The *Imago Dei* in the ICU

Why Every Patient Matters

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1.0 Introduction

This opening section performs three essential tasks. First, it identifies the anthropological conflict at the heart of modern bioethics, showing how autonomy-centered and utilitarian frameworks reduce human dignity to measurable capacities and instrumental calculations. Second, the section introduces the core Lutheran theological concepts—the Two Kingdoms distinction, the *imago Dei* (the image or likeness of God), and the doctrine of vocation as *larva Dei* (mask of God)—that together constitute a coherent alternative framework for clinical judgment. Third, the section outlines the essay's overall argument and method: careful biblical exegesis interpreted through Lutheran hermeneutical principles and applied to selected bioethical points of contention. The goal is to equip medical professionals to practice with both confessional integrity and joyful vocational confidence, even within institutions that most clearly expose the brokenness of the present fallen age.[1] This tension surfaces at the bedside across medical practice and becomes particularly visible in the ICU (intensive care unit), where autonomy is often suspended and life is mediated through technology.[2] Here, just as truly as in the clinic, the ward, and home hospice, the *imago Dei* grounds the conviction that every patient matters.

1.1 The Problem: Anthropological Conflict in Clinical Practice

Contemporary medicine increasingly operates within bioethical frameworks that prioritize individual autonomy as the ultimate guiding principle, often relying on utilitarian calculations.[3]These judgments aim to maximize overall benefit or minimize overall harm by effectively allocating limited resources and determining acceptable outcomes.[4] What began as a necessary and legitimate correction to paternalistic medical practice (in which physicians made decisions unilaterally, often without meaningful patient input) has, in many institutional settings, evolved into a reductive

anthropology. That is, it has produced an impoverished understanding of what it means to be human, one in which the worth of individuals is effectively measured by their present capacity for autonomous self-determination or their anticipated contribution to society's aggregate welfare.[5]

In Luther's terms, such patterns function as a latter-day "Babylon," not because they are evil by nature, but because they elevate human control over God's Word and thereby bind consciences.[6] This reductive logic is most starkly evident when critical decisions must be made. Within such a framework, choices about withholding treatment, withdrawing life-sustaining interventions, or pursuing aggressive medical measures are framed primarily in terms of preference-satisfaction (honoring whatever the patients or their surrogates desire) or cost-benefit calculations (weighing resource expenditure against projected outcomes). What often goes missing is any meaningful appeal to an objective human good. This conception of human flourishing and dignity transcends both the patients' current subjective desires and their instrumental value to others.[7]

The ethical landscape outlined above places clinicians in a particularly difficult position. For those who confess that every human being bears the *imago Dei* (the image or likeness of God), that human life constitutes a sacred gift whose origins and terminus belong ultimately to the Creator, and that medicine exists fundamentally to serve one's neighbor in their concrete, embodied need, this dominant framework generates profound and persistent tension. Physicians, nurses, or therapists cannot in good conscience retreat into a parallel "Christian" healthcare system insulated from these pressures, nor may they simply accommodate every protocol or practice that bears the institutional stamp of legitimacy. They must instead practice faithfully in professional environments where appeals to "reproductive rights," "death with dignity," or "resource stewardship" can be utilized to conceal what amounts to a functional denial of the human dignity these concepts purport to safeguard.[8]

Wherever medicine meets profound dependency—whether in primary care, oncology, geriatrics, or the ICU—this tension becomes unavoidable. Consequently, the challenge facing practitioners is not only procedural but also profoundly theological and existential. The two primary questions addressed in this essay are as follows: First, in what ways can clinicians remain faithful to their convictions while working in what amounts to a latter-day Babylon?[9] Second, how do they serve as medical professionals, not against or apart from secular institutions, but faithfully within them?

1.2 Thesis Statement

This essay argues that medical practice[10] within secular institutions represents neither an uncomfortable compromise nor a necessary evil to be reluctantly tolerated.

Rather, it constitutes a proper and theologically legitimate exercise of one's vocation within what Lutheran theology identifies as God's left-hand kingdom. To unpack this claim requires clarifying several interlocking theological concepts.

God's Two Kingdoms: Lutheran theology distinguishes between God's right-hand kingdom (the realm of redemption, where God rules through Gospel proclamation, the Sacraments, and the Spirit's work in the Church) and God's left-hand kingdom (the realm of preservation, where God maintains order, restrains evil, and promotes temporal welfare through civil institutions, vocations, and structures of authority—what Paul calls "governing authorities" in Rom 13:1).[11] Both kingdoms belong to the one God and serve his purposes, though they operate through different means: the right hand through grace and faith, the left through law and reason. Crucially, the left-hand kingdom remains under God's firm control, even when the structures themselves do not recognize divine authority. The Creator even uses pagan rulers and secular institutions to accomplish his preserving work.[12] This distinction is paramount because it fundamentally alters the very context of secular endeavors.[13]

Imago Dei (divine image): The conviction that every human being bears God's image means that their dignity is neither intrinsic nor self-generated but alien, that is, bestowed from outside themselves by the Creator. This dignity is therefore inviolable and unchanging, remaining fully intact despite any possible diminished capacity, contribution, or consciousness. The *imago Dei* precedes and grounds all human rights, rather than being constructed by them. This foundational principle of inherent dignity finds its active expression in the one's vocational role.[14]

Larva Dei (masks of God): Luther's striking metaphor depicts human beings in their various callings as masks behind which God's own providential care hides and works. The nurse administering medication, the physician setting a bone, and the therapist counseling the anxious become the concrete, physical means through which the Lord's beneficent will to preserve and care for creation is enacted. This is not just a metaphor, but a theological ontology where the Creator genuinely cares for the sick through the hands and judgment of the clinician.[15]

When woven together, these three theological strands—the two kingdoms, the divine image, and the masks of God—form a coherent framework for faithful action. Grounded in the conviction that every patient bears the *imago Dei* and thus possesses inherent dignity, clinicians are called to seek the welfare of their community, much as the exiles were called to seek the peace of Babylon (drawn from Jer 29). In this vocation, the medical professional serves as a "mask of God," carrying out the Messiah's love through ordinary acts of diagnosis, treatment, and

compassionate presence. This theological foundation frees them from ideological captivity and empowers a genuine pursuit of the neighbor's good, whether on the hospital ward, in the clinic, at the home bedside, or most urgently, in the ICU. Such a pursuit consciously rejects two extremes: the overreach of medical vitalism, which treats biological life as an absolute good to be preserved at any cost, and the abandonment driven by utilitarian calculation, which too readily deems some lives not worth sustaining.[16]

1.3 Methodological Approach

The essay's argument proceeds through careful grammatical-historical exegesis of three foundational biblical texts: Genesis 1:26–27 (establishing the creation of humanity and the meaning of bearing God's image), Jeremiah 29:4–7 (articulating the exilic community's mandate to seek the *shalom*, namely, the peace, welfare, and flourishing of Babylon), and Matthew 25:31–46 (presenting Christ's radical identification with the "least of these" and thereby with every vulnerable patient). Because clinical care often confronts diminished consciousness and contested utility—most vividly in the ICU—this hermeneutic clarifies why every patient matters. Guided by this exegetical foundation, these passages are interpreted through distinctively Lutheran hermeneutical lenses, above all:

> The Two Kingdoms Distinction: This framework allows practitioners to affirm the goodness and divine approval of medical work within secular structures, while maintaining clear distinctions about what such work can and cannot accomplish (temporal preservation versus eternal salvation) and what authority governs it (reason and civil law versus Gospel proclamation).[17]
>
> The Theology of the Cross (*theologia crucis*): Luther's insistence that God works most profoundly through what seems weak, foolish, or hidden. For medical professionals, this challenges them to seek God's presence not in institutional power, technological mastery, or professional prestige, but in the vulnerable patient, the ethically complex case, and their own humble, daily acts of care.[18]

Equipped with this integrated theological framework, the resulting perspective is then applied to specific contemporary bioethical issues that arise from the clinic to the ICU: end-of-life decision-making (where autonomy-centered frameworks can facilitate premature abandonment), resource allocation (where utilitarian logic can instrumentalize patients), reproductive technologies (where human life's origins become subject to quality control), and conscience protections (where institutional demands can coerce participation in practices that violate foundational convictions).

The intent here is not to provide detailed casuistry, that is, exhaustive case-by-case moral reasoning for every possible clinical scenario. Rather, the goal is to articulate a distinctively Lutheran vocabulary and to demonstrate how this theological framework profoundly reorients clinical judgment. It directs practitioners away from both vitalistic overreach (the assumption that extending biological life is always the paramount good) and utilitarian abandonment (the calculus that some lives, being less productive or more burdensome, merit less protection). Instead, this objective points toward the neighbor's genuine welfare as understood through a biblically grounded anthropology.

Therefore, the essay's aim is constructive and pastoral: to equip medical professionals to serve with both theological integrity and joyful vocational confidence. This aim is especially important in institutional settings, which often reveal the most dire aspects of the present age's brokenness and confusion. If medicine can be faithfully practiced in Babylon, it can be faithfully practiced anywhere. Accordingly, the exegesis of Genesis 1:26–27, Jeremiah 29:4–7, and Matthew 25:31–46 is brought to bear on clinical judgment and practice (from routine consultations to the ICU) so that the same alien dignity, exilic vocation, and cruciform service govern every bedside decision.

2.0 The Bestowed Dignity: Genesis 1:26–27 and the *Imago Dei* as Foundation for Care

After identifying the anthropological conflict at the heart of contemporary bioethics and introducing the Lutheran theological framework that will guide this essay's constructive proposal, the discourse now turns to the first of three foundational biblical texts. What follows is a careful exegesis of Genesis 1:26–27, read through the lens of ancient Near Eastern royal ideology and developed through Lutheran categories of alien righteousness. The argument systematically progresses from exegesis to theology to clinical practice. It shows that the *imago Dei* grounds bedside decisions in the God-given dignity of every person, rather than in capacity-based measures of worth.

2.1 Exegetical Foundation: The Royal Image in Ancient Context[19]

Genesis 1:26–27 portrays the creation of humanity as the climactic act of God's life-imparting work. This event, rooted in space-time history, unfolds through a deliberate unilateral decree: "God said, 'Let us make man…'" The text underscores its significance by a threefold use of the Hebrew verb *bara* ("create"), setting humanity apart from all that preceded. These linguistic markers signal a decisive

transition: the divine Artisan and Architect's personal and purposeful act to fashion image-bearers who reflect his glory.

