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SAYING THE UNSAID: VOICING QUALITY-OF-LIFE CRITERIA IN AN EVANGELICAL SANCTITY-OF-LIFE PRINCIPLE

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The advances made in life-sustaining technology over the last twenty years have permitted the prolongation of biological life with questionable outcomes. Patients' experiences with pain, suffering, indignity and financial burdens have forced the medical community to reconsider sustaining life at all costs. Currently this reconsideration has issued into the acceptance of quality-of-life (QoL) criteria over an ever-weakening sanctity-of-life (SL) principle in the majority of medical literature guidelines and praxis studies that address life-sustaining care in the United States.[1]

Evangelical theologians and ethicists have recognized the dilemma of the latest medical technological advances as well. The majority have responded to this dilemma by qualifying their SL position while rejecting

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[1] The President's Commission Report is an early benchmark document using these criteria in the context of surrogate decision-making. In this context the QoL standard is used to constitute the criterion determining the patient's best interest. In assessing whether a procedure or course of treatment would be in the patient's best interest, the surrogate must take into account such factors as the relief of suffering, the preservation or restoration of functioning, and the quality as well as extent of life sustained. Cf. the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Lifesustaining Treatment: Ethical, Medical, and Legal Issues in Treatment Decisions* (Washington: United States Government Printing Office, 1983) 137. Other influential guidelines using QoL criteria in the determination of treatment obligations include the Stanford University Consensus, the Appleton Consensus and the ACCP/SCCM Consensus. Cf. J. E. Ruark *et al.*, "Initiating and Withdrawing Life Support: Principles and Practice in Adult Medicine," *New England Journal of Medicine* 318/1 (January 7, 1988) 30. The most satisfactory resolutions in such cases occur when professionals and families painstakingly explore the quality-of-life values previously held by the patient. Cf. J. M. Stanley *et al.*, "The Appleton Consensus: Suggested International Guidelines for Decisions to Forego Medical Treatment," *Journal of Medical Ethics* 15/3 (September 1989) 134. Cost-effective analysis should be used whenever feasible to inform decisions about appropriate life-prolonging treatments in particular circumstances. It should incorporate the best available scientific information about the results of the therapies being considered and all the appropriate medical and nonmedical costs and benefits, including an assessment of foreseeable changes in the patient's QoL as a result of proposed therapies. Cf. C. L. Sprung *et al.*, "Consensus Report on the Ethics of Foregoing Life-sustaining Treatments in the Critically Ill," *Critical Care Medicine* 18/12 (December 1990) 1435: "Foregoing therapy should be discussed in the following situations: a. When the patient has a grave prognosis; b. When the burdens of therapy outweigh the benefits; c. When the quality of the patient's life is expected to be unacceptable to the patient."

QoL criteria by implication or statement. A few appear to maintain an absolute SL position while stating that they reject QoL criteria. Such rejections and qualifications have left these positions open to criticism. One of the more articulate critics of any form of the SL position is Australian bioethicist Helga Kuhse.

Kuhse portrays those who hold to an absolute SL position as cruel vitalists.[2] She accuses those who reject vitalism by qualifying the SL principle as doing so by utilizing "unsaid" QoL criteria.[3] She criticizes such qualifications as an "unarticulated and obtuse" use of QoL criteria.

> What we have in the qualified SLP (sanctity of life principle) is a principle that says that it is never permissible intentionally to kill a patient, but that it is sometimes permissible to refrain from preventing her death as long as the latter decision is a means-related one not based on quality or kind of life in question. But this is where the confusion comes in, because judgments that it is sometimes permissible to withdraw or withhold life-prolonging means are, in fact, based on quality of life criteria that are unarticulated and obtuse.[4]

Kuhse concludes that because of the common usage of QoL criteria it is better to scrap the antiquated notion of a SL position altogether:

> When we refrain from preventing the deaths of handicapped infants, comatose patients, and the terminally ill and suffering, by classifying the means necessary for keeping them alive as "extraordinary", "not medically indicated", "disproportionately burdensome", and so on, we are resorting to an equally spurious device in order to preserve our sanctity-of-life ethics unscathed. If we want to go beyond definitional ploys, we must accept responsibility for making life and death decisions on the basis of the quality or kind of life in question: we must drop the sanctity-of-life doctrine and work out a quality-of-life ethic instead.[5]

The aim of this article is threefold: (1) I will attempt to clarify a general evangelical position on the use of QoL criteria. (2) I will explore the validity of Kuhse's accusation that qualified SL positions use "unarticulated and obtuse" QoL criteria. (3) I will reflect upon responses appropriate to Kuhse's criticisms in light of my findings.

