# Living Well and Dying Well

## Toward a Reimagined Christian Approach to Medicine

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### Introduction

Is there a moral imperative to use medicine when it may save or extend life? The question of whether to use medicine, even when it may save or extend life, falls within the realm of Christian freedom. The Christian is free to use or not use medicine guided by the best use of reason. There may be uses of medicine that are morally objectionable, creating a moral imperative to reject its use. Abortion and euthanasia, in most cases, are prime examples. Likewise, there may be instances where there is a moral imperative to treat. In both cases, and in all choices, whether to use medicine or not is a matter of Christian freedom. The question for the Christian is: how does one know when to use medicine and when to refuse it?

Gilbert Meilaender, in his book *Bioethics: A Primer for Christians*, approaches this inquiry from the paradigm of refusing treatment. The unspoken assumption in this paradigm is that using medicine, especially when it may save or extend life, is the moral imperative, and that refusing treatment must be ethically defensible. In this paradigm, the choice, or the exercise of Christian freedom, is not the choice to use medicine but only the choice to refuse it. Meilaender provides two simple guidelines for how a Christian may exercise their freedom in refusing treatment. These guidelines are: (1) "a treatment may be refused if it is useless,"[1] and (2) a treatment may be refused, even if it may be lifesaving, if it is "excessively burdensome."[2] These guidelines provide theological foundation for considering the exercise of Christian freedom in medical decision-making. Building on Meilaender's account, this article develops a complementary paradigm that attends not only to the conditions under which treatment may be declined, but also to the moral and theological significance of choosing when, and when not, to employ medicine. In this respect, Meilaender's framework helps illuminate a broader movement from an "opting out" model to-

ward an "opting in" model. Within questions of life, death, and faithful creaturely dependence, such an affirmative paradigm offers a constructive way to understand Christian freedom as a form of responsible discernment before God.

The paradigm shift proposed here is one with which Christians need to wrestle, particularly because contemporary evidence suggests that Christians are often not dying well. Rob Moll addresses this concern in *The Art of Dying*. As a layperson and journalist, Moll offers a voice that complements Gilbert Meilaender's more academic account. He cites a study in the *Journal of the American Medical Association* that found:

> People of religious faith, 95% of whom were Christians, were three times more likely to choose medical treatment at the end of their lives, even though they knew they were dying and that the treatments were unlikely to lengthen their lives. The study determined "that relying upon religion to cope with terminal cancer may contribute to receiving aggressive medical care near death." One of the researchers told me, "patients who received outside clergy visits had worse quality of death scores in comparison to those who did not."[3]

Moll goes on to add that, "In other words, our churches are not teaching us to die well."[4] This is a sobering indictment of the Church. Moll notes that, due to a compulsion to reconcile a pro-life stance internally, many Christians "as a matter of faith" believe that "all deaths should come only after deploying an arsenal of medical treatment."[5] This way of thinking is called "naïve vitalism" or, as Moll puts it, "life at any cost."[6] However, Moll is wise to point out that "Life's sanctity, however, does not require its preservation at all costs when a lifetime is fulfilled."[7] That is, there is not a moral imperative to always opt in to medicine. Life at any cost is not always the best life. The moral agent must consider what kind of life they wish to live.

In his chapter on refusing treatment, Meilaender argues that the patient who refuses treatment according to these guidelines "chooses life–one life in particular from among the several still available."[8] This idea of choosing one life in particular inspires the positive paradigm of opting in proposed here. The question, then, is not only when a Christian may refuse medicine, but how a Christian may discern when to use medicine faithfully. The argument that follows develops this paradigm through four claims:

- Medicine is a tool to be used through the exercise of Christian freedom.
- Christian freedom is exercised in one's vocations, or places of responsibility.
- How the tool of medicine is used in one's vocations depends on life goals.
- Vocations are dynamic, so life goals and the application of the tool of medicine will change as one moves through life and approaches death.

## Christian Freedom[9]

Before beginning this argument, a bit more needs to be said about what is meant by Christian freedom in this context. Christian freedom is to be understood in two ways, as presented by Martin Luther in his treatise *The Freedom of a Christian*. "A Christian is a perfectly free Lord of all, subject to none. A Christian is a perfectly dutiful servant of all, subject to all."[10] What does this mean? First, the Christian is justified not by his/her own works, but by the work of Christ in His death, resurrection, and ascension. In His work, Christ fulfilled the law, and those who are baptized into Christ are therefore set free from the law. As Luther writes repeatedly, "It is clear, then, that a Christian has all that he needs in faith and needs no works to justify him,"[11] and "anyone can clearly see how a Christian is free from all things and over all things so that he needs no works to make him righteous and save him, since faith alone abundantly confers all these things."[12] So, for the purpose of this article, the Christian is free from the law and can therefore exercise that freedom to use medicine or reject it, without fear that their salvation is somehow dependent on their decision or on extending their life through medicine.