To appreciate the weight of this claim, it is important to consider how its first hearers would have understood it. The Hebrew nouns *tselem* ("image") and *demuth* ("likeness") are not abstract philosophical categories attempting to describe some invisible essence of the soul. Rather, they are concrete, embodied, and relational words borrowed directly from the royal and cultic vocabulary of the ancient Near East. When monarchs conquered distant territories, they would erect *tselem*-statues—physical representations of themselves—to assert their authority over lands they could not personally occupy. The statue functioned as the king's authorized representative, his visible presence announcing his sovereignty despite his absence.

Seen against this cultural backdrop, the biblical assertion becomes astonishing. Genesis declares that every human being—not merely rulers, priests, or other societal elites—functions as God's authorized representative on earth. Consequently, the image is not something humans gradually achieve through moral development or rational cultivation. It is something they receive instantaneously from the Creator in the very act of being spoken into existence. This is not a capacity to be developed but an identity to be recognized.[20]

The narrative structure itself confirms this immediacy. As noted earlier, the divine deliberation ("Let us make man…") is followed by the sovereign speech-act of creation ("God created man…").[21] There is no gap, no intermediate stage, and no probationary period. Dignity is not negotiated through ethical performance, earned through demonstrated competence, or developed through the acquisition of certain cognitive abilities. It is bestowed by divine fiat, that is, by the Creator's authoritative word alone.

Finally, the text drives home this truth with emphatic repetition. The threefold refrain—"in our image," "in his own image," and "in the image of God"—stands like three pillars supporting a singularly important truth. This is the defining, non-negotiable reality of human existence. Moreover, the *imago Dei* belongs to humanity as male and female together, not to one gender privileged over the other, and certainly not only to those who are cognitively intact, physically robust, or socially productive. No conditions are attached, no future capacities are required, and no minimum thresholds are established. The unborn child still forming in the womb, the Alzheimer's patient who no longer recognizes her own children, the man with trisomy 21 who will likely not live independently, and the newborn with anencephaly who will survive only hours all stand equally under the declaration, "in the image of God he created him." This theological assertion is constantly tested in healthcare settings where patients are vulnerable. While the prognosis may be

uncertain, the inherent dignity of the *imago Dei* remains intact. The ICU serves as a microcosm where this truth is most vividly demonstrated.

2.2 Theological Development: The Structure of Alien Dignity

Lutheran theology insists that the righteousness by which believers stand justified before God is alien or *extra nos*. It originates entirely from outside people, through Christ, and is not received through active achievement but through passive trust (faith). Believers contribute nothing to their justification. They simply receive what God declares and accomplishes on their behalf. This is the theological revolution of *sola gratia* (grace alone) and *sola fide* (faith alone). Salvation is not constructed from below by human effort but bestowed from above by divine mercy (John 3:3, 5; Titus 3:3–7; 1 John 4:10).[22]

That same pattern of divine initiative extends beyond redemption into creation itself. The same logical structure—the same grammar of gift—governs human dignity in the order of creation. Before people do anything, before they think anything, before they choose anything, and even before they possess the neurological architecture that would enable doing, thinking, or choosing, God has already spoken his creative verdict over them: "very good" (Gen 1:31). Their worth *coram Deo*, namely, their standing before God, rests wholly and exclusively on this prior divine speech-act, not on any subsequent performance, capability, or contribution they might (or might not) later demonstrate.[23]

From this truth emerges a striking theological implication. It creates what might be called a passive anthropology that mirrors justification's passive righteousness. The lost do not generate their own dignity through achievement. Instead, they receive dignity as a gift antecedent to all achievement. Just as the Gospel announces "you are forgiven" before people have done anything to merit God's pardon, creation (personified) announces "you are an image-bearer" before people have done anything to merit that ontological status. In both cases, the declaration creates the reality rather than merely recognizing something already present or achieved.[24]

Conversely, present-day bioethics frequently locates human dignity and moral considerability in various capacities that can be empirically measured, progressively lost, or never fully developed in the first place. Depending on the specific philosophical framework employed, dignity might be grounded in any of the following:

Rational self-awareness and second-order desires (the ability to reflect on one's own preferences)

The capacity to form and pursue life plans over time

Potential for reciprocal relationships and social bonds

Present or future contribution to society's aggregate welfare

Sentience and the capacity to experience pleasure or pain

Autonomy in the strong sense: the ability to make reasoned choices independent of external determination[25]

These criteria have a certain surface plausibility, since they reflect qualities and capacities that society rightly values. The problem arises, however, when human dignity is defined by these attributes rather than merely expressed through them. Once dignity is functionally tied to measurable criteria, it inevitably becomes graduated and conditional. Under such a view, some possess the relevant virtues fully, others only partially, and still others only potentially. Individuals such as the permanently unconscious, the profoundly cognitively disabled, or the previable fetus (one unable to survive outside the womb) may then be seen as possessing these abilities not at all, or in so diminished a form that their claim to life-sustaining care is proportionately weakened.

The practical consequence is chillingly logical. If dignity is proportional to capacity, then the obligation to provide care is similarly proportional. Treatment decisions may then legitimately be based on whether a patient still possesses enough of the relevant qualities to justify continued investment of limited resources. The demented elderly woman who can no longer recognize her family, the infant born with severe neurological impairments, and the young man in a persistent vegetative state become borderline cases. Their moral status is perpetually in question, and their claims on medicine's resources are subject to ongoing cost-benefit recalculations.

The biblical witness will have none of this. Because the *imago Dei* is conferred by divine declaration rather than constituted by human achievement, it cannot be diminished by disease, disability, or decline. It is not subject to empirical assessment because it does not consist in any measurable aptitude. The patient who lies unconscious in the ICU, breathing only because of a ventilator and showing no signs of awareness, is no less God's image-bearer than the physician standing at the bedside conducting rounds. The child with profound intellectual disability who will never speak a sentence, read a book, or live independently is no less the object of divine delight and no less stamped with the Creator's own likeness than the university professor who lectures on ethics or the surgeon who performs groundbreaking procedures.

This is not a sentimental refusal to acknowledge real differences in capacity. A cognitively intact adult can, of course, do things a profoundly disabled infant cannot, and certain medical treatments do require specific neurological functions. The crucial point, however, is that these operational differences do not correspond to distinctions in fundamental moral worth or in the right to care. Medical treatment is therefore not a reward dispensed according to demonstrated ability or value. Rather,

it is a response to a worth that is inherent and irrevocable, declared by God apart from any human achievement.

2.3 Clinical Implications: Where Theory Meets the Bedside

This theological understanding of bestowed, alien dignity strikes at the root of several pervasive temptations and troubling trends in contemporary clinical practice, pressures that arise with particular urgency in the ICU but are present wherever medical decisions are made. First, it renders morally incoherent any allocation or triage protocol, whether for outpatient access, inpatient bed assignment, or ICU ventilator distribution, that systematically assigns lower priority to patients based on projected "quality-adjusted life years" (QALYs), anticipated economic productivity, or baseline cognitive function. For example, during the COVID-19 pandemic, numerous proposed allotment frameworks explicitly or implicitly devalued patients with intellectual disabilities, the elderly, or those with multiple comorbidities. These are precisely the populations whose inherent dignity the *imago Dei* most forcefully protects.[26]

From the perspective developed here, the ninety-year-old widow with advanced dementia is not a "net drain" on resources whose life may be legitimately sacrificed so that younger, more productive patients might benefit. She is a living icon—a *tselem*, a physical representation—of the God who called her into being and still sustains her. Systematically withholding ordinary care from her because other patients might statistically derive greater benefit repeats the primal logic of Cain: "Am I my brother's keeper?" (Gen 4:9) and functionally, answers "No, not when keeping my brother becomes too costly."

The preceding observations do not mean that all triage distinctions are illegitimate. Clinical care must at times make rapid decisions. This includes screening in the emergency department (ED), prioritizing operating room (OR) schedules, and assigning ICU beds. Each decision is based on medical urgency and the likelihood of benefit from intervention. Nonetheless, such clinical triage differs fundamentally from systemic policies that permanently and categorically assign lower priority to entire classes of patients based on characteristics unrelated to the immediate medical situation. The former responds to medical need; the latter ranks human worth.

Second, this framework redefines the concept and scope of informed consent. Patient autonomy is real and weighty and must be respected, but it is not ultimate or absolute. When a patient or his surrogate demands withdrawal of medically provided nutrition and hydration from a person in a minimally conscious state, or requests cessation of all treatment for a newborn with Down syndrome and a surgically correctable heart defect, the clinician is not obliged to treat such requests as unquestionable sovereign commands that override all other moral considerations.

Why not? Because the body is not private property to be used or discarded according to personal preference when it becomes burdensome or no longer serves the life an individual had planned. It is, rather, a gift held in stewardship, a trust received from the Creator who retains ultimate ownership. As Psalm 24:1 declares, "The earth is the Lord's and everything that fills it, the world and all who live in it." People are stewards, not owners, of their embodied lives.[27]

This inviolable truth means that consent functions as an act of faithful stewardship rather than autonomous ownership. The patient or his surrogate must make decisions for the good of the person whose life is at stake, not merely according to what seems convenient, economically rational, or emotionally tolerable. Autonomy rightly protects against unwanted imposition, yet it is not an absolute warrant to end the life of an image-bearer. This principle holds true in outpatient refusals, inpatient directives, and ICU decisions.

Third, this theological anthropology gives the practitioner moral courage to resist the quiet nihilism that sometimes masquerades as compassion. When colleagues speak casually about "futility" or urge "letting nature take its course" while genuine possibilities for significant recovery still remain, the Lutheran framework calls for caution. It also provides clarity when institutional pressures prompt an early transition to comfort care, often driven by family exhaustion or the high cost of treatment. Additionally, this framework serves as a reminder of several important truths.

For one, the "course of nature" is not an autonomous force operating independently of God's sovereign governance. It is itself under the command of the Creator who spoke it into being and who continually sustains it. Thus, to "let nature take its course" is never a neutral, hands-off option. It is itself a decision about how to steward the life God has given.

For another, believers whom God calls to be clinicians are to serve their neighbors in their concrete, embodied needs, not to act as sovereign potentates by deciding whose image has become too marred, too diminished, or too costly to matter anymore. Medical professionals are neither obliged to pursue every possible intervention regardless of burden (the error of vitalism), nor permitted to abandon patients whose care has become complex or whose outcomes remain uncertain (the error of utilitarian calculation).

A third consequential truth is that the judgment about what constitutes a life "worth living" belongs to God alone. When medicine begins to make such judgments, such as deciding that certain disabilities render life unworthy of protection or that diminished consciousness cancels a person's claim to ordinary care, clinicians usurp the divine prerogative and betray their vocation. Their calling is not to measure the value of life but to honor its Giver by protecting and caring for every person he entrusts to practitioners.