I. EVANGELICAL USAGE: AN INQUIRY

1. *Everett Koop and Francis Schaeffer.* Koop and Schaeffer represent some of the earlier opponents of QoL criteria. They reject the utilitarian notion represented by Peter Singer. They argue that Singer's position

[2] H. Kuhse, *The Sanctity of Life Doctrine in Medicine: A Critique* (Oxford: Clarendon, 1987) 204–205.
[3] Ibid. 24.
[4] Ibid. 206–207.
[5] Ibid. 220.

lacks any final basis for placing value on human life. They assert that it strips away the fundamental foundation of man's dignity, his creation in the image of God. They suggest the following consequence of using such criteria:

> Quality of life, arbitrarily judged by fallible and sinful people, becomes the standard for killing or not killing human life—whether born, newly born, the rich, or the aged.[6]

Schaeffer and Koop use the wedge argument as another reason for their rejection. The context of the discussion is the determination of the United States Supreme Court's opinion on what a meaningful life is. Schaeffer suggests that the Court's consideration reflections the opinions of a new breed of medical personnel who advocate euthanasia when meaningful life is not apparent.

> The next step is to destroy human individuals or groups of individuals because they are unwanted, imperfect, or socially embarrassing. Senility, infirmity, retardation, insanity, and incontinence are conditions that come to mind. Obviously when one comes to this practice, he has gone far beyond so-called mercy killing. He has entered into the same realm as that of the Nazi behavior during World War II.[7]

While Koop and Schaeffer reject these utilitarian QoL determinations, they do not associate the SL principle with a radical vitalism in practice. They acknowledge that extraordinary means should be withheld if such treatment is only "prolonging the experience of dying."[8] In their position, the physician is expected to use his skills in patient care in a way answerable to society and to God.[9] These two criteria are weighed in regard to the patient's prognosis and in regard to the intent of treatment by the physician. If the physician

> believes that the technological gadgetry he is using is merely prolonging the experience of dying, rather than extending life, he can withdraw the extraordinary means and let nature takes its course, while keeping the patient as comfortable as possible.[10]

Although their position uses an "unarticulated" QoL criterion that disvalues the suffering of prolonged death, they provide an alternative approach to biological reductions of the human person in the guise of vitalism and physician-assisted mercy-killing.

[6] F. A. Schaeffer and C. E. Koop, *Whatever Happened to the Human Race?* (Westchester: Crossway, 1982) 375–376. They are reacting to Singer's rejection of human life as sacrosanct. Singer supports his position by suggesting that the standard of practice in hospitals is now utilitarian. He asserts that an ethic built on the image of God is philosophically untenable and calls for the abandonment of views based on "religious mumbo jumbo."

[7] Ibid. 333.

[8] Ibid.

[9] Ibid. 332–333.

[10] Ibid. 333.

2. *Franklin Payne, Jr.* Payne rejects both utilitarian and personalist uses of QoL criteria. He asserts that a QoL ethic is dangerous because the standard is relative. In his opinion, if the SL principle is altered to include QoL criteria it will degenerate to the point that "quality of life becomes the standard of the group that is in control."[11] He appeals to the Nazi holocaust to prove his point.