However, Christian freedom, as Luther presents it, does not end there. As Luther continues, the Christian is also "a perfectly dutiful servant of all, subject to all." What does this mean? The righteousness received through justification in Christ sets the Christian free from the law. This frees the Christian from a focus on the self, turning them outward toward the needs of their neighbor. The Christian is thus free to serve their neighbor. As Luther notes:

> Man, however, needs none of these things for his righteousness and salvation. Therefore he should be guided in all his works by this thought and contemplate this one thing alone, that he may serve and benefit others in all that he does, considering nothing except the need and the advantage of his neighbor.[13]

And:

> Although the Christian is thus free from all works, he ought in this liberty to empty himself, take upon himself the form of a servant, be made in the likeness of men, be found in human form, and to serve, help, and in every way deal with his neighbor as he sees that God through Christ has dealt and still deals with him.[14]

Again, Luther notes, "I will do nothing in this life except what I see is necessary, profitable, and salutary to my neighbor, since through faith I have an abundance of all good things in Christ…."[15] So the Christian who is truly free is free to serve their neighbor and is primarily oriented toward that service. The Christian does this through Godly vocations, as will be addressed further below. And as the Christian

approaches death, he/she is again free to serve the neighbor with regard to choices concerning how to use medicine to live well and die well.

## Medicine Is a Tool

Robert Benne, in his book *Ordinary Saints*, describes the cycle of Christian life through the metaphor of a cup that is regularly being filled and spilled. The cup is the Christian life. The spilling of the cup is the pouring out of the Christian life for others. The filling of the cup is in the receiving of God's good gifts that fulfill, inspire, and encourage Christian life.[16] Benne considers gifts such as worship, family life, and recreation to be some of the good gifts.[17] One such gift that he does not name, but surely must be included, is medicine. Medicine is a good gift from God, given to His creation through His creatures fulfilling their vocations as physicians, nurses, scientists, and pharmacists, among so many others. In the hands of these skilled and caring professionals, medicine is a tool that facilitates healing.

Medicine, however, is only a tool. Properly wielded in the hands of a skilled caregiver, it can seem to do incredible things. But this is no different from any other tool wielded by a skilled craftsman. Healing, however, comes from God alone. Only God has the power to heal. Healing is an act of creation, and only the Creator can create, not the creature. To bring about healing, God uses the instruments of His creation, His creatures with their tools such as medicine.

Medicine, therefore, must be viewed like all other tools, as a gift from God to be used in stewarding and making responsible use of creation. Fire was one of mankind's first tools, and with it people were able to see in the dark, cook food, and eventually shape metals into more tools, such as plows for farming. As technology advanced over the millennia, tools grew more sophisticated, and humanity's ability to make responsible use of creation became more complex and expansive. Today, there are tools that can help feed billions of people, fly around the globe, explore the cosmos, and yes, even cure many diseases. For the Christian, these tools are used in filling and spilling the cup of Christian life. But medicine, with all its marvels, is still merely a tool, just one of the elements that fills the Christian's cup so that he or she may spill it in service to others. This service to others, this pouring of one's cup, is done through one's numerous vocations.

Viewed as a tool, medicine makes no inherent moral claim on Christian freedom. Christians are not obligated to employ medicine for medicine's sake, even when medicine may extend life. In the twentieth and twenty-first centuries, many have come to think of medicine as something to which they are obligated, but Christians are no more obligated to medicine than to any other tool. Medicine is the tool, not the master. It should therefore be used in the pursuit of one's Christian life, in service to the neighbor, and in fulfillment of one's vocations.

When understood as a tool, medicine should also be viewed somewhat skeptically. Like all other tools, it can cause death and be used for evil when in the wrong hands, or wielded inappropriately. In the extreme, consider the eugenics movement in the first half of the twentieth century, Nazi experimentation during World War II, or the Tuskegee Syphilis Study in the United States. Today, this can also be seen entering—or perhaps reentering—mainstream and accepted practices in physician-assisted dying and abortion. The potential dangers of medicine used inappropriately provide further justification for adopting a paradigm of opting in to selective use of medicine.

## Vocation: A Life Lived for Others

CHRISTIANS DO NOT LIVE FOR THEMSELVES; they live for others through their vocations. Vocations are the places of responsibility in which God places His creatures to serve their neighbors.[18] They are relational, fulfilled in and through the lives of those among whom one has been placed. For this author, these vocations include being a husband, a son, a godfather, a consultant, a student and teacher at the Institute of Lutheran Theology, an elder in his local parish, a neighbor to the widow down the block, and a friend to an aging couple around the corner. These examples are only a few of the many vocations that shape a Christian life. Vocation is therefore significantly more than a fashionable term for work or career. Work is one vocation among many, and earning a paycheck is not a responsibility given to everyone. The stay-at-home parent who never receives a paycheck nevertheless has many vocations as father, mother, husband, wife, volunteer, coach, citizen, and many others, all of which are pleasing to God.

Christian life is lived in vocation, in service to the neighbor. In all the vocations God gives His creatures, there are tools and competencies to be used in fulfilling the responsibilities of those various vocations. Benne would refer to these as "technical excellences" of vocation.[19] A husband will quickly learn what tools he has, what tools he does not have, and what tools he needs to fulfill the vocation of husband. 1 Corinthians 13, while not specifically about the love of a husband for his wife, showcases a few of the tools a husband needs to fulfill his vocation, such as being patient and kind. But he will also need other tools, such as communication skills, and maybe even learning how to cook or clean, if that was not part of his upbringing. These are just a few of the tools that a husband needs to fulfill his vocation, and, of course, these tools can also be brought to bear in other vocations as well.

