A Serious Christian Journal of Life and its Significance

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Verba Vitae

A Serious Christian Journal of Life and its Significance

Verba Vitae is committed to bringing the classical Christian tradition into conversation with life issues now confronting us. Modeling the reasoned *logos* of the theological tradition, *Verba Vitae* explores the truth-claims made by thinkers and examines the grounds upon which these assertions are made.

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Introduction

Christian Medical Ethics in a Secular Medical Environment

Is medicine ever merely technical? What happens when questions of treatment and refusal, suffering and care, dependence and dignity, life and death move from abstract debate to the bedside, the intensive care unit, the clinic, the laboratory, the pastor's study, or the public square? How should clinicians, patients, families, pastors, and congregations respond when decisions must be made amid fear, uncertainty, and limited knowledge? And what do those decisions reveal about our understanding of the human person and the goods medicine exists to serve?

This summer issue of *Verba Vitae* takes up the theme "Christian Medical Ethics in a Secular Medical Environment." The essays and reviews gathered here neither retreat from the complexities of contemporary medicine nor substitute slogans for careful judgment. Instead, they invite readers to consider the goods medicine properly serves, the limits it must acknowledge, the suffering it can alleviate, and the persons entrusted to its care. Throughout the issue, particular attention is given to Lutheran resources for such reflection: vocation, the distinction between the Two Kingdoms, the theology of the cross, natural law, and the abiding confession that every human life is received from God and lived *coram Deo*.

Dan Lioy opens the issue by bringing the doctrine of the *imago Dei* into the intensive care unit, where human dignity can be obscured by sedation, machinery, incapacity, fear, and profound dependence. His essay insists that a loss of agency is not a loss of worth. Drawing on Genesis, Jeremiah, and Matthew, together with the Lutheran doctrines of vocation and the Two Kingdoms, Lioy interprets clinical service within secular institutions as faithful participation in God's preserving care. The clinician does not confer dignity upon the patient but serves a dignity already given by the Creator.

Dennis Bielfeldt's "Consent Is Not Enough" then examines both the moral achievements and the limitations of informed consent. Consent is indispensable because medical treatment ordinarily requires the authorization of the person upon

whose body medicine acts. Yet authorization alone cannot establish that the action is medically good or morally justified. Autonomy must therefore be situated within a richer account of the patient, the physician, the ends of medicine, and the responsibilities arising from embodied creaturehood. Choice matters, but it does not create the good; consent may permit an intervention, but it cannot by itself determine whether that intervention ought to occur.

Eric Brinkert's "Living Well and Dying Well" develops a constructive Lutheran framework for medical decision-making. Medicine is received as a gift and used as a tool, but it is not elevated into an absolute good before which every other good must yield. Treatment must instead be discerned in relation to the Christian's vocations, the responsibilities those vocations entail, and the goods they are ordered to serve. Such discernment resists both the rejection of medicine and the demand that medicine preserve biological life at any cost.

Roland Weisbrot turns from clinical decision-making to pastoral care in the face of euthanasia and medical assistance in dying. He attends carefully to the reasons people give for seeking death and to the fears that often lie beneath such requests: loneliness, suffering, loss of control, dependency, and the belief that one has become a burden. His essay asks how pastors may shepherd the faithful without minimizing suffering, abandoning moral clarity, or allowing the language of autonomy to obscure the neighbor's need for presence, consolation, and hope. The pastoral task is not merely to prohibit a course of action but to accompany the suffering person with truthful speech and enduring care.

Roni Grad brings the issue to the beginning of human life. His essay argues that the human zygote and preimplantation embryo must not be regarded merely as biological material, as instruments for other ends, or as entities whose worth depends upon later development or social recognition. The embryo is instead to be received as a neighbor whose life calls forth protection, love, and service. By bringing embryology into conversation with philosophical, legal, exegetical, and theological reflection, Grad presses the reader to consider what becomes of Christian neighbor-love when the neighbor is microscopic, hidden from view, and unable to make any claim in his or her own defense.

The two book reviews carry the issue's argument beyond its immediate clinical settings. Tony Seel's review of Jim Belcher's *Cold Civil War* considers whether a renewed public philosophy might resist political polarization and restore the possibility of meaningful civic deliberation. Although Belcher's book is not principally a work of medical ethics, Seel's attention to natural law, public reason, Christian witness, and the Lutheran doctrine of the Two Kingdoms bears directly upon the conditions under which Christian moral claims may remain intelligible within a secular society. Medical ethics is never isolated from the wider moral culture in which medicine is practiced.

Benjamin Parviz's review of Charles Camosy's *Living and Dying Well* returns explicitly to physician-assisted killing. Parviz commends Camosy's appeal for a counterculture formed by hospitality, dependence, presence, and compassion, while also identifying the need for Lutheran readers to ground such resistance more explicitly in their own biblical, sacramental, ecclesial, and vocational resources. Opposition to euthanasia cannot rest merely upon the assertion of a rule. It must take embodied form in communities capable of receiving dependency, accompanying suffering, and refusing to abandon those whose lives have become difficult, costly, or unproductive by the standards of the surrounding culture.

Readers will therefore find in these pages neither a rejection of medicine nor an uncritical embrace of every possibility medicine places before us. They will find arguments to test, distinctions to ponder, pastoral counsel to receive, cultural assumptions to examine, and theological resources to recover. The contributors share the conviction that Christian faith does not make medical ethics less rigorous but more fully attentive to the reality of the person; not less responsive to suffering but less willing to define the sufferer by suffering alone; not less engaged with secular institutions but more capable of serving faithfully within them.

Medicine remains a profound human good, but a penultimate one. It can diagnose and treat, relieve pain, restore function, accompany the dying, and preserve life. Yet technical capacity alone cannot tell us which lives possess value, what suffering means, or what human beings owe one another. For these questions, medicine requires an account of creation, moral obligation, human dependence, and final hope that it cannot generate from within its own practices.

May this issue of *Verba Vitae* lead its readers toward a richer understanding of life, medicine, and the neighbor before God. May it also strengthen clinicians, patients, families, pastors, and congregations to serve human life with wisdom and courage, to accompany suffering with compassion and truth, and to bear witness to the hope that neither illness, dependency, nor death can finally overcome.

Dennis Bielfeldt

General Editor, *Verba Vitae*

The *Imago Dei* in the ICU

Why Every Patient Matters

Dan Lioy

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.

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Consent Is Not Enough

Autonomy, the Ontology of the Patient, and the Vocation of Medicine

Dennis Bielfeldt

1.0 Consent as Moral Achievement and Moral Limit

The modern doctrine of informed consent represents a genuine moral achievement. Several histories converge in its development and should not be conflated. Research ethics was transformed by the Nazi medical experiments and by the deception and withholding of treatment in the United States Public Health Service study of untreated syphilis at Tuskegee. Clinical informed consent developed through partly distinct professional and legal challenges to undisclosed or coercive treatment. The common moral lesson is narrower than any single genealogy: expertise and benevolent intention do not confer unrestricted authority over another person's body. The patient or research subject must ordinarily be treated as a participant whose understanding and voluntary authorization precede intervention.[1]

That correction was morally necessary, and nothing argued here proposes its reversal. Patients must be told the truth about their condition. Material risks and reasonable alternatives must be disclosed. Their questions must be answered, their values taken seriously, and their refusals ordinarily honored. Coercion, manipulation, and deception remain genuine wrongs, even when employed in the name of therapeutic benefit. The physician's judgment that an intervention would be beneficial does not, by itself, establish the authority to perform it on an unwilling patient.

Consent was therefore a necessary corrective to a paternalistic medicine that could too easily confuse professional expertise with moral jurisdiction. The patient is not merely a biological substrate upon which the physician exercises technical skill. He is a participant in the clinical encounter, and what happens to his body cannot ordinarily be decided without him.

Yet moral achievements can be asked to do more than they can bear. A principle that corrects one distortion can generate another when detached from the larger moral

framework within which it first made sense. The present criticism is therefore not that contemporary bioethics uniformly declares autonomy supreme. It is that, in many clinical, legal, and institutional settings, authorization has come to function as though it were the principal source of an intervention's legitimacy rather than one indispensable condition among others.

The resulting difficulty is not that contemporary bioethics takes patient agency too seriously. It is that agency is sometimes construed too thinly, as the capacity to form preferences and authorize their implementation. Medicine can then appear as the provision of technically competent services to autonomous consumers, while the physician becomes chiefly the professional who supplies information and executes the authorized choice.

This transformation raises three fundamental questions. First, does a patient's consent make an intervention medically or morally good, or does it merely remove one important prohibition against performing it? Second, does the patient's authority to refuse an intervention entail an authority to demand an intervention from another moral agent? Third, what accounts for the dignity of patients who cannot exercise autonomy at all?

These questions disclose a problem more basic than disputes over the application of informed consent. An autonomy principle need not claim to be an ontology, and the criticism here is not that it fails to accomplish a task it explicitly undertakes. The criticism is one of insufficiency: an ethics that makes present agency carry the decisive moral burden must nevertheless presuppose an account of the subject whose agency it is. Autonomy cannot by itself explain who the patient is, why he commands equal respect, or why his life remains morally significant when the capacities associated with autonomous agency are diminished or absent.

The patient precedes the patient's choices. He remains the patient when he cannot deliberate, remember, communicate, or consent. To understand why requires distinguishing at least three questions that are often run together: numerical identity through change, basic moral status, and authority to make a particular clinical decision. A theory may answer one without answering the others. Medical ethics therefore needs an account of personal identity and dignity that does not reduce the person to the present exercise of a function, together with an account of medicine in which professional judgment has moral content.

In previous contributions to this journal, I have argued that intrinsic accounts of personal identity are inadequate and that the individuation of persons is grounded finally in the intentional love of God.[2] I have also argued that vocation names not merely an occupation but a more fundamental ontological condition: the creature is called into being, relation, and responsibility.[3] The present essay brings those arguments into the clinical setting.

Its central claim can be stated simply: consent is ordinarily necessary because the patient is a person, but consent is insufficient because the patient is more than a will. Medicine must honor agency without identifying the patient with agency, protect against paternalistic domination without erasing the physician's responsibility, and acknowledge that justice and the goods of medicine constrain what may be offered even when consent is present.

2.0 From Respect for Persons to the Ascendancy of Autonomy

2.1 The Moral Architecture of Modern Bioethics

The Nuremberg Code placed voluntary consent at the center of ethical research involving human subjects, but it also imposed substantive limitations concerning scientific necessity, avoidable suffering, proportionality of risk, and the responsibilities of investigators. Consent was essential, but even voluntary consent could not legitimate every experiment.[4]

The Belmont Report likewise did not identify respect for autonomy with the whole of research ethics. It articulated three principles: respect for persons, beneficence, and justice. Informed consent was the principal practical expression of respect for persons; assessment of risks and benefits expressed beneficence; and fair subject selection expressed justice. Respect for persons itself contained two requirements: autonomous persons were to be treated as agents, while those with diminished autonomy were entitled to protection.[5]

This architecture matters. Consent was not intended to replace judgments about benefit, harm, justice, or protection of vulnerable persons. It was one indispensable element within a moral field containing several goods and obligations. The consent of a vulnerable subject did not relieve the investigator of duties to minimize harm, justify risk, and distribute burdens fairly.

The Nuremberg Code and the Belmont Report concern research rather than ordinary clinical care, and they should not be treated as the sole genealogy of clinical informed consent. Their relevance here is analogical and architectural: both make clear that autonomous authorization operates within, rather than in place of, substantive norms. The history and theory of clinical consent likewise distinguish an autonomous act of authorization from the institutional procedures by which consent is documented.[6]

A similar balance appears formally in the principlist framework developed by Tom Beauchamp and James Childress. Their *Principles of Biomedical Ethics* organizes biomedical morality around four prima facie principles: respect for autonomy, beneficence, non-maleficence, and justice. No principle possesses automatic lexical priority; each requires specification and balancing in concrete circumstances.[7]

The central criticism should therefore not be that principlism formally declares autonomy supreme. It does not. The more accurate claim is that autonomy has acquired practical and cultural priority in the reception of a formally balanced framework, especially where institutions can measure authorization more easily than benefit, proportionality, trust, or justice.

The competent patient's refusal of treatment ordinarily has powerful negative authority even when the physician believes treatment would preserve life or prevent grave injury. This is often entirely appropriate. Yet the resulting asymmetry can encourage a conceptual migration: because intervention without authorization is ordinarily prohibited, authorization begins to look like what makes intervention legitimate. That inference does not follow.

2.2 From Kantian Autonomy to Preference Satisfaction

The modern elevation of autonomy has a serious philosophical pedigree, but the concept has changed in transmission. Kantian autonomy does not mean unrestricted preference satisfaction. It names the rational will's self-legislation under a law valid for rational agency as such. The autonomous agent is not one who does whatever he happens to desire, but one whose maxim can answer to universal moral law.[8]

No simple genealogy runs from Kant to contemporary consumer choice. Nevertheless, modern accounts that connect distinctive moral standing with rational self-government have sometimes encouraged later theories to locate personhood in sophisticated capacities for choice. Mill's defense of liberty contributes a different emphasis: competent adults should ordinarily be free to pursue their own good in their own way, provided that they do not harm others.[9]

Within contemporary clinical culture, these more demanding accounts of autonomy have often been thinned into the idea that the patient is the authoritative source of his own values and that respect consists principally in facilitating choices formed from those values. Autonomy gradually ceases to name rational self-government and comes to name the sovereignty of preference.

Onora O'Neill has rightly warned that contemporary appeals to autonomy often lack a sufficiently coherent account of what autonomy requires. Multiplying options does not necessarily increase genuine agency, and the formal provision of information does not by itself create understanding or trust. A patient may be offered several choices and still remain frightened, confused, socially isolated, or unable to discern how those choices bear upon the life he is trying to live.[10]

The reduction of autonomy to choice therefore mistakes the outward form of agency for its moral substance. It imagines that the task of medicine is complete once information has been transferred and an uncoerced preference expressed. But clinical decisions are not selections from a morally neutral menu. They concern the

good and ill of an embodied person, and they are made within a relationship in which knowledge, vulnerability, dependence, fear, hope, and professional responsibility are unequally distributed.

In some capacity-based accounts of personhood, the capacities associated with autonomy assume a status structurally analogous to that once assigned to the rational soul or the *imago Dei*: they become the decisive features by which full moral standing is recognized. The analogy is structural rather than genealogical. It does not imply that principlism simply reproduces theology under secular terms, but it does disclose the extraordinary ontological burden placed upon capacities that can be absent, impaired, or intermittently exercised.

Contemporary accounts of relational autonomy rightly object that agency is neither formed nor exercised by isolated wills. Feminist, disability, and care-ethical treatments emphasize that social power, bodily dependence, family relations, material conditions, and practices of recognition can sustain or deform self-direction.[11] This correction matters clinically: a choice may be formally voluntary while shaped by dependency, stigma, fear, or institutional constraint. Yet relational autonomy remains primarily an account of agency and its social conditions. It does not by itself settle the prior question of why this embodied person retains equal moral standing when agency cannot presently be exercised or restored.

2.3 Engelhardt and the Procedural Settlement

H. Tristram Engelhardt Jr. drew the procedural implications of modern pluralism with unusual clarity. In a society of 'moral strangers,' he argued, no thick account of the human good possesses authority for everyone through secular reason alone. In the absence of a shared moral vision, permission becomes the nonviolent basis for coordinated action.[12]

The strength of Engelhardt's position lies in its honesty. If no common account of human flourishing exists, the authorization of the persons involved appears to offer the only nonviolent basis for coordinated action. Consent becomes the bridge across moral difference. The physician need not endorse the patient's values; it is enough that the physician disclose what he can provide and that the patient authorize what is done.

Yet a procedural settlement inevitably shapes the institutions it governs. When medicine is organized chiefly around permission, questions about what medicine is for can become subordinate to questions about who has authorized what. This is not a logical consequence of consent itself, but a recurrent institutional temptation: beneficence becomes thin, professional judgment becomes technically informative but morally reticent, and the clinical encounter begins to resemble a contract between provider and consumer.

Leon Kass and others have described one possible outcome as the transformation of medicine into a service industry.[13] The criticism should not be directed at patient-centered care as such. It concerns a specific reduction: the physician possesses techniques, the patient supplies preferences, and ethical adequacy is measured chiefly by accurate disclosure and voluntary selection.

This picture is understandable in a pluralistic society, but it is not morally neutral. It contains an anthropology and a philosophy of medicine. The patient appears principally as a chooser, the physician principally as a provider, and medicine principally as a collection of techniques awaiting authorized use. What the picture suppresses is precisely what must now be recovered: the patient's embodied and dependent existence, the physician's continuing moral agency, and the substantive goods toward which medicine is properly ordered.

3.0 Why Consent Is Not Enough

3.1 Authorization and Justification

The first limitation of consent is normative: consent authorizes, but it does not by itself justify. In the influential analysis of Faden and Beauchamp, informed consent in its primary moral sense is an autonomous authorization of a professional's action. Authorization changes who may act and upon what terms; it does not settle every feature of the action authorized.[14]

Authorization answers an important question: has the person whose body and life are directly implicated agreed to the proposed intervention? A negative answer will ordinarily prohibit proceeding. A positive answer, however, does not establish likely benefit, proportionality of risk, justice of access, fidelity to medicine's ends, or the moral permissibility of the clinician's participation.

The distinction can be illustrated outside medicine. Consent may transform what would otherwise be an assault into a permitted physical interaction, but it does not make every consensual act prudent, just, or good. Two people can agree to something degrading, exploitative, dangerously reckless, or injurious to others. The presence of consent changes the moral description of the act, but it does not exhaust that description.

The same is true in medicine. A patient's authorization can remove the wrong of unauthorized bodily intervention. It cannot create therapeutic benefit where none exists, convert a gravely disproportionate risk into a reasonable one, or transform an act foreign to medicine's goods into a medical good. Professional ethics accordingly continues to require physicians to recommend and provide interventions that are scientifically grounded and medically appropriate in light of the patient's goals.[15]

This does not mean that physicians possess comprehensive authority over the patient's good. The physician is not the ruler of the patient's life and cannot claim

expertise concerning every moral, familial, religious, or existential question that bears upon a decision. Medical beneficence must be bounded. The physician's proper concern is the health-related good of this embodied patient: truthful diagnosis, appropriate treatment, healing where possible, palliation where cure is impossible, relief of suffering, protection from medically caused harm, and accompaniment through illness and dying.

Within that bounded sphere, however, the physician's judgment remains genuinely moral. He is not merely predicting consequences for a patient who alone supplies all value. He is discerning whether a proposed act can reasonably be ordered toward the goods constitutive of medicine. Consent cannot substitute for this judgment because it answers a different question.

3.2 The Asymmetry between Refusal and Demand

A central confusion arises when the authority to refuse is treated as symmetrical with a general authority to demand. The two are related exercises of agency, but they generate different kinds of claims.[16]

The authority to refuse ordinarily follows from bodily integrity and from the patient's status as the person upon whom the intervention would be performed. A medically advisable procedure may not ordinarily be imposed upon a decisionally capable patient who rejects it. The physician may explain, warn, persuade, and seek to understand, but may not simply erase the patient's agency because he believes the choice unwise.[17]

The authority to prevent another person from acting upon one's body does not by itself entail authority to compel another person to act. Refusal establishes a limit upon intervention. A positive request makes a claim upon another agent, a professional practice, institutional resources, and sometimes third parties. Such claims may be valid, but they require grounds supplied by medical appropriateness, professional obligation, contract, emergency duty, or justice; they are not generated by preference alone.

A decisionally capable patient may refuse an antibiotic that would probably cure an infection. It does not follow that the same patient may require an antibiotic for a condition in which it offers no benefit. A patient may decline surgery because its burdens conflict with a tolerable life. It does not follow that he may require surgery the physician judges medically destructive. The right not to be treated is not a general right to compel treatment on one's own terms.[18]

This asymmetry is obscured when medicine is understood through the model of consumer choice. Consumers ordinarily select among goods offered for sale, and providers are expected to supply the selected product if contractual conditions are met. But the physician-patient relationship is not adequately described by this model. The physician is not the proprietor of a morally neutral inventory. He is a responsible participant in a practice whose skills are ordered toward characteristic goods.

Shared decision-making therefore involves two moral agents, not one chooser and one instrument. The patient brings knowledge of his history, burdens, commitments, fears, and hopes. The physician brings clinical knowledge, practiced judgment, and an obligation to recommend only what he believes can responsibly serve the patient's health-related good. A legitimate decision must respect both agencies. The patient need not accept what the physician recommends, and the physician need not perform whatever the patient requests.

3.3 Capacity and Moral Status

The second limitation is ontological. Autonomy is an activity of a subject; it cannot by itself explain the subject whose activity it is. Decision-making capacity, moreover, is decision-specific, can fluctuate, and is not identical with basic moral status.[19]

The difficulty becomes clearest in infants, persons with profound cognitive disabilities, patients in a coma, those undergoing acute psychosis, and persons in advanced dementia. Surrogate decision-making, advance directives, substituted judgment, and best-interest standards are indispensable, but their very existence reveals that the patient's moral significance does not depend on presently exercisable autonomy.[20]

The Belmont Report acknowledged this point when it joined respect for autonomous agency with the duty to protect persons whose autonomy is diminished. But what grounds the latter duty? Why is diminished autonomy a reason for increased protection rather than reduced moral concern?

Principlism can assign such patients to the domains of beneficence and non-maleficence, but that classification does not yet explain why their good matters. Beneficence is owed to someone. Before one can determine what benefits the patient, one must already recognize the being before us as a patient whose good commands attention.

The problem becomes acute in theories that connect personhood or the strength of a claim to continued life with capacities such as self-consciousness, rational deliberation, future-directed preference, or psychological connectedness.

Singer distinguishes membership in the human species from personhood and associates the latter with rationality, self-consciousness, and awareness of oneself through time. Tooley makes a concept of oneself as a continuing subject, together with a corresponding desire to continue existing, central to a serious right to life. McMahan offers a more complex embodied-mind account, but the strength of time-relative interests in continued life varies with psychological unity. These theories differ materially and should not be collapsed into one another.[21]

They nevertheless share a family resemblance relevant here: the strength of the claim not to be killed is indexed wholly or substantially to psychologically sophisticated functioning or connectedness rather than to the enduring identity of the embodied human being.[22]

The shared difficulty lies not in one disputed threshold but in the kind of criterion doing the moral work. The criteria are scalar, episodic, and vulnerable to interruption. A newborn, an adult under anesthesia, a patient with dementia, and a fully self-conscious adult differ dramatically in the capacities named by these theories.

If the moral claim of each depends upon the present strength of those capacities or upon the degree of psychological connectedness to a future self, equal human dignity becomes something to be reconstructed after the fact rather than something the theory can straightforwardly affirm.

These positions should not simply be labeled Kantian. Kant's moral philosophy cannot be reduced to contemporary functionalist criteria of personhood, and his account of duties concerning vulnerable human beings is more complex than such a genealogy sometimes suggests. The narrower and more defensible criticism is that modern functionalist appropriations of autonomy treat the capacities associated with agency as the basis of moral status rather than as activities of beings whose status is already given.

Once capacity bears this weight, moral equality becomes unstable. Capacities occur in degrees. Human beings differ radically in memory, intelligence, self-awareness, rational consistency, communicative ability, and control over their circumstances. If dignity is grounded in the degree to which such capacities are present, it becomes difficult to explain why dignity itself does not also occur in degrees.

Our most defensible clinical judgments presuppose that diminished function does not erase the patient. The person with advanced dementia may no longer remember family, formulate a life plan, understand a diagnosis, or recognize himself as the author of past choices. Yet he does not become a less proper object of care.

Disability and dementia scholarship has also shown that agency can persist at its margins through valuing, affective attachment, relationship, and responsiveness, even when full decisional capacity is absent.[23] One's dependence intensifies obligations; it does not dissolve them.

Autonomy-centered frameworks can accommodate this judgment through protection, beneficence, relational agency, or prior wishes. The narrower claim is that autonomy alone does not ground it. Medical ethics still requires an account of the being whose capacities vary, whose history remains one history, and whose good continues to matter through those variations.

3.4 Why a Richer Account Need Not Restore Paternalism

At this point an obvious objection arises. If consent is not the foundation of medical morality, and if physicians may appeal to objective medical goods, does the argument not simply restore the paternalism that informed consent rightly overcame?

The objection must be taken seriously. 'The patient's good' can conceal professional self-interest, institutional convenience, racial or disability bias, cultural

prejudice, and failure to listen. Medical history and contemporary disparities give abundant reason to distrust any account that places unrestricted interpretive authority in professional hands.

But rejecting autonomy as the master principle does not require returning to unilateral medical rule. The alternatives are not consumer sovereignty and professional sovereignty. A richer medical ethics places limitations on both patient demand and physician power.

The patient ordinarily retains authority to refuse. The physician must disclose relevant facts, give reasons, acknowledge uncertainty, invite questions, attend to disability and cultural perspectives, and distinguish clinical judgment from personal preference. Second opinions, ethics consultation, institutional review, legal protections, and mechanisms of appeal are not external annoyances; they are disciplines of fallible professional authority.

At the same time, the physician cannot be required to abandon judgment in order to prove that he has abandoned paternalism. Refusing to perform an intervention is not equivalent to imposing one. A physician who declines to provide what he judges harmful, futile, or incompatible with the goods of medicine has not thereby taken control of the patient's body. He has declined to make his own agency and skills instruments of the requested act.

The corrective to paternalism is not moral silence but responsible deliberation. It is a relationship in which neither party disappears: the patient is not reduced to a body, and the physician is not reduced to a tool.

The argument must therefore move from the limits of consent to the more basic question that both parties' responsibilities presuppose: who the patient is. Only an ontology of the patient can explain why agency must be honored without becoming the measure of worth, and why professional judgment must serve rather than dominate.