> The words "quality of life" have similar problems. Its hidden agenda is brought out by the questions, "What are the criteria of quality and who determines those criteria?" The beginning of the Nazi holocaust involved the elderly and mentally ill who were considered not to have a "quality" which gave them a right to life. In a very short time, Jews and others had lost their "quality," as well. A "life not worthy to be lived" is less subtle, but this euphemism is similarly applied to people with various problems.[12]

What he is rejecting then is a quality based on a "capacity or trait" that "belongs to a person" who is experiencing life in the sense of biological "animate existence."[13] Oddly, he introduces caveats to these medical dilemmas that entail QoL criteria. He posits that

> granting human status to deformed babies does not mean that all that can be done medically should be done. Many recognize that the moral way to deal with terminally ill people is to withhold or stop treatment. The same principles can be applied to the other end of life, the unborn and the newborn.[14]

Several points appear inconsistent in Payne's argument. First, he uses unarticulated QoL criteria in weighing medical moral decisions. He himself admits that this SL principle is not absolute but only addresses the issue in the context of capital punishment. By doing this he avoids a main issue of the debate. Further his praxis demonstrates the existence of QoL criteria that are apparent in his "Guidelines for Casuistry."[15] In the example of his mother he rejects radiation and chemotherapy on the basis of misery. They ceased to consider surgery because she was diagnosed as being terminal. During her stay at home she stopped eating, she convulsed, and her breathing became labored three days before death. This is not to ridicule his care of her but to say that certain criteria existed to determine what care was to be given and what care was to be withheld.

In this context Payne forwards a quantitative and qualitative criterion, respectively: the irreversible terminal nature of his mother's disease, and the disvalue of misery exacerbated by life-prolonging therapy. The element of quality is present in the "capacity" to thrive without misery that "belongs" to the "condition of power or animate existence" of the patient's

[11] F. E. Payne, Jr., *Biblical/Medical Ethics: The Christian and the Practice of Medicine* (Michigan: Mott Media, 1985) 201.

[12] Ibid. 201–202.

[13] *The Oxford English Dictionary* (2d ed.; ed. J. A. Simpson *et al.*; Oxford: Clarendon) 12.973; 8.910–913.

[14] Payne, *Ethics* 150.

[15] Ibid. 207–209.

physiological life.[16] If this is indeed so, then an unarticulated QoL criterion exists and should be reckoned with.

Payne alludes to a third QoL criterion that it is almost taboo to speak about in evangelical medical circles: economic rationing of treatment. In a rather confusing discussion he presents the problem of "the staggering reality and continued increase" of medical expenditures.[17] he adds a caveat common to medical thinking in the evangelical world: "Economics seems out of place when human lives are involved."[18] He introduces the example of heroic procedures done upon a man with an abdominal embolism who survived sixteen hours and left his family post mortem with a medical bill of over ten thousand dollars. He cites statistics demonstrating the enormous hospital costs incurred in intensive-care units by those 55 to 75 years of age.[19] His conclusion is that a balance is needed without lessening the SL principle economically.[20] Concretely he suggests hospice or home health care in many of these cases, appealing to the guidelines of casuistry.

Whether Payne recognizes it or not, QoL criteria are resident in his position. The economic balance he appeals to is little less than a proportional weighing of patient treatment to the quality of life of society or family that is diminished post mortem by the costs of that treatment. It is weighing the quality or capacity of the family or society to thrive after having been impinged upon by the economic consequences of applying the maximum care available to someone whose capacity to thrive is less than that deemed normal by the medical community: the irreversibly terminal patient.

3. *John Jefferson Davis.* Davis rejects a QoL ethic where quality is seen as a capacity or mental attribute and life means animate existence:

> The choice, then, between the "sanctity of life" based on the image of God, and the "quality of life" ethic based on brain function, is a choice between an ethic that protects all human beings in principle, and an ethic with a sliding scale of human worth based on intelligence and mental function.[21]

He gives three reasons supporting his rejection of the QoL ethic. First, he finds the use of these criteria incompatible with patient autonomy. He posits that "those selected for non-treatment have no say in the decision."[22] In his opinion this situation "leaves the weak and powerless subject to the arbitrary will of the strong and powerful."[23]

[16] *Oxford English Dictionary* 12.973; 8.910–913.
[17] Payne, *Ethics* 208.
[18] Ibid. 209.
[19] Ibid.
[20] Ibid.
[21] J. J. Davis, *Evangelical Ethics: Issues Facing the Church Today* (Phillipsburg: Presbyterian and Reformed, 1984) 170.
[22] Ibid.
[23] Ibid.