The demands of one's particular vocations shape how one uses the tools available for fulfilling those responsibilities, and this is no less true of medicine. A father with chronic back pain may choose to take a pain pill so that he can sit comfortably through his daughter's recital and be present to her. A mother with a sinus infection

may choose not to take medicine because it makes her feel foggy and she wants to remain alert while helping her son with his math homework. These simple examples show how medicine can be used, or declined, in service to vocation. In many cases, however, especially as one ages and approaches death, medicine plays a much larger role in how Christians fulfill their vocations.

It is important to remember that physicians and other medical professionals are also fulfilling their vocation, and that the vocation of physician is a vocation of a caregiver. This vocation, like all others, is about serving one's neighbor through one's skills and expertise. Physicians, therefore, are not authorities in the life of the Christian. For the Christian, there is only one authority, the Triune God. Physicians may be authorities in their respective fields of expertise, but they have no authority over anyone's life that is not handed over to them. The vocation of physician is that of a trusted, educated, and informed guide who assists patients in selecting the tools of medicine that will help them achieve their life goals, or rather, to fulfill their vocations or places of responsibility. During the period of expansive medical paternalism in the West, we have largely ceded our Christian freedom in many instances to physicians, misunderstanding both their vocation and seeking salvation where it cannot be found, in medicine rather than in Christ. James F. Keenan, in his 1996 article in the *Journal of Religion and Health*, points out that this handing over of medical decision-making would come to be countered by the development of the concept of informed consent in healthcare.

Informed consent, as described by Keenan, "attempts to prevent the paternalistic tendencies of a doctor who may decide what's best for the patient, without seeking to know and respect the patient's wishes."[20] Keenan goes on to add that: "In arguing that a patient has the right to give or not give consent for treatment, society restores to patients a notion of personhood that was often lost in paternalistic practice. Informed consent helps, then, to revitalize the understanding of the patient as a person…."[21] Informed consent is a secular way of regaining possession of the patient's personhood, but a Christian life lived in vocation does not cede this ground in the first place. Christians living their lives in vocation always retain their sense of personhood in their service to their neighbor, even in the face of the temptations toward medical paternalism. Christian healthcare professionals can help advance this vision of medicine, as L. Gregory Jones argues that "Christians, health workers and laity alike, should be willing to revise and reform our expectations of medicine in the light of Christian convictions about a life and death that are good."[22] Christian patients and healthcare providers alike must work together to present medicine in its proper light, as a tool in the service of vocation. This will allow patients to think about how to live well and die well, especially as death approaches. As Jones goes on to say, "Our understanding of what it means to 'age' as well as to 'die' ought to be shaped by the convictions and practices of Christian communities, not by the

current state of medical technology....”[23] This is why it is important that everyone actively think about, and make goals around, both living well and dying well.

## Life Goals: Living Well and Dying Well

Should we fail to set our own life goals of living well and dying well, biology will do that for us. As Meilaender points out in his article “Thinking About Aging,” in *First Things*, “We age because nature has relatively little stake in keeping us alive beyond our reproductive years. Insofar as we speak of our lives having a point, it is to be carriers of DNA.”[24] Ecologically speaking, this may be a satisfying life goal, but for most human beings, simply being carriers of one’s DNA does not give sufficient meaning to life. Beyond simply passing on DNA, survival is the next most obvious purpose for life, but Meilaender goes on to note that:

> To take survival as our primary goal—however necessary at times in a seemingly Hobbesian world—does not express the full dignity of our humanity. A virtuous commitment to the indefinite prolongation of life cannot be founded merely on the narcissistic desire to survive. But perhaps—put more hopefully—it can take root in the virtue of love.[25]

Meilaender’s call to love is a call to vocations, and to how Christians live out their vocations in love in the service of their neighbor. What gives life meaning is not simply procreating, although parenthood is one of the most important vocations, nor is it simply living longer. What brings life meaning is found in relationships, in the love shared with those whose lives one has been placed into. The choices made toward fulfilling those vocations require setting life goals.

It is important that Christians regularly set goals and reevaluate them in all their callings within their Christian life. This type of goal setting should not be confused with the goals discussed in the secular, corporate world. Goals for Christians are not goals tied to Key Performance Indicators as a corporate boss might expect. They are not goals tied to production targets, milestones, or achievements. However important these types of goals may be, Christian goal-setting in one’s vocations means deciding how one can best fulfill the responsibilities of relationships into which the Christian is placed and determining how to strike a balance between these various places of responsibility as one goes about fulfilling those responsibilities.

Christian life includes many places of responsibility, each with its own demands and competencies. The Christian should seek faithfulness in all of them while resisting the temptation to let one calling eclipse the others. This does not mean that every vocation requires the same amount of time or attention. It does mean that Christians must attend to the demands of their various vocations so that none is ignored or needlessly left unfulfilled. In twentieth- and twenty-first-century North

America, for example, men have often been taught to treat paid work as though it trumped the vocations of husband and father. To be a husband and father was reduced to making a living for the family. Attention to wife and children could then be treated as secondary, so long as the obligation to provide financially was met.