4.0 Who Is the Patient?

4.1 The Patient as Embodied Creature

The preceding critique establishes what an adequate ontology of the patient must accomplish. It must account for the patient's identity and moral significance before, during, and after the exercise of autonomous choice. It must explain why vulnerability and dependence do not diminish dignity. And it must resist both the reduction of the patient to biological mechanism and the reduction of the patient to disembodied will.

Christian theology begins by identifying the patient as an embodied creature. This is not a decorative theological description appended to a bioethical argument. It makes a specific ontological claim. To be a creature is to exist as the recipient of

a life one did not originate and cannot finally secure. Existence is received before it is exercised. The person acts, chooses, creates, and assumes responsibility, but none of these activities explains why he exists in the first place.

The language of autonomy easily obscures this givenness. The autonomous self appears as the author of its purposes, the source of its values, and the proprietor of its body. But the body is not first a possession over which an otherwise disembodied will exercises sovereignty. The body is the concrete form in which the person exists. The patient does not merely *have* the body that is sick; the patient is bodily present in and through the illness.

Gilbert Meilaender, drawing upon Hans Jonas, has observed that living beings do not exist as rocks do, simply and fixedly identical with themselves. Organisms maintain themselves through metabolic exchange with an environment; their identity is enacted through dependence, activity, receptivity, and exposure to dissolution. Human life intensifies rather than escapes this creaturely structure. We live through bodies that require food, shelter, touch, language, culture, and the care of others.[24]

In *Bioethics and the Character of Human Life*, Meilaender presses the ethical significance of this creatureliness. Human life has a character that is received rather than manufactured by choice. We are begotten rather than made, born into bodily histories and relations we did not select, and sustained by exchanges with others that no assertion of independence can abolish. The self is in this sense ecstatic: it lives outside itself in bodily dependence, temporal continuity, and bonds of obligation that precede reflective authorization.

This account exposes the abstraction involved in treating the patient as a self-contained will. Autonomy is real, but it is exercised only within an embodied life already given and sustained through relations of dependence. Meilaender thus supplies a powerful phenomenology and moral theology of creaturely life. Yet the account does not by itself provide a complete criterion of numerical identity: it shows why embodied dependence belongs to personal existence, but not finally why this patient remains this same person through radical psychological discontinuity. The extrinsic account developed below takes that further metaphysical step.

This creaturely structure bears directly upon the clinical relationship. Illness does not introduce dependence into an otherwise self-sufficient life; it intensifies and discloses a dependence that was always present. The person who becomes a patient discovers that the ordinary transparency of embodiment has been interrupted. The body no longer recedes into the background of action but imposes itself through pain, weakness, fear, limitation, and the need for assistance.

The clinical encounter begins in this asymmetry. One person appears in need, while another possesses knowledge and skills relevant to that need. The vulnerability is real, and precisely because it is real the patient requires protection against

domination. But vulnerability is not a defect that cancels personhood. It belongs to the creaturely condition within which personhood is lived.

The patient is therefore neither pure biology nor pure will. A reductive naturalism sees an organism whose malfunctioning mechanisms require repair. A voluntarist autonomy model sees a chooser whose body becomes the site upon which preferences are implemented. Christian anthropology sees an embodied creature: a living unity whose body, relations, history, agency, dependence, and destiny cannot be morally separated.

This creaturely account also limits medicine. Because life is received rather than manufactured, medicine cannot promise mastery over finitude. It can heal many diseases, relieve much suffering, extend life, and restore significant forms of function. It cannot remove creatureliness or turn mortality into a technical error. A medicine that treats death as the final failure of technique will either over-treat the dying or redefine death as a problem to be administered according to preference. A medicine that recognizes creaturely finitude can distinguish abandonment from the acceptance of limits and can remain faithful when cure is no longer possible.

4.2 The Patient as a Relationally Constituted Person

The patient is also a relationally constituted person. This claim must be stated carefully. It does not mean that social recognition creates personhood. If the person's identity depended upon recognition by family, community, or state, the isolated, unwanted, forgotten, and abandoned would possess the least secure claim to dignity. Social relations reveal and sustain much of human identity, but no human community possesses authority to create or extinguish the person.

The claim is instead that personal identity cannot finally be grounded in an inventory of intrinsic properties. Bodily continuity, psychological continuity, and theories of an immaterial soul each illuminate something important, but none can by itself explain the identity of this person across radical change.

The psychological criterion, classically associated with Locke and elaborated in contemporary form by Parfit, locates personal identity or what matters in identity in overlapping continuities of memory, intention, character, and consciousness.[25] This account appears congenial to an autonomy-centered ethics because it connects the person with the narrative structure of values and choices.

Yet the clinical consequences are troubling. The patient in advanced dementia may exhibit only fragmentary psychological continuity with the person who earlier formed an advance directive. Memories have disappeared, dispositions have altered, relationships are no longer recognized, and future-directed projects can no longer be conceived. If psychological continuity constitutes the person, the status of the present patient in relation to the earlier author of the directive becomes uncertain.

Bodily continuity avoids some of this difficulty, but it also appears insufficient as a complete theory of personal identity. The body changes throughout life, and the appeal to an immaterial soul faces the question of what individuates one soul from another. An appeal to bare haecceity may name rather than explain the individuality at issue.[26]

The failure of intrinsic accounts does not entail that persons are unreal. It suggests that personal identity is fundamentally relational. The decisive question is not simply what properties the person possesses but in what individuating relation this person stands.

I have argued elsewhere that the intentional love of God supplies the uniquely specifying relation required for individuation.[27] God does not love humanity merely as an undifferentiated kind. God intends and loves particular persons. This relation is not elicited by the person's current properties and does not disappear when those properties alter.

This proposal develops an extrinsic criterion of individuation. Identity is grounded not in a property enclosed within the person but in the uniquely specifying divine relation in which the person stands. God's intentionality does not merely recognize an individuality already fully constituted elsewhere; it establishes and sustains the creature as the particular creature he is.

An objection must be anticipated. If divine love were elicited by rationality, self-consciousness, usefulness, or any other qualifying property, the appeal to God would simply reproduce graded dignity at a higher level. God would love more fully where the relevant capacities were more fully present.

But that is not the order of explanation proposed here. God does not first discover an independently constituted bearer of sufficient capacities. Nor does God then confer regard in proportion to those capacities. The divine intention is individuating. By intending this creature as this one, God establishes and sustains the relation in virtue of which the creature is this person. Capacities manifest the life of the person; they neither solicit nor measure the love that secures his identity.

The fuller defense of this claim belongs to the earlier argument concerning extrinsic individuation. Its implication for the present essay is narrower but decisive: divine love is not a response to person-making capacities. It is the relation within which the particular person and all his changing capacities are held together.

Applied to medicine, the implications are direct. The patient with dementia remains the same patient not because sufficient memories have survived, not because he can still narrate his life, and not because others happen to recognize him. He remains this patient because the divine intention by which he is this person has not altered. His capacities may diminish; the relation that grounds his identity does not.

Extrinsic individuation does not deny psychological or narrative discontinuity. The patient in advanced dementia may possess desires, affective responses, and forms of awareness markedly different from those of the earlier agent who executed an advance directive. These are differences within the history of one person, not evidence of numerically distinct subjects.

Three questions must remain distinct. Extrinsic individuation answers the numerical question of why these changing phases belong to one person. The doctrine of creation and divine love grounds equal dignity. Neither conclusion by itself decides how a prior directive should govern a present clinical situation. That question requires practical judgment about precedent autonomy, present experiential interests, residual capacities to value, burdens of treatment, and the fiduciary responsibilities of surrogates.[28]

The same applies to the infant who has not yet developed rational agency, the unconscious patient who cannot manifest it, and the cognitively disabled person who may never exercise it in conventionally recognizable ways. They are not potential, former, or marginal persons. They are particular embodied creatures whose identities do not await the emergence of a qualifying function.

4.3 The Patient before God

The theological language that gathers these claims is *coram Deo*: the person exists before God.

The patient stands before God prior to standing before physician, hospital, family, insurer, court, or state. This priority is ontological, not merely chronological. It means that no human system confers the patient's ultimate worth. Medical institutions may recognize or fail to recognize that worth; legal systems may protect or violate it; families may cherish or neglect it. None creates it.

The *coram Deo* dimension of existence names the givenness of life. Address precedes achievement. God's creative address does not respond to the creature's accomplishment; it calls the creature into being. The person's dignity therefore cannot be contingent upon successfully displaying independence, rationality, social usefulness, self-awareness, or control.

The doctrine of the *imago Dei* expresses this dignity but should not itself be reduced to a capacity. If the image were identified exclusively with rationality, dominion, moral agency, or relational performance, it would appear most securely in those who exercise those functions most successfully. A theology adequate to vulnerability understands the image as God's relation to and intention for the whole embodied creature.[29]

Robert Kolb's exposition of Luther's definition of the human creature clarifies the point. The human being is not defined first by an isolable faculty and only afterward

placed into relation with God. The creature is understood theologically through the whole posture of trust, love, and creaturely dependence before the Creator. Reason, will, dominion, responsibility, and social relation genuinely manifest human life in God's image. They are not threshold properties by which an otherwise indeterminate organism earns admission to personhood.

The image therefore belongs to the whole person in the concrete unity of embodied life and divine address. The infant does not bear the image merely in anticipation of future rational agency, and the patient with advanced dementia does not retain only a damaged remainder of it. Each is the creature whom God addresses, sustains, and calls into relation. Differences in functional capacity are clinically and morally relevant, but they are differences within an equality that those capacities do not create.

The patient's standing *coram Deo* has a corresponding *coram hominibus* dimension. Life before God does not terminate in private spiritual consolation. The creature addressed and loved by God appears before other creatures as a neighbor. The divine relation grounds human responsibility rather than replacing it.

The movement from one relation to the other is not an inference from divine valuation to an externally added ethical rule. It belongs to the social form of creaturely existence itself. God's address locates persons among other persons. The command to love the neighbor specifies how life received from God is to be lived in the world. The other's need does not create his dignity, but it makes a concrete claim upon the gifts, offices, and opportunities entrusted to those who encounter him.

The clinical encounter is one such relation of entrusted responsibility. The sick person appears before the physician not merely as the bearer of preferences. He appears as a neighbor whose vulnerability addresses the physician's knowledge and skill. Conversely, the physician does not become responsible only after a contractual request has generated an obligation. He already stands within an office whose capacities are ordered toward the service of precisely such need. The ontology of the patient and the vocation of the physician are therefore correlative: the one whom God sustains as this person is given to the physician as this neighbor.

This does not erase the patient's agency or convert illness into passivity. The patient remains an agent called to speak, question, deliberate, consent, refuse, and receive care within the limits of his condition. But the moral relation is deeper than an exchange between two sovereign wills. It is a meeting of embodied creatures whose unequal knowledge and vulnerability place them under different, though reciprocal, responsibilities.

The patient before the physician is therefore someone to whom more is owed than technical competence or procedural recognition. He is owed truthful attention to his embodied condition, protection against exploitation, proportionate care, relief

of suffering where possible, and continued presence when technical success is no longer available.

This account is explicitly theological and does not pretend that secular public reason compels assent to divine individuation or *coram Deo* existence. The argument is therefore layered. Philosophical and clinical considerations establish that autonomy presupposes a subject, capacities occur in degrees, authorization does not justify every act, and medicine cannot function without judgments of appropriateness and good. Theology offers a fuller account of why these claims cohere: identity and dignity rest in a relation that precedes every variable human capacity. The theological layer should deepen public reasons, not substitute confession for the work of argument.

5.0 What Is Medicine?

5.1 Medicine and the Health-Related Good of the Patient

An adequate account of the patient requires a corresponding account of medicine. If the patient is an embodied creature rather than a preference-bearing will, medicine cannot be understood merely as the technical implementation of authorized choices.

Edmund Pellegrino argued that medicine possesses an internal morality arising from the distinctive structure of the clinical encounter. A person made vulnerable by illness seeks assistance from one who professes relevant knowledge and skill; the profession is a public promise to use those capacities for the patient's good.[30]

The appeal to internal goods is contested. Critics have argued that Pellegrino's account risks treating medicine's ends as an ahistorical essence and have proposed an evolutionary internal morality whose goals and duties are interpreted through the history of practice and common morality. The modest claim required here does not depend upon a frozen essence. It is that medicine's ends are corrigible but not infinitely plastic: a practice cannot become any technically possible service without losing the distinctions by which it remains medicine rather than engineering, commerce, punishment, or personal assistance.[31]

The good at issue must be described neither too narrowly nor too expansively. Medicine is not concerned only with biological function considered apart from the person. The restoration of a physiological measure can be medically pointless or even burdensome when detached from the condition of the whole patient. Yet medicine is also not responsible for producing human flourishing in its entirety. Physicians do not possess comprehensive authority over the patient's religious commitments, familial duties, political identity, ultimate happiness, or conception of the good life.

Medicine is ordered toward the health-related good of the embodied person. This includes truthful understanding of the patient's condition, prevention of avoidable

disease, healing and restoration where possible, proportionate preservation of life and function, relief of pain and other forms of suffering, palliation, and faithful accompaniment when cure is no longer available.

These goods are objective without being mechanically determinative. Their application requires prudential judgment. Health is not always the patient's highest immediate good. A patient may reasonably decline a burdensome treatment in order to remain at home, preserve clarity for a final conversation, fulfill a religious obligation, or avoid extending the dying process. Recognizing medicine's internal goods does not mean that the physician's preferred clinical outcome always governs.

It means instead that medical action must remain intelligibly related to the goods that make it medical action. The physician must be able to say not merely that the patient requested the intervention, but why the intervention belongs to the practice of healing, palliation, prevention, or care.

Consent cannot create this relation. It can authorize a medically responsible option, select among several such options, or reject all of them. It cannot by itself make an act therapeutic.

5.2 Practices, Internal Goods, and Professional Virtue

Alasdair MacIntyre's account of practices provides a wider framework. A practice is a coherent and complex form of socially established cooperative activity through which goods internal to that activity are realized in pursuit of standards of excellence appropriate to it.[32] Internal goods differ from external goods such as income, prestige, institutional power, and market share.

Medicine is a practice in this sense. Diagnostic accuracy, clinical wisdom, technical excellence, proportionate therapy, truthful communication, and appropriate palliation are not simply products purchased by consumers. They are excellences internal to the activity of caring for the sick.

Practices require virtues because rules and techniques cannot anticipate every circumstance. The physician must possess dispositions enabling him to perceive and pursue the patient's good under conditions of uncertainty, competing obligations, emotional strain, institutional pressure, and personal inconvenience. Fidelity, honesty, compassion, practical wisdom, courage, humility, and justice are not optional personal decorations upon technical competence. They belong to competent medicine itself.

The consumer model threatens these goods from two directions. On one side, patient satisfaction can displace the distinction between what is desired and what is medically beneficial. On the other, institutional profitability and efficiency can turn both patient and physician into instruments of external goods. The autonomy

model may protect the patient from some forms of professional domination while leaving both parties exposed to market domination.

A patient can be offered many choices while the institution quietly determines which choices are affordable, reimbursable, legally convenient, or administratively efficient. Formal autonomy can coexist with severe practical dependence. Indeed, the language of patient choice can conceal institutional decisions by presenting structurally constrained options as though they were expressions of personal sovereignty.

Recovering the internal goods of medicine therefore protects both patient and physician. It allows the patient to ask whether an offered intervention genuinely serves his health-related good rather than merely generating revenue or avoiding liability. It allows the physician to resist pressures that would subordinate clinical judgment to institutional or consumer demand.

5.3 Medicine as Vocation

The Christian tradition adds a dimension not exhausted by the MacIntyrean account. The physician's calling is not only the consequence of entering a practice with internal goods. It is a vocation in the theological sense: a calling that comes from outside the self and places the physician in responsibility to God and neighbor.

Vocation does not name first what one chooses to do. It names what one is as a creature called into being and relation. The creature receives existence, gifts, circumstances, and neighbors that he did not create, and becomes responsible within those relations.[33]

The physician's vocation specifies this more fundamental creaturely calling. The knowledge and skills of medicine are received through education, discipline, tradition, institutions, teachers, patients, and the created intelligibility of the body itself. They are not private possessions to be deployed without moral limit. They are gifts entrusted for service.

The neighbor appears to the physician in the particular vulnerability of illness. The physician is called to attend to that vulnerability through truthful judgment, competent care, and compassionate presence. He does not serve because the patient has manufactured an obligation through preference alone. He serves because this patient has been given to him as a neighbor within the concrete responsibilities of medical practice.

The vocational account does not romanticize medicine. Physicians work for wages, institutions operate under economic constraints, and clinical relationships are often brief, fragmented, and technologically mediated. Vocation does not require pretending that these external realities do not exist. It requires refusing to let them define what medicine ultimately is.

Medicine remains vocation even within bureaucracy because the physician remains answerable for what he does. Institutional policy, legal permission, financial incentive, and patient request can shape action, but they cannot wholly transfer moral responsibility away from the acting physician.

The category of vocation therefore adds something that a practice-based account alone cannot supply. MacIntyre can explain how medicine contains internal goods and standards of excellence that become intelligible through participation in the practice. Vocation identifies the giver of the gifts, the neighbor for whose sake they are exercised, and the responsibility under which the practitioner stands even when the institutions of the practice become corrupt. The physician is not answerable only to the historically developed norms of a profession; he is answerable through that profession to God and to the neighbor whom the office exists to serve.

Luther's paradox in *The Freedom of a Christian* gives this vocation its evangelical form. Before God, the Christian receives identity and righteousness rather than producing them; before the neighbor, the same Christian is freed for active service. Applied analogically to medicine, the physician need not secure his worth through mastery, cure, prestige, or the successful defeat of death. Because his identity is received rather than achieved, he can attend to the patient without making the patient the instrument of his own professional self-justification.

In Lutheran language, God ordinarily cares for creatures through creaturely offices and callings. The physician can therefore be described as one of the *larvae Dei*, the masks through which God's preserving care reaches the neighbor in need.[34] The image does not canonize every medical act; it intensifies accountability, since a mask can fail in its office and an institution can deform the practice entrusted to it.

Vocation also bounds medicine. The physician is called to heal, palliate, counsel, and accompany; he is not called to overcome creatureliness, guarantee happiness, or deliver salvation through technique. Nor should illness itself be romanticized as though every affliction were a divinely assigned lesson. The vocational claim concerns the responsibility created by the neighbor's need, not the moral approval of the disease that occasions it. Precisely because sickness is an evil to be resisted where possible, the physician's gifts are summoned into service; precisely because mortality cannot finally be mastered, that service must remain faithful when technical victory is no longer available.

5.4 Professional Conscience: Integral but Disciplined

The autonomy-centered framework often describes a physician's moral resistance as 'conscientious objection,' as though professional obligation were settled by patient demand and conscience entered afterward as a private exception. A vocational account rejects that presumption: conscience is the first-person form of responsibility

for what one does. But conscience is neither infallible nor self-authenticating. It must be tested by evidence, professional competence, medicine's goods, equal regard for patients, and the duties voluntarily undertaken in entering the profession.[35]

A physician cannot act medically without judging what is being done, why it is being done, and whether he may responsibly participate. Professional formation and institutional deliberation may correct that judgment, but they cannot make the physician morally absent from his action.

Accordingly, neither conscience absolutism nor the claim that professional roles eliminate conscience is adequate. Legitimate protections may be conditioned by advance disclosure where possible, non-discrimination, emergency care, continuity of unrelated treatment, truthful explanation, and serious efforts to avoid abandonment or disproportionate burdens on patients and colleagues.[36]

5.5 Faithful Accompaniment

Medicine's vocation becomes especially visible when cure is impossible. A technical conception of medicine tends to understand the incurable patient as a case in which medicine has failed or has nothing further to offer. A consumer conception may then oscillate between technological escalation and the provision of whatever final option the patient requests.

Paul Ramsey's description of the patient as person points toward another possibility.[37] The physician's task includes accompaniment: remaining truthfully and compassionately present to a person whose illness cannot be conquered.

The patient who is dying does not cease to be the proper object of medicine because cure has become impossible. The ends of medicine are not exhausted by defeating disease. Relief of suffering, avoidance of disproportionate treatment, truthful preparation for death, and refusal to abandon the patient remain genuine medical goods.

This is where the difference between consent and care becomes clearest. A signed form cannot accompany anyone. Authorization cannot substitute for fidelity. Consent protects the patient against being acted upon without permission; it does not by itself supply the presence through which medicine remains humane.

6.0 Consent within a Richer Medical Ethics

6.1 Consent as a Practice of Deliberation

Once patient and physician are understood more adequately, informed consent can be recovered in a richer form. Consent is neither discarded nor demoted into irrelevance. It is returned to its proper function within a moral relationship already ordered toward goods that neither party creates by choosing them.

Informed consent should first be understood as a practice of communication and deliberation rather than a discrete legal event. The signature on a form may document consent, but it does not constitute understanding. Contemporary professional guidance likewise describes informed consent as a communicative process that culminates in authorization.[38]

Genuine informed consent requires disclosure, comprehension, voluntariness, and decision-making capacity. These are not achieved simply by transferring data. Information must be interpreted in relation to the patient's circumstances; probabilities must be communicated intelligibly; uncertainty must be acknowledged; and the physician must seek to understand what the patient believes the options mean.[39]

Deliberation differs from preference elicitation. Preference elicitation asks, "Which intervention do you want?" Deliberation asks, "What are we trying to accomplish, what goods are at stake, what burdens are proportionate, and which available course can responsibly serve this patient?"

The physician should not manipulate the patient toward a predetermined answer. But neither should he pretend to be indifferent. A recommendation is not a violation of autonomy when it is honestly offered, supported by reasons, responsive to the patient's circumstances, and open to question. Patients often seek physicians precisely because they need judgment, not merely information.

Shared decision-making is therefore not a compromise halfway between paternalism and consumer sovereignty. It is joint practical reasoning in which asymmetrical forms of knowledge are brought into conversation. The physician knows medicine in ways the patient does not; the patient knows the concrete life in which treatment will be received in ways the physician does not. Neither knowledge is dispensable.[40]

6.2 The Moral Sequence of Medical Authorization

A richer medical ethics distinguishes at least four questions that an autonomy-centered model can compress.[41]

1. Is the proposed intervention medically responsible? Does it bear an intelligible relation to the patient's health-related good? Is there reasonable evidence of benefit, and are risks and burdens proportionate?
2. Is the intervention responsive to this patient's goals, commitments, relationships, and understanding of acceptable burden? Patient values do not create medical benefit, but they are indispensable to judging what benefit means in this life.
3. Is the intervention morally and institutionally permissible? This includes professional integrity, justice, stewardship of scarce resources, and the interests of other persons who may be affected.

4. Has the patient or legitimate surrogate authorized the intervention after adequate disclosure and deliberation?

An affirmative answer to the fourth question cannot compensate for negative answers to the first three. Nor do affirmative answers to the first three compensate for the absence of the fourth. A medically responsible and morally permissible intervention may still not ordinarily be imposed upon a decisionally capable refusing patient.

These questions are not merely chronological steps. They are mutually informing dimensions of responsible action. Patient values affect the assessment of burdens and benefits; evidence shapes which options can honestly be offered; justice and professional commitments establish limits; and authorization completes rather than creates the moral intelligibility of the act.

6.3 Incapacity, Surrogacy, and Vulnerability

The richer framework is especially important when the patient lacks decision-making capacity. Advance directives, substituted judgment, and best-interest standards can preserve self-determination and guide care, but each has limits. Surrogate authority is fiduciary rather than proprietary, and the physician remains responsible for clinical judgment.[42]

Prior wishes ordinarily deserve serious, often presumptive, authority because they belong to the history of this patient and may express enduring values and critical interests. They should not, however, be treated as a disembodied sovereign ruling mechanically over a present dependent life. The classic debate between precedent autonomy and present interests shows why neither the earlier nor the current perspective can simply erase the other.[43]

The tension is clearest when a patient who once rejected life with disability later appears content, responsive, and relationally engaged. Dresser emphasizes the moral claims of the present person; Dworkin defends the authority of earlier critical interests; Jaworska shows that persons with dementia may retain capacities to value even after losing full decisional competence. A responsible judgment must attend to all three insights rather than reducing the case to a contest between an 'authentic' former self and an 'inauthentic' present one.[44]

A surrogate does not become proprietor of the patient's life. The surrogate is entrusted to interpret and protect the patient's good by considering known commitments, prior statements, present experience, residual agency, relationships, and proportionate medical interests.[45]

Best-interest judgments should also be freed from the suspicion that they are merely disguised paternalism. Some judgment of the patient's good is unavoidable whenever the patient cannot decide. The moral question is not whether such judgment

will occur but whether it will be disciplined by an adequate account of the person, transparent reasoning, clinical evidence, protection from conflicts of interest, and appropriate communal review.

The patient with diminished capacity is not respected by pretending that dependence does not exist. He is respected by receiving the protection, interpretation, and care appropriate to his actual condition. Equal dignity does not always require identical modes of decision-making. It requires that differences in capacity never become differences in fundamental worth.

6.4 The Limits of Requested Action

A richer doctrine of informed consent also clarifies the limits of patient request. The patient may challenge a physician's judgment, seek a second opinion, and refuse what is offered. But preference alone cannot establish the medical character, distributive priority, or moral legitimacy of an intervention.[46]

This conclusion does not depend upon resolving every contemporary controversy. It applies across the spectrum of medical practice. Requests for medically non-beneficial antibiotics, disproportionate surgery, unnecessary diagnostic testing, continued invasive treatment during irreversible dying, elective enhancement, assisted reproduction, abortion, and physician-assisted death raise different moral questions. They should not be collapsed into a single category.