His second objection is based on the discriminatory character of the QoL ethic, which he argues allows for an arbitrary annihilation of "lives that are burdensome and inconvenient."[24] He feels that this kind of discrimination will result in eventual active euthanasia projects targeting "classes of unwanted human beings."[25]

Davis' third objection is in regard to the danger of this ethic in the context of a society driven by a cost-benefit economy. In his opinion QoL considerations are easily confused with cost-benefit analyses.[26] He feels that *Roe* v. *Wade* was an example where cost-benefit analysis was confused with QoL considerations. In his opinion the weak and unprotected lost. He believes this is the thin edge of the wedge, since the Supreme Court appealed to a "meaningful life" criterion in their decision.[27] Because of this decision, other groups such as the terminally ill, comatose and senile are now openly targeted by the same criterion.

Although Davis rejects a utilitarian QoL ethic he does not advocate a radical vitalism. On the contrary he recognizes situations where treatment can and should be refused.

> There is, however, no moral obligation to provide useless treatment to a genuinely terminal patient. In such cases, the patient will die whether or not the treatment is provided. There is no moral necessity to extend an irreversible process of dying.[28]

There are at least three points in his praxis worthy of notation. (1) Davis' method is open to the necessity of contextualizing the conflicting moral obligation in medical dilemmas. He advocates a position he calls "contextual absolutism."[29] Criteria in the decision-making process revolve around the poles of intentionality and "a higher obligation suspending a lower

[24] Ibid. The QoL philosophy, based on degree of brain function, endangers the lives not only of the handicapped newborn but also of the mentally retarded, the comatose and the senile. Their lives, too, may be considered burdensome and inconvenient.

[25] Ibid.

[26] Ibid. 170–171. In the context of the expense of treatment for a handicapped newborn Davis says, "It has been suggested that some of these expenditures on 'marginal' patients could more profitably have been diverted to other forms of medical treatment for patients whose 'quality of life' suggests a more viable future." This is no longer merely a suggestion; in some places, such as the state of Oregon, it is the law. Cf. also H. T. Engelhardt, Jr., and M. A. Rie, "Morality for the Medical-Industrial Complex: A Code of Ethics for the Mass Marketing of Health Care," *New England Journal of Medicine* 319/16 (October 20, 1988) 1086–1087. These authors advocate the "virtues of dumping" in order to raise the issue of cost shifting to public consciousness. The evil, premoral or moral, of treatment denial on the basis of socio-economic status for the sake of consciousness raising is disproportionate. The disproportion is based on the sacrifice of the originality of human persons bound to a social class for the purposes of political reflections on hidden taxation.

[27] Davis, *Ethics* 172.

[28] Ibid. 173.

[29] Ibid. 14. The view advocated in this work regarding conflicting moral obligations could be termed "contextual absolutism." The position forwards the idea that in every ethical situation, no matter how extreme, there is a course of action that is morally right and free from sin (1 Cor 10:13). N. Geisler calls the same position "graded absolutism."

one."[30] (2) Davis openly recognizes the principle of double effect when using the method of contextualization. Thus evil may flow from the decision for which man is not culpable and which he must attempt to minimize. (3) Davis introduces an agapistic norm into his praxis.

> A medical practice informed by the spirit of Christ and love for the neighbor will see as its goal never to harm or choose death as a primary end, to cure whenever possible, and always to provide care and comfort to all patients, both in their living and in their dying.[31]

Thus Davis tempers his rule deontology in theory and practice by the application of a contextual absolutism and an agapist norm. Davis' contribution does, however, lead to one major criticism. He carefully avoids other QoL positions by targeting only Joseph Fletcher's brain criteria.