Setting goals that strike a balance in vocational callings is paramount to achieving the goals required for living well. God created human creatures with the ability to fulfill multiple places of responsibility, and humans thrive in their creatureliness when they are fulfilling all of their places of responsibility, striking that balance so they live well in all of them. As we think about and approach death, it is important to continue this process of setting goals for balance in all of one's vocations. It is equally important to set goals in one's vocations related to dying well as to living well. In vocation, the Christian's life is not his or her own; it is lived in service to and in relation with others. In the same way, the Christian's death is not truly his/her own either. One's death can and should still be in the service of others. This means that death must also be conceived of through the eyes of vocation. This informs the decisions as one approaches death and the tools that will be employed in fulfilling the responsibilities of vocation as death approaches. Included among these tools, of course, is medicine. As the Christian sets life goals, he or she should assess how medicine will be used as a tool in the service of fulfilling his/her responsibilities. This includes when a Christian exercises the freedom of opting in to using medicine that may save or extend life, as well as the freedom of opting out, even if that medicine may save or extend life.

With the rapid advances in medical technology, Christians now more than ever must actively engage in making life goals around living well and dying well. These advances are leading to two historically significant developments that must be considered when making decisions about living well and dying well. First, despite recent dips in life expectancy coming out of the COVID-19 pandemic, life expectancy is historically high, especially in the global north. Second, as people live longer, there is an expectation that, for most, a significant portion of their lives will be lived with some disability. A Rand Corporation report authored by Joanne Lynn and David M. Adamson highlights that—for Americans at least—life expectancy and overall health have improved dramatically. "However, increasingly fragile health and complicated care needs ordinarily mark the years just before death."[26] The report also notes that "Americans will usually spend two or more of their final years disabled enough to need someone else to help with routine activities of daily living because of chronic illness."[27] This is a relatively new situation in human history, and one that requires all people, especially in the global north, to think about how they will both live well and die well in this era of rapid medical advancement.[28] Unfortunately, modern healthcare systems, particularly in the United States, are not well equipped to address the social ramifications of an aging society. As the Rand report

notes, "Shaped largely in the two decades after World War II, the U.S. healthcare system is designed mainly to prevent illness and to engineer dramatic rescues from injury or illness—mostly with surgery and medication."[29] This means that modern medicine is equipped to keep people alive, but not to wrestle with the questions of living well or dying well.

This is why it is critical to set goals throughout life about how to live well and die well. Medical technology provides the tools to do both, but the Christian cannot rely on medical technology to set those goals or make those decisions. Speaking directly to this issue, Rob Moll writes that, "If we look at how medicine can help us achieve these goals [dying well], rather than assessing what treatments are right and wrong, we could take dying out of the culture wars and put it back into the category of normal spiritual disciplines alongside prayer and fasting."[30] Moll goes on to explain how the fulfillment of vocation can influence these goals, stating that, for himself, "I want my healthcare decisions to be guided by my desire to spend a good deal of time in comfort and peace so that I'm able to give my thoughts to God, my family and loved ones."[31] Moll is discussing his life goals toward living well and dying well, and it is clear how vocation influences these decisions in his thoughts toward God (being a Christian is also a vocation), his family and loved ones.

Furthermore, Moll highlights how death can play an important role in how the Christian approaches his or her vocations, writing, "The prospect of death focuses the mind on our priorities. So good deaths naturally followed good lives."[32] If we are thoughtful in planning for death and in setting vocational goals toward a good death, we will still be fulfilling our vocations even as we are dying. Earlier in his book, Moll comments, "A death that doesn't afford the opportunity for last words, for reconciliation, for repentance and for spiritual preparation to the next world is not a good death, according to traditional Christian teaching."[33] Recalling that vocation is fulfilled in relationship, last words and reconciliation are part of fulfilling many vocations. Much of this, of course, should not be left to the very end, but even at the very end, there is opportunity for last words and reconciliation if one has prepared for death and afforded themselves this opportunity by choosing medicine wisely.

Setting goals for one's vocations, including goals for both living well and dying well in vocation, makes it easier for individuals and their families to decide whether to use medicine or forgo it as anyone approaches their inevitable death. These goals give their lives, and even their deaths, meaning. But seeing meaning in dying and death requires pushing back against the current culture and the advance of medical technology. As Kent Burreson and Beth Hoeltke point out, "for modern culture, death has no meaning, no potential for being a meaningful event. Death is simply a problem to be addressed. That is why we seek solutions to death through the medical machine and through making the experience of death as therapeutically pleasing as possible."[34] Death can and should have meaning, but that meaning is

diluted or eviscerated if one cedes their choices to modern medicine. However, Christians should not cede their choices to modern medicine, and this can be avoided by actively setting life goals and evaluating them over time.

## Vocations are Dynamic

Benne describes three characteristics that mark our places of responsibility, but for this part of the discussion, his second characteristic is especially important. He writes that, "The second major characteristic of the roles associated with their places of responsibility is that they are dynamic—they change."[35] This means that all places of responsibility change over time, and the ways those places of responsibility are fulfilled also change over time. This has two critical implications for setting goals in vocation.