What unites them is only the formal point that authorization cannot settle their substantive moral character. Each requires judgments concerning the nature of the act, medicine's ends, benefits and harms, justice, the interests of other affected persons, and the integrity of the professionals involved.

This formal limitation is important in pluralistic societies. It permits disagreement to be identified rather than concealed. When participants disagree about whether an intervention is healing, killing, restoring, mutilating, relieving suffering, or abandoning the vulnerable, the dispute concerns the description and moral reality of the act. It cannot be dissolved by observing that someone consents.

When a physician declines a requested act, refusal must be distinguished from abandonment. A defense of conscience does not permit arbitrary withholding of ordinary care, discrimination, concealment of relevant information, abandonment in an emergency, or contemptuous treatment. Nor does every clinical disagreement rise to conscience; many concern uncertain evidence or prudent interpretation of goals.[47]

Where the physician judges that an act would directly contradict medicine's goods or make him an agent of serious moral wrong, the demand for compliance requires justification. He remains obligated to communicate candidly, disclose foreseeable limits, provide emergency and unrelated care, and protect the patient against

abandonment. Institutions also bear responsibility to design access arrangements that do not treat either patient or clinician as morally negligible.[48]

The precise requirements of referral or transfer remain contested, particularly where referral is understood as intentional facilitation of the disputed act. Those disputes should be analyzed in terms of cooperation, burden, access, and continuity of care rather than hidden beneath slogans. What cannot be surrendered is the recognition that patient and physician remain moral agents.

Referral is therefore not automatically morally neutral, but neither is every transfer equivalent to direct performance. Its permissibility depends upon the nature of the act, the object and intention of the referral, the proximity of cooperation, available alternatives, the patient's vulnerability, and the professional's remaining duties.[49]

Consent is powerful within its proper domain. It marks the patient's participation, protects bodily integrity, and prevents the physician from substituting professional will for patient agency. It is powerless to convert moral disagreement into neutrality.

6.5 What the Richer Framework Protects

A medical ethics that situates consent rather than enthrones it protects several goods simultaneously.

It protects the patient's agency by maintaining the requirement of disclosure, understanding, voluntariness, and authorization. The physician cannot appeal to objective goods as a pretext for secrecy or coercion.

It protects vulnerable patients by grounding their dignity in something deeper than present decision-making capacity. The infant, the unconscious patient, and the person with dementia do not become peripheral cases within an ethics designed for independent choosers.

It protects the physician's agency by recognizing that medical professionals remain responsible for the acts they perform. Technical competence does not cancel moral accountability.

It protects medicine from reduction to commerce by distinguishing patient good from patient satisfaction and internal goods from institutional or market goods.

It protects the truthfulness of the clinical encounter by allowing physicians to say that not everything technically possible, legally permitted, or sincerely requested is medically wise.

Finally, it protects accompaniment. When neither cure nor preference satisfaction can resolve the patient's condition, the physician still has something to offer: competent palliation, truthful presence, and fidelity to the person who remains before him.

The fundamental distinction can therefore be stated again. Consent is ordinarily necessary because the patient is a person. He is not a passive object, and what

happens to his body demands his participation. Consent is insufficient because the patient is more than a will. He is an embodied creature whose life is received, a relationally constituted person whose identity survives radical changes of capacity, and a self who stands before God independently of every successful act of choice.

7.0 Conclusion

Modern informed consent emerged from a justified protest against the reduction of patients and research subjects to objects of professional expertise. The protest was right. Physicians and investigators do not acquire unrestricted authority over other persons by possessing knowledge, skill, or benevolent intentions. Patients must ordinarily understand and authorize what is done to them.

But an indispensable safeguard is not yet a complete moral foundation. Consent cannot explain by itself why the patient commands respect, why the patient who cannot consent remains fully within the moral community, what goods medicine properly serves, how justice limits choice, or why the physician remains responsible for acts the patient requests.

A more adequate medical ethics begins by recognizing that the patient precedes his preferences. Philosophically, this means distinguishing identity, status, capacity, authorization, and good. Theologically, it means confessing the patient as an embodied creature whose identity is sustained in the intentional love of God and whose dignity does not fluctuate with performance.

Medicine adequate to this patient must be more than a service industry. It is a practice ordered toward the health-related good of embodied persons and a vocation in which knowledge and skill are given for the service of vulnerable neighbors. Its goods include healing, truthful diagnosis, proportionate treatment, relief of suffering, palliation, and faithful accompaniment.

The physician who practices medicine as vocation does not rule the patient. He must listen, disclose, recommend, receive refusal, and remain accountable for the power conferred by expertise. But neither does he disappear into competent compliance. He remains a moral agent answerable for whether his actions serve the goods entrusted to medicine.

The physician's retained agency is therefore not a rival to the patient's dignity, but its vocational counterpart: the patient's identity calls forth responsible judgment in service of his good.

Consent belongs necessarily within this richer medical ethics. It protects bodily integrity and honors the patient's participation without constituting the whole. The patient entering the clinic is not first and finally a will but a creature—embodied, dependent, addressed, loved, and called—whose dignity the physician is summoned to serve.

The framework developed here should now be tested in focused treatments of medical aid in dying and the just allocation of scarce medical resources, where the relations among consent, professional vocation, vulnerability, and equal dignity come under especially severe pressure.

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Notes

1. 'The Nuremberg Code,' in *Trials of War Criminals before the Nuremberg Military Tribunals under Control Council Law No. 10*, vol. 2 (Washington, DC: United States Government Printing Office, 1949), 181–82; Centers for Disease Control and Prevention, "About the Untreated Syphilis Study at Tuskegee," updated September 4, 2024, accessed July 1, 2026, https://www.cdc.gov/tuskegee/about/index.html; Ruth R. Faden and Tom L. Beauchamp, with Nancy M. P. King, *A History and Theory of Informed Consent* (New York: Oxford University Press, 1986), chs. 3–6.
2. Dennis Bielfeldt, "Personal Identity, Divine Love, and Extrinsic Individuation," *Verba Vitae* 1, no. 3–4 (Autumn/Winter 2024): 21–44; Dennis Bielfeldt, "Gaining Clarity on the That and What of Life," *Verba Vitae* 1, no. 1–2 (Spring/Summer 2024): 39–52.
3. Dennis Bielfeldt, "Alienation, Vocation, and the Ontology of Life," *Verba Vitae* 3, no. 1 (Spring 2026): 39–58.
4. 'The Nuremberg Code,' 181–82. Its first principle declares voluntary consent essential, while the remaining principles impose substantive restrictions concerning scientific necessity, avoidable suffering, risk, and investigator responsibility.
5. National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research* (Washington, DC: United States Government Printing Office, 1979), https://www.hhs.gov/ohrp/regulations-and-policy/belmont-report/index.html. The report states that respect for persons includes both respect for autonomous agents and protection for persons with diminished autonomy.
6. Faden and Beauchamp, *History and Theory of Informed Consent*, chs. 7–10; Neil C. Manson and Onora O'Neill, *Rethinking Informed Consent in Bioethics* (Cambridge, UK: Cambridge University Press, 2007), chs. 2–4. Faden and Beauchamp distinguish informed consent as autonomous authorization from institutionally effective consent; Manson and O'Neill recast consent as a norm-governed communicative transaction.
7. Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 8th ed. (New York, NY/Oxford, UK: Oxford University Press, 2019).

8. Immanuel Kant, *Groundwork of the Metaphysics of Morals*, trans. and ed. Mary Gregor and Jens Timmermann, rev. ed. (Cambridge, UK: Cambridge University Press, 2012), 4:431–40.

9. John Stuart Mill, *On Liberty*, ed. Elizabeth Rapaport (Indianapolis: Hackett, 1978), 9–14.

10. Onora O'Neill, *Autonomy and Trust in Bioethics* (Cambridge, UK: Cambridge University Press, 2002), 28–48, 83–86.

11. Catriona Mackenzie and Natalie Stoljar, eds., *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self* (New York: Oxford University Press, 2000), 3–31; Eva Feder Kittay, "At the Margins of Moral Personhood," *Ethics* 116, no. 1 (2005): 100–131.

12. H. Tristram Engelhardt Jr., *The Foundations of Bioethics*, 2nd ed. (New York: Oxford University Press, 1996), 67–114. His later *The Foundations of Christian Bioethics* (Lisse, NL: Swets and Zeitlinger, 2000) explicitly abandons the expectation that secular reasoning can yield a content-full morality binding upon moral strangers.

13. Leon R. Kass, *Life, Liberty, and the Defense of Dignity: The Challenge for Bioethics* (San Francisco: Encounter Books, 2002), 1–40.

14. Faden and Beauchamp, *History and Theory of Informed Consent*, chs. 7–8; American Medical Association, Code of Medical Ethics, Opinion 5.5, "Medically Ineffective Interventions," https://code-medical-ethics.ama-assn.org/ethics-opinions/medically-ineffective-interventions. The AMA states that respect for autonomy does not require provision of an intervention merely because a patient or surrogate requests it.

15. American Medical Association, *Code of Medical Ethics*, Opinion 5.5, "Medically Ineffective Interventions."

16. See *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990), on the liberty interest of a competent person in refusing treatment; American Medical Association, Code of Medical Ethics, Opinion 5.3, "Withholding or Withdrawing Life-Sustaining Treatment," https://code-medical-ethics.ama-assn.org/ethics-opinions/withholding-or-withdrawing-life-sustaining-treatment, and Opinion 5.5, "Medically Ineffective Interventions," https://code-medical-ethics.ama-assn.org/ethics-opinions/medically-ineffective-interventions, accessed July 1, 2026. The ethical asymmetry defended here does not deny that positive entitlements can arise from emergency duties, contractual relationships, anti-discrimination law, or justice.

17. *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990); American Medical Association, *Code of Medical Ethics*, Opinion 5.3, "Withholding or Withdrawing Life-Sustaining Treatment."

18. American Medical Association, *Code of Medical Ethics*, Opinion 5.5, "Medically Ineffective Interventions."

19. American Medical Association, *Code of Medical Ethics*, Opinion 2.1.2, "Decisions for Adult Patients Who Lack Capacity," accessed July 1, 2026, https://code-medical-ethics.ama-assn.org/ethics-opinions/decisions-adult-patients-who-lack-capacity. Decision-making capacity is ordinarily assessed relative to the decision at hand and should not be confused with the patient's basic moral standing.

20. American Medical Association, *Code of Medical Ethics*, Opinion 2.1.2, "Decisions for Adult Patients Who Lack Capacity."

21. Peter Singer, *Practical Ethics*, 3rd ed. (Cambridge: Cambridge University Press, 2011), 73–105; Michael Tooley, 'Abortion and Infanticide,' *Philosophy & Public Affairs* 2, no. 1 (1972): 37–65; Jeff McMahan, *The Ethics of Killing: Problems at the Margins of Life* (New York: Oxford University Press, 2002).

22. Singer, *Practical Ethics*, 73–105; Tooley, "Abortion and Infanticide," 37–65; McMahan, *The Ethics of Killing*.

23. Kittay, 'At the Margins of Moral Personhood,' 100–131; Agnieszka Jaworska, "Respecting the Margins of Agency: Alzheimer's Patients and the Capacity to Value," *Philosophy & Public Affairs* 28, no. 2 (1999): 105–38.

24. Gilbert Meilaender, "Death in the History of Redemption," *Verba Vitae* 1, no. 1–2 (Spring/Summer 2024): 17–28, esp. 19; Gilbert Meilaender, *Bioethics and the Character of Human Life: Essays and Reflections* (Notre Dame, IN: University of Notre Dame Press, 2020), 1–20, 43–62; Hans Jonas, *The Phenomenon of Life: Toward a Philosophical Biology* (New York: Harper and Row, 1966), 80.

25. John Locke, *An Essay Concerning Human Understanding*, ed. Peter H. Nidditch (Oxford: Clarendon Press, 1975), bk. 2, chap. 27; Derek Parfit, *Reasons and Persons* (Oxford: Clarendon Press, 1984), 199–347.

26. Bielfeldt, "Personal Identity, Divine Love, and Extrinsic Individuation," 26–36. The argument there treats difficulties in bodily, psychological, and soul-based criteria, including the pairing problem for dualist accounts.

27. Ibid., 32–38; Robert C. Koons, "Divine Persons as Relational Qua-objects," *Religious Studies* 35, no. 4 (1999): 383–401.

28. Ronald Dworkin, *Life's Dominion: An Argument about Abortion, Euthanasia, and Individual Freedom* (New York: Knopf, 1993), chap. 8; Rebecca Dresser, "Dworkin on Dementia: Elegant Theory, Questionable Policy," *Hastings Center Report* 25, no. 6 (1995): 32–38; Jaworska, 'Respecting the Margins of Agency,' 105–38.

29. Bielfeldt, "Personal Identity, Divine Love, and Extrinsic Individuation," 38–43; Dan Lioy, "The *Imago Dei*: Biblical Foundations, Theological Implications, and Enduring Significance," *Verba Vitae* 1, no. 3–4 (Autumn/Winter 2024): 45–72; Robert Kolb, "Martin Luther's Definition of the Human Creature," *Verba Vitae* 2, no. 2 (Summer 2025): 41–62.

30. Edmund D. Pellegrino and David C. Thomasma, *A Philosophical Basis of Medical Practice: Toward a Philosophy and Ethic of the Healing Professions* (New York: Oxford University Press, 1981), 192–220; Edmund D. Pellegrino and David C. Thomasma, *For the Patient's Good: The Restoration of Beneficence in Health Care* (New York: Oxford University Press, 1988), 147–70; Edmund D. Pellegrino, "The Internal Morality of Clinical Medicine: A Paradigm for the Ethics of the Helping and Healing Professions," *Journal of Medicine and Philosophy* 26, no. 6 (2001): 559–79.

31. Franklin G. Miller and Howard Brody, "The Internal Morality of Medicine: An Evolutionary Perspective," *Journal of Medicine and Philosophy* 26, no. 6 (2001): 581–99. Their account criticizes essentialism while retaining goals and duties internal to clinical medicine.

32. Alasdair MacIntyre, *After Virtue: A Study in Moral Theory*, 3rd ed. (Notre Dame, IN: University of Notre Dame Press, 2007), 187–203.

33. Bielfeldt, "Alienation, Vocation, and the Ontology of Life," 40–47; Martin Luther, "The Freedom of a Christian," in *Luther's Works, American Edition*, vol. 31, ed. Harold J. Grimm (Philadelphia: Muhlenberg Press, 1957), 327–77.

34. Martin Luther, *Selected Psalms III*, ed. Jaroslav Pelikan, vol. 124, pp, 112-115 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–).; Kolb, "Martin Luther's Definition of the Human Creature," 41–62.

35. Daniel P. Sulmasy, "What Is Conscience and Why Is Respect for It So Important?" *Theoretical Medicine and Bioethics* 29, no. 3 (2008): 135–49; Mark R. Wicclair, *Conscientious Objection in Health Care: An Ethical Analysis* (Cambridge: Cambridge University Press, 2011); American Medical Association, *Code of Medical Ethics*, Opinion 1.1.7, "Physician Exercise of Conscience," accessed July 1, 2026, https://code-medical-ethics.ama-assn.org/ethics-opinions/physician-exercise-conscience.

36. Wicclair, *Conscientious Objection in Health Care*; American Medical Association, *Code of Medical Ethics*, Opinion 1.1.7, "Physician Exercise of Conscience."

37. Paul Ramsey, *The Patient as Person: Explorations in Medical Ethics* (New Haven: Yale University Press, 1970), xi–xviii; Daniel P. Sulmasy, *The Healer's Calling: A Spirituality for Physicians and Other Health Care Professionals* (New York: Paulist Press, 1997).

38. American Medical Association, *Code of Medical Ethics*, Opinion 2.1.1, "Informed Consent," accessed July 1, 2026, https://code-medical-ethics.ama-assn.org/ethics-opinions/informed-consent; Manson and O'Neill, *Rethinking Informed Consent in Bioethics*, chs. 2–4.

39. American Medical Association, *Code of Medical Ethics*, Opinion 2.1.1, "Informed Consent," accessed July 1, 2026, https://code-medical-ethics.ama-assn.org/ethics-opinions/informed-consent; Manson and O'Neill, *Rethinking Informed Consent in Bioethics*, chs. 2–4.

40. Glyn Elwyn et al., "Shared Decision Making: A Model for Clinical Practice," *Journal of General Internal Medicine* 27, no. 10 (2012): 1361–67.

41. Beauchamp and Childress, *Principles of Biomedical Ethics*. The addition of justice and patient-specific goals is meant to prevent the sequence from reducing moral permissibility to clinical benefit and consent alone.

42. Allen E. Buchanan and Dan W. Brock, *Deciding for Others: The Ethics of Surrogate Decision Making* (Cambridge, UK/New York, NY: Cambridge University Press, 1989); American Medical Association, *Code of Medical Ethics*, Opinion 5.1, "Advance Care Planning," https://code-medical-ethics.ama-assn.org/ethics-opinions/advance-care-planning, and Opinion 2.1.2, "Decisions for Adult Patients Who Lack Capacity," https://code-medical-ethics.ama-assn.org/ethics-opinions/decisions-adult-patients-who-lack-capacity.

43. Dworkin, *Life's Dominion*, chap. 8; Dresser, "Dworkin on Dementia," 32–38; Jaworska, "Respecting the Margins of Agency," 105–38. These positions do not yield a simple algorithm; they identify distinct moral claims of precedent autonomy, present welfare, and residual valuing agency.

44. Dworkin, *Life's Dominion*, chap. 8; Dresser, "Dworkin on Dementia," 32–38; Jaworska, "Respecting the Margins of Agency," 105–38.

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47. Wicclair, *Conscientious Objection in Health Care*; Sulmasy, "What Is Conscience?"; American Medical Association, *Code of Medical Ethics*, Opinion 1.1.7, "Physician Exercise of Conscience," accessed July 1, 2026, https://code-medical-ethics.ama-assn.org/ethics-opinions/physician-exercise-conscience. The AMA guidance treats conscience as important but limited by emergency duties, continuity of care, non-discrimination, and obligations to avoid abandonment.

48. Wicclair, *Conscientious Objection in Health Care*; American Medical Association, *Code of Medical Ethics*, Opinion 1.1.7, "Physician Exercise of Conscience."

49. Wicclair, *Conscientious Objection in Health Care*; Sulmasy, "What Is Conscience?"

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Living Well and Dying Well

Toward a Reimagined Christian Approach to Medicine

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Introduction

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

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

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

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

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

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

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

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

Christian Freedom[9]

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

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

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

And:

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

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

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

Medicine Is a Tool

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

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

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

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

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

Vocation: A Life Lived for Others

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

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

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

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

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

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

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

Life Goals: Living Well and Dying Well

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

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

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

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

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

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

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

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

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

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

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

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

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

Vocations are Dynamic

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

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

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

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

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

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

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

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

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

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

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

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

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

A New Paradigm: Choosing Life

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

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

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

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

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

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

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

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

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

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

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

Final Thoughts

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

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

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Notes

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

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

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

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

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

44. Ibid., 82.

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

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

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

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

49. Gregory, "Good Life," 292.

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

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

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

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How Pastors Can Shepherd the Faithful Away from Euthanasia

Roland Weisbrot

Introduction

In 2015, a Supreme Court of Canada ruling "struck down the *Criminal Code* prohibitions on assisted suicide," prompting the Canadian Parliament to pass Bill C-14 in 2016, "which amended the *Criminal Code* and established a framework in which doctors could legally end the lives of some of their patients."[1] This marked the beginning of euthanasia, known officially as Medical Assistance in Dying (MAiD/MAID), in Canada. Although MAiD was originally limited to those who were actively dying and whose death was foreseeable and imminent, Bill C-7, passed in 2021, expanded eligibility "to people who are not dying, to people with disabilities or chronic illnesses that are not terminal."[2] Regrettably, the ambiguous definitions in both Bills have allowed "plenty of leeway for personal preference" for MAiD assessors and providers, making MAiD widely available and accessible to almost anyone who requests it or is referred to it as an option.[3] As can be imagined, this has led to some truly disturbing circumstances and incidents in which individuals with various physical and psychological ailments, who may not be anywhere near death and were not necessarily expressing any desire to die, are being offered MAiD.[4] The sobering fact, however, seems to be that "the change in the *Criminal Code* is to protect the euthanizers, not the patient."[5] Consequently, as one Christian advocacy group highlights, "the legal availability of MAiD shifts the societal discussion from how to alleviate suffering to which sufferers can be eliminated. It demonstrates a profound lack of compassion toward the most vulnerable Canadians: the elderly, the sick, the chronically depressed, those with disabilities, and the lonely."[6] This has left some feeling as though their continued existence must have justification.[7] In other words, MAiD has already had a dehumanizing effect on certain vulnerable portions of Canada's population.[8]

Presently, MAiD is available in every province and territory of Canada and is fully publicly funded, meaning there is no direct cost to the "patient."[9] According to the *Fifth Annual Report on Medical Assistance in Dying in Canada 2023*, published in December 2024 by Health Canada, there were nearly 20,000 MAiD requests across the country and 15,343 individuals who died via MAiD—a sizable number for a country just shy of forty million people.[10] In fact, between 2019 and 2022, MAiD "had an average growth rate of approximately 31%" year-over-year; that said, MAiD usage has slowed somewhat in recent years (for example, growth was 15.8% in 2023).[11] Nevertheless, Canada is witnessing aggressive adoption and embrace of MAiD—seeing as it already accounts for approximately 5% of all deaths in the country as of 2023, which is the year with the most current relevant statistics available at the time of writing.[12] Whatever the future holds for MAiD in Canada, it is a phenomenon that simply cannot be ignored or avoided.

Now that the necessary penultimate matters concerning a brief history of MAiD in Canada have been established and current statistics have been shared, this essay turns to its ultimate purpose: pastoral care. To avoid entering the quagmire of the ongoing debate about the morality and permissibility of euthanasia, this essay will presuppose that MAiD is morally wrong for Christians and, consequently, assume that it should neither be endorsed nor utilized by them in any circumstance.[13] This is not because such a debate is unimportant—on the contrary, it is perhaps the foremost ethical debate of our generation—but because this essay does not want to reproduce and reiterate the work being undertaken by far more qualified individuals. Instead, it wants to address a very practical pastoral question: How does a pastor shepherd the faithful to avoid choosing MAiD?[14] To answer this question, this essay will first examine the best time to approach the topic of MAiD, consider the reasons people choose or reject MAiD, and offer helpful insights and practical steps for pastors to follow in their mission to minimize (or eliminate) MAiD deaths in their congregations and wider sphere of influence.

Timing the Discussion

When it comes to pastoral care, particularly when dealing with a sensitive issue such as euthanasia, timing the conversation is just as important as the words chosen. It should come as no surprise that the encouraging of one's parishioners, or their loved ones and decision-makers, not to choose MAiD ought to happen before, even long before, they are in the throes of suffering.[15] This is because suffering clouds judgment and adding existential burdens to the already present mix of physical and psychological suffering is unhelpful at best and spiritually harmful at worst.[16] As Martin Luther proclaimed in his 1519 sermon on preparing to die:

> We should familiarize ourselves with death during our lifetime, inviting death into our presence when it is still at a distance and not on the move. At the time of dying, however, this is hazardous and useless, for then death looms large of its own accord. In that hour we must put the thought of death out of mind and refuse to see it, as we shall hear. The power and might of death are rooted in the fearfulness of our nature and in our untimely and undue viewing and contemplating of it.[17]

It is simply basic pastoral sensitivity to not make the process of dying any more difficult than it needs to be, especially since most people (80–90%) will experience it gradually.[18] Put simply, dying is the time for pure Gospel. Consequently, telling a person who has been given a terrible prognosis and is experiencing the worst suffering—usually in the form of physical pain—that they should not expedite their death because it offends the divine and moral law can be perceived by some as nothing short of sadistic, both on the part of the pastor and of whom the pastor represents, that is, God. In the words of one seasoned hospital chaplain, "when someone is begging to die, all kinds of reactions occur in the caregiver that ultimately are not helpful. When all a patient wants is for it to be over, I feel a heightened urge to 'fix' things. There is nothing to be fixed, and if left unchecked that impulse can prompt a lot of clumsy pastoral care. This is when hurtful, careless things get said—perhaps more to comfort ourselves than the one dying."[19] What people need in such circumstances is not a moral lecture but compassionate care, clear Gospel proclamation, and a prayer for their death to come quickly and mercifully according to God's good and gracious will. As the Scriptures make clear, "for everything there is a season and a time for every matter under heaven: a time to be born and a time to die" (Eccl 3:1-2, NRSV).