Davis appears to remain silent about his own QoL criteria. With his constant emphasis on the SL ethic, one might miss these criteria. The notion of quality is used by Davis in the sense of a capacity sourced in an animate life, which is expressed in the capacity to thrive in a condition with a quality that is neither "precarious or burdensome" nor fraught with "excessive expense, pain, or other inconvenience without hope or benefit from medical intervention."[32] The term "burdensome" seems to imply a condition of power, activity or happiness. The capacity to thrive is a second criterion. If one does not have this quality in the context of available medical care, then "termination of treatment" is appropriate.[33] These criteria seem to suggest an unarticulated QoL ethic working in tension with a SL ethic. Thus Kuhse's criticism of inconsistency in utilizing QoL criteria has some validity in Davis' position as well.[34]

4. *Norman Geisler*. Geisler rejects the QoL ethic in biomedical decision-making because of the lack of moral acceptability of the consequences as demonstrated historically. He offers three reasons in support of his opinion. (1) He believes that the QoL ethic is a "thinly veiled form of utilitarianism."[35] He posits that the ambiguity of the words allows for justification of "actions that lack any proper ethical quality whatsoever."[36] Those who are in power define the meaning and hence allow the potential for abuse because of self-interest. In his opinion, even if self-interest were precluded, no utilitarian possesses the omniscience to know for certain what outcome would bring about the best QoL.[37] Utilitarianism, in the

[30] Davis, *Ethics* 14–15. The important point to note is that the moral absolutes of Scripture need to be understood and applied within their proper context.
[31] Ibid. 174.
[32] Ibid. 183.
[33] Ibid.
[34] Kuhse, *Sanctity* 206–207.
[35] N. L. Geisler, *Christian Ethics: Options and Issues* (Grand Rapids: Baker, 1989) 176.
[36] Ibid.
[37] Ibid.

opinion of Geisler, is a dangerous approach. (2) He asserts that "we are not sovereign over our own life."[38] He bases this idea on various texts of Scripture. He suggests that neither the creation of life nor its end is in our hands.[39] Thus "we have no right to claim sovereignty over it when it leaves."[40] (3) He rejects the notion that the "end justifies the means."[41] He suggests that the means and the end must each have its own justification.[42] He appeals to the negative consequences such an ethic had when the Nazis sought to purify their race by obliterating the Jews.[43]

In the place of a utilitarian QoL ethic, Geisler forwards a qualified SL position. He suggests "that every attempt should be made to preserve a human life, by whatever means are available."[44] The key word in his position is "preserve." Geisler rejects radical vitalism by differentiating between preserving life and prolonging death.

> However, there is no divine duty to use heroic or unnatural means to prolong human death. This is contrary to the principles of human morality and Christian charity. There is no duty to prolong misery or to fight mortality. Hence, when sustenance of life is artificial and the process of death is irreversible, there is no moral obligation to prolong life by artificial means.[45]

His use of QoL criteria can be found in other statements as well. Geisler uses two criteria in the context of his discussion on euthanasia.

> When artificial supports are interfering with the natural process of death, rather than enriching the person's natural life, then their use is wrong. It is resisting the hand of God involved in the very process of death.[46]

> *The disease must be irreversible*—No one should be allowed to die if we have the means at hand to save his life. If possible, correctable situations should be corrected. Unless the process of the disease is irreversible, even natural euthanasia is not justifiable.[47]

In the preceding citations Geisler uses "quality" in the sense of the capacity to thrive without prolonged misery when faced with irreversible imminent death. The person must have the capacity, with the aid of intervention, to overcome a life-threatening condition and the capacity to experience an enriched life.

Kuhse's criticism seems aptly suited here. Geisler has both an unarticulated and obtuse QoL principle underlying his praxis. What does he mean by an irreversible disease? Does this include kidney dialysis, brittle diabetes, *grand mal* epilepsy, stage three senile dementia, and the like?

[38] Ibid. 177.
[39] Ibid.
[40] Ibid.
[41] Ibid. 178.
[42] Ibid.
[43] Ibid.
[44] Ibid. 183.
[45] Ibid. 183–184.
[46] Ibid. 188.
[47] Ibid.

His notion is ambiguous. Further, his statement regarding the capacity to experience an enriched life could be interpreted by those outside evangelical circles as utilitarian eudemonism or theistic utilitarianism. The presence of an unarticulated QoL principle in his method leads to the possibility of situational analyses that mirror the situation ethic that he refutes. Left unresolved, the apparent inconsistency leaves the compatibility of his praxis with his methods and principles open to Kuhse's criticism.