First, it must be acknowledged that vocations are themselves changing over time. The vocation of father or husband has different demands, expectations, and competencies today than it did 100 years ago, and certainly 1,000 years ago. The same is true for all places of responsibility. It is important to seek guidance from the past but also to remain attuned to the dynamism of the present. For example, take the vocation of father. When the term *oeconomia* (Latin, "household," alternatively *oikonomia* in Greek) was coined in antiquity, the vocation of father included, among other things, training the son in the family business—be it farming, carpentry, textiles, etc. The father would be an educator and a professional mentor for his son, and in so doing, would spend a lot of what is today called "quality time" with his son. This was true in many instances as recently as 150 or even 100 years ago. But today, the father most likely works outside the home for an employer and has no family business or farm to pass down. The father, however, is still expected to ensure that his son is educated and positioned for a career of his own, but now that is most often done by making sure that his son attends a public or private school where he can develop a marketable skill set. Other vocational responsibilities of fatherhood might include joining the PTA, volunteering at his son's school, and perhaps even picking up extra shifts at work to pay for an instrument so his son can join the school orchestra. Because the father and son are not spending everyday working together, the father also needs to find ways to spend "quality time" with his son. This illustrates the dynamism of vocations over time.

Second, how individuals experience vocational callings in life, and the responsibilities in fulfilling those vocations, change over their lifetime as well. The father in the example above will not be expected to sit on the PTA once his child has graduated and started working. Likewise, in ideal circumstances, the father will no longer be paying for his child once the child is grown, moves out, and has a job and a family of his own (though the father might pick up an extra shift at work now and again if their child falls on hard times or he and his wife are trying to help with raising their

grandchildren). This is all to say that while many vocations persist over time—that of being a father, husband, and/or son—the responsibilities within those vocations, and how they are fulfilled, are dynamic and change over time. It can even be argued that, at times, the responsibilities of a vocation are completely discharged. This is most clearly exhibited in work for pay. When people retire, they no longer have vocational responsibilities to their employer. In some ways, this can also be true of relational vocations. At a certain point, a father largely discharges his responsibilities to his son. This occurs once the son is financially secure, has a family of his own, and has received all the wisdom his father has to impart. The relationship remains, perhaps even vital to both father and son, and the vocation remains intact, but the father's responsibilities to the son have been largely, or even entirely, discharged.

This has two implications for medicine. First, vocations in the medical sciences have changed over time, so the options available today differ greatly from those available 100 years ago, 50 years ago, or even 20 years ago. The old adage "do your best and let God do the rest" illustrates the difference. If a patient presented with an uncontrollable fever in 1875, the best a physician could likely do was place a cool cloth on the patient's forehead and try to keep the patient cool and hydrated. The available tools were limited. By contrast, in 2026 hospitals and physicians have countless options and, in many cases, can continue exploring treatment possibilities relentlessly. "Doing one's best" therefore means something very different today than it did 150 years ago, and doing all that can be done now carries consequences for one's life goals that would have been unimaginable in earlier eras. As Moll writes:

> Pursuing powerful medicine until there is "nothing left to do" we'll likely forgo time with loved ones, final pursuits or perhaps a spiritual deepening in anticipation of life with God. There is a trade-off when choosing aggressive care, and we must learn to balance the proper desire for healing with the eventual need to die.[36]

Today, there are significantly more choices in the use of medicine, and Christians need to be active moral agents in opting into the treatments that will support the life goals they have set for both living well and dying well in vocation. It is important here to recognize how both vocations themselves, and one's place within them change, and therefore to adjust one's life goals accordingly in order to strike the balance Moll speaks to.

This leads to the next point that as people age and the demands of their vocations change over time, how they might want to use the tools of medicine may change as well. This all depends on the life goals people set and on how they reevaluate those goals as they age. A mother of two young children who are dependent on her not only for love and caregiving, but also for material needs like food and shelter, may use every tool at her disposal in fighting cancer to save or extend her life because

the responsibilities of her vocation as a mother demand that she be there for her children. If this same mother, having now raised her children, who now have families of their own, and having retired from work for pay, confronts cancer again, she may still choose to fight it as she continues to fulfill the vocations of grandmother and a volunteer in her church, but she may choose not to pursue treatments that, referring back to Meilaender's criteria, are excessively burdensome. She may exercise her Christian freedom here to select certain tools of medicine while refraining from others. Then, when this mother is now a great-grandmother, her own children have retired, and she can no longer volunteer in the church, and she confronts cancer a third time, she may reflect on her life goals for living well and dying well, and exercise her Christian freedom to choose not to use any of the tools of medicine. At this time, she may exercise her Christian freedom in pursuing her goals of dying well and bearing a final witness to her faith in the service of her family.

The illustration above shows how viewing medicine as a tool can contribute to living well amid the dynamism of one's places of responsibility. When people do not actively establish and reevaluate their life goals in vocation, however, both living well and dying well become more difficult. To this effect, Brad Mellon notes that "As persons age, there is an experience of loss, perhaps the most difficult of which is the loss of meaning."[37] This loss of meaning is widely discussed in the literature on death and dying. Mellon adds that "the focus is on meaning that once had been found through work, career, family, etc. The dying process and related illness threaten that sense of meaning." He observes that this loss of meaning can lead seniors "to compensate by striving for better health through modern medicine."[38] When the focus drifts away from vocation, it easily shifts toward the self, and this shift can encourage the pursuit of medical intervention until, as Moll states, there is "nothing left to do." Such a pursuit can interfere with living well and dying well.