Now, this does not mean conversations about MAiD cannot happen late in the dying process; however, that timing is far from optimal because the message is considerably less likely to be received well and graciously. The prudent pastor should make it the goal to have parishioners so well catechized on matters of death and dying that MAiD is not even considered an option, let alone a preferable alternative to the reality of human suffering, particularly as manifested in a prolonged dying process.[20] After all, in Canada, if the pastor is not the one having the MAiD conversation with a person, then it will likely be their doctor, and who knows what his or her worldview and moral framework might be?[21] In the rare best-case scenario, the doctor would be someone like Margaret Cottle, a palliative care physician who offers the following advice on engaging the topic of MAiD, especially with people late in the dying process:

> If possible, wait for an invitation to be involved. It is good to remember that Job's friends were agreat comfort to him while they sat with him in silence and commiserated for an entire week. It was only after they tried to

> explain the situation that their presence became harmful and distressing. Listen first. Ask the person to share his or her complete story with you in whatever detail he or she desires. State clearly that you are ready to listen without judgment and that you will only interrupt if you need clarification. Then truly *listen*. It is important to thank the person for sharing and for trusting you with the story and its details before you move on to commiserate. If you can comment in an empathetic way about specific aspects of the story you have just heard, it will show that you were paying attention and thus be more meaningful. Give the person time to respond to your words and thoughts and to add other thoughts as needed. Trite platitudes and easy answers are simply irritating. Just be yourself and pray moment by moment for the Holy Spirit to guide your thoughts and words.[22]

Nevertheless, such matters should not be left unattended by the Church, nor should they be left to those whose viewpoints are not shaped by Scripture and a devotion to Jesus Christ. For the reality is that "medical termination is not just for the 'end of life', but takes aim at all suffering, not by alleviating the suffering, but by eliminating the sufferer," and that sufferer is made in the image of God and Christ has Himself suffered for them.[23] Accordingly, "the primary ethical requirement at the end of life is to care for the dying, to comfort them, to be in community with them. To render assistance in dying would be abandonment, a separation from one still living, which is a 'contradiction at the heart of Christian charity.'"[24]

To MAiD or Not to MAiD, That Is the Question

It has been clearly observed that "people typically have several reasons for seeking MAiD, the most predominant of which are relational—[that is,] based not on physical pain, but on existential, spiritual, social, or psychological suffering."[25] In fact, according to the Government of Canada's own statistics, seven of the ten most cited reasons for people choosing MAiD have nothing to do with physical pain and suffering.[26] Shockingly, "inadequate pain control" is only the *fourth* most cited issue at 54.4%, following "loss of dignity" at 64.9%, "loss of ability to perform activities of daily living" at 87.3%, and above all, "loss of ability to engage in meaningful activities" at 95.5%.[27] Thus, the statistics clearly show not a physical suffering crisis but a psycho-spiritual (existential) crisis behind the embrace of MAiD. This is somewhat ironic, given that much of the argument in favor of MAiD rests on eliminating physical suffering deemed "unbearable" by the individual.[28] That said, this observation in no way seeks to minimize the very real fact of physical pain and the undeniable suffering it causes people, especially those dying. This fact must always be met with the deepest empathy and sensitivity by pastors and other caregivers.[29] No one can be faulted for fearing dying, suffering, and death.[30]

Though it is only the fourth-most cited reason to choose MaiD, the fact that pain still factors in over 50% of these cases merits a brief examination. As one commentator notes, in the present North American culture, "lingering in pain, suffering, and isolation constitutes the worst imaginable end," meaning that nowadays more people report fearing suffering more than death itself—hence why many wish for or opt for a sudden death.[31] The chief irony here, however, is that in a rush to respect an individual's desire to endure pain no longer, one physician points out that "intentionally causing death … require[s] us to render valueless that which is of essential value: the patient."[32] That is, for medical professionals to obey the request for MAiD is to eliminate the patient making the request, and that patient was the one who morally justified the request in the first place. Thus, in obedience to the principle of autonomy, you are eliminating the agent of that autonomy—a logic marked by profound internal contradiction.

There is also the unavoidable problem of the highly subjective nature of suffering caused by pain deemed "intolerable," meaning the patient alone can determine whether a treatment is worth pursuing, not objectively, but based solely on their own tolerance for continued pain.[33] The fact remains, however, that "suffering is universal. No one is exempt. We experience it in its myriad forms from the moment of our birth until the moment of our death. The total elimination of suffering is incompatible with living."[34] Fortunately, as countless medical professionals, researchers, and advocates have pointed out, adequate and well-administered palliative care can almost always control and manage pain, allowing the sufferer to experience little to none of it.[35] This means that by advocating for and offering better care to the dying, such as through a hospice, pain can effectively be eliminated as a reason for choosing MAiD.[36] That said, statistics have shown that pain is not a motivator for everyone receiving MAiD, meaning that there are differences in the way individuals handle pain, physically, mentally, and even spiritually, a crucial point that shall be taken up later.[37]

The third most cited issue (at 64.9%), which drives people to MAiD, is a loss of dignity—perceived or actual. Loss of dignity is usually accompanied by a loss of control. Thus the natural response for many individuals who feel they have lost their dignity is to take control of whatever they can. In light of the contemporary, highly medicalized dying process, many have chosen to see the time and manner of their death as "their 'last big decision.'"[38] The problem with this line of reasoning is that:

> This argument implies that dependence, illness, and vulnerability are themselves undignified. Dignity is equated with the exercise of autonomy. It has no objective meaning. Rather, dignity is a qualitative outcome of choice in a situation in which one either could have chosen otherwise (a different manner of dying, say) or would have had no control to exert of [sic] her or

> his manner of death. A dignified death is reductively defined in terms of the dying person's choice to die on his own terms.[39]

Nevertheless, in Canada, through MAiD, people are given the ability to control their death with the "medical arsenal" and, so the argument goes, die with some shred of "dignity," thereby eliminating "suffering by eliminating the sufferer."[40] As Lutheran theologian Martha Stortz highlights, "beneath this attitude is a possessive individualism, a my body-my self mentality. This is my body; this is my death; this is my choice; these are my wishes."[41] Put bluntly, this rationale and claim are incompatible with a Christian understanding of the world and of oneself, though more on this will be explored later.

Returning to the present subject, according to "The Model of Dignity in the Terminally Ill," as formulated by Canadian psychiatrist Harvey Chochinov, "there are three primary elements that influence patient dignity": Illness-Related Concerns, the Dignity-Conserving Repertoire, and the Social Dignity Inventory.[42] Without delving too deeply into these categories, Chochinov's point is "that a patient's sense of dignity has clearly defined sources and that specific questions and therapeutic interventions can enhance a patient's sense of their dignity."[43] In other words, MAiD is not the only way, or best way, to address a loss of dignity in the dying. Rather, "when people are vulnerable like this, they need care, support and encouragement to see their dignity when it gets obscured by trauma, fear, and the challenges of navigating the health care system"; caregivers, family, and friends can all have an enormous impact by affirming a vulnerable person's dignity.[44] Thus, "by acknowledging and affirming the dignity of those with chronic conditions, disability, or life-limiting illness through this method, we can offer a profoundly Christian response to suffering," and thereby vastly reduce or eliminate this cited issue as a reason for people choosing MAiD.[45]

Having covered the citations on pain and dignity, we now address the top two reasons people give for choosing MAiD, both of which pertain to meaning and other existential questions: loss of ability to perform activities of daily living at 87.3%, and loss of ability to engage in meaningful activities at 95.5%. Nobody enjoys being restricted from or unable to do what they enjoy in life, or even what is necessary in life, especially if that restriction or inability becomes permanent rather than temporary. Without a doubt, doing things can bring incredible meaning to life, and the absence of those things can be crushing, both mentally and spiritually and can cause deep depression.[46] However, consider the work of renowned psychotherapist and Holocaust survivor Viktor Frankl on the topic of meaning even in the midst of the worst imaginable suffering, dehumanization, and loss of personal freedom and autonomy: "If there is a meaning in life at all, then there must be a meaning in suffering. Suffering is an ineradicable part of life, even as fate and death. Without suffering and death human life cannot be complete."[47] By this, Frankl is not insinuat-

ing that one ought to look for suffering in life, only that one ought to be prepared to find meaning in it, because of its inevitability.[48] In Frankl's mind, "suffering ceases to be suffering at the moment it finds a meaning."[49] Hence, Frankl asserts that,

> We must never forget that we may also find meaning in life even when confronted with a hopeless situation, when facing a fate that cannot be changed. For what then matters is to bear witness to the uniquely human potential at its best, which is to transform a personal tragedy into a triumph, to turn one's predicament into a human achievement. When we are no longer able to change a situation—just think of an incurable disease such as inoperable cancer—we are challenged to change ourselves.[50]

Put plainly, when we cannot change our circumstances, all we can do is change our approach to a given situation and our mindset about it.

In a deeply personal account of the cancer-induced dying and death of her pastor husband, Joy Anna Marie Mills, also a pastor, noted that instead of wallowing in grief over what he was no longer able to do, he became "deeply contemplative" and found meaning in sharing love, laughter, life lessons, and memories with family, friends, and neighbors during his last days.[51] Though he wanted to live, he embraced the reality of his death in a way that was profoundly meaningful to himself and those around him.[52] Now as Mills freely admitted, this in no way meant the dying process was always easy or a joy for her late husband, only that meaning can be found in terrible circumstances and the suffering they cause.[53] Thus, just because someone may feel and claim that their life has lost all its meaning and purpose does not mean it has, or that there could be no purpose or meaning left for them.[54] After all, a person is far more than what they can or cannot do, and their conditions—much more on this will be explored later.[55] Bearing all this in mind, with some care, transformation of thinking, and the right approach, the issue of meaning can effectively be addressed and removed as a citation for those choosing MAiD.

The Good Shepherd

Having now considered the timing of conversations about MAiD and briefly addressing the top four reasons people in Canada give for choosing MAiD, this essay turns to key insights and practical advice for pastors to grasp and employ in their mission to reduce or eliminate MAiD deaths, thereby promoting and safeguarding the sanctity of life. In his *Small Catechism*, Martin Luther makes the following faithful assertion: "I believe that God has created me together with all that exists. God has given me and still preserves my body and soul: eyes, ears, and all limbs and senses; reason and all mental faculties. In addition, God daily and abundantly provides… all the necessities and nourishment for this body and life."[56] In defining and explaining

the Fifth Commandment, "you are not to kill," Luther declares that "we are to fear and love God, so that we neither endanger nor harm the lives of our neighbours, but instead help and support them in all of life's needs."[57] In light of this, we learn that God created and sustains the body, and that as believers we ought to care for our bodies and help care for and preserve the bodies, and thus the lives, of others. This, however, is not always as straightforward as it seems because, for example,

> our love towards a terminally ill patient is expressed either as a desire to deliver him from pain, or as a wish to prolong his life so as to be together. The suffering of our fellowman and our compassion for him create an inner conflict of love with our desire for togetherness. In a Christian perspective, this conflict presents an inner crisis, which provides an opportunity for strengthened trust in God's will. His consolation, the revelation of a 'sign,' and His enlightenment of our soul. Although it is humanly understandable that we wish to postpone death, the broad use of medical technology may go beyond the limits of spiritual ethics.[58]

Consequently, before venturing any further, it must be noted that North American Christians have a certain tendency to be "too pro-life," as "people of religious faith were three times more likely to choose aggressive medical treatment at the end of their lives, even though they knew they were dying and that the treatments were unlikely to lengthen lives."[59] This betrays "an unrealistic[, and perhaps idolatrous,] expectation that medicine can cure whatever disease we or our loved ones might have," resulting in a sometimes misplaced "hope for a miracle from God, the pharmaceutical companies or our doctors."[60] Accordingly, it ought to be taken into consideration that a person's "quality of life should be compatible with survival" when determining medical intervention and end-of-life care.[61]

Regrettably, instead of simply accepting that the time of death has come, many Christians fight to the bitter end because of a radically pro-life theology;[62] however, "life's sanctity … does not require its preservation at all costs when a lifetime is fulfilled."[63] Sadly, this commitment to life at all costs, in all circumstances and without exception, often causes Christians to miss the proper understanding and place of dying and death in their faith. As one thinker observed, "it is certain that we die. Even after having one's life prolonged by medical techniques, one finally does die."[64] Thus, "disregarding death is equivalent to evading life. Death is so much a part of life that the two should be conceived as forming a single whole. If life is the foreground, death is the background and sets its mood and tone…. Therefore, only those who are honestly addressing the fact of death can lead a full life. Death is, indeed, the mode in which we live."[65] A necessary corrective, then, is to rediscover, redevelop, and re-educate believers about an authentically Christian conception of dying and death, because "a decision *not* to keep a person alive is as morally deliberate as a decision

to *end* a life."[66] There is, of course, a massive moral difference between allowing death to take place naturally under appropriate circumstances, such as the end of a person's foreseeable lifespan, and actually causing death, that is terminating one's lifespan prematurely.[67] This is a point pastors must reckon with and discern carefully when they are called upon to help in decision-making for a dying person.

To be clear, a Christian conception of dying and death does not include MAiD, but it does include choosing, when and where appropriate, to simply let go and allow nature to take its prescribed course.[68] As Rob Moll observes in his book *The Art of Dying: Living Fully into the Life to Come*, "God is glorified when people die having lived a full life, accepting God's plan, hoping for continued life in Christ and trusting God to care for them in the journey from this life to the next."[69] Christians, therefore, ought to seek to know how they can die well, which will inevitably force them to rethink what it means to die a good death.[70] Indeed, a good death is not an expedited one, such as in the case of MAiD, nor is it necessarily one that comes after weeks, months, or even years of aggressive, invasive, and debilitating medical treatments.[71] As Orthodox theologian Nikolaos Hatzinikolaou put it, "the moment of biological death epitomizes the value of a human's life. It is the moment at which God's closeness to man is realized in its most intense form."[72] Therefore, great care should be undertaken for dying a good death and helping to facilitate good deaths in the Christian community.[73] In summary, "transcendence of death is proposed as an alternative to euthanasia. Good life and a good death for the Church mean life and death with meaning and perspective. When the choice to die emerges from the denial of the will of God, it is considered a sin. On the contrary, when yearning to die springs from the love of God it constitutes a blessing and a unique virtue (Phil 1:23)."[74]

Interestingly, a recent (2022) statistical study on views and opinions about euthanasia among Protestants in the Netherlands found that very little conversation takes place on the topic in the church or between a pastor and a parishioner; consequently, no one seems to know what the other believes and thinks.[75] This is despite the study finding that parishioners overwhelmingly want their pastor involved in their end-of-life journey, providing counsel, comfort, reassurance, and, when the time comes, a funeral service and grief care for their family and friends.[76] As the study summarizes,

> Church members of all sub-denominations stress the importance of pastoral care at the end of life. They expect pastors to play a central role in guiding them when they become ill, counseling their loved ones, and participating in the funeral service. When there is a desire for euthanasia, parishioners expect pastors to be willing to discuss this openly and provide support and guidance, and they indicate that they will not hesitate to contact their pastor when necessary.[77]

In other words, pastors have a wide and open door to engage their parishioners in conversation about dying and death, and, more specifically, on euthanasia. Pastoral care is not just desired; it is expected! Although this was a Netherlands-based study, many helpful conclusions and inferences can be drawn for the Canadian ministry context, as similar feedback and expectations can be anticipated from Canadian parishioners. Consequently, Canadian pastors should not fear conversations about dying, death, and especially MAiD, but instead seek sensitive and impactful ways to engage in such talk through the lens of Scripture and Jesus Christ.[78] Undoubtedly, if pastors want to see a reduction in MAiD, churches must break the silence surrounding dying and death.[79]

Fortunately, baptism, more than anything, opens the door to dialogue about life and death as a Christian. As Stortz argues:

> Baptism brings beginning and ending of human life together with sacramental power. Baptism is the sacrament that welcomes people into this world as children of God. It incorporates them into the body of Christ. Yet, that incorporation is finally complete only in death. Baptism ushers people out of this world. The pall harkens back to the white garments of baptism; sprinkling of water on the casket or urn recalls the waters of baptism. Death in the Lord is final inclusion into the body of Christ. But baptism is not the sacrament only of beginning and ending of life; daily return to baptism forms and informs the lives we live in between these two events. Baptism bears the key both to how we live and to how we die. Throughout our lives, we turn to this practice, because it offers powerful alternatives to the world's ways of dying, to the world's denial of death, and to the world's despair in the face of disease.[80]

Thus, discussions about dying and death begin at the very start of the Christian life, in the baptismal waters that bring death to the old life and bring about the new life in Christ (cf. Rom. 6:1-14).[81] A robust baptismal theology uniquely positions Lutherans to revitalize a Christian theology of dying and death, reframing the conversation. "In Luther, the *ars moriendi* becomes an *ars vivendi*, the art of dying becomes an art of living, choreographed by a daily return to baptism, chastened by daily remembrance of sin, and strengthened by daily experience of forgiveness."[82] Baptism also shows that we are not our own and thus cannot do whatever we see fit with our bodies, as the Apostle Paul makes clear in 1 Corinthians 6:19-20 "do you not know that your body is a temple of the Holy Spirit within you, which you have from God, and that you are not your own? For you were bought with a price; therefore glorify God in your body" (NRSV).[83] This truth can be proclaimed from the pulpit or taught during Bible study or Confirmation by pastors.[84]

Accordingly, "baptism sets one into a web of relationships that will sustain and nurture, admonish and challenge, support us in living and accompany us through

death…. Concretely, the practice of baptism articulates reciprocal responsibilities in the face of death: responsibilities of the community and responsibilities of the dying."[85] The responsibility of the Christian community, as bestowed in baptism, is to ensure, insofar as possible, "that no one moves through life and death alone," and thus "ministry to the shut-in and the dying is not the pastor's responsibility alone but falls squarely upon all the baptized."[86] As for the responsibility of those who are dying in the Christian community, it is "to leave behind the greatest possible peace, hope, and trust among the survivors" by accepting their complete dependence on the grace and mercy of God through His Son, Jesus.[87] Thus, even in the act of dying, life can be purposeful. The pastor must share this truth with the flock.[88] There is ample meaning in this sort of community engagement and connection. Pastors must communicate this fact and encourage its practice.[89] Community, after all, is a great bulwark against isolation and the corresponding "maladaptive tendencies" that come out of it, thereby offering another protective layer against MAiD.[90] For this and other reasons, death can and should be understood by a Christian not as a private issue, but as a communal issue.[91] Therefore, "we should pursue the question of death, not as an individual problem, but as a community issue for those on the health care team, including the physicians, nurses, family members, pastor, friends[, fellow believers,] and neighbors. This health care team has a significant role to play in the healing process. Dying within a caring community may have spiritual benefits and even reduce pain."[92] Although only the dying individual experiences the act of death, the impact of death and its reality make it a truly public matter because of the many it involves, voluntarily or involuntarily.[93]

Having reviewed how the Lutheran view of baptism can help pastors in the fight against people choosing MAiD, this essay now turns to another uniquely Lutheran theological category: *anfechtung*, or spiritual distress/anguish. Throughout his life and work, Luther often referred to the personal spiritual struggle he was enduring as *anfechtung*, driven primarily by doubt about God's mercy, forgiveness, and love.[94] This means Lutherans have a deep and rich theological history of dealing with suffering, whether it be caused by the body, mind, or soul. As Lutheran theologian James Childs Jr. explains,

> in the mystery of the divine life, God chose to die in unfathomable love for us and all creation. For Luther this is an essential truth of our faith: 'If it is not true that God died for us, but only a man died, we are lost.' God is love, and love and impassibility do not go together; love suffers the pain of the beloved, like any parent knows who agonizes for their hurting child. The unity of human and divine in the Incarnation is both the symbol and reality of God intimately and lovingly with us in all things. God is with us in our pain and in our dying. God is with us, loving us unconditionally also in the

> pains of our choosing at the end of life or in the throes of terrible suffering as we struggle with how to decide.[95]

This profound truth, made so plain in Lutheran proclamation and teaching, can help those who are suffering in their dying process and show them that they do not suffer alone, for they have a Savior, Jesus, the Son of God, who cares and suffers alongside and for them. It is the pastor's privilege and duty to reveal that

> the solace of those in the pains of illness and dying is to be found in turning one's gaze to the cross. There the suffering one beholds in Jesus, who has suffered all that we may suffer, who knows our suffering and is in empathetic solidarity with our suffering. There we find the hope we need to bear with our agony. Pain is existentially bearable only where there is hope. The hope that Christ communicates to the sick and the suffering is that of his presence, of his true nearness.[96]

This is real hope, not mere platitudes or wishful thinking. After all, "part of ministry is to pass on the beliefs and practices of the spiritual tradition as received—including beliefs about suffering—so that each generation can benefit from those who have gone before. Such a tradition establishes a grid of understanding for us to plot and navigate our own life events."[97] Lutherans, in particular, have a rich tradition to draw from and pass down.

The above approach to suffering complements the traditional Christian understanding that suffering purifies the sinful person and presents an opportunity for spiritual growth. However, it also stands in contrast to the traditional Christian understanding because it points people to pure objective grace that truly saves, rather than a subjective righteousness program undertaken chiefly by suffering well—whatever that might mean.[98] There is no way around suffering, but "Jesus, the Suffering Servant of Isaiah 53, shows us that not all suffering is meaningless and without purpose. It is right and good to work diligently to eliminate needless suffering, especially for those who are vulnerable, ill, or unable to speak for themselves. But it is wrong and evil to take the lives of those who are suffering under the false pretext of 'mercy.'"[99] Suffering is in no way "shameful," and it undoubtedly has its place in the Christian life, for Christ Himself suffered and clearly stated that those who follow Him would as well (cf. Matt 24:9).[100] Therefore, to those who suffer, the pastor prescribes a posture not of despair but of humility before God, trusting that He will do His good and gracious will, which includes eventual deliverance from suffering. This mindset also shifts the focus away from subjective questions about "quality of life" and toward faithful submission to God's will for a person's life. In doing so, self-worth and dignity can be located outside of one's self rather than being made subject to one's fragile and ever-shifting sense of self.[101] Such views inevitably help inoculate Christians against choosing MAiD.[102] Pastors, therefore,

can and should assure those they serve that "when you come to the end of your rope, when the agonies and terrors of living exceed the care of those around you, there is only God and God's promise through the mouth of Paul that nothing in all creation can separate you from the love of God in Christ Jesus (Rom. 8:39)."[103]

Conclusion

In conclusion, this essay has explored how pastors can work to prevent euthanasia/MAiD deaths under the assumption that such a pursuit is theologically and morally valid and right. It did so by first examining the timing of the conversation about MAiD and highlighting that it is preferable to begin teaching about it before a person enters the often painful and difficult dying phase. Second, the top four reasons people gave for choosing MAiD, according to Health Canada statistics, were analyzed in turn, and commentary was offered on how pastors could address each. Third and finally, this essay offered insights and practical advice for pastors to engage their congregations in ways that help prevent MAiD deaths, using a variety of techniques that focus on the sanctity of life, end-of-life conversations, the role of baptism, communal identity, and Lutheran theology. Although MAiD is a relatively new reality in Canada, it is likely one that is here to stay. Pastors must be ready and armed with solid Scriptural and theological knowledge in order to help stem the tide of euthanasia and its surrounding culture of eugenic value-judgments that insist death be the solution to suffering. For pastors are called to walk with the people they serve in life and, in dying and death.

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Notes

1. "Assisted Suicide and Euthanasia," Policy (Ottawa, Ontario: Association for Reformed Political Action Canada, Fall 2021), 1, https://arpacanada.ca/publication/assisted-suicide-and-euthanasia/. More specifically, "doctors were permitted to cause a patient's death or assist a patient's suicide by administering a lethal injection (consensual homicide) or by prescribing a lethal drug for the patient to self-administer (assisted suicide)."
2. Ibid.
3. Ibid., 2; Margaret Cottle, "Grace and Truth in the Shadowlands," *Focus Magazine*, August 2023, 6; Unpaginated reprint at https://cmdacanada.org/how-to-talk-to-someone-considering-euthanasia/. Robert J. Dean, ed., "MAID in Canada: A Multidisciplinary Conversation about End-of-Life Issues with David Guretzki, Kristin Harris, and Paul Blair," *Didaskalia* 30 (2021-2022): 80.
4. "Assisted Suicide and Euthanasia," 3. This is happening because "Bill C-14, and then C-7, codified the principle that it is permissible to intentionally kill a person who asks to

be killed, provided they no longer possess the qualities or capabilities that society deems necessary for sufficient 'quality of life.' In other words, it is okay for some people—particularly medical doctors—to make value judgements about whose life is worth living and to offer either suicide *assistance* or suicide *prevention* based on their assessment" (p. 2).

5. Ibid., 5.
6. Ibid.
7. Ibid., 3.
8. Larry Worthen, "Providing Dignity Affirming Care: Acknowledging Human Dignity," *Focus Magazine*, August 2023, 19. As Worthen points out, "when people are vulnerable like this, they need care, support and encouragement to see their dignity when it gets obscured by trauma, fear, and the challenges of navigating the health care system. Christ identifies with people in these circumstances and tells us 'Whatever you do for these my brothers and sisters you do it to me.'"
9. "Assisted Suicide and Euthanasia," 2; Cottle, "Grace and Truth," 6.
10. "Fifth Annual Report on Medical Assistance in Dying in Canada 2023," Informational, Medical Assistance in Dying (Ottawa, Ontario: Health Canada, December 11, 2024), 7, https://www.canada.ca/content/dam/hc-sc/documents/services/publications/health-system-services/annual-report-medical-assistance-dying-2023/annual-report-medical-assistance-dying-2023.pdf. It should be noted that "the remaining cases were requests for that did not result in MAID (2,906 died before receiving MAID, 915 individuals were deemed ineligible and 496 individuals withdrew their request)."
11. Ibid.
12. Ibid. Interestingly, despite Canada's vast ethnic diversity, requests for MAiD are nearly a mono-racial phenomenon as 95.8% of MAiD recipients "identified as Caucasian (White)" (p. 8). Although not every MAiD recipient chose to respond to the question asking for them to identify their race/ethnicity, those who did number so disparately to confidently infer the conclusion.
13. Karen Mason et al., "The Moral Deliberations of 15 Clergy on Suicide and Assisted Death: A Qualitative Study," *Pastoral Psychology* 66, no. 3 (June 2017): 335–51, https://doi.org/10.1007/s11089-016-0744-y. Although this essay has presupposed a firm stance against euthanasia, this limited, United States based, study does a good job highlighting that there is not a black and white consensus on the issue, even among clergy.
14. James M Childs Jr, "Medical Assistance in Dying and the Trust of Faith," *Dialog* 61, no. 4 (December 2022): 288–95, https://doi.org/10.1111/dial.12776. For those so inclined, Childs offers an interesting alternative perspective on the euthanasia debate from a Christian framework.
15. Stephen Faller, "Serving the Dying," *Family and Community Ministries* 21, no. 1 (2007): 44.
16. Martha Ellen Stortz, "'The Curtain Only Rises': Assisted Death and the Practice of Baptism," *Currents in Theology and Mission* 26, no. 1 (1999): 9.
17. Martin Luther, "A Sermon on Preparing to Die," in *Martin Luther's Basic Theological Writings*, ed. Timothy F. Lull (Minneapolis: Fortress Press, 1989), 640–41.
18. James MacMillan, "The Dying Process," *Focus Magazine*, August 2023, 10.
19. Faller, "Serving the Dying," 45.