5. *Nigel M. de S. Cameron.* Cameron also rejects certain kinds of QoL models. One category includes models based upon "value-for money indicators."[48] A second category encompasses models whose emphasis for medical function is relief of suffering rather than healing.[49] Cameron's alternative is a return to an absolute SL position, one with no qualifications.

> It is clear why the term sanctity has become cold shouldered. It is an absolute, so it cannot be qualified. There cannot be "more" or less sanctity as there can be more or less respect.[50]

Cameron's position is clear, but questions of possible inconsistency necessitate clarification. For instance, it appears that in other writings he deabsolutizes the principle both by statement and by implication and admits exceptions to the SL in certain contexts. The following statements exemplify my observations:

> The sanctity of human life is a non-negotiable of the biblical view of man, underlined rather than undermined by the exceptions to which Scripture itself adverts—self-defense, the capital sentence, and just warfare.
>
> The medicalising of the context makes no difference to the character of the intentional killing of the patient (with or without consent, by omission or commission), just as it makes no difference to the relation of the doctor to the patient as that of one citizen to another.[51]

The meaning of the term "absolute" is abrogated by the introduction of exceptions, and thus his use is inconsistent.[52] It may be argued that these exceptions are not found in the medical world. But there is the implication of possible qualification permitted by the principle of double effect in the previous citation. The question is this: Does Cameron permit killing if death ensues unintentionally? For instance, if a physician gives high doses of opiate with the intention to control excruciating cancer pain and, as a side effect, the patient's death is hastened by respiratory depression, is

[48] N. M. de S. Cameron, *The New Medicine* (Wheaton: Crossway, 1992) 137.

[49] Ibid. 159.

[50] Ibid. 131.

[51] "Theological Perspectives on Euthanasia," *Death without Dignity: Euthanasia in Perspective* (ed. N. M. de S. Cameron; Edinburgh: Rutherford House, 1990) 43.

[52] A definition of the term "absolute" follows: "not limited by restrictions or exceptions." Cf. *Webster's II: New Riverside University Dictionary* (ed. A. H. Soukhanove *et al.*; Boston: Riverside, 1984) 68.

that permissible? The answer was not readily apparent to me. If he permits this possibility, then the absolute SL principle is compromised.

In all fairness, one text seems to militate against the use of the principle of double effect and could be interpreted as a form of vitalism. In his discussion of Job, Cameron suggests that an intolerable quality of prolonged life must be brought before God as a test of faith. The dignity of man is tempered by the indignity of man who, corrupted by the fall, must die. This, according to Cameron, is not only an affront to man but to God as well. Sickness and suffering are but manifestations of the curse, which culminates in death. In the context of suffering, Cameron almost echoes the Heideggerian "living is learning to die," but with a Christian resonance. In a discussion regarding the suffering of Job, Cameron suggests that Job lays hold of the sober truth of human life's temporal story. If life should find us in

> intolerable quality, we should not be surprised. If like Job we have learned to bring the intolerable to God—and if in Jesus Christ we have found him to share it with us—we have grasped something of the life of faith.[53]

I do not disagree with the notion of prayers of lamentation and the place of the test of faith. I do question the implications of the possible consequences of applying this pericope in a current technomedical environment where biological life can be prolonged without reversal of the disease process and with excruciating and debilitating suffering. I do not accuse Cameron of this type of vitalism, but I caution that there is a need for clarification in order to avoid this possibility.[54]

II. EVANGELICAL REJECTION OF CERTAIN QOL CRITERIA

1. *Rejection of the utilitarian QoL ethic.* Our study of the preceding authors brings us to the completion of the first aim of this study: a clarification of common evangelical positions on the use of QoL criteria in medical ethics. Most evangelicals reject QoL criteria similar to the view-

[53] Cameron, "Theological Perspectives" 42.