Fourth, in every bedside encounter, medical professionals engage with more than a collection of symptoms to manage, a diagnosis to treat, or a cost-benefit calculation. They meet human beings—living, breathing bearers of the divine image—upon whom God has permanently set his likeness. Moreover, clinicians recognize that every person, regardless of present suffering or future prognosis, is worthy of the same care and compassion believers would offer to the Creator.[28]

That recognition changes everything. It transforms an exhausting overnight shift with a difficult patient into an act of worship. It reframes the frustrating case conference in which colleagues advocate withdrawing care as an opportunity to bear witness to a dignity that transcends utility. It converts the unglamorous work of turning and bathing a patient who will never express gratitude into participation in God's own ongoing creative and preservative work.

To reiterate a previous observation, the *imago Dei* is neither a theological abstraction nor a pious sentiment for ethical debate. It is the foundational reality that constitutes every patient's identity and must therefore govern every bioethical decision. To practice medicine in light of this truth is to align clinical intervention with God's own purpose. Such practice means caring for our neighbors not because they have earned it, not for reciprocation, cost-effectiveness, or professional reward, but simply because God has declared them good and has called practitioners to embody his kindness and compassion. In this way, divine care becomes tangible in the patient's moment of need. This is why every person matters: not because of utility or projected recovery, but because each bears the Creator's image, even in the ICU's most vulnerable moments.[29]

3.0 Faithful Service in a Foreign Land: Jeremiah 29:4–7 and the Two Kingdoms

With the anthropological foundation now firmly established—human dignity as alien, bestowed by divine declaration rather than constituted by human achievement—the essay turns to a pressing practical question: Where does the clinician exercise this theologically grounded care? What follows is an exegesis of Jeremiah 29:4–7, which records God's command to the Judean exiles to seek Babylon's peace (*shalom*), interpreted through the Lutheran doctrine of the Two Kingdoms and applied to the concrete challenges of institutional medical practice. The aim is to demonstrate that presence within secular healthcare is neither uncomfortable compromise nor regrettable necessity, but rather a legitimate and divinely ordained vocation, from ambulatory clinics to tertiary-care ICUs. It is a participation in God's left-hand kingdom work of preserving temporal life and promoting genuine human flourishing, even in contexts that do not acknowledge his lordship.

3.1 Exegetical Foundation: A Mandate for Exilic Presence[30]

The biblical narrative in Jeremiah 29:4–7 captures a pivotal moment of divine instruction for God's people in a state of dislocation. The prophet sends a letter from Jerusalem to the first wave of Judean exiles, those deported to Babylon in 597 BC (vv. 1–3). Strikingly, God's command through Jeremiah is not to foment rebellion, plot an escape, or withdraw into a purist enclave. Instead, the "Lord of Armies" (v. 4), the "God of Israel," issues a series of surprisingly ordinary imperatives: "build houses" (v. 5), "plant gardens," marry and have children (v. 6). Most remarkably, they are to "seek the peace" (v. 7) of the city and to "pray" to the Creator for it, "because when it has peace and prosperity, you will have peace and prosperity." The Hebrew verbs used are durative, indicating continuous action. These directives call for a long-term, constructive, and engaged presence.

To grasp the radical nature of God's command, it is crucial to understand the key terms. *Shalom* signifies far more than the absence of conflict. It denotes comprehensive flourishing, that is, a right ordering of relationships, material stability, social harmony, and communal health.[31] To "seek" this *shalom* is to actively and intentionally pursue the city's genuine good. Furthermore, the imperative to "pray" for "Babylon" (vv. 1, 3) grounds this entire vocational project in divine dependence, framing the exiles' public engagement as an extension of their liturgical life.

Consequently, the text presents a paradox that defines the exilic posture. The Israelites are to invest deeply in the welfare of a foreign, at times hostile, power without succumbing to its idolatrous worldview. This divine mandate navigates between two perennial errors. On the one hand, God's directive rejects a revolutionary theocracy that would seek to impose Israel's unique covenantal identity onto Babylon's civil structures. On the other hand, this imperative condemns a quietistic withdrawal that would refuse public engagement out of fear or disdain. The God-ordained alternative is a prayerful, constructive, and critically engaged presence within foreign institutions. It involves working for their genuine well-being while remaining vigilant against all forms of idolatry.[32]

As noted briefly in section 1.1, in *The Babylonian Captivity of the Church*, Luther employs "Babylon" as a prophetic image for any power—most notably the late-medieval papacy—that imprisons the Gospel by transforming God's gifts of Word and Sacrament into instruments of human control.[33] Applied analogically today, "Babylon" signifies temporal structures that elevate human authority or ideology above God's Word, thereby burdening consciences, whether in ecclesial or secular life.[34] Within the framework of the two kingdoms, Christians honor legitimate temporal authority and serve their neighbors, yet they discern "Babylon" wherever institutions absolutize themselves, commodify persons, or suppress the free course of the Gospel.

The Redeemer shatters Babylon's claims through his atoning work and the liberating promise of the Gospel, thereby freeing consciences and commissioning the Church to witness with humility, mercy, and courage. Rooted in Christ's grace, this vocation is marked by daily repentance, steadfast endurance under the Cross, and responsible engagement in public life for the good of one's neighbor. While seeking the city's welfare (*shalom*), practitioners resist its idols by fearing, loving, and trusting God above all things. They live confident in Christ's sovereign reign, knowing that their good works do not earn salvation but flow from their faith in the Son.

Consequently, the prophetic charge to "seek the peace of the city" (Jer 29:7) calls not for assimilation but for faithful presence within a foreign system. In the secular sphere, such as the modern hospital, an alternative epistemology rules, one that defines human worth by measurable traits such as autonomy and utility. The clinician, however, lives by a radically different logic grounded in God's inspired and authoritative Word, which affirms the inviolable dignity of every person irrespective of performance or capacity. The task, therefore, is to pursue *shalom* not by adopting Babylon's calculus of value, but by embodying God's countercultural vision of human worth through faithful service, patient love, and courageous witness.

3.2 Theological Development: The Two Kingdoms and God's Preserving Grace

Jeremiah's mandate to seek Babylon's *shalom* finds its theological depth in the Lutheran doctrine of the Two Kingdoms. As noted earlier, this distinction clarifies how the one sovereign Lord governs his creation in two distinct ways.

> Right-hand kingdom: God rules through the Gospel, the Sacraments, and the Spirit's work in the Church to forgive sins and grant eternal salvation.
>
> Left-hand kingdom: God rules through law, reason, and civil structures (such as governments and vocations) to preserve temporal life, restrain evil, and promote earthly welfare. Hospitals, courts, and universities belong to this left-hand governance.

This distinction is not abstract. It reorients how Christians understand their presence in secular institutions. Medicine practiced in a modern ICU is neither a godless sphere to be conquered (the Culture War model) nor abandoned (the Benedict Option), but a legitimate arena of God's preserving work. Even when hospitals do not acknowledge divine authority, they remain instruments through which the Creator sustains life and cares for neighbors in their embodied needs. Within this sphere, believers serve as *larvae Dei* ("masks of God"), human agents through whom the Lord's providential care becomes tangible. The clinician's skill and compassion are not salvific, yet they are genuine conduits of divine preservation.

Jeremiah explicitly attributes the exile to God's own agency. He "deported" (Jer. 29:4) the inhabitants of Jerusalem and Judah to "Babylon." Likewise, practitioners understand their placement in secular medicine as providential, not accidental. They are not reluctant guests in a foreign house but stewards in a divinely appointed field.[35] This theological lens guards against two distortions:

> Theocratic confusion: collapsing the left-hand kingdom into the right by turning hospitals into quasi-churches, imposing confessional oaths, or "gospelizing" bioethical protocols. This misuses the Gospel as a tool for civil governance.
>
> Separatist abandonment: treating secular medicine as irredeemably corrupt and retreating into sectarian enclaves. This denies God's preserving rule and forsakes the call to love one's neighbors in their bodily need.

The Two Kingdoms doctrine offers a distinctively Lutheran framework for medical vocation, guarding against both errors by calling for principled, patient engagement. This approach embodies what may be termed *holy secularity*. It is the conviction that God works through ordinary vocations as masks to care for his creation.[36] Thus, hospitals, clinics, and even ICUs are not godless spaces but arenas where the Lord actively preserves life through human hands. In this light, administering medication, adjusting ventilator settings, and guiding family conferences become acts of worship. It epitomizes service rendered to the Creator by tending to his image-bearers.

This vision stands in sharp contrast to modern secularism, which commodifies life and reduces vocations to jobs, patients to cases, and ethics to cost-benefit analyses. Where holy secularity regards a patient as a divine image-bearer and clinical care as a conduit of God's preserving grace, secularism sees only resource-allocation problems. Thus, Jeremiah's call to "seek the peace of the city" (v. 7) summons practitioners to inhabit secular institutions with theological clarity. They serve as the Creator's preserving presence, resisting both idolatry and withdrawal, until the day the Lord gathers his children into the sacred metropolis whose "architect and builder is God" (Heb 11:10).

The conceptual distinction outlined above should not be confused with an existential separation. Practitioners do not move between kingdoms as if changing professional roles. Rather, their conscience is simultaneously shaped by both realms. In the left-hand kingdom, natural reason guides the competent practice of medicine. In the right-hand kingdom, the Gospel informs the clinicians' understanding of true human welfare. Medical decisions (such as determining proportionate treatment, withdrawing life support, or allocating limited resources) depend on empirical evidence and sound rational judgment. Yet discernment about what genuinely serves the neighbor (such as distinguishing faithful care from either vitalistic excess or utilitarian neglect) is inevitably illuminated by a Gospel-shaped anthropology. Thus,

while the Two Kingdoms remain distinct in their means and purposes, practitioners inhabit both at once, serving temporal welfare with a vision clarified by eternal truth.

3.3 Clinical Implications: Seeking *Shalom* at the Bedside and in the Boardroom

The mandate to "seek the peace of the city" (Jer 29:7) provides robust theological warrant for full participation in secular healthcare systems. For medical professionals, it means actively pursuing the patient's genuine health and the institution's common good, whether on the floor, in the clinic, or in the ICU. This remains the case even when working under pagan leadership, navigating budget constraints, or implementing imperfect policies. Such participation is not a spiritual compromise but a faithful exercise of vocation within God's left-hand kingdom, where he sustains life through ordinary means and human reason.

