally, some have argued that quality-of-life justifications for passive euthanasia regarding infants will lead to a greater acceptance of assisted suicide by physicians and to active euthanasia. The strength of these slippery-slope arguments depends on whether the results do, in fact, become more prominent as a result of quality-of-life justifications of infanticide and on whether these results are morally unacceptable. The former is a factual issue; the latter a matter of values.

A fifth and final argument can be raised against the quality-of-life view: the principle of justice demands that equal protection be extended to the strong and those with strong friends as well as to the weak and those who are friendless. If justice is not viewed in this

way, then power will eventually be regulated in the interests of the powerful; the concept of fairness will be impacted; and justice will be dispensed unequally, depending on the quality of life possessed by different individuals. The quality-of-life view fails to be consistent with a morally justifiable view of justice and, thus, is inadequate.

C. *Withhold Treatment Judged Not in the Child's Best Interests*

1. *Exposition.* Advocates of this third view hold that the morality of withholding treatment should focus solely on the infant and not on the harm to parents or society and, thus, disagree with view one. But they claim to disagree with the quality-of-life view as well. We should not compare abnormal vs. normal infants and neglect treating the first group because it fails to exemplify some vaguely held notion of "meaningful life." Rather, the decision to withhold or withdraw treatment from a defective newborn should be based on the infant's own best interests. We should err on the side of preserving life, recognizing that treatment can be foregone when the burden of continued existence is so severe that death is preferable to life.

Advocates of this view claim that the main feature which distinguishes it from view two is the focus on the burden of continued existence and not on the presence or absence of quality of life. Only when death appears to be in the infant's best interests (because continued existence would be a wrongful life and a greater burden than death) can we forego treatment of a defective newborn. The key question here is not, does the infant have the potential for a meaningful life? Rather, it is this: given the fact that a meaningful life is not likely, is continued life a burden worse than death? Thus lack of quality of life is a necessary but not sufficient condition for foregoing treatment, and view three is more conservative than view two.

The concept of a "wrongful life" or the "injury of continued existence" means that certain forms of life—Tay-Sachs disease, Lesch-Nyhan syndrome, or spina bifida cystica—cannot be considered a gift, and in these cases we have a duty not to prolong life based on detriment/benefit judgments made for the infant's own sake. Such a decision is not made as a substituted judgment, but as a best-interests judgment.

Advocates of this view agree that the principle of nonmaleficence requires us not to harm others. But a harm can be interpreted broadly (e.g., interference with any interest of a person or psychological/mental suffering) or narrowly (e.g., intense and intractable physical pain, or loss of—or permanent paralysis in—two or more limbs). When harms of the latter sort are present, life itself can be a harm, and death is morally preferable to life. The main advocate of this position is R. Weir.[10]

[10] Weir, 170–77, 188–223.

2. *Evaluation.* a. Strengths. Four main strengths have been cited for this view. First, it regards infants as persons, or at least potential persons, and thus avoids problems inherent in positions which take a nonperson view of the infant (see view four below). Second, it places the ethical focus on the infant and its life and not on the harms/benefits to third parties. Third, it places the burden of proof on those who forego treatment, making mere value judgments about the potential for "meaningful" life insufficient in themselves for foregoing treatment, and thus ultimately represents an improvement over view two regarding the respect for human life. Fourth, it uses a best-interests standard of judgment rather than a substituted-judgment standard; the latter are especially problematic because they require the impossible—trying to decide what a newborn would like to have done.

b. Weaknesses. Even if one accepts these points as strengths, view three suffers from serious weaknesses which make it a morally inadequate view. First, it is difficult and perhaps impossible to compare "life with harms" to nonexistence, and there appears to be no rational way to show why the latter is preferable to the former. Second, death itself is a serious harm, as Weir and others admit, and it is arguably a more serious harm than any of those listed above. It certainly is not clear that those other harms are more serious than death and that is exactly what view three needs to show, given the prima facie burden to sustain life.