20. Darlene Fozard Weaver, "Dying under a Description? Physician-Assisted Suicide, Persons, and Solidarity," *Christian Bioethics* 27, no. 3 (December 8, 2021): 307–8, https://doi.org/10.1093/cb/cbab014.
21. Simran Kripalani, John P. Gaughan, and Elizabeth Cerceo, "The Role of Religion in Physician Outlook on Death, Dying, and End of Life Care," *Journal of Religion and Health* 60, no. 3 (June 2021): 2112, 2121, https://doi.org/10.1007/s10943-020-01126-0; Hiromasa Mase, "Death and Dying: Towards an Ethic of Death," *Currents in Theology and Mission* 12, no. 2 (1985): 73.
22. Cottle, "Grace and Truth," 7. Italics in original.
23. Ibid., 6.
24. Childs, "Medical Assistance in Dying and the Trust of Faith," 290.
25. "Assisted Suicide and Euthanasia," 4.
26. "Fifth Annual Report on MAiD in Canada," 32.
27. Ibid.
28. Ewan C. Goligher, "Six Questions about Physician-Assisted Death from a Conscientious Objector," *The Linacre Quarterly* 84, no. 2 (May 2017): 105, https://doi.org/10.1080/00243639.2017.1261561. As this conscientious physician notes, "advocates for [MAiD] contend that death should be used to treat suffering because for some patients, death is better than life. This assumes some notion of what it is like to be dead. Yet the medical profession has no idea what it is like to be dead. All beliefs about the afterlife (including the belief that there is no afterlife) are metaphysical (quasi-religious) beliefs which cannot be confirmed or refuted by scientific medical evidence. Thus [MAiD] is innately experimental, and its outcomes are hidden from us. Though there is always a measure of uncertainty in medicine, medical care must be based on evidence and observation and sound reasoning; and doctors should not be forced to practice medicine based on untestable quasi-religious assumptions."
29. David George Rinaldi, "Dying Like a Dog," *Journal of Pastoral Care & Counseling* 77, no. 2 (June 2023): 125, https://doi.org/10.1177/15423050221136803.
30. Cottle, "Grace and Truth," 8.
31. Stortz, "The Curtain Only Rises," 5.
32. Goligher, "Six Questions," 106.
33. Cottle, "Grace and Truth," 6.
34. Ibid., 6-7.
35. MacMillan, "The Dying Process," 11.
36. Mase, "Death and Dying," 74.
37. Faller, "Serving the Dying," 44.
38. Stortz, "The Curtain Only Rises," 8.
39. Fozard Weaver, "Dying under a Description?," 301.
40. Stortz, "The Curtain Only Rises," 9; Worthen, "Providing Dignity Affirming Care," 18.
41. Stortz, "The Curtain Only Rises," 11.
42. Worthen, "Providing Dignity Affirming Care," 18.
43. Ibid.

44. Ibid., 19.

45. Ibid.

46. Stephen M. Saunders, *Martin Luther on Mental Health: Practical Advice for Christians Today* (St. Louis: Concordia Publishing House, 2023), 102–04.

47. Viktor E. Frankl, *Man's Search for Meaning*, trans. Ilse Lasch, 5th ed. (Boston: Beacon Press, 2006), 67. Expanding on this thought, he states that "the way in which a man accepts his fate and all the suffering it entails, the way in which he takes up his cross, gives him ample opportunity—even under the most difficult circumstances—to add a deeper meaning to his life. It may remain brave, dignified and unselfish. Or in the bitter fight for self-preservation he may forget his human dignity and become no more than an animal. Here lies the chance for a man either to make use of or to forgo the opportunities of attaining the moral values that a difficult situation may afford him. And this decides whether he is worthy of his sufferings or not."

48. Frankl, *Man's Search for Meaning*,113.

49. Ibid.

50. Ibid., 112.

51. Joy Anna Marie Mills, "Living into Dying," *Journal of Pastoral Care & Counseling* 57, no. 2 (June 2003): 225–26, https://doi.org/10.1177/154230500305700212.

52. Ibid., 227.

53. Ibid., 226.

54. Saunders, *Martin Luther on Mental Health*, 35.

55. Frankl, *Man's Search for Meaning*, 130.

56. "The Small Catechism," in Robert Kolb and Timothy J. Wengert, eds., *The Book of Concord: The Confessions of the Evangelical Lutheran Church* (Minneapolis: Fortress Press, 2000), 354.

57. Ibid., 352.

58. Nikolaos Hatzinikolaou, "Prolonging Life or Hindering Death?: An Orthodox Perspective on Death, Dying and Euthanasia," *Christian Bioethics* 9, no. 2–3 (2003): 196.

59. Rob Moll, *The Art of Dying: Living Fully into the Life to Come* (Downers Grove, IL: IVP Books, 2010), 32.

60. Ibid., 31.

61. Hatzinikolaou, "Prolonging Life or Hindering Death?," 190. Hatzinikolaou goes further on the following page, asserting "it seems that sometimes technological surviving is even worse than death. When life runs the risk to be degraded to the level of unbearable suffering, even nature itself protects man's dignity by initiating the process of death. Contemporary technology may hinder this protection and produce unprecedented forms of death or conditions of painful survival incompatible with life. In other words, technological advancements may create human beings who would either be unable to die, or be unable to die in a natural way."

62. Ibid., 191.

63. Moll, *The Art of Dying*, 34.

64. Mase, "Death and Dying," 73. Further to this point, Mase observes that "hospitals are supposed to help people live, not die. But does 'helping people live' necessarily have to

mean prolonging the dying process by artificial means and not letting them die? Modern medical treatment can sometimes seem to be playing with life by abstracting illness as mechanical dysfunction. Physicians may sometimes seem indifferent to the illness as an affliction of the whole person. A mechanical theory still underlies medical treatment. The approach taken by the physician is the same mechanical one which Descartes proposed. Since the development of life-prolonging machines, physicians have become insensitive to the humanity of their patients; physicians always feel obliged to take remedial action in every case and can not just relate personally to the patient."

65. Ibid., 69.

66. Childs, "Medical Assistance in Dying and the Trust of Faith," 291. Italics in original.

67. Dean, "MAID in Canada," 87.

68. Hatzinikolaou, "Prolonging Life or Hindering Death?," 192. Conversely, "in certain cases, respect for life means that we must invest all available resources for keeping a patient alive, even if this life is marred by extensive bodily disability. Our love, which is beyond measure, can complement in excess the deficiencies of this disability. The success of our efforts does not lie in the fact that our fellowman will live; nor is it undermined by the eventual physical disability. The expression of medical love, the common struggle of doctors and nurses, and the desire not to let 'evil' (i.e., the illness, the accident, the criminal act, carelessness, etc.) win all focus on the life of our fellowman, which is of utmost value."

69. Moll, *The Art of Dying*, 34.

70. Dean, "MAID in Canada," 79.

71. Moll, *The Art of Dying*, 38.

72. Hatzinkolaou, "Prolonging Life or Hindering Death?," 188. Expanding on this point on page 190, Hatzinikolaou states that "death is so sacred to all of us that its purity should be safeguarded by any means. It is the process and moment during which the person is worth the greater respect from society. Society should in no way reduce death from a spiritual mystery to a mechanical and merely temporal event. It is unethical to denude the body from the last clothing of its dignity, when it has just been deprived from the protection of the soul. Finally, the last moments of a patient favour the bond between him and his relatives and the medical staff, the growth of love and communion, the manifestation of sympathy and mercy. The request of certain patients to end their lives may conceal a wish to test their relatives' love and desire to be with them for as long as possible. During these moments one can experience the grace of God and the love of human beings."

73. Hatzinikolaou, "Prolonging Life or Hindering Death?", 192–93.

74. Ibid., 197.

75. Wim Graafland et al., "Protestant Parishioners, Their Pastors, and Euthanasia," *Journal of Empirical Theology* 35, no. 1 (September 8, 2022): 3, 13, https://doi.org/10.1163/15709256-20221429.

76. Ibid., 11–12.

77. Ibid., 19.

78. Faller, "Serving the Dying," 44.

79. Dean, "MAID in Canada," 86.

80. Stortz, "The Curtain Only Rises," 11–12.

81. Ibid., 13–14.

82. Ibid., 14. Stortz goes on saying, "we need to hear again that 'the just shall live by faith,' emphasis on the word 'live.' That life does not begin in heaven. According to the medieval mind, in the midst of life we are surrounded by death. Luther's sturdy conviction of justification turned this on its head: 'In the midst of death we are surrounded by life.' As incorporation into the body of Christ, baptism allows the iconic meaning of Christ to be in us, our seal against sin, death, and the devil."

83. Cottle, "Grace and Truth," 7.

84. Dean, "MAID in Canada," 82–83.

85. Stortz, "The Curtain Only Rises," 15.

86. Ibid. Furthermore, Stortz asserts that "congregations should be bold about setting end-of-life discussions in the midst of congregational life and in the context of baptism, lest the terms of discussion be set by court decrees and state initiatives and cast entirely in terms of rights. Congregational forums on living wills, durable power of attorney, Do Not Resuscitate (DNR) orders, hospice and palliative care could be part of this, as well as visitation teams to the dying that offer relief to family caregivers. No one ought to die alone. There should be frank and fearless preaching of death from the pulpit, and follow-up discussion in the Sunday school rooms and church basements afterwards."

87. Stortz, "The Curtain Only Rises," 16.

88. Dean, "MAID in Canada," 78–79.

89. Ibid., 78.

90. Ibid., 82.

91. Mase, "Death and Dying," 72.

92. Ibid.

93. Childs, "Medical Assistance in Dying and the Trust of Faith," 289. As Childs notes, "the idea that the right of patient self-determination should include the right to assisted dying assumes that this is a private choice, whereas in fact it is a public matter: 'The focus of legalization advocates on patient rights and interests has generated moral myopia regarding the presence of other stakeholders including various intermediate communities such as families, the healing professions, hospice care, and spiritual care advisors, as contributors to end-of-life caregiving.'"

94. Saunders, *Martin Luther on Mental Health*, 51–52, 58–60, 63.

95. "Medical Assistance in Dying and the Trust of Faith," 294.

96. Childs, "Medical Assistance in Dying and the Trust of Faith," 292.

97. Faller, "Serving the Dying," 44.

98. Childs, "Medical Assistance in Dying and the Trust of Faith," 293; Faller, "Serving the Dying," 44.

99. Cottle, "Grace and Truth," 7.

100. Dean, "MAID in Canada," 77.

101. Ibid., 80-81.

102. Cottle, "Grace and Truth," 7. As Cottle explains so well, "when we observe the most common reasons people seek medical termination, we gain valuable insights into how we can address the existential suffering and fear at the core of their requests. Our society

places its highest value on independence, control, and power. But Christians are called to follow Christ's example of interdependence, submission, humility, and powerlessness. Christ in the garden of Gethsemane said, 'Not my will but Thine' and Mary replied to Gabriel at the annunciation, 'I am the Lord's servant. [...] May your word to me be fulfilled.' (Luke 1:38) If the Lord is to be able to 'guide our feet into the way of peace,' we must come to a place of deep understanding and acceptance that if something is forbidden or prohibited in the Lord's Word, doing that thing will never bring shalom—peace with order, well-being—to ourselves, our loved ones, or our world. It is easy to underestimate the extent to which our thoughts, opinions, and actions are influenced by the culture in which we live. The wrong action or thought, the disobedience—may seem to be more convenient or more private or even more loving or more considerate of others, but those are lies, just like the first lie recorded in the Bible, 'Did God really say…' (Genesis 3:1 NIV). This is the life-giving truth: only what the Lord approves will bring long-term, eternal peace (*shalom*) and joy. Our journey may be very hard, but we can trust Him to sustain and enable us as we choose to 'be the Lord's servant' even when it is challenging. This is an especially powerful way to demonstrate that we 'have no other gods' before the Lord—gods like autonomy, utility, security, a good reputation, and perfection."

103. Childs, "Medical Assistance in Dying and the Trust of Faith," 294.

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Respiration, Ensoulment, and Personhood of the Human Zygote and Preimplantation Embryo

Roni Grad

Introduction

On February 16, 2024, the Alabama Supreme Court ruled 7-2 in *LePage v. Center for Reproductive Medicine, P.C.*, SC 2022-0515, SC-2022-0579, that extrauterine embryos in the first week of development and kept alive at subzero temperatures in the freezer of a fertility clinic are to be considered persons with legal protections under the state's Wrongful Death of a Minor Act.[1] In his concurring opinion, Chief Justice Tom Parker noted that, by their 2018 ratification of the Sanctity of Life Amendment to the state constitution, the people of Alabama had, "declared the public policy of this State to be that unborn human life is sacred. We believe that each human being, from the moment of conception, is made in the image of God, created by Him to reflect His likeness.… Carving out an exception for the people in this case, small as they were, would be unacceptable to the People of this State, who have required us to treat every human being in accordance with the fear of a holy God who made them in His image."[2]

The decision sent shockwaves through the secular medical community and the general public. In the immediate aftermath, fearing liability from the deaths of frozen embryos, fertility clinics across Alabama put their *in-vitro* fertilization (IVF) programs on hold, as Justice Gregory Carl Cook had predicted in his dissent.[3] Medical ethicist Arthur Caplan, along with Michelle Bayefsky, and Gwendolyn Quinn, warned of "real and dire" public-policy implications of the ruling, including high liability costs for providers and ultimately patients; denial to the families of the options to donate unused stored frozen embryos for research or to destroy them, thus leading to sustained and indefinite high storage costs; the end

to "preimplantation genetic testing" (PGT) which could lead to more abortions if later in pregnancy, babies tested positive for a genetic disorder; and impaired "fertility preservation" in women about to undergo treatments that could result in their infertility.[4] The American College of Obstetricians and Gynecologists (ACOG) called embryonic personhood "ideological and unscientific," and "a dangerous insertion of individual ideological beliefs into policy making about what medical care is available to all of us."[5] Other professional societies issued similar statements of concern.[6] The decision quickly made the national news, echoing the anxieties raised in the medical community.[7] Of note, and probably unknown to many, Louisiana already had a law on the books dating back to 1986 that stated, "A viable in vitro fertilized human embryo *is a juridical person* which shall not be intentionally destroyed by any natural or other juridical person or through the actions of any other person."[8]

The Alabama legislature responded by quickly adopting SB 159, which relieved fertility clinics of civil and criminal liability for the deaths of embryos, limiting potential damages to these centers to compensation "paid for the impacted in vitro cycle."[9] Nationally, pro-life Senators Ted Cruz and Katie Boyd Britt, citing the need to "protect both life and access to IVF treatments, which many families rely on to have children," introduced the IVF Protection Act in the United States Senate to ensure that IVF access is legally protected nationwide.[10] Neither the Alabama bill nor the proposed legislation in the US Senate directly questioned the personhood of the embryo. Yet at the same time, neither bill prohibited the intentional killing of unused embryos either for use in biomedical research and development, or for simply discarding them to make room for others. During his second term in office, President Donald Trump has supported expanded access to IVF.[11] At the same time, recognizing "the needs of children who already exist and are in need of a family," the Office of Population Affairs of the Department of Health and Human Services has recently announced a grant program to fund agencies to promote embryo adoption awareness and services. While previously, such funding was available to promote public awareness of embryo adoption, this represents an expansion of the scope of the program "to include medical and administrative services that make embryo adoption more attainable."[12] Notably, these grants do not allow for the destruction of embryos.[13]

Today's secular medical environment does not consider those extrauterine embryos residing within their mothers to be persons. The ACOG does not consider a woman to be pregnant until the embryo has been implanted in her uterus. Furthermore, the group does not recognize the term "conception" to be one with scientific validity. The term "fertilization" is defined by ACOG as "A multistep process that results in the formation of a zygote by the union of sperm and ovum," and a "zygote" is defined as "A single cell resulting from fertilization of an oocyte

by spermatozoa." In turn, an embryo is defined as, "The result of the division of the zygote up to 10 weeks' gestational age (eight completed weeks after fertilization)."[14] From this, one can easily see how the embryo is thus construed by many as being merely a "clump of cells" rather than a person in his/her earliest stage of development. Furthermore, the widespread use of various contraceptives, including the "emergency morning-after pill," without regard to the potential impact on an embryo already formed, underscores the lack of consideration of personhood for these individuals.[15] In a culture that permits abortion, this is hardly surprising.

This essay, like others before it, will make the case for personhood of the human embryo beginning at fertilization, through the lens of Scripture and the Lutheran Confessions. Additionally, it will consider the biology of the embryo to make the argument for ensoulment from the very beginning.

Preimplantation Embryonic Development[16]

Human life begins at fertilization, namely the joining of a sperm from the father and an ovum (egg) from the mother to form a single-cell zygote. The process is complex and involves a series of physiological, biochemical, and structural changes to the sperm that take place within the mother's procreative tract[17] that allow it to enter the ovum. Of note, the ovum is surrounded by a coating called the *zona pellucida*, which will allow for the entry of a single sperm; after which it becomes impenetrable, thus preventing the entry of additional sperm and the development of an unviable zygote. The *zona pellucida* then protects the developing embryo until it hatches upon entry to the uterus and is about to be implanted into the uterine wall. Thus, even at this early stage before implantation in the uterus, one may discern the mother's provision of tender care to her child (1 Thessalonians 2:7).[18] In the current secular medical environment, it bears repeating that the zygote is a separate individual from his/her mother with his/her unique set of 46 chromosomes, half of which originated in the sperm and half of which originated in the ovum.

Fertilization most often takes place in the ampulla of the fallopian tube. The ampulla is the middle, widest, and longest part of the fallopian tube. Following fertilization, the zygote begins the process of mitosis, or cell division, to produce two daughter cells, called blastomeres. The zygote is a large cell, and the blastomeres are smaller, allowing the embryo to fit within the bounds of the *zona pellucida*. The blastomeres continue to divide, and by days 3-4, the embryo consists of a 16-32 cell spherical mass called the morula (from the Latin word for "mulberry"). With increasing number, the blastomeres become increasingly small and compacted. Abnormal cells are eliminated by the embryo, and the healthy cells begin to differentiate; those at the center will eventually develop into the body of the baby and those at the periphery will eventually develop into the fetal part of the placenta. Thus,

function is coordinated toward ongoing growth and development, the hallmark of the human organism as a whole, occurring even before the embryonic baby enters his/her mother's uterus.[19]

By 5-6 days after fertilization, the embryo has grown to 50-150 cells, with an inner cavity filled with fluid that has been pumped in by the cells at the periphery. By that time, the embryonic baby has entered his/her mother's uterus and has reached the blastocyst stage of development. It is possible that the newly conceived Jesus was at this stage of development at the time of the Visitation (Luke 1:39-55).[20] As fluid increasingly fills the cavity, the differentiation between the inner cell mass and the cells at the periphery becomes more pronounced. The embryo then hatches from the *zona pellucida* and is implanted in the wall of the uterus, which has been prepared to receive it. The implantation typically takes place during the second week of development. Ectopic pregnancies, namely implantation of the embryo outside of the uterus, can occur for a variety of reasons, including early disappearance of the *zona pellucida*, chronic inflammation and scarring of the mother's procreative tract, and defects in the fallopian tubes. These are often life-threatening emergencies, particularly if the embryo implants in the fallopian tube.

In IVF, sperm are washed in media designed in an attempt to mimic exposures in the mother that prepare them for fertilization.[21] Ova are obtained from the mother by ultrasound-guided transvaginal aspiration following stimulation of the ovaries. Fertilization then occurs either by "natural" sperm penetration of the ova, or, in the case of low numbers or poor quality of sperm, by direct injection of a sperm into an ovum. Embryos formed by IVF undergo the same stages of development as those formed through the one-flesh union of husband and wife (Genesis 2:23-24). Transfer of the embryo to the mother may take place either 3 days after fertilization, or at the blastocyst stage on day 5. Before transfer, the embryos are evaluated, at times using PGT, and those assessed as having the best chance at resulting in a healthy pregnancy are transferred, one at a time, into the mother. If more than one embryo is deemed suitable for transfer, the parents may opt for them to be kept alive at sub-zero temperatures for future use; the process of freezing involves the addition of cryopreservative chemicals which dehydrate the cells, preventing the formation of ice crystals, while maintaining the structure of the interior parts of the cells, allowing them to resume function when thawed. Once parents decide that they do not desire more children, they may opt to continue cryopreservation, to donate the embryos to others to adopt and bring to term, donate them for research, or simply to "discard" them.[22] Note that either of the latter two options amounts to the killing of the embryonic baby. Some research laboratories have kept embryos alive for up to 14 days. Various rationales for the 14-day limit have included:

1. The idea that implantation is generally completed by that time (thus marking the end of the pre-pregnancy state of the embryo).

2. The emergence at that time of the primitive streak, which establishes the head/bottom and the left/right axes of the embryo, and the beginning of the process in which the embryonic cells differentiate into the three layers of cells that will give rise to the tissues of the body, including the nervous system.
3. The end of the time period in which the embryo can split into two identical twins ("twinning").

These rationales on the part of the secular medical community thus impute a level of dignity on the embryonic baby only once he/she has reached a certain stage of development. Of course, that dignity is limited, given the acceptability of later abortion. It is thus hardly surprising that attempts are being made to eliminate the ban on embryo research beyond the 14-day limit.[23]

Personhood and Ensoulment

As noted above, the secular medical community largely denies that embryos are persons, despite the biological reality that new human life begins at fertilization. The question then naturally arises as to when human beings acquire full moral status as persons.

Scripture teaches that human beings consist of body and soul/spirit (Matthew 10:28); the soul conveying personality and spirituality.[24] Furthermore, each individual human's moral status is grounded solely on his/her being one for whom Christ died (John 3:16; Formula of Concord, Solid Declaration, Article VII, paragraphs 70-71) and in whom God ultimately desires the restoration of the fullness of His image (Genesis 1:26-28; Colossians 3:10).[25] Finally, Scripture does not differentiate moral status between individuals based on whether or not they have yet been born:

1. God forms each human from the time of fertilization (Ruth 4:13; Job 10:8-11; Psalm 139:13-16; Isaiah 49:1,5; Jeremiah 1:5).
2. Unborn babies are sinners, just as are those who have emerged from the womb (Psalm 51:5).
3. Even from before fertilization, God ultimately desires the restoration of the fullness of His image in all babies to come (Ephesians 1:4; 1 Timothy 2:4).
4. Babies may be gifted with faith regardless of whether they have yet been born (Psalm 22:9-10; Luke 1:41-44; 1 Peter 3:21).[26]
5. Scripture uses similar terminology to refer to children who are unborn as well as those already born. Examples include *ben* (son/child; compare Genesis 25:22 and Psalm 113:9); *yeled* (boy/child; compare Exodus 21:22 and 2:9); and βρέφος (*brephos*, infant; compare Luke 1:41 and 2:16).

6. Jesus Himself was fully God and fully man from the time of His conception, and sanctified the fallopian tube and womb by His presence there; furthermore, the author of Hebrews writes that "He had to be made like His brothers in every respect" (Hebrews 2:17), thus, one can conclude that unborn babies, like those who have already been born, are fully human persons, consisting of body and soul/spirit, from the time of fertilization.[27]
7. Jesus died for the unborn ("all" in Romans 5:18-19 and 1 Timothy 2:6, including the unborn).[28]

Thus, the witness of Scripture stands in stark contrast to the ethos of the secular medical community. Yet God's Word does not specifically reveal how the soul originates, nor precisely at what moment the soul enters the body to create a human being (or, for that matter, when it leaves the body at the end of one's earthly life). Thus, theologians have been left to speculate.

Origin of the Human Soul

Regarding the origin of the human soul, early Christian theologians advanced numerous theories, which Jerome (340/2–420) narrowed to three.[29] These include:

1. Pre-existentialism; namely the theory that the soul existed before the body. This theory was first advanced by Plato (c.429–347 BC), adopted by the Greek-speaking Jewish philosopher Philo of Alexandria (c.20 BC–c. AD 40), also adopted by the Essene sect per Flavius Josephus (AD 37–100), hinted at in the Old Testament Apocryphal book *The Wisdom of Solomon*, and referred to in parts of the Talmud.[30] Based on Scripture passages like Jeremiah 1:5 ("Before I formed you … I knew you, and before you came forth… I sanctified you"), Origen (c.185–c.253) argued for the pre-existence of the human soul, placed into the human body as punishment for sin in its pre-existent state.[31] Given that Origen's teaching was at odds with the Scriptural witness on Original Sin, as well as a possible lead-in to reincarnation (though Origen himself rejected reincarnation), it was condemned by the Second Council of Constantinople, which was the fifth ecumenical council of the Church, in AD 553.[32]
2. Traducianism; namely the theory that the soul is received from the seed, the sperm of the father. This was the view of Tertullian (c. 155–c. 220), and later Martin Luther (1483–1546) and other Lutheran theologians, following on the Scriptural truth on Original Sin that "… along with the nature which God still creates and makes at the present time, original sin is transmitted through our carnal conception at birth out of sinful seed from the father and the mother," and "…in the first moment of our conception the seed from

which man is formed is sinful and corrupted" (Formula of Concord, Solid Declaration, Article I, Paragraphs 7, 28; cf. Romans 5:12).[33]

3. Creationism; namely the theory that God creates each soul individually at the time the body is formed. This view was championed by Jerome and others, and later by Philip Melanchthon (1497–1560), John Calvin (1509–1564), and others. According to Detlev Schulz, it is the position most commonly held by theologians today, as it avoids the materialism some see in Traducianism and reject.[34]

Timing of Human Ensoulment

Since, for the Christian, human beings, by definition, consist of body and soul, it follows that human life and personhood begin at the time of ensoulment. The specific time of ensoulment, like the origin of the soul, has long been a matter of speculation and conversation. Clement of Alexandria (c. 150–c. 215) believed that angels introduce pre-existent souls at the time of conception.[35] Holding to Traducianism in various forms, Tertullian and Gregory of Nyssa (c. 335–c. 395) taught ensoulment at fertilization/conception.[36] Over time, however, theologians who held to Creationism taught ensoulment at the moment the embryo's formation is complete. The question thus arises: when is the formation of the embryo complete? Many took their cues from the work of the ancient Greeks.