This ethical framework enables principled cooperation in morally complex environments. It draws on classical moral reasoning to distinguish between two types of involvement:

> Formal cooperation: Direct, intentional participation in an intrinsically wrong act (such as elective abortion or euthanasia) is impermissible.[37]
>
> Material cooperation: Working within a system that permits such acts while personally refusing to participate and striving to uphold the patient's true good in one's own practice can be not only permissible but necessary.[38]

This distinction allows practitioners to bear witness to their values within imperfect systems. For example, a surgeon may work in a hospital where other departments perform morally objectionable procedures, provided he clearly avoids any direct involvement and focuses his own work on authentic patient care. In this way, the framework protects one's conscience without requiring an unsustainable withdrawal from professional and public life. It provides a path for faithful engagement in a world where moral wrongdoing exists.

Furthermore, the divine commands to "build" (v. 5) and "plant" authorize Christians in healthcare to engage constructively with the prevailing culture for the genuine good of patients and the community. This may include adopting evidence-based medical protocols, mastering electronic health records, or supporting diversity initiatives that promote equitable care. However, when institutional policies directly violate the sanctity of human life as bearing the *imago Dei*, cooperation becomes a formal endorsement of a modern idolatry. Examples include redefining personhood to justify organ harvesting from vulnerable patients, performing non-therapeutic surgeries that mutilate healthy tissue, or instrumentalizing the incapacitated for research. In such cases, the exilic vocation requires prophetic resistance: conscientious objection, truthful advocacy, and a willingness to accept professional consequences.

This resistance does not reject the wider community but seeks its true *shalom*, a peace grounded in justice rather than on compromised principles.[39]

Finally, the command to "pray to the Lord for that city" (v. 7) reorients the clinician's efforts. Lasting reform is not achieved through technocratic maneuvering alone but is grounded in petition to the Creator who holds the hearts of administrators and ethics committee chairs in his hands. Prayer provides steadfastness when institutional change is slow and vocational faithfulness seems unproductive. Prayer also binds the practitioner's work to divine agency, ensuring that one's efforts to "build" (v. 5) and "plant" remain acts of faithful stewardship rather than a frantic quest for self-salvation through professional achievement.

In summation, the experience of the Judean exiles in Babylon serves as a living parable for healthcare workers. God places his children in a medical "Babylon" not to storm its ziggurats of power or retreat into isolated ghettos, but to build, plant, heal, and pray. Their primary calling is to serve their neighbors as *larvae Dei*, honoring the *imago Dei* in every patient. They do so by engaging constructively with the structures of secular medicine while resolutely refusing to bow to the idols of autonomy and utility. Their objective is to faithfully serve until the day the Messiah returns with "great power and glory" (Matt 24:30; 25:31; Mark 13:26; Rev 1:7).

4.0 Christ in the Patient: Matthew 25:31–46 and the Clinician as *Larva Dei*

With both the anthropological foundation and the institutional context now established—the patient's alien dignity grounded in the *imago Dei* and the practitioner's calling to seek *shalom* within secular structures—the essay reaches its theological summit. What follows is an exegesis of Matthew 25:31–46, Christ's parable of the sheep and goats, interpreted through the interlocking Lutheran doctrines of vocation, the Two Kingdoms, and the theology of the Cross (*theologia crucis*). The argument demonstrates how these doctrinal lenses transfigure every medical encounter, from the ICU to the outpatient clinic. In each encounter, God actively preserves through the clinician's hands (the mask), while Christ is hidden in the patient (the least). The aim is to provide medical professionals with a vision of their work that transcends both utilitarian calculation and vitalistic overreach. This enables them to practice with joyful vocational confidence grounded in the certainty that every bedside encounter is a meeting with the incarnate Lord.

4.1 Exegetical Foundation: The Great Identification[40]

Matthew 25:31–46 frames the final judgment around a radical identification: the King equates himself with the "least of these brothers of mine." The point is not

metaphorical embellishment but Christological reality. The glorified "Son of Man" (v. 31) locates his presence in the embodied distress of the hungry, the stranger, and the sick.[41] The surprise of both the sheep and the goats ("Lord, when did we see you?", vv. 37, 44) reveals the uncalculated nature of true service. Works are not rendered as spiritual transactions to accumulate merit. Rather, they spring as the fruit of faith active in love, concretely meeting the neighbor in need without any self-conscious pursuit to gain "spiritual credit." The clinician is thereby freed from a works-righteousness ethic and called to a devout simplicity: see and serve the neighbor, for Christ has pledged himself to the "least of these" (vv. 40, 45).

Because they are already justified by grace, clinicians recognize the crucified and risen Messiah hidden under the neighbor's embodied distress, whether in a traumatized inpatient, an anxious outpatient, or a ventilated ICU patient. These are precisely the individuals most easily discounted by utilitarian reasoning. The textual logic of Matthew 25:31–46 binds together anthropology and eschatology. Since each patient has an intrinsic, bestowed dignity as *tselem*—a living image by divine declaration—service at the bedside is not contingent on capacities or projected utilities. It is a response to value already spoken by God. The recognition of the Redeemer's identification in the least intensifies, rather than replaces, that creational verdict. The *imago Dei* grounds the claim, and the Christological identification heightens the urgency.

4.2 Theological Synthesis: Vocation, the Two Kingdoms, and the *Theologia Crucis*

Luther's doctrine of vocation frames the clinical environment (particularly the hospital ICU) as a site of God's preserving action. Within the left-hand kingdom, the Lord rules through law, human reason, and ordained offices to sustain temporal life. Medicine falls unambiguously under this governance.[42]

Clinical care becomes a vivid locus of this vocation, whether on the ward, in the clinic, or, with heightened intensity, in the ICU. Consider the nurse turning a patient to prevent decubitus ulcers, the surgeon repairing trauma, the chaplain offering a consoling presence,[43] and the clinician titrating vasopressors, adjusting ventilator parameters, interpreting hemodynamic data, or guiding goals-of-care discussions. All serve as *larva Dei*, the masks through which God concretely cares for fragile bearers of his image. Such is not mere metaphor but theological ontology. In the ICU (as elsewhere throughout any hospital setting), the Creator truly tends to the sick through human skill, judgment, and hands.

This vocation is framed by the Two Kingdoms distinction, which guards medicine from both sacral overreach and secular despair. In the right-hand kingdom, God grants forgiveness, creates faith, and saves through Word and Sacrament. In the left-hand kingdom, God preserves through ordinary means. The practitioner

therefore does not administer salvation but participates in preservation. It is not Gospel ministry per se, yet it is unmistakably divine service to the neighbor. This distinction authorizes faithful presence in institutions that may not confess the Lord. It also forbids both theocratic confusion (turning the hospital into a quasi-church) and separatist abandonment (withdrawing as though God did not rule there).

The *theologia crucis* thus directs where believers are to look for God. He is not found in mastery, prestige, or triumph, the *theologia gloriae*, but *sub contrario*, under the contrary appearance of weakness and suffering. In the clinical setting, this means that Christ is not only present in the victories of recovery. He is most surely encountered precisely where contemporary professional culture is tempted to perceive failure or futility. Such places include the noncompliant patient, the terminally ill, the cognitively impaired, the disabled child whose condition does not improve, and the ICU patient who dies despite heroic intervention. At the bedside, then, two mysteries converge: God actively preserves life through the clinician, who serves as a mask of divine agency, while Christ remains hidden in the patient, the least of these.

4.3 Clinical Praxis: Faithful Presence at the Bedside

This identity yields a via media between the twin distortions of modern bioethics. For example, because practitioners are stewards, not lords, they are not bound to extend biological life at all costs. Acceptance of medicine's limits is not abandonment of care but fidelity to one's vocation. It is a refusal to torture the dying with burdensome interventions to prove one's zeal. Comfort, presence, and proportionate means are the order of love for the neighbor in whom Christ suffers. Thus, in every clinical setting, and most acutely in the ICU, every patient's life is precious because their worth is determined by their *imago Dei*, not by their physical abilities.[44]

Moreover, because the King calls the least his "brothers" (Matt 25:40), no life is too burdensome or "low quality" to merit care. Calculation that downgrades the unproductive, the disabled, or the aged contradicts both the creational dignity bestowed *extra nos* and Christ's self-identification in the weak. Non-abandonment becomes a non-negotiable norm. Here, palliative care, symptom management, and companionship must be pursued vigorously, even when a medical cure is impossible.

These moral refusals are not merely negative. Rather, they open the door for faith to be active in love through tangible service to one's neighbor. For example, turning, bathing, charting, and listening are the sorts of unglamorous acts transfigured into sacred moments characterized by worship of God. In them, the Lord's preserving rule is enacted through the vocation that clinicians bear. Likewise, these acts are the daily liturgy of love rendered to the Creator who redeemed his children in the waters of their baptism.

Furthermore, medical professionals build, plant, heal, and pray within institutions that may neither confess nor recognize the Lord. There, they seek the institution's true *shalom* without capitulating to its idols. Where policies coerce formal cooperation in wrongdoing, conscience resists. Conversely, where material cooperation can be ordered to the genuine good of the patient, vocation perseveres. The posture is neither conquest nor retreat but faithful presence.

Practicing medicine within this theological framework is to inhabit the clinic with joyful vocational confidence. Practitioners need not manufacture their worth, curate spiritual heroics, or grasp for salvific outcomes. Their vocational office is given, their neighbor's dignity is declared, and their Creator is ever-present. As they come alongside the patient, medical professionals serve the King, even as he serves the patient through his children. The *theologia crucis* dismantles illusions of power and trains the eyes of faith to recognize the Messiah precisely where the world averts its gaze. The Two Kingdoms remind clinicians that Babylon is not beyond God's rule. He preserves life there through his children's hands.

5.0 Addressing Potential Objections

The theological vision articulated in this essay, which is anchored in the *imago Dei*, the exilic call to seek Babylon's *shalom*, and the clinician's role as *larva Dei*, offers a robust framework for faithful medical practice amid secular pressures. Nevertheless, this approach invites legitimate critique, particularly given its insistence on sustained engagement with institutions that often undermine human dignity through reductive anthropologies. Two primary objections emerge: one centered on moral complicity and the other on perceived ineffectiveness. Addressing them directly is essential not only to affirm the model's coherence but also to render it viable for practitioners navigating real-world tensions with confessional fidelity.