Third, while the notion of a harm in view three is clearer than the notion of quality in view two, it is still vague and subjective and relies too much on intuition. For example, when Weir lists a series of harms (e.g., death, severe mental deficiency, permanent institutionalization, and severe physical handicaps), he agrees that traditional views of medicine hold death to be the most severe harm, but he believes that most people's intuitions would agree that certain harms are worse than death.[11] But this appeal is ultimately too vague and subjective to be convincing.

Finally, this view seems in reality to be merely a specification of the quality-of-life view rather than an alternative to it. For the harms which allegedly justify withholding or withdrawing treatment do so because the quality of the infant's life is more burdensome than death. So it is arguable that this view merely offers another voice in the competing chorus of ways to spell out what quality-of-life means.

D. Withhold Treatment for Defective Nonpersons.

1. *Exposition.* Ethicists in this group hold that infanticide is morally justifiable because moral rights, especially the right to life,

[11] Ibid., 199–215.

are grounded in being a person and infants are human nonpersons. We can distinguish the following: actual persons are beings who meet or have met the sufficient conditions for personhood; potential or future persons are nonpersonal beings who *will become persons* in the normal course of their development; and possible persons are entities like human sperm or ova which will become persons only after some causal event (e.g., fertilization) or structural event takes place.

Advocates of this view reject the notion of something being a potential person because they believe that something either is or is not a person. Personhood is not something that develops, but rather is an all-or-nothing condition. Infants do not meet this criterion for personhood and therefore are human nonpersons without the requisite criteria to ground a right to life.

What are the key properties which constitute personhood? Advocates give different responses to this question, some listing one or two conditions, others listing 15 to 20. Here are some of the properties cited: a concept of self, minimum intelligence, relational capacity, mental states unified by memory, agency, awareness of existing through time, self-motivated activity and the desire for future goals and interests, the ability to use language, and the capacity to feel pain.

According to proponents of the nonperson view, sanctity-of-life advocates who place intrinsic value on being a human being are guilty of "speciesism," a prejudice towards the interests of one's own species and against other species. But in this view homo sapiens merely constitutes a biological classification and is therefore morally irrelevant. What is relevant is being a person—we would deed a moral right to life to dolphins, chimpanzees, angels, or Martians precisely because they appear to have the criteria for personhood even though they are not humans.

When does an infant become a person? Again, opinions vary on this question, but the answer is usually within the first year of life after birth. Prior to that time, an infant is a "nonhuman person." If it is defective and/or causes harm to others, then infanticide is morally justifiable. Advocates of this view include M. Tooley,[12] H. Kuhse, and P. Singer.[13]

2. *Evaluation.* a. Strengths. We have already alluded to the two main arguments usually offered in favor of this view. First, personhood is an all-or-nothing notion, and the idea of potential personhood is problematic because it admits of degrees of personhood. This observation seems correct, but as we shall see below, advocates of this view do not use this observation correctly. Second, some claim that our

[12] M. Tooley, *Abortion and Infanticide* (Oxford: Clarendon, 1983).
[13] H. Kuhse and P. Singer, *Should the Baby Live?* (Oxford: Oxford, 1985).

intuitions about the moral rights of Martians, angels, and dolphins illustrate the fact that it is persons who have value, not human beings. The former is a moral concept, the latter a biological one. But this argument, even if successful, only shows that being a human being is not a necessary condition for intrinsic moral value; it does not show that it is not a sufficient condition.

In addition to these arguments, advocates of the nonperson view support their position by criticizing other views, especially the sanctity-of-life view (see the charge of "speciesism" above), and by claiming that their view survives these criticisms. Some of these objections will be considered later when we look at the sanctity of life view.

b. Weaknesses. Several objections have been raised against this view. First, both the variety in number and nature of criteria for personhood show the subjectivity and vagueness of these conditions for personhood. The fact is, we know so little about the real conditions for personhood that those conditions should not be used to demarcate persons from nonpersons. We are better able to recognize persons than to agree on criteria for personhood, and our knowledge of the latter depends on the former, not vice versa. We normally recognize personhood by sight (i.e., whether or not something resembles human physical or behavioral traits), not by applying a set of criteria. If we did recognize humans by such criteria, then whenever we met someone, we would have to withhold judgment about their status as persons until we could determine if the criteria were actually present.