Hippocrates of Kos (c. 460–c. 375 BC) and the members of his school, based on examination of miscarried babies, and through experiments on chicken eggs (noting that chickens are not completely comparable to humans), concluded that the limbs and organs of the male embryo are formed by 30 days in males and 42 days in females, with movement beginning at 3 months for males and 4 months for females. Hippocrates did not speculate on the origin of the soul.[37] Later, Aristotle (384–322 BC) hypothesized that the male embryo was fully formed at 40 days and the female at 90. Along with this, he posited a progressive ensoulment of the growing individual, with a "nutritive soul" (nourishing itself) appearing at conception, when the seed from the father acts on the menstrual blood from the mother, just as rennet acts on milk, causing it to curdle; a "locomotive animal soul" appearing when the body is fully formed and the baby begins to kick inside the womb; and a "rational soul," coming from the seed of the father and expressed when the child starts to reason, one to two years after birth.[38] Thus, for the Greeks, a demarcation occurs between conception and birth of a time at which the growing body is considered formed.

The Greek concept of formed vs. unformed found its way into the Septuagint (LXX) translation of Exodus 21:22-25. Consider the translation of the pericope from the Hebrew in the ESV:

> When men strive together and hit a pregnant woman, so that the children come out, but there is no harm, the one who hit her shall surely be fined, as the woman's husband shall impose on him, and he shall pay as the judges determine. But if there is harm, then you shall pay life for life, eye for eye, tooth for tooth, hand for hand, foot for foot, burn for burn, wound for wound, stripe for stripe.

The Hebrew phrase for "there is no harm," *lo yihyeh ason*, is translated in the LXX with the words μὴ ἐξεικονισμένον (*me exeikonismenon*), "not completely formed." Buried in this is the term εἰκών (*eikon*, like the English term icon), suggesting that at the time of formation, the embryo possesses the image of God. The contrast is to "completely formed" in the following verse.[39]

Based on these considerations, many proponents of Creationism argued for a delayed ensoulment/humanization of the unborn child. Similar to Aristotle, Thomas Aquinas (1225–1274) proposed a progressive ensoulment of the embryo, beginning with a vegetative/nutritive soul, followed by an animal soul, and finally a human/intellectual soul at 40 days in the male and 90 days in the female. The big differences, of course, between Aquinas and Aristotle are that Aquinas taught that the human soul is created by God and infused once He has prepared the embryo sufficiently to receive it; he also taught the infusion of the rational soul *in-utero*.[40] Delayed ensoulment was widely taught by scholastic theologians and remained dominant until the times of the Reformation and the Scientific Revolution, as understanding of human embryology and genetics improved.[41] Yet, with the more recent pushes for abortion, IVF (with consequent embryo destruction), embryo research, along with the occasional embryonic twinning, the idea of delayed ensoulment/humanization, even to term, is again prominent, certainly in secular circles, but also by implication in the "Pro-Choice" Christian community.[42] One major problem with delayed ensoulment is the reality that Christ Himself had a soul at the time of His conception; thus, considering that "He had to be made like His brothers in every respect" (Hebrews 2:17), positing delayed ensoulment becomes problematic. This very issue was raised by Maximus the Confessor (580–662), himself a proponent of Creationism.[43] Indeed, while Creationism allows for the possibility of delayed ensoulment, it does not necessarily demand it; in light of the science of embryology, "formed" may simply point to the development of the zygote.

Soul, Spirit, and the Language of Breathing in Scripture

In both the Old Testament Hebrew and New Testament Greek, one finds a common terminology for soul/spirit and breathing/respiration. These terms include:

1. *nephesh*: that which breathes, the soul[44]
2. *neshama*: breath, spirit[45]
3. *ruach*: breath, wind, spirit[46]
4. πνεῦμα (*pneuma*): wind, breath, spirit[47]
5. πνοή (*pnoe*): breath, wind;[48] soul/spirit[49]
6. ψυχή (*psuche*): (breath of) life, soul[50]

Furthermore, God's Word suggests that the two are intimately linked. Consider God's creation of Adam: "And the LORD God formed man of the dust (*aphar*) of the ground, and breathed into his nostrils the breath of life (*nishmat hayyim*), and man became a living soul (*nephesh hayyah*)" (Genesis 2:7, KJV). While there are various ways in which this Hebrew verse may be translated,[51] one can discern a link between breathing/respiration and ensoulment. Consider also, from Job's reply to Zophar, "In whose (YHWH's) hand is the soul (*nephesh*) of every living thing and the breath (*ruach*) of all mankind" (Job 12:10, KJV).[52] Again, the connection between breathing/respiration and ensoulment. The angel tells Zechariah that his son will receive the Holy Spirit (πνεύματος ἁγίου, *Pneumatos Hagiou*) "even from his mother's womb" (Luke 1:15, ESV/KJV). This of necessity implies that John the Baptizer has been ensouled *in-utero*. Scripture likewise documents the departure of the soul from the body at the end of life, when a person stops breathing (e.g., Genesis 35:18; Ecclesiastes 3:19-21, 12:7; Luke 23:46; James 2:26a).[53] John Kleinig summarizes, "Just as the human mind is associated with the heart of a person in the Scriptures, so human souls are connected with the throat and its breath."[54] The question remains at what point in human development does breathing/respiration begin?

Embryonic Breathing/Respiration and Ensoulment

The *telos* of breathing/respiration is simply to enable the conversion of nutrients into energy in the body's cells, fueling the body's functions. This is most efficiently done utilizing oxygen, a process called aerobic respiration. Aerobic respiration yields carbon dioxide, water, and the energy-capturing adenosine triphosphate (ATP). As oxygen levels drop, the body initially tries to compensate, but as they continue to fall, body systems begin to fail. Cells of the body eventually shift to anaerobic respiration, namely, nutrient conversion utilizing chemicals other than oxygen. Anaerobic respiration is much less efficient than aerobic respiration at producing energy; less ATP is generated, and in animals, lactic acid is produced. Humans cannot survive without oxygen. Of note, some single-celled organisms, most of which are bacteria, are "anaerobes," meaning that they do not use oxygen (and may in fact be damaged by it).

In the extrauterine environment, the breathing/respiration of the human organism consists of:

1. Inhalation of air containing about 21% oxygen (or more if an individual requires supplemental oxygen) into the lungs
2. Uptake of the oxygen into the bloodstream, where it is pumped by the heart to the tissues
3. Aerobic respiration in the cells of the tissues
4. Uptake of carbon dioxide from the tissues into the bloodstream to be pumped by the heart back to the lungs
5. Exhalation of the carbon dioxide-enriched air (about 4%) from the lungs

As noted above, at the beginning of his or her life, the human consists of a single-cell zygote, who is very much alive and in whom respiration is taking place. The ambient oxygen in the environment of the female procreative tract, and which the embryonic baby is taking in, is well below that of the outside air; namely about 8.7% in the fallopian tube, decreasing to about 2% in the uterus. These lower oxygen levels are designed to protect the embryo, foster his or her normal development prior to (and post) implantation via heterodimer (2 protein subunits bound together) mediators known as hypoxia-inducible factors, and facilitate implantation itself. Attempts are made to replicate these low-oxygen environments when culturing embryos in the IVF facility.[55] Also in the IVF facility, measurement of a 3-day-old embryo's oxygen consumption rate is a factor that can be used to predict its development into a "good quality" blastocyst.[56] Once the placenta develops, the gas exchange takes place through it by diffusion from the mother's blood, and respiration continues.

Many use the terms "breathing" and "respiration" interchangeably when describing the activity of the lungs, but distinguish respiration at the cellular and tissue levels as separate processes. Consider the United States National Library of Medicine description of the Medical Subject Heading (MeSH) "Respiration":

> The act of breathing with the LUNGS, consisting of INHALATION, or the taking into the lungs of the ambient air, and of EXHALATION, or the expelling of the modified air which contains more CARBON DIOXIDE than the air taken in (*Blakiston's Gould Medical Dictionary*, 4th ed.). This does not include tissue respiration (=OXYGEN CONSUMPTION) or cell respiration (=CELL RESPIRATION).[57]

This differentiation applies better to a developed individual after birth than to one at the zygote or embryonic stage of development, in which cell respiration (zygote) and tissue respiration (after first cell division) apply to the organism as a whole. Once the placenta develops, it serves as the lungs for the growing baby. It thus seems fair to say that indeed the human zygote and embryo breathes/respires in a

manner appropriate to his or her developmental stage. If this were not the case, he/she would not survive. Furthermore, cellular respiration was not well described until the late 19th and into the 20th century,[58] and, to the knowledge of this author, has not yet entered the conversation on ensoulment. It is reasonable, though, to consider that beginning at fertilization, whether in the fallopian tube or in the laboratory, a human is a breathing and ensouled person, one for whom Jesus died, and whom God desires to be born, baptized, and saved. As an aside, while this adds science to the argument for immediate ensoulment, it does not adjudicate the debate between Traducianism and Creationism.

Objections

One might raise a number of objections to the concept of immediate ensoulment in general, and more specifically to the idea that embryonic breathing/respiration testify to it. These will now be considered and addressed.

The first objection addresses the situation considered in *LePage v. Center for Reproductive Medicine, P.C.*; namely, given that the embryos in question were in a state of cryopreservation, in which respiration and all biological activity are completely stopped, were they in fact still alive and ensouled? The Roman Catholic bioethicist Nicholas Tonti-Filippini(†), drawing on Aquinas ("…Now it is clear that the first thing by which the body lives is the soul…"), argued that a cryopreserved embryo, while no longer "integrated or dynamic in the way in which we normally consider to be essential to being a living organism," retains the capacity to be reintegrated and is therefore not dead. Thus, it is fair to give the benefit of the doubt to the cryopreserved embryo, and to treat him/her as a living human person in suspended *animation* (italics his; *anima* being the Latin term for "soul").[59] Jason Eberl, also Roman Catholic, agrees, arguing also from a Thomistic framework that the zygote and embryo have a rational soul and that the cryopreserved embryo retains "intrinsic active potentiality to engage in (life functions) again and develop into a more fully actualized person…."[60] One does not need to rely on Aquinas to conclude that, given that the embryo's basic infrastructure is preserved during the deep freezing process, it is reasonable to posit that he/she remains ensouled, although not actively breathing, as he/she retains the capacity to resume once carefully thawed. In contrast, when Jesus raised Lazarus (John 11:38-44), decay had already set in; thus, one could posit that Lazarus' soul had departed and was reunified with his body when he rose again.[61] In the opinion of this author, Justice Parker and the Alabama Supreme Court were correct in their assessment of the moral status of the cryopreserved embryonic babies who had died. In the case of embryonic babies that do not survive the freeze/thaw process, the soul has clearly departed the body at some point in the sequence of events.

Second, as noted above, some are hesitant to declare personhood during the first 14 days, when twinning is possible. Gilbert Meilaender responds:

> The claim that there can be no individual human organism before the time at which twinning either has or has not taken place seems to rest on the notion that if twinning occurs the developing blastocyst has split into two (which is the sort of thing that can happen to a clump of cells but not, except in science fiction, to a living human being). The philosophical difficulty with this claim, however, is that it seems impossible to know that this would be the right way to describe what happens if twinning occurs. The argument supposes that where once there was simply *X*, a collection of cells, there is now *Tom* and *Tim*. But, metaphysically, it is just as possible that where once there was *Tom* there are now *Tom* and *Tim*, and it seems unlikely that science can tell us why this should not be the case. The capacity to twin may simply be one of the characteristic capacities of a developing human organism at a particular (early) stage of its development.[62]

Given the presence, though, of a living, breathing embryo at the start, there is no obvious reason to posit a delay in ensoulment. Rather, one may trust the process to God's perfect will.

Third is the rare occurrence of natural human chimerism, in which two zygotes fuse, resulting in an individual who originated from two sperm and two ova and whose cells contain two distinct sets of DNA.[63] This would not negate the ensoulment status of the two original zygotes; how God brings them together is unrevealed in His Word, and a matter on which one can only speculate. Certainly, individuals with chimerism are ensouled persons for whom Jesus died.

Fourth, many point out that spontaneous abortions, otherwise known as miscarriages, occur in up to 50 percent of pregnancies, with many occurring in the early first trimester, before the mother knows she is pregnant. Genetic anomalies are undoubtedly common among these babies. Consider the following from Lindsey Disney and Larry Poston (†) in an Episcopalian journal:

> This statistic becomes extremely problematic if all of those miscarriages are deemed actual human beings…. Consider that the cumulative population of the earth throughout history is estimated to be approximately 60 billion persons. If that number represents the 50 percent that survived pregnancy, then there are at least 60 billion souls that did *not* survive and who never lived a day on earth. If these souls are innately evil, as Christianity teaches on the basis of such passages as Psalm 58:3 ("The wicked are estranged from the womb, they go astray as soon as they are born, speaking lies," ASV), then more than 60 billion human beings were essentially born into hell. How disturbing to think of souls being eternally tormented without

> ever having the chance of living an earthly life. Some, of course, would argue that infants are innocent, and therefore those 60 billion souls are "in heaven." But this claim is theologically problematic, for would it not imply that "heaven" is overwhelmingly populated by fetuses that were spontaneously or intentionally aborted? Is this a heaven that … Christians … would be satisfied to be a part of?[64]

From the perspective of Scripture and the Lutheran Confessions, this statement raises issues. Akin to secular humanism, the authors deny original sin. Furthermore, accepting that God can work outside of nature, it is reasonable to suggest that at least some of these babies may have heard God's Word in the fallopian tube and/or womb and believed. Regarding the argument that it is counterintuitive to think that heaven will be heavily populated by human beings who have lived only a few days, David Jones writes:

> Though this argument has been much repeated, it is very weak. It amounts to saying that because many embryos do not survive, they are not valuable in the eyes of God…. As Christians are required to say that there are very many newborn infants in the life of the world to come then they should remain open to the possibility that there will be many human embryos. If they are human and they have died, then they will be raised from the dead, though we cannot say what that will be like.[65]

Christians can die in the certain hope of the Resurrection on the Last Day, with the body glorified and reunited with the soul (1 Corinthians 15:50-57), and can confidently entrust these embryonic babies to God's mercy. And yes, rejoice over any who are in heaven.

Fifth, some may ask whether all individual human cells and/or tissues, in isolation from the rest of the body, should be considered ensouled. After all, they are exhibiting respiration as well; otherwise, they would die. Yet, while they are part of the person, they are not in themselves a person.[66] Still, isolated cells and tissues come from ensouled and baptized (in the case of those who have received the sacrament) bodies, and deserve to be treated with respect.[67]

Sixth, some may raise the issue of hydatidiform moles, which result when a sperm enters an ovum that has lost its chromosomes, producing a cell containing only paternal DNA that can form only the placenta and amnion (the protective sac around the baby), but not the body of the baby. The resulting tumor is able to implant in the uterus, grow into a large mass, mimic pregnancy, and endanger the life of a woman.[68] The index cell is breathing. Are we to say that it too is ensouled? Although the initial cell mimics a zygote, the absence of maternal DNA means God has not granted conception (Ruth 4:13), and the cell is not ensouled. The same can be said for the parthenote, which arises when an immature oocyte begins dividing either

spontaneously or after being stimulated in a laboratory setting.[69] These manifestations of Adam's fall, though, are no reason to question the ensoulment of the true zygote.

Finally, we return to the objections raised by the secular medical community and others to the *LePage v. Center for Reproductive Medicine, P.C.* decision:

1. The declaration of personhood at fertilization threatens the availability of IVF for families who rely on it to have children of their own, including women hoping for fertility preservation. Yet IVF is fraught with ethical issues for the Christian, including bypassing the one-flesh union of one man and one woman for the procreation of children (Genesis 2:23-24); prioritizing adult desires over the rights of children; treating embryos as property rather than as persons with inherent dignity; and the forming of ensouled embryos who are destined to be killed, among other issues. A comprehensive discussion of the ethical issues associated with IVF is beyond the scope of this essay; for a brief synopsis, the reader is directed to the position statement on IVF adopted by Lutherans For Life in 2026.[70]
2. The declaration of personhood at fertilization results in the indefinite need to maintain "spare" embryos in a cryopreserved state, leading to high ongoing costs for parents, a burden too onerous. Even if IVF were to cease, more than one million embryonic babies would remain in frozen storage.[71] What is one to do with them?

   a. Allowing the parents to donate the embryos for research could potentially benefit others to come, yet this utilitarian approach results in the killing of embryonic babies, treating them as means rather than ends in themselves, and is thus ethically problematic from a Christian perspective.

   b. Allowing the parents to opt for destruction, i.e., active killing, of the ensouled embryonic babies, amounts to a violation of the Fifth Commandment. Some couples, moved by the plight of these very young children, have adopted them with the biological parents' permission, agreeing to receive them in the adoptive mother's womb, carry them to term, and bring them into their homes. While opposing IVF, Lutherans For Life adopted a position statement in 2023 supporting this approach to rescue these tiny people.[72] Furthermore, Lutheran Family Service, working in Illinois, Iowa, Nebraska, and South Dakota, provides support for couples eager to receive these embryonic babies.[73] Other Lutherans have reservations; Richard Eyer, for example, expresses concern that, among other issues, embryo adoption may encourage the practice of IVF and that "the adoption of embryos for implantation by strangers might add to the as yet unknown risk of producing a new generation of persons who are no longer capable of seeing any need for or connection between the biological and the relational in marriage and conception."[74] Additionally, not every embryo will survive transfer, even

though the intent is to sustain the baby's life. From his Roman Catholic perspective, Nicholas Tonti-Filippini(†) argued against embryo adoption, stating that the intimate bond between the mother and her child in the womb should be strictly reserved for children procreated through the one-flesh marital union of the woman and her husband.[75] Furthermore, arguing that "suspended animation is itself a moral wrong," he maintained that the frozen embryo should be thawed, the cryopreservative removed, and its cells rehydrated, and thus "returned to its natural state in which it regains its dynamism, albeit for a short time before death intervenes through lack of sustenance and a favorable environment."[76] On the other hand, the author of this essay supports embryo adoption. That said, the question of embryo adoption, and, barring that, the fate of those remaining in cryopreserved suspended animation, is an issue of casuistry that invites further ethical reflection.

3. The declaration of personhood at fertilization threatens the availability of PGT, introduces liability concerns for any invasive prenatal diagnostic procedures (chorionic villus sampling, amniocentesis) given the risk of fetal death, and, in the end, removes a woman's "right" to an abortion. The ultimate purpose of PGT is eugenic; namely, not allowing a "defective" baby to live. This is likewise the *telos* of much testing of babies in the womb, although such testing can also have a life-affirming intent; for example, learning of specific issues that may be amenable to *in-utero* treatment, or alternatively, allowing parents to prepare in advance for the birth of a baby who may need tertiary care upon delivery. Eugenics is anathema to the Christian, as each person is one for whom Jesus died, and whose dignity and moral status are rooted *solely* in this fact.

   Furthermore, the weakest members are indispensable to the Body of Christ (1 Corinthians 12:22).[77] Abortion, whether chemical (even from the time of fertilization) or surgical, for whatever reason, kills an ensouled baby and violates the Fifth Commandment.[78] While those who historically held to delayed ensoulment may have imposed lighter penalties for abortion before full formation of the embryo, the position of the Church has always been that abortion at any stage of pregnancy is a sin.[79] Thus, the Christian knows neither of abortion as healthcare nor of any so-called moral "right" to an abortion. Furthermore, far from being "dangerous," the personhood at fertilization declaration ultimately promotes safety for both mother and baby.[80]

What Does This Mean?

While the secular medical community continues to dehumanize the preimplantation embryo and increasingly, the baby in the womb until term (and sadly at times in the postnatal period as well), the Christian can proclaim the ensoulment, per-

sonhood, and dignity of the baby from the moment of fertilization. The biological evidence of embryonic breathing/respiration testifies to that theological truth, yet the non-believer will not make the connection without the intervention of the Holy Spirit. This may, however, be a useful point in a pro-life apologetics conversation that God can use to change hearts.

For the Christian, the embryonic baby, from the single-cell zygote stage of development, like his/her parents and family, is a neighbor whom the believer is called to *sacrificially* love and serve (Galatians 5:13-14).[81] That means recognizing the dignity with which he/she has been gifted, and bearing the associated burdens. For families, these might be financial, including the cost of ongoing cryopreserved storage until the mother is able to receive the baby into her womb and hopefully carry him/her to as close to term as possible. Of course, there are already financial and physical burdens associated with natural procreation. Alternatively, there is an emotional burden of letting go and allowing another couple to adopt one's embryonic baby. Raising a child with long-term physical and/or developmental disability entails significant burdens of its own and presents an opportunity for the Body of Christ as a whole to bear these along with the family, praying for and with them and helping in any way they can (Galatians 6:2). Similarly, the Church can jointly with the family, bear the burdens of infertility, loss, and the like. All of these works of sacrificial love, whether on the part of the parents and immediate family or of the congregation, flow out of the gifts received in God's Divine Services.[82] The role of the Pastor is critical: to hear the penitent sinner's confession and to absolve him or her "in the stead and by the command" of Jesus (John 20:19-23);[83] to care for souls, to teach the sanctity of life from fertilization into eternity from the pulpit, which can easily be done in the context of the weekly lectionary pericopes, and in Bible studies, and to equip the saints, i.e., the members of the congregation, to care for each other (Ephesians 4:13). In the end, all believers can look forward to the certain hope of the resurrection on the Last Day, when, "death shall be no more, neither shall there be mourning nor crying nor pain anymore, for the former things have passed away" (Revelation 21:4b, ESV), and perhaps many who did not survive embryonic life will be there in their risen and glorified bodies, joining in the marriage supper of the Lamb (Revelation 19:9b)! Amen. Come, Lord Jesus! (Revelation 22:20).

Postscript: A Note on Jeremiah 1:5

The ESV text of God's call to Jeremiah reads, "Before I formed you in the womb I knew you, and before you were born I consecrated you…" This is somewhat different from the KJV, which reads, "Before I formed thee in the belly I knew thee; and before thou camest forth out of the womb I sanctified thee…" The KJV is closer to the Hebrew text than the ESV. The Hebrew reads, "Before I formed

you in the *beten* (belly) I knew you, and before you came forth from the *rechem* (womb) I consecrated/sanctified you…." The word *beten* (belly) is a more general term referring to the part of the torso below the diaphragm, while the word *rechem* refers more specifically to the womb (and is related to the word *racham*, to have compassion!). Given that critical formation of the embryonic baby takes place prior to his or her being implanted in his or her mother's womb, coupled with the lack of appreciation for this and a pervasive attitude of dehumanization of the tiniest of people in the secular community, perhaps, to help equip the Christian sanctity of life witness, it is time for the Bible translators to readopt the words, "belly … womb" of the KJV, albeit embedded in current English usage.

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Notes

1. The opinion, SC 2022-0515, SC 2022-0579, may be downloaded at https://law.justia.com/cases/alabama/supreme-court/2024/sc-2022-0579.html. For a brief synopsis of the case and its background, see John Eidsmoe and Mary Huffman, "Law and Personhood: A Biblical and Medical Study from a Two Kingdoms Perspective," *Verba Vitae* 1, no. 3-4 (2024): 129-131.
2. SC 2022-0515, SC 2022-0579, 47-48.
3. SC 2022-0515, SC 2022-0579, 80.
4. Michelle J. Bayefsky, Arthur L. Caplan, and Gwendolyn P. Quinn, "The Real Impact of the Alabama Supreme Court Decision in *Le Page v Center for Reproductive Medicine*," *JAMA* 331, no. 13 (2024): 1085-1086. Regarding the effect on PGT, the authors noted that couples might use IVF coupled with genetic testing of the embryos to avoid passing on genetic disease; if this were not available, the baby would be tested *in-utero*, and aborted if afflicted. Regarding fertility preservation, this refers to women who may, for example, be about to begin chemotherapy which could impact later fertility; IVF allows her to freeze embryos for later transfer when she has recovered and is better able to carry a pregnancy to term. The authors note that freezing eggs is another option, but adds risk due to repeat freezing and thawing.
5. Verda J. Hicks, "ACOG Statement on Alabama Supreme Court IVF Decision," may be accessed at https://www.acog.org/news/news-releases/2024/02/acog-statement-on-alabama-supreme-court-ivf-decision?utm_source=redirect&utm_medium=web&utm_campaign=int.
6. See, for example, Susan Crockin and Francesca Nardi, "Alabama Supreme Court Rules Frozen Embryos Are 'Unborn Children' and Admonishes IVF'S 'Wild West' Treatment," which may be accessed at https://integration.asrm.org/news-and-events/asrm-news/legally-speaking/frozen-embryo-destruction-and--potential-travel-restrictions-for-surrogacy-arrangements2/.