5.1 The Complicity Objection

A central concern revolves around maintaining a clear conscience. Does working in a hospital that allows elective abortions, euthanasia, or the commodification of embryos implicate the clinician in those acts? If secular medicine resembles a contemporary Babylon, does accepting its structures, including its payroll, protocols, and shared facilities, compromise one's witness to the Gospel?[45]

This anxiety is valid, as the risk of ethical drift or rationalized compromise looms large. Yet Lutheran theology provides a clarifying response. Mere proximity to evil does not equate to participation in it. Jeremiah's directive to "seek the peace of the city" (Jer 29:7) is bounded by God's law, not Babylon's norms, compelling believers to advance genuine flourishing, that is, life's preservation and healing, without endorsing the city's distortions.

The Two Kingdoms doctrine sharpens this insight. In God's left-hand kingdom, where temporal order is maintained through flawed human institutions, Christians labor amid sin's pervasive effects, knowing that absolute purity in civic structures is unattainable short of heaven. Insisting on a sin-free workplace would require total disengagement from society, a stance Paul rejects: "for then you would have to leave the world" (1 Cor 5:10). Faithful vocation thus entails enduring evil's presence while refusing to perpetrate it, distinguishing between passive tolerance and active wrongdoing.

This discerning posture draws on the traditional distinction made in section 3.3 between formal and material cooperation, rooted in Catholic moral theology and adapted here to Lutheran vocational principles. To expand on what was stated earlier, formal cooperation is any act in which one intentionally assists or shares in the immoral purpose of another's wrongful action. It entails aligning one's will with the evil, whether explicitly (by approving or endorsing it) or implicitly (by intending the evil as a means to some other end, even if not the primary goal).

Doing so involves more than mere physical involvement. The decisive factor lies in the intention or consent of the mind and will. This form of cooperation is always morally illicit because it constitutes a direct participation in sin, making the cooperator complicit in the principal agent's wrongdoing. In Lutheran terms, as this framework implies, it would betray the clinician's role as *larva Dei* by concealing the human distortion of the *imago Dei*.

By contrast, material cooperation involves providing aid or resources that contribute to an evil act without sharing in the immoral intention. This can be further subdivided into immediate (directly enabling the act, such as supplying instruments for an illicit procedure) or mediate (more remote, such as general administrative support in a facility). Immediate material cooperation is typically wrong, while mediate forms may be permissible if there's a proportionate reason (for example, the good achieved outweighs the harm, and no better alternative exists) and the cooperation is not scandalous.

Lutheran ethics ultimately returns to the question: "Can I, in good conscience before God, continue in this role while remaining faithful to my vocational calling to love my neighbor?" The practitioner therefore asks not only, "Is my cooperation material or formal?" but also, "Can I still serve my neighbor faithfully in this context, or have the institution's demands so compromised my vocation that remaining would require acting against conscience?"

Consider a relevant application of the exilic model involving a clinician who is committed to preserving life, whether a hospitalist, intensivist, or outpatient physician. This person may work in a setting where policies sometimes allow life support to be withdrawn unilaterally against a patient's known wishes, even when

such withdrawal is not medically beneficial. In such a setting, the practitioner may materially cooperate in a remote and unavoidable way, for example, by providing routine general care for other patients in the same ICU. However, he must refuse formal cooperation, for example, by personally administering lethal sedation or directly facilitating the morally objectionable terminal extubation.

Intentionally aiding an intrinsically evil act (formal cooperation), such as directly performing or endorsing an elective abortion, remains forbidden, as it aligns one's will with sin. However, contributing to an institution's legitimate healing work while avoiding illicit practices (material cooperation) can be licit when oriented toward the neighbor's good. For instance, an obstetrician delivering healthy babies in a facility that also terminates pregnancies is not complicit in those terminations. Rather, he/she embodies a counter-witness to life's sanctity precisely where it is most contested. Yet this engagement has firm boundaries. When policies mandate direct involvement in grave wrongs, such as requiring a physician to prescribe lethal drugs, the clinician must prophetically resist, invoking conscience protections or even accepting professional costs. In such cases, the *larva Dei* must not veil demonic ends. Presence in Babylon demands vigilance, ensuring that service to the city advances God's preservation, not its perversion.

5.2 The Ineffectiveness Objection

While the complicity objection worries about ethical contamination, this second critique questions the practical impact within medical settings. Is "faithful presence" merely a spiritualized surrender to the status quo? In a bioethical arena dominated by autonomy and utility, does emphasizing personal integrity and patient care forfeit the power to drive institutional reform?[46]

This charge overlooks both the left-hand kingdom's scope and Scripture's model of influence. Systemic advocacy has value, but the Bible prioritizes the transformative force of lived fidelity over programmatic overhauls. As Peter urges, believers should conduct themselves honorably among unbelievers so that "even though they slander you as evildoers, when they observe your noble deeds, they may glorify God" (1 Pet 2:12). In medicine, this means pursuing excellence that subverts utilitarian norms. It is seen when a clinician treats a "low-utility" patient with profound dignity, or when an ICU nurse offers unwavering compassion instead of rushed triage. These acts present a tangible alternative to impersonal healthcare frameworks. When repeated daily, they erode ideological strongholds more effectively than abstract arguments alone.

Furthermore, this critique is often rooted in an over-realized eschatology. This refers to the expectation that Christians are responsible for bringing about the fullness of God's kingdom through human effort and political power. Lutheran theology, however, rejects such a notion as an impossible burden.[47] It views med-

ical professionals not as saviors tasked with redeeming history, but as instruments through whom the Creator acts to preserve and heal. Their primary calling is to faithful practice: to diagnose, treat, and advocate for their patients with excellence.

The broader impact, whether involving policy reform or saving a single life, is entrusted to the Lord's providence. In this way, the practitioners' work, especially in settings of intense brokenness like a hospital ICU, fulfills a biblical mandate to resist evil and cultivate peace (*shalom*) within a fallen world. Even if the system itself remains unchanged, and even if individual acts of care seem overwhelmed by bureaucratic pressures, the vocation remains sacred because it is commanded by God and participates in his left-hand rule of preservation. This accords with a Lutheran theology of the Cross, in which God's power is hidden *sub contrario* (under its apparent opposite). Here, his purposes are fulfilled not through the visible triumph of clinicians, but through their faithfulness amid marginalization and suffering. This cruciform perspective frees them from the burden of outcome-based success.

In essence, these two objections, when met with theological clarity, reinforce rather than undermine the framework advocated in this essay. Faithful presence in secular medicine is neither naive nor futile but a divine commissioning. Clinicians are empowered to serve with integrity, hope, and the assurance that their "labor is not in vain in the Lord" (1 Cor 15:58).

6.0 Conclusion

This final section synthesizes the essay's core argument, demonstrating how the three foundational biblical texts converge to form a coherent Lutheran framework for medical ethics. Grounded in the *imago Dei*'s bestowed dignity, the exilic mandate to seek Babylon's *shalom* (peace), and the clinician's identity as *larva Dei* (mask of God), this framework charts a course between sectarian withdrawal and secular assimilation. The result is a model of faithful presence that equips medical professionals with vocational confidence, empowering them to serve with integrity and hope within secular institutions. When applied across all areas of clinical practice, such as routine visits, inpatient care, and the ethically intense crucible of the ICU, this framework clarifies why every patient matters, regardless of prognosis or productivity. To serve in these spaces is to bear witness to a foundational truth that human dignity is divinely bestowed, not earned.

6.1 Synthesis of the Argument

This essay has articulated a Lutheran framework for medical practice by exegeting three biblical texts through confessional lenses. Genesis 1:26–27 grounds human dignity in God's creative fiat, not in fluctuating capacities or social utility. The

Hebrew *tselem* (image), which is drawn from the royal iconography of the ancient Near East, designates every person as the Lord's representative on earth. This alien dignity remains inviolable across all conditions, resisting bioethical models that tether worth to autonomy or productivity. The Creator's declaration of "very good" (v. 31) roots clinical judgment in a divinely given reality that precedes and transcends all human performance.

Jeremiah 29:4–7 situates this dignity within the context of vocation. God commands the Jewish exiles to seek Babylon's *shalom* (comprehensive welfare) through constructive engagement. Read through the Two Kingdoms doctrine, this mandate legitimizes medicine as a left-hand kingdom calling, where God preserves life through civil structures and reason, even when his authority is unacknowledged. Such engagement avoids both sectarian withdrawal and theocratic confusion, enabling clinicians to serve faithfully without conflating temporal preservation with eternal redemption.

Finally, Matthew 25:31–46 discloses the mystery that Christ identifies with the "least of these." Through the theology of the Cross and Luther's *larva Dei* motif, the practitioner becomes an instrument of divine care, encountering the Messiah hidden in vulnerability rather than in strength or success. These texts converge: the *imago Dei* defines the patient's identity; the exilic mandate locates the institutional arena; and the *larva Dei* concept clarifies the medical professional's role. Together, they orient clinical practice toward the neighbor's authentic good, rejecting both vitalism's absolutization of biological life and utilitarianism's conditional valuation.

6.2 The Distinctive Contribution

The above framework offers a principled alternative to two common distortions among clinicians navigating secular bioethics. Sectarian withdrawal (constructing insulated healthcare enclaves) misreads the Two Kingdoms distinction, treating left-hand structures as inherently adversarial and thereby forfeiting opportunities for neighbor-love and public witness. Secular assimilation, however, absorbs prevailing ethical paradigms with minimal theological critique. It privileges institutional harmony over doctrinal fidelity and erodes anthropology until professional decisions mirror those grounded solely in either utility or autonomy.

The Lutheran approach put forward in this essay charts a different course, namely, an engaged presence shaped by confessional clarity. The Two Kingdoms doctrine authorizes participation in secular systems while safeguarding one's conscience against all forms of coercion. The *imago Dei* secures an anthropological baseline that resists any reduction to functional metrics. The theology of the Cross trains practitioners to discern God's work in hidden forms, countering cultural impulses to marginalize the impaired or burdensome.

This model operates constructively rather than defensively. It anchors vocational confidence in God's own commissioning rather than in personal accomplishment, and it offers a quiet yet compelling form of witness. In this framework, reverent care for the vulnerable expresses an anthropology that surpasses capacity-based reasoning, prompting colleagues to reexamine the foundations of their ethical commitments. Ultimately, this vision locates medical ethics and clinical interventions within God's providential work of preservation, especially by presenting every provisional healing as a sign and foretaste of eschatological restoration.

The 2017 *Bioethics* special issue on the *imago Dei* offers a valuable discussion partner for the distinctly Lutheran framework presented in this essay.[48] Specifically, Mark Cherry contrasts secular capacity-based theories with a stable ontology of the *imago Dei*, establishing it as the necessary ground for human flourishing.[49] Bryan Pilkington further defends the normative force of dignity, countering skeptics by framing the human person through the lenses of mystery and vocation.[50] Meanwhile, John Kilner critiques the standard account of attributes to emphasize humanity's fundamental connection to and need for God.[51] The present essay's Lutheran framework aligns with these authors' shared consensus that human worth is an alien dignity received rather than an attribute achieved. Here, though, the application is further refined through the doctrine of the Two Kingdoms. Also, it distinguishes the institutional setting of the ICU as part of God's left-hand rule, where he preserves life through civil means, reason, and the vocation of the neighbor.