Mellon's work was informed by the work of Catholic bioethicist James F. Drane, but Mellon is not willing to go as far as Drane. Drane himself writes that "One frequent source of meaning for contemporary persons is medicine. Doctors are for many today what priests were for people during more religious periods. Health is equivalent to salvation. Disease and disability are hell."[39] This should not be surprising to even a casual observer, but to the Christian, it should be quite alarming. For Drane, as for Mellon, this all comes back to the search for individual meaning for the person approaching death. This search for meaning as we approach death has been exacerbated by the rise of the so-called Protestant work ethic and the advent of the industrialized economy. These two developments in the eighteenth, nineteenth, and twentieth Centuries have drastically altered how industrialized societies, especially in the United States, think about the *oeconomia* and our vocations. As Drane notes, "The modern industrial system with its pension plans and a specified time to stop working has created and defined the new period in contemporary culture which we

call retirement."[40] Retirement is a relatively new phenomenon. When life expectancy was much shorter and living standards lower, most people worked until they were physically unable to work. When they were physically unable to work, it was an indication that they were most likely approaching death. As the aforementioned Rand report illustrated, in 1900 life expectancy was only 47 years, and the leading causes of death were infectious diseases, meaning a relatively short period of time between the onset of illness and death.[41] Today, retirement can last years, if not decades, yet those living in the global north, and again, particularly in the US, have been conditioned to associate one's meaning with their work. However, even this association of meaning with work for pay was not always the case, according to Drane.

In response to the development of the Protestant work ethic, Drane writes that "In pre-industrial society a different ethic operated. Different inner attitudes or dispositions or background personality traits provided moral direction and meaning. The theological virtues (faith, hope, and charity) gave meaning to life…." Drane also notes that "in the pre-industrial society, many good people never worked… But their lives had meaning and they were respected members of society."[42] Drane illustrates two developments that need attention: first, the potentially long period of retirement, in part due to modern medicine extending the average life span in the global north; and second, that meaning in life, in the global north, has become conflated with one's work. Therefore, as people retire and begin the slow process of approaching death, they risk losing a sense of meaning in life, which paradoxically leads to the desire to double down on fighting death. However, through the lens of vocation, the meaning of life remains embedded in one's vocations, and the Christian continues to fulfill many vocations, even when they no longer work for pay. As one understands the dynamism of vocation, they can prepare for their vocations to change over time. They can therefore set life goals as they approach retirement that are still based on living well and dying well, and they can approach death with a sense of meaning and even find meaning in fulfilling their vocations in their dying, and ultimately in their death itself.

## A New Paradigm: Choosing Life

Recall Meilaender's claim that, in refusing treatment under certain conditions, the Christian "chooses life—one life in particular from among the several still available."[43] This claim invites a new paradigm for framing medical decisions throughout life, especially at the end of life and when preparing for death. In this paradigm, the focus is not on fighting death but on choosing life: more precisely, on discerning how one will live the life one has been given in the fulfillment of one's various places of responsibility. Different choices lead to different lives. Some decisions may shorten one's life, while others may extend it, but each is still a choice about how to live the life one has been given. As Meilaender observes, the soldier who jumps on a

grenade to save his compatriots or who storms a beach under heavy gunfire may be making a choice that almost certainly shortens his life. Yet he is also choosing how to live in fulfillment of his vocations as soldier, citizen, and friend.[44] Within the Christian's places of responsibility, Christian freedom is exercised, however limited by time and circumstance, in choosing how to live and serve in his or her vocations.

This new paradigm need not be adversarial toward medicine. Again, medicine is a tool in the service of each Christian fulfilling his or her vocations, so the Christian need not view medicine as the enemy or adversary in this process. In fact, medicine may even be an ally, helping the Christian think about how to use it more effectively to achieve life goals of living well and dying well. James Fries is the father of the medical concept known as the "compression of morbidity." Daniel Callahan describes this concept as "accept[ing] aging as a biological given but work[ing] medically to reduce the illness and disability associated with it."[45] Essentially, this is a medical approach to reducing lifetime morbidity by postponing the onset or impairments associated with life-ending disease. Fries identifies four distinct strategies required to attain this objective:

1. Primordial prevention: Preventing the development of risk factors for illness, such as reducing teenage smoking.
2. Primary Prevention: Reducing the prevalence of risk factors, such as smoking cessation.
3. Secondary Prevention: Preventing the progression of disease, such as reducing the risk of second heart attacks.
4. Tertiary Prevention: Reducing morbid states that have already occurred, such as joint or organ replacement.[46]

According to Fries, implementing these four strategies in healthcare could prolong good health and compress the period at the end of life when one is limited by poor health. These strategies also raise ethical questions that need to be worked out, such as organ replacement, but they offer a useful example of a paradigm-shifting approach to medicine. Commenting on Fries's work, Aimee Swartz acknowledges that the compression of morbidity is a paradigm shift in medicine, writing, "The compression of morbidity hypothesis presented a new lens through which to examine aging."[47] Callahan adds, however, that "for the compression of morbidity to actually work we would also have to foreswear intensive medical intervention at the end of life."[48] That would be a paradigm shift for both medicine and for many Christians, but it is one that could lead to living well and dying well.