7. See, for example, Christina Maxourlis, "In unprecedented decision, Alabama's Supreme Court ruled frozen embryos are children. It could have chilling effects on IVF, critics say," https://www.cnn.com/2024/02/20/us/alabama-embryo-law-ruling-supreme-court.
8. Acts 1986, No. 964, §1. Italics have been added for emphasis. This document may be accessed at https://legis.la.gov/legis/Law.aspx?d=108446. A 2025 revision defined a human embryo as a "fertilized human ovum that is biologically human, with certain rights granted by law, composed of one or more living human cells and human genetic material"; an *in-vitro* fertilized human embryo as a "human embryo created through the in vitro fertilization process that has certain rights granted by law, and is composed of one or more living human cells and human genetic material so unified and organized that it may develop in utero into an unborn child"; and nonviable *in-vitro* fertilized human embryo as "an in vitro fertilized human embryo that fails to meet necessary developmental milestones, except when the embryo is in a state of cryopreservation. An embryo shall not be deemed nonviable before seventy-two hours from fertilization. Viability of an in vitro fertilized human embryo is presumed unless it is deemed nonviable." Acts 2025, No. 116, §1, may be accessed at https://law.justia.com/codes/louisiana/revised-statutes/title-9/rs-9-121/. The Louisiana law was mentioned by legal scholars Rebecca S. Feinberg, Michael J. Sinha, and I. Glenn Cohen, in their editorial, "The Alabama Embryo Decision – The Politics and Reality of Recognizing 'Extrauterine Children,'" *JAMA* 331, no. 13 (2024): 1083.
9. The text of SB 159 may be accessed at https://legiscan.com/AL/text/SB159/2024.
10. Ted Cruz and Katie Boyd Britt, "We'll Protect Both Life and IVF," *Wall Street Journal Opinion*, May 19, 2024, may be downloaded at https://www.wsj.com/opinion/well-protect-both-life-and-ivf-81e2bf1f. The text of the "IVF Protection Act" may be accessed at https://www.britt.senate.gov/wp-content/uploads/2024/05/2024.05.17-IVF-Protection-Act-LYN24343.pdf. The bill was actually introduced by Cruz, and cosponsored by Britt, along with Senators Cynthia Lummis, Roger Wicker, and Robert Marshall. The bill called for the denial of federal health care funds to states that prohibit IVF, though it did not compel individuals or organizations clinics to provide IVF services. It was referred to the Finance Committee and did not go to the full Senate for consideration. See the summary at https://www.congress.gov/bill/118th-congress/senate-bill/4368/all-info.
11. See Donald Trump's February 18, 2025 Executive Order "Expanding Access to In Vitro Fertilization" at https://www.whitehouse.gov/presidential-actions/2025/02/expanding-access-to-in-vitro-fertilization/. Also, Trump's work to lower the cost of and increase coverage for IVF at https://www.whitehouse.gov/fact-sheets/2025/10/fact-sheet-president-donald-j-trump-announces-actions-to-lower-costs-and-expand-access-to-in-vitro-fertilization-ivf-and-high-quality-fertility-care/; and https://www.dol.gov/newsroom/releases/ebsa/ebsa20260510.
12. U.S. Department of Health and Human Services Office of Population Affairs, "Embryo Adoption Awareness and Services," page 5, may be accessed at https://files.simpler.grants.gov/opportunities/167d140c-52a1-4ebb-99be-ecddf378082d/attachments/13b771a1-4ca4-4420-a526-efabdbccb0da/PA-EAA-26-001_EAA_NOFO.pdf.
13. "Embryo Adoption Awareness and Services," 4.
14. These definitions may be found at https://www.acog.org/practice-management/health-it-and-clinical-informatics/revitalize-gynecology-data-definitions. Technically, an oocyte is a developing egg cell, while an ovum is one that has matured and is ready for fertilization.

15. For a full review, see Donna J. Harrison, "Contraception: An Embryo's Point of View," *Concordia Theological Quarterly* 84, no. 1-2 (2020): 137-159.

16. These details may be found in any embryology text. For a concise online review aimed at physicians, and used by the author in the writing of this paper, see Yusuf S. Kahn, and Kristin M. Ackerman, "Embryology, Week 1," in *StatPearls* (Treasure Island, FL: StatPearls Publishing, 2026), https://www.ncbi.nlm.nih.gov/books/NBK554562/. For a review aimed at those outside the health care professions, the author recommends the *Voyage of Life* interactive website developed by the Charlotte Lozier Institute, which may be accessed at https://lozierinstitute.org/voyage/.

17. In other words, reproductive tract. This author prefers the use of "procreation" to "reproduction." In the words of John Pless, "We often speak of the conceiving and birthing of children as reproduction. Yet this language is deceptive, for it carries with it the imagery of the factory and the assembly line. The language of procreation is preferable to reproduction. Procreation better illustrates the reality of creation. We are created, not manufactured or mass produced." See John T. Pless, *A Small Catechism on Human Life*, rev. ed. (St. Louis: LCMS Life Ministries, 2023): 22.

18. The verb θάλπω (*thalpo*), literally meaning "make warm," is used here by Paul to refer to the mother's cherishing of her children. See the entry in Walter Bauer, Frederick William Danker, W. F. Arndt, and F. W. Gingrich, eds., *A Greek-English Lexicon of the New Testament and Other Early Christian Literature*, 3rd ed. (Chicago: University of Chicago Press, 2000), 442; henceforth BDAG.

19. Maureen L. Condic, Samuel B. Condic, "Defining Organisms by Organization," *The National Catholic Bioethics Quarterly* 5, no. 2 (2005): 335-341. For more intricate details of preimplantation human development, see, for example, Maureen L. Condic, "When Does Human Life Begin? The Scientific Evidence and Terminology Revisited," *University of St. Thomas Journal of Law & Public Policy* 8, no. 1 (2013): 46-70.

20. See Douglas V. Morton, "The Incarnation and Human Personhood," *Verba Vitae* 1, no. 3-4 (2024): 81-82. Morton's use of the term zygote here is inaccurate, and the text should read "blastocyst." This author agrees that Jesus may not yet have been implanted in his mother's uterus at the time that John leaped in Elizabeth's womb.

21. For a concise review of the medical aspects of IVF used by the author in the writing of this paper, see Francesca Mancuso, Manvinder Singh, and Anthony L. Shanks, "In Vitro Fertilization," in *StatPearls* (Treasure Island, FL: StatPearls Publishing, 2026), https://www.ncbi.nlm.nih.gov/books/NBK562266/.

22. See "It Takes More Than One," from the American Society for Reproductive Medicine, available at https://www.asrm.org/advocacy-and-policy/fact-sheets-and-one-pagers/it-takes-more-than-one/.

23. See, for example, Henry T. Greely, "The 14-Day Embryo Rule: A Modest Proposal," *Houston Journal of Health Law & Policy* 22, no. 1 (2022): 147-182, available at https://houstonhealthlaw.scholasticahq.com/article/38532-the-14-day-embryo-rule-a-modest-proposal.

24. Some theologians, including Martin Luther (1483-1546) later in his life, posit a dichotomous view of the human being as consisting of body and soul/spirit, while others, including Luther in his earlier writings, propose a trichotomous view of the human as consisting of body, soul, and spirit. Either view can be supported in Scripture. For the sake of simplicity, this essay assumes a dichotomous view. For an overview of the nature of the soul and the

"Dichotomy or Trichotomy" debate, see Klaus Detlev Schulz, *Theological Anthropology and Sin* (Ft. Wayne, IN: The Luther Academy, 2023), 90-91, 99-104.

25. For a comprehensive discussion of the *Imago Dei* (image of God), see Dan Lioy, "The *Imago Dei*: Biblical Foundations, Theological Implications, and Enduring Significance," *Verba Vitae* 1, no. 3-4 (2024): 45-72.

26. And, as noted above, the One who was the object of the faith given to John the Baptizer was at the time very early in the first trimester of His prenatal human development.

27. Morton, "Incarnation and Personhood," 84-86.

28. The word ἄνθρωπος (*anthropos*) in the Romans verses can simply refer to a human being.

29. For a concise summary, see Schulz, Theological Anthropology, 92-99. For a more expansive summary, see David Albert Jones, *The Soul of the Embryo: An Enquiry into the Status of the Human Embryo in the Christian Tradition* (London: UK/ New York: Continuum, 2024), 92-108.

30. Jones, *Soul of the Embryo*, 92-97. The specific references in *Wisdom of Solomon* are 8:19-20 and 15:8; the commentary on these verses in the 2012 Concordia Publishing House edition of the Apocrypha refers back to the Platonic view of pre-existing souls; see Edward A. Engelbrecht, ed., *The Apocrypha: The Lutheran Edition with Notes* (St. Louis: Concordia Publishing House, 2012), 40, 49.

31. Schulz, *Theological Anthropology*, 94-95.

32. Jones, *Soul of the Embryo*, 99; Schulz, *Theological Anthropology*, 95.

33. Jones, *Soul of the Embryo*, 100-110 & 142-144; Schulz, *Theological Anthropology*, 92-94; Dennis Di Mauro, *A Love for Life: Christianity's Consistent Protection of the Unborn* (Eugene: Wipf & Stock, 2008) 13-14; Michael J. Gorman, *Abortion & the Early Church: Christian, Jewish & Pagan Attitudes in the Greco-Roman World* (Eugene, OR: Wipf and Stock, 1998), 56-57. Johann Gerhard (1582-1637), holding to Traducianism, bluntly stated, "God would be unjust in sending a pure soul into an impure body" in his Commonplace "On the Image of God in Man before the Fall," Chapter VIII, Paragraph 128, in Johann Gerhard, *On Creation and Predestination–Theological Commonplaces*, trans. Richard J. Dinda (St. Louis: Concordia Publishing House, 2013), 319. Quotations from the Formula of Concord are taken from The Book of Concord, *The Confessions of the Evangelical Lutheran Church*, ed. and trans. Theodore G. Tappert (Philadelphia: Fortress Press, 1959), 510, 513.

34. Jones, *Soul of the Embryo*, 102-105, 146; Schulz, *Theological Anthropology*, 95-99.

35. Jones, *Soul of the Embryo*, 112-113; Gorman, *Abortion & the Early Church*, 52.

36. Jones, *Soul of the Embryo*, 113-116.

37. Ibid., 18-21.

38. Ibid., 21-31. Regarding the curdling at conception, Jones compares Aristotle to Job 10:10. Johann Gerhard picks up on this in his *Commonplace*, "On Providence" Chapter VIII, Paragraph 73; regarding Job 10:8-11, "In this passage, the formation of the fetus in the womb is described with very meaningful words. For the seed corresponds with the milk with regard to material, conditions, manner of generation, places in which they occur, and their use. In fact, the first formation of the embryo is a sort of curdling (Aristotle, *De generat. animal.*, bk. 1, ch. 20): 'Just as in the curdling of milk the milk is the substance, but the fig juice or rennet is that which has the curdling element – likewise

the emission from the male is divided within the female.'" Gerhard, *On Creation and Predestination*, 75.

39. Jones, *Soul of the Embryo*, 48-50; Di Mauro, *A Love for Life*, 2. Jones points out that the rabbis interpreted "no harm" as causing a miscarriage, while "harm" implied the death of the mother. While the death of the baby is an injustice, this crime merits only a fine, as the unborn baby is not yet ensouled. Jones also points out the NIV translation of "no harm" as "gives birth prematurely," implying that the baby is born alive, while "harm" is translated "serious injury." Jones, *Soul of the Embryo*, 46-47, 50-51. The commentary in the *Concordia Self-Study Bible* (NIV) explains that "serious injury" in verse 23 applies to either the mother or the child; see *Concordia Self-Study Bible: New International Version*, Robert G. Hoerber, General Editor (St. Louis: Concordia Publishing House, 1986) 117. The commentary in *The Lutheran Study Bible* (ESV) on this pericope simply states "God considers unborn children human beings"; see *The Lutheran Study Bible: English Standard Version*, ed., Edward A. Engelbrecht (St. Louis: Concordia Publishing House, 2009), 131.
40. Jones, *Soul of the Embryo*, 119-121; Di Mauro, *A Love for Life*, 22.
41. Jones, *Soul of the Embryo*, 121, 123-124, 156-174.
42. Ibid., 214-235. For a description of the thought processes within "Pro-Choice" Christian groups, see Di Mauro, *A Love for Life*, 35-45.
43. Cosmin Lazar, "The Dignity of the Human Embryo in the Anthropology of Saint Maximus the Confessor," *International Journal of Orthodox Theology* 11, no. 2 (2020): 185 & 198. The paper may be accessed at https://www.orthodox-theology.com/media/PDF/2.2020/CosminLazar.pdf.
44. See the entry in Francis Brown, S.R. Driver, and Charles A. Briggs, *Hebrew and English Lexicon of the Old Testament* (Boston and New York: Houghton Mifflin Company, 1907): 659; henceforth BDB. The classical work is accessible online at https://hbionline.org/research/images/brown-driver-briggs.pdf.
45. BDB, 675.
46. BDB, 924.
47. BDAG, 832-836.
48. BDAG, 838.
49. Used in the LXX translation of *nephesh* (ex. Proverbs 24:12); *neshama* (ex. Job 26:4); *ruach* (ex. Job 27:3).
50. BDAG, 1098-1099.
51. The ESV, for example, concludes the verse, "living creature."
52. The ESV translates the verse as follows, "In his hand is the life of every living thing and the breath of all mankind." The connection between "his" and "YHWH" comes from the previous verse.
53. Consider, for example, "Then Jesus, calling out with a loud voice, said, 'Father, into your hands I commit my spirit (πνεῦμά, *pneuma*)!' And having said this he breathed his last (ἐξέπνευσεν, *exepneusen*)." (Luke 23:46, ESV; the KJV concludes, "gave up the ghost." Either way, Jesus' soul departs as he takes his last breath.)
54. John W. Kleinig, *Wonderfully Made: A Protestant Theology of the Body* (Bellingham, WA: Lexham Press, 2021), 8.

55. See, for example, Franchesca D. Houghton, "Hypoxic Regulation of Preimplantation Embryos: Lessons from Human Embryonic Stem Cells," *Reproduction* 161, no. 1 (2021): F41-F51. Note that the data presented are derived from experimentation on human and animal embryos. This writer does not condone human embryonic experimentation.

56. Kaori Goto, et. al., "Prediction of the In Vitro Developmental Competence of Early-Cleavage-Stage Human Embryos with Time-Lapse Imaging and Oxygen Consumption Rate Measurement," *Reproductive Medicine and Biology* 17, no. 3 (2018): 289-296. The author does not condone this type of work with human embryos, and shares the work specifically to document embryonic respiration.

57. Uppercase lettering is theirs. The MeSH heading description may be accessed at https://www.ncbi.nlm.nih.gov/mesh?Db=mesh&Cmd=DetailsSearch&Term=%22Respiration%22%5BMeSH+Terms%5D.

58. Sukhamay Lahiri, "Historical Perspectives of Cellular Oxygen Sensing and Responses to Hypoxia," *Journal of Applied Physiology* 88, no. 4 (2000): 1468-1469. Interestingly, the Hippocratic corpus posits the incorporation of air/breath (*pneuma*) very early in development; Jones, *Soul of the Embryo*, 19.

59. Nicholas Tonti-Filippini, "The Embryo Rescue Debate: Impregnating Women, Ectogenesis, and Restoration from Suspended Animation," *The National Catholic Bioethics Quarterly* 3, no. 1 (2003): 134-136.

60. Jason T. Eberl, "Metaphysical and Moral Status of Cryopreserved Embryos," *The Linacre Quarterly* 79, no. 3 (2012): 306, 311. Although Aquinas argued for delayed ensoulment, Eberl, drawing on the work of Benedict Ashley (1915–2013), argues that had Aquinas had the current understanding of human embryology at his disposal, he would have argued for full ensoulment (rational soul) at fertilization/conception. Ibid., 306.

61. Note that Lazarus had been dead four days; thus, decay had already set in.

62. Gilbert Meilaender, *Bioethics: A Primer for Christians*, 4th ed. (Grand Rapids, MI: William B. Eerdmans Publishing Company, 2020), 37-38. Italics are Meilaender's. David Jones shares the view that "human embryos possess certain powers that are lost later in life." Jones, *Soul of the Embryo*, 227.

63. Natural human chimerism is complex and has a number of variants, including fusion chimerism, described above, as well as microchimerism, from cells passing between the baby and the mother across the placenta, and twin chimerism, caused by cells passing between fraternal twins via fused placentas. For purposes of the question of ensoulment, only the case of fusion chimerism is relevant here. For a review of natural human chimerism, see Kamlesh Madan, "Natural Human Chimeras: A Review," *European Journal of Medical Genetics* 63, no. 9 (2020), available at https://www.sciencedirect.com/science/article/pii/S1769721220302895. Natural human chimerism is thought to be rare, but many may have it without knowing it. Madan reminds the reader that "recipients of tissue and organ transplants are artificial chimeras."

64. Lindsey Disney, Larry Poston, "The Breath of Life: Christian Perspectives on Conception and Ensoulment," *Anglican Theological Review* 92, no. 2 (2010): 291. Italic emphasis is Disney's and Poston's. ASV is the American Standard Version translation of Scripture.

65. Jones, *Soul of the Embryo*, 228-229.

66. Condic and Condic, "Defining Organisms," 335-338.

67. This same consideration informs how the Christian treats a body after death.

68. Condic and Condic, "Defining Organisms," 339-340; Maureen L. Condic, "When Does Human Life Begin? A Scientific Perspective," *Westchester Institute White Paper Series*, 1, no. 1 (2008): 10.

69. Condic, "When Does Human Life Begin?" 9-10. Spontaneous parthenogenesis may lead to the development of ovarian teratoma, a tumor that contains tissues from the embryonic germ cell layers (ectoderm, mesoderm, and endoderm); thus, one may see body parts such as teeth, hair, fat, and muscle in these tumors. On parthenogenesis and ovarian teratoma, see Abdelmonem Awad Hegazy, Aiman Ibraheem Al-Qtaitat, Raafat Awad Hegazy, "A New Hypothesis May Explain Human Parthenogenesis and Ovarian Teratoma: A Review Study," *International Journal of Reproductive BioMedicine* 21, no. 4 (2023): 277-284.

70. "In Vitro Fertilization," *Position Statements of Lutherans For Life*, available at https://lutheransforlife.org/life-issues/position-statements/. Note that the document is continually being revised; thus, specific page numbers are not static.

71. In the ten-year period from January 1, 2004–December 31, 2013, an estimated 1,237,203 embryos were cryopreserved in the United States and possibly still in storage; see Mindy S. Christianson, et. al., "Embryo Cryopreservation and Utilization in the United States From 2004-2013," *Fertility and Sterility Reports* 1, no. 2 (2020): 73.

72. "Embryo Adoption," Position Statements of Lutherans For Life; see note 70 above.

73. See "Embryo Adoptions" at https://lutheranfamilyservice.org/adoption-services/embryo-adoptions/.

74. Richard C. Eyer, *Holy People, Holy Lives: Law and Gospel in Bioethics* (St. Louis: Concordia Publishing House, 2000), 120-121.

75. In his words, "Heterologous embryo transfer may be at best a mistaken, misguided charity though an extraordinarily generous charity, but the mistake may be a very grave mistake, striking as it would seem to at the very dignity of the woman and of her marriage." Tonti-Filippini, "Embryo Rescue Debate," 124. Not all Roman Catholics agree; see, for example, the discussion in Christopher M. Reilly, "Embryo Adoption: A Radically Counter-Cultural Act of Mercy," *Dignitas* 27, no. 1-4 (2020): 30-31.

76. Tonti-Filippini, "Embryo Rescue Debate," 134.

77. One example of this is that the weak pull the strong out of self, in service to the other.

78. Management of ectopic pregnancy is not abortion.

79. Di Mauro, *A Love for Life*, 16-17, 19-24; Gorman, *Abortion & the Early Church*, 63-73; Jones, *Soul of the Embryo*, 57-74.

80. For a brief overview of the risks to the mother, see Ingrid Skop, "Wounded Women: The Consequences of 'Choice,'" available at https://lozierinstitute.org/wounded-women-the-consequences-of-choice/. Additionally, a 2025 study by the Ethics and Public Policy Center examined all-payer insurance claims from women prescribed mifepristone abortions from 2017-2023 (a total of 865,727 such prescriptions). Of these women, 10.93% experienced sepsis, infection, severe bleeding, or another serious event requiring emergency care within 45 days after such an abortion, a rate 22 times higher than the less than 0.5% reported from clinical trials on the drug label. The full study is available at https://eppc.org/publication/insurance-data-reveals-one-in-ten-patients-experiences-a-serious-adverse-event/.

81. The noun ἀγάπη (*agape*, love) in v. 13, and the associated verb ἀγαπάω (*agapao*, to love) in v. 14, point to the sacrificial love shown by Jesus on the Cross (cf. John 3:16).

82. Consider Martin Luther's Post-Communion Collect: "We give thanks to Thee, Almighty God, that *Thou hast refreshed us with this Thy salutary gift*, and we beseech Thy mercy *to strengthen us through the same in faith toward Thee and in fervent love among us all*; for the sake of Jesus Christ our Lord. Amen" (emphases mine), in Martin Luther, *Liturgy and Hymns*, ed. Ulrich S. Leupold, vol. 53, p. 138 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–).

83. Cf. The Commission on Worship of the Lutheran Church–Missouri Synod, *Lutheran Service Book* (St. Louis: Concordia Publishing House, 2006), 185, 214.

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Review Essay

Jim Belcher, *Cold Civil War: Overcoming Polarization, Discovering Unity, and Healing the Nation* (Downers Grove, IL: InterVarsity Press, 2022), 349 pp. $28.00

Reviewed by M. Anthony Seel

In *Cold Civil War: Overcoming Polarization, Discovering Unity, and Healing the Nation*, author Jim Belcher takes his readers on a search for a public philosophy for government grounded in the gospel and capable of drawing together the various and disparate elements of our current polarized electorate. The author's educational background, from two evangelical schools to Georgetown University, plays a prominent role in his search.

As an undergraduate at Gordon College, Belcher was introduced to Abraham Kuyper, the Dutch theologian and prime minister whose work centered on common grace. At Fuller Seminary, under the instruction of Richard Mouw, a professor and later president of Fuller, he learned about neo-Kuyperians, which is how he now identifies himself. At Georgetown, his horizon was broadened by the Roman Catholic natural law tradition. These foundations support Belcher's work as he envisions a public philosophy rooted in the special and general revelation of God.

As an evangelical, he notes that his tradition experiences the same divisions over politics and culture that challenge all of American society. He is dismayed not only by the divisions, but also by the inability of pastors and evangelical leaders to speak meaningfully to the current chaos. He highlights what he calls the "twin problems of accommodation and inflation." Accommodation refers to the tendency of evangelicals to tailor their understanding of Scripture to fit their political views (29). According to Belcher, this accommodation occurs among both conservative and liberal evangelicals. Inflation happens when evangelicals take portions of Scripture and expand their meaning beyond what the text warrants. He names Eric Metaxis and Franklin Graham as representatives of the conservative side and Rod Sider and Michael Gerson as representatives of the liberal side among those who use accommodation and inflation in constructing political philosophies (28).

As J. Budziszewski of the University of Texas points out, "The problem for evangelical thinkers is not that the Bible contains no political teaching (for it does), but that the Bible does not provide enough by itself for an adequate political the-

ory" (28). Lutherans have a basis for arguing against this viewpoint in our Two Kingdom approach to how God orders and rules over life, which aligns with the natural law tradition the author learned at Georgetown. Otherwise, evangelicals practice accommodation and inflation. In some instances, they find biblical support for their political views by taking biblical history and creating a template for our current times. Accommodation and inflation form the crux of what the author calls the "evangelical dilemma"(30). What is the solution to this problem? It is linking general revelation with special revelation as Belcher explains:

> General revelation, or natural law, then, is the conviction that design permeates the natural realm in general, and human beings in particular, that our conscience bears witness to its existence; and that when we violate natural law we not only know it intellectually, often suppressing it, but we experience it with deep feelings of guilt and brokenness (30).

Following Budziszewski, Belcher asserts, "Without a natural-law doctrine, without these first principles, rooted in both special revelation and general revelation, evangelicals will never be able to work out a coherent public philosophy" (31). Having laid that groundwork, the author explains that his graduate studies at Georgetown still left him searching for a coherent public philosophy that balances liberty and freedom with order and responsibility. He observed that in the mid-2010s, "the Left was moving further left, and the Right seemed to become more radical as well…" (37). This led to what he calls "My Breakthrough." At this point, Belcher introduces his conception of the American political landscape using a quadrant framework with two axes replacing the typical and inadequate left-right continuum. The two axes are a left-right axis and an order-freedom axis. The center of the quadrants is the "new vital center." In part two of his book, Belcher offers chapters subdividing each quadrant, from moderate to extreme.

Following Christian Smith's lead, Belcher uses the worldview narrative arc that Smith presents in his book, *Moral Believing Animals: Human Personhood and Culture*, for each segment of Smith's quadrant system. According to Smith, worldviews typically follow a storyline from "once upon a time" (a beginning), to a middle ("how we fell from the golden age"), to an end ("a plan for recovery") (59).

Starting with what he calls the Freedom Left 2 position, Belcher says, "For those in the freedom left 2 position, America was founded on a secular, godless constitution, one that is under siege by conservative religious forces who want to turn it into a theocracy" (79). Would that this were a caricature, but Belcher cites enough sources to strongly document this analysis, including how Amy Coney Barrett was treated in her confirmation hearings for the Seventh Circuit and, three years later, for the U.S. Supreme Court. In her confirmation hearing for the Seventh Circuit, Barrett was vilified by Senator Diane Feinstein, who said about Barrett's Roman

Catholic faith, "the dogma lives loudly within you, and that's a concern" (63). The fear about Barrett's ascension to our nation's highest court was articulated by Peter Hammond Schwartz in an essay in the *New Republic*. He cautioned that Barrett was an adherent to what he labeled the "new natural law," which he described as "a rigid, reactionary, punitive, and self-righteous propaganda platform for the most conservative elements of the Catholic Church and its intellectual apologists" (65).