Furthermore, this treatise's application of the Lutheran motif of *larva Dei* (the mask of God) offers a concrete mechanism for the bioethical import the above authors seek. Indeed, the clinician's routine acts, such as bathing, monitoring, and medicating, are portrayed as the very means by which God cares for vulnerable image-bearers. This is especially true in high-stakes healthcare settings like the ICU, where patient autonomy is often compromised. Such a vocational stance allows the practitioner to navigate between the extremes of vitalism and utilitarianism by prioritizing faithful presence over curative success. Consequently, this Lutheran account acts as a complement to the work of Cherry, Pilkington, and Kilner. The essay affirms their doctrinal foundations while providing the specific public-theological grammar necessary for clinicians to operate faithfully within secular institutions.

6.3 Final Exhortation

Clinical professionals participate in the Church's mission by exercising their vocation as a distinct sphere of God's created order. For example, in the ICU, where autonomy is diminished, technology sustains life, and human frailty is most evident, the practitioner confronts both the remarkable capacities of medical science and the unyielding boundaries of human mastery. Here, theology is not an abstraction but a matter of lived faith.

Rather than conceding the medical field to supposed neutrality or to a secular opposition to faith, clinicians recognize it as a place where God is at work through human vocation. In their daily tasks, they become instruments through whom the Lord's preserving care is extended to his creatures. Within this calling, the practitioner bears witness to several enduring theological realities: that God upholds and preserves life through creaturely means; that human dignity, grounded in creation and redemption, remains intact despite decline and dependency; and that the Messiah's compassionate presence is mirrored in the attentive, merciful care given to the suffering.

Furthermore, while acknowledging that the healthcare system's structural limits fall under God's left-hand rule of civil governance, the Church continues to resist every "Babylon" that seeks to constrain the proclamation of the Gospel. This witness is expressed less through explicit evangelism than through faithful practice. Such includes refusing to abandon the vulnerable, recognizing worth beyond productivity, and meeting institutional pressures with principled steadiness. Such actions help sustain order, restrain harm, and promote human flourishing in a fractured world. In the ICU, as in all clinical encounters, the *imago Dei* is not an abstract concept but a tangible reality. Every patient matters because they bear the image of God, and in serving them, clinicians serve Christ himself.

For those weighed down by ethical complexity or vocational fatigue, this framework offers a resilient grounding. Service within secular institutions is not a compromise but a genuine calling. Each encounter is dignified by the patient's bearing of the *imago Dei* and by Christ's hidden presence, even as structural shortcomings fall under God's left-hand rule. In this way, clinicians are summoned to pursue *shalom* with confident hope. They neither idealize nor despair of their efforts but trust that their provisional care anticipates the eternal wholeness of the "Holy City, the New Jerusalem, coming down out of heaven from God, prepared as a bride adorned for her husband" (Rev 21:2).

To the clinical professional reading these words, remember that your work is sacred, your vocation is God-given, and your patient bears the image of the One who created all things. You need not choose between professional excellence and theological fidelity, or between institutional belonging and confessional integrity. Serve faithfully where God has placed you, seek the *shalom* of your city, and trust that the Lord who calls you sustains you, even, and especially, in "Babylon."

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Notes

1. In this essay, unless the context dictates otherwise, general terms for healthcare professionals—such as clinical practitioners, physicians, nurses, therapists, and chaplains—specifically refer to Christians serving in medical vocations.
2. Common ethical challenges in the ICU include determining death by neurologic criteria (commonly referred to as "brain death"), managing disputes over potentially inappropriate or non-beneficial treatments, and supporting patients and families through complex, high-stakes end-of-life decisions. For an accessible exploration about the ethical dimensions of these issues, see Atul Gawande's *Being Mortal: Medicine and What Matters in the End* (New York: Metropolitan Books, 2014), chapters 6 ("Letting Go") and 7 ("Hard Conversations").
3. See David Hansen, Silviya Aleksandrova-Yankulovska, and Florian Steger, "Ethical Analysis of the Change of Values in Healthcare," *Nursing Ethics* 32, no. 6 (2025): 1926–39. https://doi.org/10.1177/09697330251319374; Michael Igoumenidis, "Utilitarianism: A Nursing Perspective," in *Key Concepts and Issues in Nursing Ethics*, ed. P. T. Leino-Kilpi et al. (Cham, CH: Springer, 2024), 117–34, https://doi.org/10.1007/978-3-031-54108-7_8.
4. See Elliot Marseille and James G. Kahn, "Utilitarianism and the Ethical Foundations of Cost-Effectiveness Analysis in Resource Allocation for Global Health," *Philosophy, Ethics, and Humanities in Medicine* 14, no. 1 (2019): 1–7, https://doi.org/10.1186/s13010-019-0074-7.
5. See Paul Ramsey, *The Patient as Person: Explorations in Medical Ethics*, 2nd ed. (New Haven: Yale University Press, 2002). In this work, Ramsey critiques the reductive anthropology that equates human worth with functional capacity or aggregate utility. Rather than conceiving the physician-patient relationship as a contract (one grounded in the patient's autonomy or social value), Ramsey locates the moral center of medicine in covenant fidelity. This framework requires physicians to remain faithful to the intrinsic dignity of the "patient as person," specifically protecting those who lack the power of self-determination. In doing so, Ramsey offers a durable ethical alternative to the opposing excesses of medical paternalism and the modern fixation on autonomy. See also Kar-Fai Foo et al., "Fostering Relational Autonomy in End-of-Life Care: A Procedural Approach and Three-Dimensional Decision-Making Model," *Journal of Medical Ethics*, published online March 25, 2024, https://doi.org/10.1136/jme-2023-109818; Matthew Tieu and Steve Matthews, "The Relational Care Framework: Promoting Continuity or Maintenance of Selfhood in Person-Centered Care," *The Journal of Medicine and Philosophy* 49, no. 1 (February 2024): 85–101, https://doi.org/10.1093/jmp/jhad044. These recent studies corroborate Ramsey's insight that an ethics grounded solely in individual independence is inadequate for protecting the vulnerable. While translating his covenantal vision into the contemporary language of "relational autonomy" and "person-centered care," they preserve the same moral architecture: the protection of the self through the loyal, sustaining commitments of others.
6. See the discussion in section 3.1 dealing with Luther's treatise, *The Babylonian Captivity of the Church*, where he employs "Babylon" as a prophetic image representing oppressive or corrupt power; Martin Luther, *Word and Sacrament II*, ed. Helmut T. Lehmann, vol. 36, in Luther's Works, American Edition, vols. 1-30, ed Jaroslav Pelikan (St. Louis: Concordia Publishing House, 1955-76); vols. 31-55, ed. Helmut Lehman (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–). Luther distinguishes between an ecclesial "Babylon," characterized by a false Gospel, and a civic "Babylon," denoting the idolatrous structuring of temporal life. In this essay, the term is used as a diagnostic metaphor rather than as a blanket condemnation of modern medicine or healthcare institutions.

7. See Thomas Donaldson, "Human Flourishing, the Goals of Medicine and Integration of Palliative Care Considerations into Intensive Care Decision-Making," *Journal of Medical Ethics* 50, no. 8 (July 2024): 539–43, https://doi.org/10.1136/jme-2023-109299; Christopher O. Tollefsen and Farr A. Curlin, "Solidarity, Trust, and Faith in the Doctor-Patient Relationship," *Bioethics* 27, no. 1 (April 2021): 14–29, https://doi.org/10.1093/cb/cbaa022.

8. See Ana S. Iltis, "(Re)-Emerging Challenges in Bioethics: Leading Voices in Bioethics," *Bioethics* 28, no. 1 (2022): 1–10, https://doi.org/10.1093/cb/cbab017; William R. Smith and Robert Audi, "Religious Accommodation in Bioethics and the Practice of Medicine," *Journal of Medicine and Philosophy* 46, no. 2 (2021): 188–218, https://doi.org/10.1093/jmp/jhaa038 https://doi.org/10.1093/jmp/jhaa038.

9. This refers to a cultural and institutional context that disregards the Creator's lordship and fails to recognize the practitioner's divine calling to work within healthcare settings.

10. Medical practice within secular institutions is not a regrettable compromise but a proper, God-given vocation in the left-hand kingdom (as described below). It is ordered toward the neighbor's temporal good while confessing Christ's eternal lordship. Such involves ministering to one's neighbor in need through competent and compassionate care. This service stems from justification by grace alone, freeing clinicians to act not for personal merit but in self-giving love. Practitioners utilize the Creator's good gifts of reason and science while witnessing through deed, trusting that the Lord works through these means for the good of his creation. See Tyler J. Couch, "A Re-enchanted Response to a Communal Call: Toward a Understanding of Medicine as Vocation," *Bioethics* 25, no. 3 (2019): 331–52. https://doi.org/10.1093/cb/cbz008; Warren A. Kinghorn, "Health Care as Vocation? Practicing Faithfully in an Age of Disenchantment," *Bioethics* 25, no. 3 (2019): 257–65. https://doi.org/10.1093/cb/cbz009.

11. Unless otherwise noted, all Scripture quotations are taken from the Evangelical Heritage Version, © 2019 Wartburg Project, Inc. All rights reserved.

12. For an explanation concerning how the spiritual kingdom (conscience/faith) and temporal kingdom (law/governance) are distinct yet both under God's sovereignty, see Annette G. Aubert, "The Political Theology of Martin Luther," *Verbum Christi* 10, no. 1 (April 2023): 79–92, https://www.researchgate.net/publication/371877456_The_Political_Theology_of_Martin_Luther. For an explanation concerning how the distinction between the two kingdoms allows Christians to operate in the temporal realm (politics, society) using reason and law, while remaining grounded in the spiritual realm of grace, see He Danchun and Paulos Huang, "Martin Luther's Theory of 'Two Kingdoms' and Its Practical Dimension," *International Journal of Sino-Western Studies* 24 (2023): 11, https://doi.org/10.37819/ijsws.24.310.

13. See Hans-Peter Großhans, "Religion and Politics—From the Perspective of Lutheran Christianity," *Religions* 16, no. 12 (2025): 1–11, https://doi.org/10.3390/rel16121478; Roger A. Willer, "Religious Organizations and Government: An Ecclesial Lutheran 'Take'," *Dialog: A Journal of Theology* 62, no. 1 (2023): 41–50, https://doi.org/10.1111/dial.12797.