As Christians, we should not fear such a paradigm shift but should embrace an ethic of dying well. The Christian can reject the "naïve vitalism" of pursuing life at any cost, as Moll noted above. Christians do not need to fight death to the

bitter end, because the battle over death has already been waged and won. Jesus went to battle with death on the cross and emerged victorious in the empty tomb. The Christian's hope therefore does not rest in medicine's power to postpone death indefinitely, but in Christ's victory over death. As Gregory Jones argues in his article "The 'Good Life' or a Life That Is Good? Aging, Death, and Christian Theology in American Culture":

> Christians should know that medicine cannot be expected to save us from death, for only God can do that… we ought to recognize that death, though an enemy, ought not to be fought at all costs… We ought to be willing to forgo extraordinary means of extending life, not because of any technological problems or developments, but because of the conviction that God and not death has the final word about our lives.[49]

The choice to fight death is always a choice to fight a losing battle. The fight against death is really two distinct fights, both ultimately futile, against two different types of death. Thomas Long describes these two types of death in his book *Accompany Them with Singing: The Christian Funeral*. In this book, he describes what he calls small-*d* death—"natural death"—and capital-*D* death—"death as a mystic force, as the enemy of all that God wills for life."[50] Despite the best advances in medical science and technology, small-*d* death remains an inevitability, and despite the best efforts of a few billionaires in Silicon Valley, small-*d* death seems likely to continue prevailing for the foreseeable future. And there is not a man (or woman) alive today who can hope, through any effort of their own, to conquer capital-*D* death. If we choose to fight death, we will only fail. But one can exercise Christian freedom in choosing how to live, and for those who are baptized children of God, they can make those choices knowing that they have died in Christ and that they live in Christ. Long speaks to this when he writes:

> Human life is bounded by mortality, by small-*d* death, and savaged by the voracious appetite of our old enemy, capital-*D* Death…. Human beings are set down in the midst of history, and we give our energies to making the best life we know how to make for ourselves, forming relationships, daring to bring children into the world, working at our trade, building up and nourishing communities. And yet we have a sense that life, while not other than this, is somehow more than this, that we are more than this.[51]

As creatures alive in Christ, Christians can choose how to live and how to use their tools to live their lives in vocation, fulfilling the places of responsibility granted them by God, to serve their neighbor. Christians, who are alive in Christ, can, through this new paradigm, see medicine as a tool for pursuing their vocations. It is in the fulfillment of these vocations that the meaning of life is experienced, in relationship with those for whom one has been placed in their lives.

## Final Thoughts

This essay has argued that Christians should approach medicine as a gift and tool to be received with gratitude, used with discernment, and ordered toward the faithful fulfillment of vocation. Medicine does not make an absolute moral claim on Christian freedom simply because it may extend life; rather, it becomes morally meaningful when it serves the creaturely life God has given and the neighbors to whom that life is bound. The essay began by locating medical decision making within Christian freedom, then showed how that freedom is exercised in vocation. It then argued that life goals for living well and dying well should be shaped by those vocational responsibilities, and that because vocations change over time, the use of medicine must also be reconsidered as one moves through life and approaches death. The resulting paradigm reframes medical decisions not chiefly as refusals of treatment, but as acts of responsible discernment: Christians may opt in to medicine when it helps them live faithfully in their places of responsibility, and they may opt out when a treatment no longer serves those callings or becomes ethically objectionable or excessively burdensome. In this way, the paradigm rests on a Lutheran account of freedom, creatureliness, vocation, and hope in the resurrection.

God has blessed His people with Christian freedom, enabling them, in their creatureliness, to participate in caring for and guarding creation. Medicine is one of the tools God has entrusted to His creatures for that work, but it remains a tool and not a master. Human beings remain creatures, not self-creators, and their freedom is therefore real but limited. Death is inevitable. Medicine can, in some circumstances, delay death, relieve suffering, and preserve the conditions in which vocations may still be fulfilled, but it cannot overcome death. Avoiding conversations about death does not make death less real; it often makes it harder to live well and die well. Christians, however, need not approach such conversations in despair, because death is not the end of their story. In Christ, they have the promise of resurrection, and that promise frees them to receive medicine gratefully without treating it as salvation. Thus the Christian may live and die in faith, using medicine wisely when it serves vocation and relinquishing it when faithful creaturely dependence calls for rest. Rob Moll's reflection on the Lutheran Reformers captures this posture well: "It was only natural, the Reformers said, for Christians to be fearful of death. Yet they did not need to gird themselves for spiritual warfare. The spiritual process of dying simply involved resting in the faith of Christ's victory on the cross."[52]