[54] J. Kilner, a seventh author and colleague of Cameron, takes issue with QoL valuations as well. He does so by attacking the notion of placing a value on life. He states that he rejects vitalism and QoL judgments as well. Although he denies the use of QoL criteria, his judgment is that certain persistent vegetative-state (PVS) patients can forgo treatment based on QoL criteria. Such a criterion and valuation is found in the term "useless." In the discussion of PVS patients he advocates forgoing treatment and states: "The reason it seems so completely useless to continue to treat certain patients, such as those who are permanently unconscious, may be that they have died (i.e., they have moved beyond experiencing life in this world)." Although I agree with his conclusion, determinations such as "useless to continue treatment" are by definition qualitative determinations. Further, the issue of "experiencing life" is a value judgment as well. Cf. Kilner, *Life on the Line: Ethics, Aging, Ending Patients' Lives and Allocating Vital Resources* Grand Rapids: Eerdmans, 1992) 122–125. For definitions of quantitative and qualitative futility cf. S. H. Miles, "Medical Futility," *Law, Medicine, and Health* (Winter 1992) 310–311. Regarding forgoing treatment in PVS patients as a value judgment see Council on Scientific Affairs and Council on Ethical and Judicial Affairs, "Ethical Considerations in Resuscitation," *Journal of the American Medical Association* 268/16 (October 28, 1992) 2282–2288.

points of Singer, Fletcher or Kuhse. What is rejected, then, are QoL criteria based on utilitarian notions of life's worth. This rejection of a utilitarian QoL ethic was commonly supported by five reasons. First, QoL criteria are fraught with standards that are relative. In the evangelicals' opinion, these standards become the standards of the group in control. This allows for the possibility of the exploitation of the standards to the benefit of those in control. They are concerned these standards will be concretized in actions that annihilate lives considered too burdensome, too costly and too inconvenient for the good of the society at large.

A second reason for the rejection of a utilitarian QoL standard is the historical precedent of abuse found in the Nazi Germany euthanasia program. The beginning of the Nazi holocaust involved the elderly and mentally ill, who were considered not to have a quality that gave them a right to life. Their utilitarian egoism issued into an "end justifies the means" mentality that cost the lives of over six million noncombatants. Evangelicals suggest that history should teach humanity the lesson that QoL criteria are the thin edge of a wedge that ends in the murder of the weak and powerless by the strong and powerful. A third reason for rejection is the loss of patient autonomy—that is, those chosen for nontreatment have no say in the decision. A fourth reason is an appeal to God's sovereignty over life. Man has no right to diminish the sovereignty of God over his life or death. The fifth reason for rejecting a utilitarian QoL ethic is that it lacks perspective regarding the purpose of man's indignity. Advocates of the utilitarian notion do not recognize the purpose or reason for human temporality, deterioration and suffering. Death is removed from the process of life, in their opinion, and loses its valuation as a part of life's narrative. Each one of these reasons carries enough weight to warrant rejection of the use of utilitarian QoL criteria in biomedical decision-making unless sufficient reasons are garnered to refute each of the five criticisms.

2. *The qualification of a SL principle.* Confrontation with biomedi-cal advancements that sustained biological life with questionable results led to an abandonment of a rigid SL principle on the basis that it no longer proved commensurate with a Christian *agapē* norm. Attempts to maintain the absolutist position resulted in accusations of unmerciful vitalism. Many evangelicals abandoned these attempts and the absolutist notion behind the principle. The corrective developed only addressed the issue of unacceptable outcomes in medical intervention. It did not go so far as to purge out the modernist vision and value of maintenance of mere biological life that has crept into the evangelical philosophical argumentation. Thus evangelicals began to acknowledge in practice what was uttered in premodern doctrine—namely, that physical death is not the supreme evil, nor is biological life the supreme good. The practical outworking of the equivocity of these two truths in medical care left the evangelical on the horns of a dilemma. How does one maintain biological being as sacrosanct and at the same time offer loving care in the face of inevitable biological death? The looming tragedy in the inconsistency of a qualified biological

SL principle was that the inherent valuation of man's transcendental sanctity was being sacrificed for an older humanistic positivism extolling a sacrosanct biology.