14. See endnote 20, which clarifies the difference between the spiritual dimension of the *imago Dei* (humanity's original righteousness, lost in the Fall) and the ontological or civic aspect (which Scripture affirms remains intact; Gen. 9:6; Jas. 3:9). Also, see Yechiel Michael Barilan, "*Imago Dei*," in *Encyclopedia of Jewish-Christian Relations Online*, ed. Walter Homolka et al. (Berlin: De Gruyter, 2023), https://doi.org/10.1515/ejcro.27835187; Roche Coleman, "The *Imago Dei*: The Distinctiveness of Humanity," *Old Testament Essays* 36, no. 3 (2023): 649–82, https://doi.org/10.17159/2312-3621/2023/v36n3a7; Dan Lioy, "Embodied Souls: Exploring Human Personhood in the Age of AI," *Verba Vitae* 2, no. 1 (March 28, 2025): 31–62, https://verba-vitae.org/index.php/vvj/article/view/36; Dan Lioy, "Created, Fallen, and Redeemed: A Lutheran Theological Anthropology for a Confused Age," *Verba Vitae* 2, no. 3 (November 1, 2025): 7–34, https://verba-vitae.org/index.php/vvj/article/view/63; Garikai Mufanebadza and Gift Masengwe, "*Imago Dei*: A Contemporary Theological and Hermeneutical Reflection," *HTS Teologiese Studies* / *Theological Studies* 81, no. 1 (2025): a10719, https://doi.org/10.4102/hts.v81i1.10719.

15. See Johan Cilliers, "The Absence of Presence: Homiletical Reflections on Luther's Notion of the Masks of God (*Larvae Dei*)," *Acta Theologica* 30, no. 2 (2010): 36–49, https://doi.org/10.4314/actat.v30i2.67262; Craig L. Nessan, "Vocation and Wellness: Baptism and Everyday Neighbors," *Word & World* 43, no. 3 (Summer 2023): 250–58, https://wordandworld.luthersem.edu/wp-content/uploads/pdfs/43-3_Vocation_and_Wellness/7_Vocation%20and%20Wellness%20%20Baptism%20and%20Everyday%20Neighbors.pdf.

16. See Peter J. Colosi, "Personalism versus Utilitarianism: An Analysis of Their Approaches to Love and Suffering," *The Linacre Quarterly* 87, no. 4 (November 2020): 425–37, https://doi.org/10.1177/0024363920948331; Maroš Šip et al., "Human Dignity in Inpatient Care: Fragments of Religious and Social Grounds," *Religions* 14, no. 6 (June 2023): 1–16, https://doi.org/10.3390/rel14060757.

17. For a comprehensive, systematic Lutheran account of the two-kingdoms (or two-realms) doctrine, see Joel Biermann, *Wholly Citizens: God's Two Realms and Engagement with the World* (Minneapolis: Fortress Press, 2017). Biermann argues that the two-realms doctrine calls us to active, responsible engagement in civic life rather than withdrawal or passivity. In this framework, secular vocations—including medicine—are understood as God-pleasing ways of loving one's neighbor, while maintaining a clear distinction between temporal goods and the eternal salvation given by grace through Christ alone.

18. See Alister E. McGrath, *Luther's Theology of the Cross: Martin Luther's Theological Breakthrough*, 2nd ed. (Malden, MA: Wiley-Blackwell, 2011). McGrath argues that the theology of the Cross is not a peripheral theme but the methodological foundation of Luther's early thought. It shaped his understanding of how God reveals himself through opposites (*sub contrario*), redefined the doctrine of justification, and informed pastoral practice. McGrath's primary conclusion is that Luther's "theological breakthrough" was a gradual, historically conditioned development whose enduring significance lies in grounding Protestant theology in the Cross as the sole locus of God's saving self-revelation and the source of the believer's righteousness.

19. The discussion in this section is a distillation of what appears in Dan Lioy, "The *Imago Dei*: Biblical Foundations, Theological Implications, and Enduring Significance," V*erba Vitae* 1, no. 3–4 (October 11, 2024): 45–72, https://verba-vitae.org/index.php/vvj/article/view/25.

20. It is imperative to distinguish between the spiritual dimension of the *imago Dei*, namely, original righteousness, which was forfeited in the Fall, and the ontological or civil dimension, which Scripture attests remains intact (Gen 9:6; Jas 3:9). Although humanity has lost its innate capacity to rightly fear, love, and trust the Creator, the ontological status of the human person as God's distinctive and authorized representative remains inviolable. This study concerns itself primarily with this latter dimension: the enduring structural reality that constitutes the theological foundation for both the divine prohibition of homicide and the universal moral imperative of care.
21. See Jacob R. Randolph, "Salvation and Speech Act: Reading Luther with the Aid of Searle's Analysis of Declarations," *Perichoresis* 15, no. 1 (2017): 101–16, https://doi.org/10.1515/perc-2017-0006. Randolph argues that Luther's theology of the Word is best understood as a performative declaration. According to this reading, God's speech (especially in the Gospel promise and in absolution) does not merely convey information but actively accomplishes what it declares, granting the very reality it signifies. By applying Searle's category of "declarations," Randolph demonstrates how scriptural proclamation and the Church's sacramental words establish new realities: sins are forgiven, faith is created, and believers are incorporated into Christ. Randolph stresses, however, that the efficacy of the Church's sacramental words derives from God's unique authority, not human convention. Within this framework, the creative "Let there be…" of Genesis 1 and the preached *promissio* represent the same kind of divine speech-act: God's sovereign, all-powerful declaration that creates, re-creates, and saves.
22. See Paul Anthony Hartog, "A Legacy Lost to the Reformed Imagination: Luther and Confessional Lutheranism on the Extent of the Atonement," *Religions* 15, no. 2 (2024): 228, https://doi.org/10.3390/rel15020228; Olli-Pekka Vainio, "Martin Luther and Justification," in *Oxford Research Encyclopedia of Religion* (Oxford: Oxford University Press, 2016), https://doi.org/10.1093/acrefore/9780199340378.013.336.
23. In keeping with what was noted in endnote 20, while both justification and the *imago Dei* share an *extra nos* (outside oneself) structure, they differ in kind. Justification is a forensic declaration that does not correspond to the believers' actual moral condition. They are simultaneously righteous and sinful. The *imago Dei*, in contrast, is an ontological reality that corresponds to humanity's created nature. People truly are God's image-bearers, not merely declared to be so in defiance of their actual condition. Both are gifts received rather than achievements, but justification concerns one's soteriological status before God, whereas the *imago Dei* concerns one's creational identity.
24. See Oswald Bayer, "Self-Creation? On the Dignity of Human Beings," *Modern Theology* 20, no. 2 (2004): 275–290, https://doi.org/10.1111/j.1468-0025.2004.00253.x; Leopoldo A. Sánchez M., "The Human Face of Justice: Reclaiming the Neighbor in Law, Vocation, and Justice Talk," *Concordia Journal* 39, no. 2 (Spring 2013): 117–132, https://issuu.com/concordiasem/docs/cjspring13.
25. See William G. Fredstrom, "Wendell Berry and Martin Luther on Creatureliness in a Technological Age," *Lutheran Quarterly* 39, no. 1 (Spring 2025): 1–20, https://doi.org/10.1353/lut.2025.a950806; Gilbert Meilaender, "Lutheranism as a Corrective," *Lutheran Quarterly* 38, no. 3 (Autumn 2024): 323–28, https://doi.org/10.1353/lut.2024.a936881.
26. See Brian H. Childs, "COVID-19 and Algorithmic Medical Ethics: A Perspective," *Review & Expositor* 119, no. 1–2 (2022): 33–40, https://doi.org/10.1177/00346373221133008; Gilbert Meilaender, "The Pandemic: Lessons for Bioethics?" *Hastings Center Report* 50, no. 3 (2020): 7–8, https://pmc.ncbi.nlm.nih.gov/articles/PMC7362133/.

27. See Gilbert Meilaender, "Comforting When We Cannot Heal: The Ethics of Palliative Sedation," *Theoretical Medicine and Bioethics* 39, no. 3 (2018): 211–220, https://doi.org/10.1007/s11017-018-9445-0; Michael W. Salemink, "The Sanctity of Life in the Lutheran Confessions," *Concordia Theological Quarterly* 87, no. 1 (January 2023): 75–82, https://ctsfw.net/media/pdfs/SaleminkSanctityofLifeintheLutheranConfessions.pdf.

28. For more on this point, see the discussion in section 4.0 dealing with Matthew 25:31–46.

29. See Jason T. Eberl, "Enhancing the *Imago Dei*: Can a Christian Be a Transhumanist?," *Bioethics: Non-Ecumenical Studies in Medical Morality* 28, no. 1 (April 2022): 76–93, https://doi.org/10.1093/cb/cbab016; Scott Stiegemeyer, "Theological Anthropology for Bioethics," *Dignitas* 30, no. 1 (2023): 13–21, https://www.cbhd.org/dignitas-articles/theological-anthropology-for-bioethics.

30. The discourse in this section has been informed by the exegetical and theological discussions of Jeremiah 29:4–7 appearing in the following: F. B. Huey, *Jeremiah, Lamentations*, vol. 16, The New American Commentary (Nashville: Broadman & Holman Publishers, 1993), 252–53; Gerald L. Keown, Pamela J. Scalise, and Thomas G. Smothers, *Jeremiah 26–52*, vol. 27, Word Biblical Commentary (Dallas: Word, Incorporated, 1995), 71–73; Jack R. Lundbom, *Jeremiah 21–36: A New Translation with Introduction and Commentary*, vol. 21B, Anchor Yale Bible (New Haven, CT/London, UK: Yale University Press, 2008), 350–53; J. A. Thompson, *The Book of Jeremiah*, The New International Commentary on the Old Testament (Grand Rapids, MI: Wm. B. Eerdmans Publishing Co., 1980), 546–47.

31. See Francis Brown, Samuel Rolles Driver, and Charles Augustus Briggs, *Enhanced Brown-Driver-Briggs Hebrew and English Lexicon* (Oxford, UK: Clarendon Press, 1977), 1022; F. J. Stendebach, "*šālôm*," in *Theological Dictionary of the Old Testament*, vol. 15, ed. G. Johannes Botterweck, Helmer Ringgren, and Heinz-Josef Fabry, trans. David E. Green (Grand Rapids, MI/Cambridge, UK: William B. Eerdmans Publishing Company, 2006), 37; James Swanson, *Dictionary of Biblical Languages with Semantic Domains: Hebrew (Old Testament)* (Oak Harbor, WA: Logos Research Systems, Inc., 1997).