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## Notes

1. Gilbert Meilaender, *Bioethics: A Primer for Christians* (Grand Rapids, MI: William B. Eerdmans, 2022), 85.
2. Meilaender, *Bioethics*, 87.
3. Rob Moll, *The Art of Dying: Living Fully into The Life to Come* (Downers Grove, IL: InterVarsity Press, 2021, 32.
4. Ibid.
5. Ibid., 37.
6. Ibid., 34.
7. Ibid., 34.
8. Meilaender, *Bioethics: A Primer for Christians*, 87.
9. This is not a comprehensive treatment of Christian Freedom. For that, see Martin Luther's *The Freedom of a Christian*. The edition and translation used here is from the American Edition of *Luther's Works* (see citation below). For a contemporary commentary and explanation of Luther's *The Freedom of a Christian*, see Wengert, Timothy J. "Luther's Freedom of a Christian for Today's Church." *Lutheran Quarterly* 28, no. 1 (2014): 1–21.
10. Martin Luther, *Career of the Reformer I*. ed. Helmut Lehmann, vol. 31, p. 344 in *Luther's Works, American Edition*, vols. 1–30, ed. Jaroslav Pelikan (St. Louis: Concordia Publishing House, 1955–76); vols. 31–55, ed. Helmut Lehmann (Philadelphia/Minneapolis: Muhlenberg Press/Fortress Press, 1957–86); vols. 56–82, ed. Christopher Boyd Brown and Benjamin T. G. Mayes (St. Louis: Concordia Publishing House, 2009-), hereafter, LW.
11. LW 31: 350.
12. Ibid., 356.
13. Ibid., 365.
14. Ibid., 366.
15. Ibid., 367.
16. To the Lutheran ear this brings to mind Luther's two kinds of righteousness, passive—that which is received from God through the work of Christ's work for our salvation, and active—that which we do for others, that does not convey salvation but is done only in the service of our neighbor out of Christian love. There are similarities here for sure, but Benne makes no direct connection in this book to Luther's two kinds of righteousness. For more on active and passive righteousness, see Robert Kolb, ed., *Alien and the Proper: Luther's Two-Fold Righteousness in Controversy, Ministry, and Citizenship* (Irvine, CA: 1517 Publishing, 2023).

17. Robert Benne, *Ordinary Saints: An Introduction to the Christian Life* (Minneapolis: Augsburg Fortress, 2003), 45–57.
18. Benne, *Ordinary Saints*, 63–65.
19. Benne, *Ordinary Saints*, 65–66.
20. James F. Keenan, "Dualism in Medicine, Christian Theology, and the Aging." *Journal of Religion and Health* 35, no. 1 (March 1996): 35, https://doi.org/10.1007/bf02354943.
21. Keenan, "Dualism in Medicine, Christian Theology, and the Aging," 35.
22. Jones, L Gregory, "The 'Good Life' or a Life That Is Good? Aging, Death, and Christian Theology in American Culture." *Word and World* 13, no. 3 (1993): 293.
23. Gregory, "Good Life," 293.
24. Gilbert Meilaender, "Thinking About Aging." *First Things* 212, April (2011): 38.
25. Meilaender, "Thinking About Aging," 42–43.
26. Joanne Lynn and David M. Adamson, *Living Well at the End of Life: Adapting Health Care to Serious Chronic Illness in Old Age*, https://www.rand.org/content/dam/rand/pubs/white_papers/2005/WP137.pdf, 3.
27. Ibid., 2.
28. This paper does not intend to delve into the well-trod discussion on physician assisted suicide. However, it is easy to see where, for some, the extension of life unto the point of disability may make a compelling argument for physician assisted suicide. The argument here may be to advance life as long as it is pleasant and then end one's life when it becomes burdensome. The Christian literature rejecting this notion is extensive and will not be repeated here, except only to say that for the Christian, physician assisted dying denies the giftedness of our lives and is a rejection of the Creator of those lives. On another note, the Christian must also reject the notion of physician assisted dying when disability is present because it also denies the personhood of the disabled. Disability does not diminish personhood or the giftedness of life and therefore cannot be used as a rationale for physician assisted dying.
29. Lynn and Adamson, *Living Well at the End of Life*, 5.
30. Moll, *Art of Dying*, 47.
31. Ibid., 49.
32. Ibid., 58.
33. Ibid., 38.
34. Beth Hoeltke and Kent Burreson. *Death, Heaven, Resurrection, and the New Creation* (St. Louis: Concordia Publishing House, 2019), 112.
35. Benne, *Ordinary Saints*, 72.
36. Moll, *Art of Dying*, 34–35.
37. Brad Mellon, "James Drane's More Humane Medicine: A New Foundation for Twenty-First Century Bioethics?" *Christian Bioethics* 12, no. 3 (December 1, 2006): 305, https://doi.org/10.1080/13803600601052391.
38. Ibid., 305.
39. James F. Drane, *More Humane Medicine: A Liberal Catholic Bioethics* (Edinboro, PA: Edinboro University Press, 2003), 216.
40. Ibid., 210.

41. Lynn and Adamson, *Living Well at the End of Life*, 2.

42. Drane, *More Humane Medicine*, 211.

43. Meilaender, *Bioethics: A Primer for Christians*, 87.

44. Ibid., 82.

45. Daniel Callahan, "Aging and the Goals of Medicine," *Hastings Center Report* 24, no. 5 (December 31, 1994): 39.

46. James F. Fries, Bonnie Bruce, and Eliza Chakravarty, "Compression of Morbidity 1980–2011: A Focused Review of Paradigms and Progress," *Journal of Aging Research* (2011): 2, https://doi.org/10.4061/2011/261702.

47. Aimee Swartz, "James Fries: Healthy Aging Pioneer," *American Journal of Public Health* 98, no. 7 (2008): 1164.

48. Callahan, "Aging and the Goals of Medicine," 39.

49. Gregory, "Good Life," 292.

50. Thomas G. Long, *Accompany Them with Singing: The Christian Funeral* (Louisville: Westminster John Knox Press, 2009), 38.

51. Long, *Accompany Them with Singing*, 40.

52. Moll, *Art of Dying*, 59.

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