Second, there is considerable divergence of opinion as well as a degree of arbitrariness involved regarding the time in which a human becomes a person. It is impossible to state a time when we should draw the line between a human nonperson and a human person.

A third and related objection is this. The criteria cited above are either absent when one sleeps or are quantifiable (i.e., capable of being realized in degrees) throughout an individual's lifetime. Well-adjusted university professors may have more of the conditions for personhood than, say, construction workers. Should they have more moral rights because they are more clearly persons? It is difficult to use these criteria so as to avoid 1) denying equal moral rights to all persons, and 2) ruling out a class of persons which most would agree are persons but who fail to have a specific property for personhood.

Fourth, the view suffers at the hands of certain counterexamples. For one thing, this view implies that a normal chimpanzee has more moral worth than a defective newborn, but charges of speciesism notwithstanding, a basic moral intuition is that the infant is of more value than the chimpanzee because of the moral properties and inherent dignity of being human. Again, this view seems to imply the

implausible notion that it would be wrong deliberately to conceive a deformed human that one knew would develop into a person, but it would not be wrong to conceive a more defective human who would not develop into a person.

Fifth, this view opens the door to unlimited, indiscriminate killing of a large number of neonates which is intrinsically wrong and which would have a negative moral impact on the respect for life in the family, medicine, and society at large.

E. Treat All Nondying Infants

1. *Exposition.* The final view is often called the sanctity-of-life view. It holds that all infants have equal intrinsic worth and dignity simply because they are human beings (Christian theists ground this in the image of God), that if it would be wrong to withhold a treatment from a nondefective infant then it is wrong to withhold it from a defective infant, and the only cases where foregoing treatment is justifiable are those where passive euthanasia in general would be justifiable.[14]

Sanctity-of-life advocates hold that membership in the natural kind "human being" is what confers intrinsic dignity and worth. Something either is or is not a human being, and the notion of a potential human being is a categorical fallacy. Further, the notion of being a human being is not merely a biological one, but a metaphysical and moral one as well. Human beings are entities with intrinsic moral properties of value. In Christianity this claim is supported by appealing to the image of God in man which is not grounded in the possession of some other property or characteristic (e.g., rationality) but accrues to man simply as such.

Further, children should not be judged as to whether they are defective or not; rather, treatments should be judged as to whether or not they are effective and beneficial. If passive euthanasia were justifiable in general, then it would be justifiable for a defective newborn: if an infant is terminal or death is imminent; if treatment is

[14] Roughly speaking, active euthanasia is the intentional, direct taking of innocent human life, often motivated by respect for patient autonomy or feelings of mercy. Passive euthanasia is the withholding or withdrawing of a medical intervention and permitting a patient to die. Traditional moral theory has held that active euthanasia is morally forbidden (it is murder), but passive euthanasia is morally permissible in certain circumstances, e.g., the patient is terminal, death is imminent, the treatment being foregone is extraordinary or heroic (it places excessive burdens on the patient and offers little hope for benefit), and death is merely foreseen and tolerated, not directly intended. For more on this see J. P. Moreland, "James Rachels and the Active Euthanasia Debate," *Journal of the Evangelical Theological Society* 31 (March, 1988) 81–90; J. P. Moreland and N. L. Geisler, *The Life and Death Debate: Moral Issues of Our Time* (Westport, CT: Praeger, 1990), chap. 3.

judged excessively burdensome, heroic, and extraordinary; and if death is not directly caused or intended, it can be permissible to allow an infant to die. However, we should not ground nontreatment decisions on the basis of a handicapped condition by itself. That would be discrimination of the worst sort.