Belcher believes that the "godless-constitution view" reached its zenith in 1980, when the religious right sounded the alarm against it. Richard John Neuhaus' *The Naked Public Square: Religion and Democracy in America*, first published in 1984, was a seminal work opposing this effort to remove religion from public discourse and to privatize it, thereby allowing the godless-constitution position that government should be neutral on the question of the 'good,' so that individuals are free to choose what good is for themselves.

For adherents of a godless constitution, questions of right and wrong and ultimate purpose should be left to individuals rather than dictated by the government or any other authority. For those in the Freedom Left 2 position, traditional authorities, such as the church, family, and local communities, give way to individual determinations.

The second position he describes is Freedom Left 3. Belcher writes, "For freedom left 3, there never was a golden age, as America was born into sin, a racist nation from the start – White supremacy was baked into the founding documents…." He illustrates this position by pointing to the Buffalo Public Schools in upstate New York, which "adopted a Black Lives Matter curriculum for its K-12 schools. Their stated goal is to educate their children in the tenets of BLM, including the dangers of Western civilization, the white supremacy of the nuclear family, and the justification of violence as an acceptable method of protest against injustice…" (93).

Belcher points to postmodern theory and asserts that we are now in the third phase of "pessimistic postmodernism," which has "mutated into critical race theory" (81). In a primer on critical race theory, Richard Delgado and Jean Stefancic write, "critical race theory questions the very foundations of the liberal order, including equality theory, legal reasoning, Enlightenment rationalism, and neutral principles of constitutional law" (87). From this position, it is argued that America is "uniquely racist" (87).

Belcher claims that

> Far from a harmless philosophy in the academy, I see the ruling class using critical race theory to extinguish our grounding, delegitimizing the American project in the eyes of the public. They are utilizing critical race theory to wear away our view of the biological self, to transform our views on gender, to erode the structure of the nuclear family, and to pit the races against one another, all with the goal of chipping away at middle-class values. In the end, their goal is to centralize and consolidate their own power (88).

The author then turns to Order Left 2, which he dates to Franklin Delano Roosevelt, whose Economic Bill of Rights opened the door to "welfare-state liberalism" (92). Lyndon Johnson expanded on this with his Great Society plan. As Harvard professor Michael Sandel argues, by making legal rights into economic rights, the welfare state was built with the necessary big government structure to support it (100).

Belcher recognizes that Freedom Left 2 and Order Left 2 share "a common narrative," but they differ on the issue of freedom (101). For Freedom Left 2, the individual decides his or her own good. For Order Left 2, the state imposes what is good on citizens. According to Sandel, this occurred through the New Deal and the Great Society government programs (101). These programs ushered in what Sandel calls the "Procedural Republic":

> A state that remains neutral, brackets out religion, doesn't propose or legislate any particular good conception of the good or purpose of life, allowing the liberated individual to choose for themselves, free from the constraints that traditionally shaped the individual (75).

In this narrative, the New Deal and Great Society programs ushered in "the golden era," but Ronald Reagan followed, and we can add Donald Trump and his Department of Government Efficiency. A dismantling of big government began with Reagan, and as President Bill Clinton proclaimed in his 1996 State of the Union address, "the era of big government is over." Between Reagan and Trump, Presidents Barack Obama and Joe Biden said "not so fast" to this dismantling. Part of the political polarization in the United States is tied to this back-and-forth between two visions of government's role in society.

Enter Order Left 3, which Belcher labels "the reified postmodernism of antiracism" (110). James Lindsay identifies this as the third stage of postmodernism. He titles the first stage the "high destructive phase," when the modern search for universal truth is upended. The second stage, the "applied postmodern phase," is when theory moves into practice through social justice activism. In the third stage, the "reified" phase, "activists and scholars … have come to take for granted a reification of the once abstract and self-doubtful postmodern knowledge principle and postmodern political principle" (111-112).

While in phases one and two postmodernism aimed to destroy metanarratives, in phase three it has created a new metanarrative. This metanarrative is a new "Theory of Everything" in "a set of unquestionable Truths with a capital "T," which becomes their new epistemology, their new theory of knowing and grounding reality, and become the basis for their new activism" (113). But what is the basis for this new metanarrative? It is the lived experience of "oppressed groups" (113). This is what fuels the antiracism activism of Order Left 3. Belcher summarizes, "Antiracism is now a faith, accepted with the certitude of dogmatic religion" (123).

Next is Freedom Right 2, described as libertarianism like that of Freedom Left 2, "affirming the voluntarist self, the procedural republic, the bracketing out of religion, the rejection of the natural law found in the Declaration of Independence, instead relying on secular pragmatism and a vision of social justice similar to the radical progressive view of order left 3" (140). His prime example of Freedom Right 2 libertarianism is Georgetown professor Jason Brennan. Brennan calls his viewpoint "bleeding-heart libertarianism," which is based on a concern for social justice. Brink Lindsay of the Cato Institute urges libertarians of this stripe to find common ground with progressives "on personal freedom, civil liberties, and foreign policy issues." One policy where common ground has been found is open immigration. For Freedom Right 2 adherents, this reflects all three of Lindsay's urgings. In the end, is there much difference between Freedom Right 2 and Freedom Left 2? I don't see it, and I am left to wonder whether distinguishing between these two positions, which look remarkably similar, is only for the sake of a balanced quadrant system. Then again, there are two forms of libertarianism, one on the left and one on the right, that could be deployed to strengthen the differences between these two positions. This could be illustrated by appeal to two well-known libertarians, the renowned Harvard Law School professor emeritus Alan Dershowitz, a libertarian on the left, and author and columnist John Stossel, a libertarian on the right.

Next up is Freedom Right 3, the "radical libertarians," which Belcher traces back to Ayn Rand (145). As a Russian immigrant to the United States, Rand was highly attuned to the dangers of powerful governments. Her assault on the welfare state and support for capitalism engendered great sympathy from conservatives, while her atheism turned off religious conservatives. According to Rand, "man exists for his own sake, that the pursuit of his own happiness is his highest moral purpose, that he must not sacrifice himself to others, nor sacrifice others to himself" (146).

This camp has two sections: the anarchists, who view government as "a moral evil" and would destroy it entirely (148-149), and the "minarchists," who support a limited government (149). What is most important to Freedom Right 3 is unfettered free-market capitalism. The commitments of the Freedom Right 3 libertarians are "liberty, free trade, globalization, and the optimism of high-tech genetic engineering and a brighter future for the human race" (160). The downside is significant: "monopolistic high-tech corporations, who, along with weak governments, rig the system in their favor, moving us in the direction of a new type of oligarchy…" (160).

This leads to Order Right 2, "Poison Pill Conservatives" (161). Rod Dreher and Patrick Deneen are cited as examples of this position. Dreher believes that contemporary American society is so bad that it has turned into a "new soft totalitarianism," and that the best solution is to create a Christian counter-culture outside the mainstream (165). Deneen arrives at a similar position to Dreher. Since it is believed that it is impossible to undo the damage that liberalism has done, "A better

course will consist in smaller, local forms of resistance: practice more than theories, the building of resilient new cultures against the anti-culture of liberalism" (171).

From Order Right 2, we move to Order Right 3, "The illiberal new right" (180). The narrative of Order Right 3 is "We are losing the culture, the people, the religion, the way of life that once characterized America, and the enemies are progressive elites on the left and right" (183). Belcher identifies three groups within the Order Right 3 position. First, the alt-right. Their solution is "White identity politics… utilizing the tactic of fascist control…" (187). The alt-right is "a mirror image of the radical left" (187). The violence of Antifa and BLM rioters is met by violence on the right from the Proud Boys and Oath Keepers.

Second are the Roman Catholic "integralists," who advocate the merger of church and state "to return authority to the church" (189). Finally, there is a Protestant counterpart to the Roman Catholic integralists, the Protestant "dominionists," who "would like to see an American theocracy…" (191).

This concludes Belcher's description of the elements of his quadrant system. The final chapters of the book focus on "the new vital center." The new vital center consists of what he calls "the four souls," which are the center positions of each of the four quadrants, freedom left and right, and order left and right. In the center of each of these positions is a fine balance between creed (what is believed) and culture (the history and traditions that stand behind each position).

The author looks to James Creaser, who appeals to Alexis de Tocqueville's understanding of the United States as resting on two foundings. The first founding came from the Pilgrims and Puritans who brought "customary history (tradition, culture, language, and religion)" (211). The second founding came with our nation's founding fathers who brought a founding rooted in natural law and Enlightenment reasoning (211). From these two foundings comes a synthesis of creed and culture "between nature and history" (212).

The new vital center, composed of the four souls, "form a dynamic, synthesized whole—each needing the other to stay in the new vital center and avoid polarization" (212). This synthesis avoids the polarization that comes from the positions outside the new vital center. After this explanation, Belcher launches into a description of each of the four center positions.

Freedom Left 1 is described as "constitutional soul," which comes from the mind and pen of James Madison. It was Madison who saw the strengths and weaknesses of republics and tempered the weaknesses with a legal system of checks and balances enumerated in a constitution. This synthesis was a tempering of the weaknesses of both republicanism and constitutionalism. A primary weakness of republicanism is the potential for tyranny from a majority. A primary weakness of constitutionalism is

the potential for undue authority vested in elites. Madison's vision is a compromise that offers limited government with protection of individual rights through the legal framework of the Constitution and the Bill of Rights (213-215).

Order Left 2, called "republican soul" is "grounded in a form of customary history in which 'the people' ruled by a majority, are committed to the ancient ways of the republic" (215). As Creaser explains,

> For republicans, the most important factor that accounts for the health of the republic is not just its political institutions but the mores of its people … without certain mores, a republic could not exist or endure (215).

Virtue is a necessary grounding for republicanism, but this raises the issue of how personal liberties are limited by social control. That balance was to be maintained by constitutional law that set boundaries for personal conduct. As Belcher acknowledges, this balance creates tensions that are not easily resolved.

This leads to Freedom Right 1, dubbed "middle class soul." Recognizing human nature for what it is, prone to "lower passions" (218), the "constrained vision" of Adam Smith, including the "invisible hand" that guides commerce through competition and cooperation based on "rival interests" and common interests, lead to "the best order." Constrained vision is a phrase from economist Thomas Sowell. This interpretation of Adam Smith is from Sowell and political philosopher Martin Diamond (218).

These three parts of the new vital center lack one critical element, Order Right 1, called "statesman soul." What holds our system together is leadership. The ideal leader is a statesman who injects wisdom into the political, economic, and social fray. The statesman raises the functioning of society by promoting virtue. The work of the statesman is "to constantly remind the other three quadrants of the need for balance, to warn them when they are polarizing, and to inspire the entire democratic republic vision to grandeur" (222-223). How does the statesman do this? By reminding "the other three souls that the American project is grounded on both reason and tradition, history and nature, creed and culture" (223).

The author summarizes the new vital center's work as teaching the citizenry "a healthy love of country, an instinctive patriotism, one that celebrates the heritage of the nation, promotes the bonds that unite us as a people, and holds a commitment to creed and culture" (226).

Belcher's case for a new vital center takes a religious turn in the chapter titled "Christianity," subtitled "The Second Constitution" (246). Following sociologist Robert Bellah, the author contends that "If the external covenant of constitutionalism (creed) is not continuously renewed by the 'internal covenant' of Christianity (culture), it will collapse" (247). To support this view, he cites Creaser: "For those of the faith, the adoption of the legal Constitution in no way abrogated" the impor-

tance of Christianity because "it has always been thought that there is a second and unwritten constitution meant to operate alongside of the legal one" (253). Belcher contends that Christianity holds the four souls of the new vital center together (254). Of course, the problem with this view is convincing secularists of its historical validity and its validity for our time.

Belcher admits that "our bipartisan cultural elites are not going to be convinced" (263). Given this, what hope is there for a new vital center that is sustainable? What hope is there for a grounding of constitutionalism on a foundation that can hold the new vital center together? Belcher posits that "without the church regaining its life-giving gospel and embracing the public philosophy of the new vital center, rooted as it is in general revelation, there is little chance to renew the external covenant that holds our democratic republic together" (269). Along with Robert Bellah, he sees the need for a third great awakening. In the final sentences of his book, he calls on the church to "rescue our republic" (274).

Throughout his work, he cites the naysayers who doubt that there is much hope for the enterprise he advocates. These naysayers include James Davison Hunter, who coined the phrase "culture wars" in his 1991 book by that name. The naysayers have a strong case, and in the end, Belcher is stronger on description than on prescription. His approach is like the Sydney Harris cartoon of a scientist at a blackboard working out a mathematical problem. He starts the equation and ends it, but in the middle of the equation are the words "Then a Miracle Happens." A colleague looks at the equation on the blackboard and says "*I think you should be more explicit here in step two*."

That's the problem. Belcher does excellent work identifying the sources of our current polarization. He offers outstanding descriptive analysis. In the end, he offers "Then a Miracle Happens." Of course, the God of Christianity does miracles. The question this book raises is whether the God of Christianity will work through His church to "rescue our republic." As sophisticated as Belcher's analysis is, there isn't an accompanying sophisticated solution to our national dilemma. Where is that solution? I believe the solution lies in our Lutheran Two Kingdom approach.

In 1535, in the preface to his commentary on Galatians, Martin Luther wrote,

> This is our theology, by which we teach a precise distinction between these two kinds of righteousness, the active and the passive, so that morality and faith, works and grace, secular society and religion may not be confused. Both are necessary, but both must be kept within their limits.[1]

The Two Kingdoms doctrine is an extension of the two kinds of righteousness that Luther found in Paul's epistle to the Galatians. This is often referred to as left-handed power and right-handed power. God rules this world with left-handed power to

preserve society through human institutions. His right-handed power is exercised through the Kingdom of God, which is also present in this world. God's right-handed and left-handed powers correspond to the vertical and horizontal dimensions of life. As those who have faith in Jesus Christ, Christians are joined to God and His Kingdom. As members of human society, they have relationships that correspond to how God exercises His left-handed power. As Robert Kolb explains,

> The horizontal relationship has bound us to the rest of creation as people who are held accountable for exercising God-given responsibilities in an adult manner toward other creatures, human but also animal, mineral, and vegetable. God's human creatures are right—really human—in their vertical relationship because their faith embraces the God who loves them through Jesus Christ with the reckless trust of total dependence and reliance on him which constitutes their identity.[2]

God works to preserve society, that is, the earthly, temporal realm, through human institutions like the family, civil government (including law enforcement and in our country, our legal system of courts with magistrates, our legislatures, and our executive branches of government at all levels—local, state, and federal), and workplaces with employers, management, and workers.

So, the Augsburg Confession teaches,

> For civil government deals with other things than does the Gospel. The civil rulers defend not minds, but bodies and bodily things against manifest injuries, and restrain men with the sword and bodily punishments in order to preserve civil justice and peace.[3]

In our system, we understand this to mean that government exists within a constitutional framework that says that God has granted us inalienable rights for life, liberty, and the pursuit of happiness.[4] The founder James Madison appealed to Luther's Two Kingdoms doctrine in a letter to F.L. Schaeffer, saying that this approach

> illustrates the excellence of a system which, by a due distinction, to which the genius and courage of Luther led the way, between what is due to Caesar and what is due God, best promotes the discharge of both obligations.[5]

There, in the words of Madison, we find the Two Kingdoms doctrine undergirding the U.S. Constitution. As citizens of the United States, we have duties to God and to others.

In an assessment of the achievement of Luther at the time of the 500th anniversary of Luther's 95 Theses, Professor Joseph LeConte wrote in *National Geographic*,

> If Luther was a flawed prophet of human freedom, his voice was nonetheless vital in the long march toward a more just and pluralistic society. In Luther,

> we find an advocate for human dignity who defied the forces of religious oppression and reimagined the political ideals of medieval Europe.[6]

The Lutheran Two Kingdoms doctrine would have strengthened Belcher's work immeasurably by adding substance to his prescription for moving our nation back to civility and common purpose for the flourishing of all Americans, as well as a way forward for our role as a superpower in the wider world.

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Notes

1. Martin Luther, *Lectures on Galatians, 1535, Chapters 1-4*, ed. Jaroslav Pelikan, vol. 26:7 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–).

2. Robert Kolb, "Luther on the Two Kinds of Righteousness; Reflections on His Two-Dimensional Definition of Humanity at the Heart of His Theology" *Lutheran Quarterly* 13, no. 4 (Winter 1999): 453.

3. Augsburg Confession, 28.11 in *Concordia Triglotta: The Symbolical Books of the Evangelical Lutheran Church* (St. Louis: Concordia Publishing House, 1921; Reprint edition: Milwaukee: Northwestern Publishing House, 1996), 85.

4. From the U.S. Declaration of Independence. See https://www.archives.gov/founding-docs/constitution-transcript.

5. Letter by James Madison to F.L. Schaeffer, dated 1821. See https://witness.lcms.org/2015/genius-and-courage/.

6. Joseph Leconte, "Martin Luther and the Long March to Freedom of Conscience" (*National Geographic*, October 27, 2017), found at https://www.nationalgeographic.com/history/article/martin-luther-freedom-protestant-reformation-500.

Book Review

Charles Camosy, *Living and Dying Well: A Catholic Plan for Resisting Physician-Assisted Killing* (Huntington, IN: Our Sunday Visitor, 2025), 184 pp., $20.95

Reviewed by Benjamin Parviz

For a long time, Christians in the U.S. have resisted the advance of physician-assisted suicide (PAS) politically and legally by activities such as campaigning against proposed laws, voting against them, and participating in lawsuits. It is difficult to measure or assess the success of this resistance effort. Since it was first put into effect in Oregon in 1997, PAS has in various ways become permitted by law in 12 additional U.S. states and the District of Columbia. Most recently, Gov. J. B. Pritzker signed the Medical Aid in Dying Bill in Illinois in December 2025, and in February 2026, Gov. Kathy Hochul signed a similar law in New York. Two states—Oregon and Vermont—have removed state residency requirements from their PAS laws, meaning that anyone who can qualify and who has the means and ability to travel to those states can die by PAS there. Despite Christian efforts to resist the advance of PAS, the practice now confronts Christian communities directly. The church must change its approach to resistance. Instead of resisting a law and practice that may come in the future, Christian communities must now resist a choice and a temptation that any member of the community and congregation may now face. What kind of approach do Christians take to resist the temptation of PAS?

This is the question that Charles Camosy—moral theologian and bioethicist at The Catholic University of America—takes up in his most recent book *Living and Dying Well: A Catholic Plan to Resist Physician-Assisted Killing*. Camosy is a prolific and respected Catholic moral theologian, and he wrote this book for a public and Catholic audience. The book would be ideal for use in a parish setting with faithful lay Catholics who want help knowing how best to respond to what they are reading online and in the newspapers. The book substantively engages an important and relevant moral question, and it is accessible and understandable for anyone. This review first provides a broad overview of Camosy's argument, then considers whether this book of Catholic moral theology is useful for Lutherans who similarly want to resist PAS.

To begin, Camosy makes use of the phrase "physician-assisted killing" instead of the more familiar phrase "physician-assisted suicide." His reason for doing so is to

emphasize that deaths that are named as "physician-assisted suicide" are not purely the result of the patient's autonomous choice. Rather, in his words, in such an act "the killing of the person is explicitly or structurally coerced, or both" (7). On one hand, Camosy's concern about coercion is a valid concern that is shared by many, and in cases in which coercion is at least partly the cause of the death of the individual, it is perfectly legitimate to correctly name such coerced deaths as "killings." On the other hand, the nomenclature for this-thing-that-we-are-talking-about is famously complex and controversial. We could name it "physician-assisted suicide," "death with dignity," "medical aid in dying," "voluntary active euthanasia," "voluntary assisted death," "assistance in dying," "assisted death," "end of life options," or more. Each of these names for this-thing-that-we-are-talking-about highlights a unique and meaningful shade of meaning, shades that are sometimes objectively discernible and that are at other times anchored in a value system and a particular moral perspective. Not knowing how to name this-thing-that-we-are-talking-about actually makes it difficult to talk about and negatively contributes to moral analysis and argumentation about it. It may be that by offering yet another name, Camosy adds more confusion than he does clarity on the subject. For the remainder of this review, Camosy's preferred term, abbreviated "PAK," will be used.

Camosy's goal is a "counterculture" that undercuts PAK. He wants to highlight the many ways the dominant culture of the contemporary West lays the foundation for the choice to die by PAK. At the same time, he wants to highlight how the dominant culture of the contemporary West is antithetical to Roman Catholicism. His project, then, is to consider a kind of culture that Catholics can help establish, one that works against PAK by cutting it off at its foundations.

The author characterizes the culture of the contemporary West as one of individualism, autonomy, independence, and control. This culture functionalizes these values, making them capacities for action. When disease, disability, aging, and dying appear to deny one of these capacities, PAK offers a helpful means of reclaiming the ability to freely act. Following Pope Francis, Camosy calls this kind of culture a "throwaway culture" that kills and discards individuals who lose these capacities and become unwanted burdens on others. One problem with throwaway culture is that it impedes human flourishing by denying access to the best and most profound human experiences that come from being cared for by another.

The culture that opposes throwaway culture is firmly grounded in the dignity of all people, which comes from their being created in the image and likeness of God. This is a culture that embraces social connectedness and interdependence and turns away from individualism, autonomy, independence, and control. At the center of this culture is a community that cares for the physical, material, and spiritual needs of its members. This culture is one of hospitality that welcomes weak, needy, fragile, and dying people. It encourages practices that uphold and honor their dignity by

encountering them in a ministry of presence and compassion, suffering with them in their suffering. It also encourages practices that continually call individuals to reflect on their own future death. Camosy says that we ought always to keep death in the front of our minds because doing so shapes a life of hospitality and compassion. This kind of culture and community will both encourage flourishing and remove the temptation of PAK.

For a Lutheran audience or congregational setting, these conclusions are intriguing enough on their own. Again, Camosy is a Roman Catholic moral theologian who writes for a Roman Catholic audience. The closest he comes to describing his book in ecumenical or pluralistic terms is when he says that establishing the counterculture can be a shared project that overcomes the right- and left-wing political divide within the Roman Catholic Church. He does not write this book for Lutherans, so we ought not to criticize either Camosy or this book on Lutheran grounds. Any such criticism is best left to Camosy's fellow Roman Catholics. The question is the usefulness of this book in Lutheran congregational settings. While Camosy's effort and conclusions are laudable, Lutherans will need to justify or explain them on different grounds.

Camosy secures his conclusions primarily through narrative. He examines narratives of the life of Christ, the lives and deaths of St. Joseph, St. Teresa of Avila, St. Robert Bellarmine, and St. Francis of Assisi, as well as the lives of modern monks and friars, and the work of contemporary Catholic care homes and hospitals. By presenting and analyzing these narratives, he illustrates the counterculture he advocates. In many ways, these narratives are interesting on their own terms, sometimes even inspiring. It seems the intended effect of the narratives is to show Catholics that the culture he describes is not new or foreign to Catholicism, but has always been embedded within it. Lutherans can experience this effect only to a limited extent. However, Camosy's telling of these narratives prompts Lutheran readers to look within their own history and tradition to see whether this culture can be found. Similarly inspiring narratives may well be found in Lutheranism's long history in healthcare, especially in the vocation and work of Lutheran deaconesses.

Camosy's preference for narrative in this book results in a surprising lack of Biblical or systematic theology. One will encounter some scriptural references in the chapter that presents a narrative of the life of Christ (chapter two) and a handful of others throughout the rest of the book. Beyond these, the book says little about what God's Word has to say on PAK. The situation is similar with regard to analysis of PAK from the perspective of the doctrine of the church. The most direct doctrinal analyses of PAK relate to the *imago Dei* and to the theology of death. The topic and his overall arguments certainly lend themselves to increased Biblical and systematic investigation. For example, Camosy's thesis advances theological anthropology, arguing that humans are social and dependent beings who thrive more in community

than in isolation. These anthropological claims would seem to lead naturally into reflections on ecclesiology and baptism. The church is the community—established on Christ and on the testimony of the Apostles and nourished by the Word of God and the sacraments—within which we flourish. One is welcomed into the church through baptism. It is surprising that this theology book about PAK, which argues that humans are dependent and social creatures who do not flourish as autonomous individuals, does not explain this in terms of membership in the body of Christ and people's baptismal identity as sons and daughters of God. Lutheran readers and audiences may be similarly surprised by this lack of engagement with Biblical and systematic theology.

For a 4- or 6-week class on physician-assisted suicide for lay parishioners in a Lutheran congregation, this book would not be the best foundation. However, no obvious alternative text comes to mind for class participants to buy and read instead. PAS is usually covered in a chapter of a larger book on end-of-life ethics. It is unusual for it to be the subject of a book-length treatment. When PAS is the subject of a book, it is usually a scholarly collection of essays that deals with detailed or minute questions, often of law or politics, that go beyond the daily concerns of the average lay Christian. Charles Camosy offers something of great value with this little book. He maintains a clear focus on PAK across an introduction and eight chapters. He asks a timely question and provides a theological answer that is appropriately formed for the audience for which he writes. The closest comparable book is Ewan Goligher's *How Should We Then Die? A Christian Response to Physician-Assisted Death*. At present, no Lutheran book appears to accomplish what Camosy does in *Living and Dying Well*. Although it may not be the assigned text for such a Lutheran lay class, it would certainly inform the instructor's thinking and preparation for those discussions. Lutherans need a book like this. Perhaps Camosy's *Living and Dying Well* will inspire a Lutheran to write one.

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"Facing the Final Frontier: Divine Perspectives and Social Narratives on Mortality"

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