32. Unlike Old Testament Israel, which had the Lord's prophetic pledge of an eventual return from Babylon (Jer 29:10), the Church does not await the reform of earthly regimes. Instead, the body of Christ looks forward to his second advent and the consummation of his eternal kingdom. This eschatological hope frees practitioners from triumphalism, namely, the belief that they must "Christianize" medicine. Likewise, this end-time expectation guards against despair, affirming that vocation-driven service to the neighbor remains faithful and worthwhile even when secular institutions do not change.

33. See "The Babylonian Captivity of the Church" in Martin Luther, *Word and Sacrament II*, ed. Helmut T. Lehmann, vol. 36 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–).

34. See Erik Herrmann, "The Babylonian Captivity (1520)," *Lutheran Quarterly* 34, no. 1 (Spring 2020): 71–81, https://doi.org/10.1353/lut.2020.0002.

35. As noted earlier, Luther, in *The Babylonian Captivity of the Church*, uses "Babylon" to name powers that confine the Gospel and burden consciences. This essay extends that image analogically to contemporary secular institutions.

36. See Robert Benne, *Ordinary Saints: An Introduction to the Christian Life* (Grand Rapids, MI: William B. Eerdmans Publishing Company, 2010), 171; J. Daryl Charles, *Our Secular Vocation: Rethinking the Church's Calling to the Marketplace* (Nashville: B&H Publishing Group, 2023), 287, 289; Paul R. Hinlicky, *Beloved Community: Critical Dogmatics after Christendom* (Grand Rapids, MI: William B. Eerdmans Publishing Company, 2015), 444–51.

37. This essay holds that elective abortion is a grave moral matter yet may be tragically necessary in rare and extreme circumstances. Such cases include situations where the mother's life is in immediate danger (such as ectopic pregnancy or severe preeclampsia) and acute fetal anomalies incompatible with life outside the womb when continuing the pregnancy threatens the mother's health or life. When such tragic situations arise, decisions should be made prayerfully, with pastoral guidance, medical counsel, and in humble reliance on God's mercy and the forgiveness offered through Christ's grace. See James T. Bretzke, S.J., "Beyond the Binary: Religious Bioethical Analysis of Post Dobbs Abortion Legislation," *Journal of the Society of Ethics* 44, no. 2 (Fall/Winter 2024): 267–82, https://doi.org/10.5840/jsce2024814111.

38. The categories of formal and material cooperation originate within Roman Catholic moral theology, particularly in the manualist tradition. Lutheran bioethicists, by comparison, tend to engage analogous moral questions through the theological frameworks of Vocation, the Two Kingdoms, and Conscience, rather than through the scholastic taxonomy of "cooperation." Nonetheless, Lutheran ethicists maintain that while direct participation in intrinsically evil acts (such as elective abortion or euthanasia) is fundamentally at odds with the faith, believers are often called to serve within imperfect and morally complex secular institutions. Fulfilling one's vocational responsibility to care for the neighbor often requires working within healthcare systems marked by ethical ambiguity. This engagement bears a functional resemblance to what Catholic moral theology designates as "material cooperation." See Jörg Hübner, "Contributions by Protestant Theology to Medical Ethics and Bio-Ethics in Germany," in *Medical Ethics and Bioethics: A German Perspective*, ed. Florian Steger (Cham, CH: Springer, 2022), 109–22, https://doi.org/10.1007/978-3-030-78036-4_7; James Thobaben, "The History of Medical Ethics," in *St Andrews Encyclopaedia of Theology*, ed. Brendan N. Wolfe et al. (August 7, 2024), https://www.saet.ac.uk/Christianity/HistoryofMedicalEthics. For more on these two types of involvement, see the discussion in section 5.1.

39. Seeking Babylon's *shalom* does not entail endorsing every institutional objective as genuine human flourishing. A central prophetic responsibility is to discern when institutional definitions of "patient welfare" or "quality of life" depart from authentic *shalom*. The practitioner pursues the true peace of the city, which may require resisting the city's own false definitions of peace. This guards against treating the mandate of Jer 29 as a blank check for institutional accommodation.

40. The discourse in this section has been informed by the exegetical and theological discussions of Matthew 25:31–46 appearing in the following: Craig Blomberg, *Matthew*, vol. 22, The New American Commentary (Nashville: Broadman & Holman Publishers, 1992), 375–80; R. T. France, *The Gospel of Matthew*, The New International Commentary on the New Testament (Grand Rapids, MI: Wm. B. Eerdmans Publication Company, 2007), 960–67; Jeffrey A. Gibbs, *Matthew 21:1–28:20*, ed. Curtis P. Giese, Concordia Commentary (Saint Louis: Concordia Publishing House, 2018), 1339–47; John Nolland,

The Gospel of Matthew: A Commentary on the Greek Text, New International Greek Testament Commentary (Grand Rapids, MI: William B. Eerdmans Publishing Company/ Carlisle, UK: Paternoster Press, 2005), 1024–37.

41. Although exegetical arguments often restrict Jesus' reference to "the least of these brothers" (Matt 25:40, 45) to his disciples, the Lutheran doctrine of vocation *coram mundo* (before the world) calls the Church to show mercy to all neighbors without distinction. Rather than narrowing the ethical scope, the recognition of Christ's hidden presence in the suffering neighbor deepens the summons to serve, as God employs human hands as his "masks" (*larvae Dei*) to care for creation. Within God's left-hand kingdom, the ICU (like other clinical settings and the home bedside) thus becomes a primary site of such neighbor-love, not a sphere beyond Christ's concern. Even when prudence advises against disproportionate treatment, mercy rejects both vitalistic excess and utilitarian neglect, steadfastly honoring the alien dignity of every image-bearer.

42. See David W. Loy, "Luther, Vocation, and the Search for Significance," *Lutheran Quarterly* 35, no. 1 (Spring 2021): 50–72, https://doi.org/10.1353/lut.2021.0004. Loy critiques modern, individualistic views on "purpose" and retrieves Luther's vocational theology, which is grounded in God's call, service to the neighbor, and the sanctification of ordinary relationships and labor. Also, see David Kristanto et al., "Hearing God's Call One More Time: Retrieving Calling in Theology of Work," *HTS Teologiese Studies*/*Theological Studies* 80, no. 1 (2024): 1–6, https://doi.org/10.4102/hts.v80i1.9703. The authors reengage Luther's teaching that everyday work is truly God's calling, dialogue with Calvin, Kuyper, and Volf, and argue that Luther's vocation framework remains essential for a contemporary theology of work.

43. See Dan Lioy, "Spiritual Care in a Medical Setting: Do We Really Need It?," *Global Journal of Classical Theology* 3, no. 2 (November 2002), https://www.galaxie.com/article/gjct03-2-04.

44. Clinicians distinguish between proportionate and disproportionate means to ensure that medical decisions faithfully serve the patient's genuine welfare. "Ordinary" means, such as nutrition when effective, are acts of stewardship that offer reasonable hope of benefit without imposing excessive burdens. "Extraordinary" means may be faithfully declined when they are futile or overly burdensome, recognizing that practitioners are free to acknowledge limits and not commanded to prolong the dying process indefinitely. This approach rejects both vitalism and utilitarian abandonment, grounding care in love for the neighbor as one created in the image of God (*imago Dei*). See Deanna A. Thompson, "A Gospel of Irresolution: Illness, Trauma, and Getting to Hope," *Dialog: A Journal of Theology* 61, no. 4 (2022): 341–48, https://doi.org/10.1111/dial.12775; Scott Stiegemeyer, "Disability and the Resurrection Body in Light of the Works of Flannery O'Connor," *Concordia Theological Quarterly* 84, nos. 3–4 (2020): 271–290, https://ctsfw.net/media/pdfs/StiegemeyerDisabilityAndTheResurrection.pdf.

45. See James M. Childs Jr., "Medical Assistance in Dying and the Trust of Faith," *Dialog: A Journal of Theology* 61, no. 4 (Winter 2022): 288–95, https://doi.org/10.1111/dial.12776; Daryl Pullman, "MAiD and the Death of Dignity," *Canadian Journal of Bioethics* / *Revue canadienne de bioéthique* 8, no. 4 (2025): 95–100, https://doi.org/10.7202/1121340ar.

46. See Robert Benne, "Martin Luther on the Vocations of the Christian," *Oxford Research Encyclopedia of Religion* (August 1, 2016), https://doi.org/10.1093/acrefore/9780199340378.013.363; Don Stiger, "'And Then There Were…None?' The

Future of Faith-Based Healthcare," *Caring Connections: An Inter-Lutheran Journal for Practitioners and Teachers of Pastoral Care and Counseling* 16, no. 3 (Winter 2019/2020): 3–39, https://lutheranservices.org/wp-content/uploads/2022/06/CaringConnections_2019_vol16_3.pdf.

47. See Joel D. Biermann, "The Star-Spangled Luther," *Concordia Journal* 50, no. 3 (Summer 2024): 13–24, https://concordiatheology.org/wp-content/uploads/2024/08/cjsummer2024.pdf; Kendall Davis, "Caesar Jesus? The Kingship of Jesus and Political Authorities in Luke and Acts," *Concordia Theological Quarterly* 88, no. 4 (October 2024): 347–66, https://www.academia.edu/126055014/Caesar_Jesus_The_Kingship_of_Jesus_and_Political_Authorities_in_Luke_and_Acts; Vitor Westhelle, "Martin Luther's Perspectival Eschatology," in *Oxford Research Encyclopedia of Religion* (Oxford University Press, August 31, 2016), https://doi.org/10.1093/acrefore/9780199340378.013.330.

48. "Created in the Image of God: Bioethics and the *Imago Dei*," special issue, *Bioethics* 23, no. 3 (December 2017), https://academic.oup.com/cb/issue/23/3.

49. Mark J. Cherry, "Created in the Image of God: Bioethical Implications of the *Imago Dei*," *Bioethics* 23, no. 3 (December 2017): 219–33, https://doi.org/10.1093/cb/cbx009.

50. Bryan C. Pilkington, "Putting Image into Practice: *Imago Dei*, Dignity, and Their Bioethical Import," *Bioethics* 23, no. 3 (December 2017): 299–316, https://doi.org/10.1093/cb/cbx012.

51. John F. Kilner, "The Image of God, the Need for God, and Bioethics," *Bioethics* 23, no. 3 (December 2017): 261–82, https://doi.org/10.1093/cb/cbx010.

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