Major advocates of this view have been P. Ramsey[15] and former Surgeon General C. E. Koop.[16]

2. *Evaluation.* a. Strengths. At least seven strengths can be cited for the sanctity-of-life view. First, it preserves our intuition that all human beings have equal and intrinsic worth and dignity by grounding that intuition in membership in the natural kind, humankind. Second, it avoids the counterexamples, vagueness, and subjectivity inherent in the quality-of-life and the nonperson views. Third, it places the proper focus of infanticide on the infant alone while preserving the principle of justice which requires that we not discriminate against the weak and helpless. Fourth, it locates the real issue about nontreatment within the broader discussion of euthanasia, rather than focusing on issues specifically involved in care of infants. Fifth, it preserves the basic moral insight that humans have special, intrinsic value compared to animals, though most sanctity-of-life advocates also respect the (lesser) rights of animals as well. Sixth, it accords with the basic conviction that it is simply wrong to kill infants. Finally, it preserves the respect for life in the family, medicine, and society at large.

b. Weaknesses. Three major objections have been raised against the sanctity-of-life view. First, it is judged to be guilty of a "speciesism," an unjustified prejudice in favor of our own species. This turns a mere biological notion (homo sapiens) into a moral one and is said to be a mere expression of bias. Sanctity-of-life advocates respond in three ways. First, the claim that humans have intrinsic value is not an expression of bias, but is metaphysically grounded in the dignity of man (called the image of God in the Judeo-Christian tradition) which is constituted by the presence of moral properties. Second, the sanctity-of-life view grounds the equality of all humans and thus avoids troublesome counterexamples. Third, humans do, in fact, have more worth and dignity than animals. These last two arguments and responses to them center on basic moral intuitions.

[15] P. Ramsey, *Ethics at the Edge of Life* (New Haven, CT: Yale, 1978); *idem, The Patient as Person* (New Haven, CT: Yale, 1970).

[16] C. Koop, "The Sanctity of Life," *Journal of the Medical Society of New Jersey* 75 (January 1978) 62–69; F. Schaeffer and C. Koop, *Whatever Happened to the Human Race?* (Old Tappan, NJ: Revell, 1979).

Second, it is objected that the sanctity-of-life view fails to make personhood the key in its emphasis on being human and thus fails to explain our respect for the intrinsic worth of nonhuman persons (e.g., Martians or angels). But at best, this objection only shows that being human is not *necessary* for having value; it does not prove that it is not *sufficient*. Further, if Martians and their kin exist, they would have intrinsic value either because we judge that they are sufficiently like us to have moral properties (it is not the presence of features of personality per se that gives value, but the fact that their presence makes likely the existence of intrinsic moral properties like those involved in the dignity of man) or because of some other factor. Finally, we know more about being human than about being persons, and we judge the latter as valuable by comparison with the former, not vice versa.

Third, it is claimed that the sanctity-of-life view sets too high a standard of treatment and fails to consider cases where life is so painful and defective that continued existence harms more than death. This criticism has already been discussed earlier. It is just not clear how one can compare defective life with nonexistence so as to show the latter preferable to the former. Coupled with the prima facie burden to sustain life, the sanctity-of-life view is the safer and more reasonable way to weigh these harms. Further, the sanctity-of-life view does allow for nontreatment under the traditional guidelines governing passive euthanasia (e.g., death is imminent, the person is terminal, the treatment is extraordinary, and death is not directly intended or a means to an end but merely foreseen).

Summary and Conclusion

We have examined and evaluated five views of infanticide. Among the important issues which surfaced were these: focusing on the infant alone vs. third parties, the differences among the relative importance of being a human, a potential person, or a person, issues involved in assessing the relative merits of quality vs. sanctity of life and the associated view of the harm of defects vs. the harm of death. In view of the evidence, the sanctity-of-life view is the best option.

As was pointed out earlier, Christians need to be aware of the important issues involved in the debate about infanticide which are currently being employed in the culture at large. How one uses these arguments and counterarguments will, of course, depend upon one's theory of the relationship between ethics, the state, and special revelation. But we can all agree that awareness of the issues is part of our responsibility to live out our lives under the Lordship of Christ.