3. *Voicing a place for QoL criteria*. As an evangelical, I agree with the authors cited who reject the use of utilitarian QoL criteria in medical ethics. Further, I believe Kuhse's criticism has only partial validity. She mistakes quantitative criteria such as irreversible, irreparable, and imminent death for qualitative determinations associated with these prognoses. Where Kuhse's criticism is correct is in the use of qualitative criteria such as burdensome or excessively painful interventions associated with the prognosis of quantitative futility. These are QoL criteria that can be used by utilitarians as well as by Christians. The difference resides in the motivation and disposition of the moral decision-maker applying the criteria. It is a question of their ideology. Matthew Edlund and Laurence Tancredi propose five views of QoL based on different ideologies: (1) the self-fulfillment view, (2) the return to normality view, (3) the social utility view, (4) the rational-man view, and (5) the individualistic view.[55] They suggest, and I think rightfully, that to understand the use of the phrase one must understand the ideology of the user.[56] The strong reaction of the evangelical community against a utilitarian QoL ethic has led to the neglect of addressing these other positions.[57] In fact our literature remains silent by reducing the critique to one type of QoL criterion.

This study has shown that a number of well-respected evangelical ethicists are to be numbered among those using QoL criteria, albeit unacknowledged. In order to avoid a merciless vitalism they integrated the triad of quantitative futility criteria (animate conditions that are acutely terminal; physical conditions that are irreversible; imminent death) with QoL criteria associated with these conditions, which when treated offer little or no relief from misery but only prolong the dying process.[58] I propose this approach to be medically reasonable and spiritually commen-

[55] M. Edlund and L. R. Tancredi, "Quality of Life: An Ideological Critique," *Perspectives in Biology and Medicine* 28/4 (Summer 1985) 597–600.

[56] Ibid. 591–607. They suggest that the term's use is inextricably bound to the user's political and social agenda: "To understand the phrase 'quality of life' one must first consider the user of the term, his understanding of it, and his position and agenda in social and political structure. Once again, no pejorative or negative component is implied. All thought is inherently ideological; unless we are empyrean observers from another world, we are, inevitably, historical actors in our place and time."

[57] J. J. Walter and T. A. Shannon support my proposal in the preface to their work, saying that there is no one definition of the concept. Cf. *Quality of Life: The New Medical Dilemma* (Mahwah: Paulist, 1990) 7. M. Fowlie and J. Berkeley cite over thirty-five varying opinions on the concept of QoL in their review of the medical literature that supports this possibility. Cf. Fowlie and Berkeley, "Quality of Life: A Review of the Literature," *Family Practice* 4/3 (Oxford: Oxford University, 1987) 226–229.

[58] The first two categories are not truly qualitative in the medical sense, since they are predominantly determined by quantitative judgments. The last category is clearly a qualitative criterion and often described in medical literature as qualitative futility determinations. Cf. B. Lo and A. R. Jonsen, "Clinical Decisions to Limit Treatment," *Annals of Medicine* 93

surate with the Christian faith. In order to maintain this position with consistency, however, one must shed a biological SL principle. Do I then concur with Kuhse's plea to scrap the SL principle altogether? Not at all. Rather, I propose a construction of a transcendental SL position compatible with elements of our theological past and compatible with the understanding of psychophysical facticity of the present.

III. SAYING THE UNSAID: TOWARD CONSTRUCTING A TRANSCENDENTAL SL PRINCIPLE

Having clarified the evangelical position on QoL and the partial validity of Kuhse's accusation regarding inconsistency, we are left with the third and final aim of this presentation: reflection upon a response appropriate to our findings. An evangelical response must consider the voicing of our psychophysical facticity and the transcendental reality it represents. The response should avoid QoL criteria that reduce man to a mere utilitarian instrumentality or a sacrosanct biology. With these parameters in mind I would like to voice a transcendental SL principle as a viable response to Kuhse's criticism.

1. *A description of a transcendental sanctity-of-life principle (TSLP).* A TSLP views our biological vitality as the material aspect of our being set aside to God and open to relationships to the "other" evidenced in truly human actions. The life of the moral subject is transcendent in two ways. First, the moral subject, by means of opening himself to a radical responsibility to the "other," breaches the boundaries of mere subjective egoism. In so being, he transcends self and yet becomes more fully self.[59] The second way in which the self is transcendent accounts for the notion of sanctity as well. The moral subject, by means of opening himself to a radical grasping by God, transcends the restrictions of his fallen existence. Both movements of transcendence are inextricably bound to the moral

(November 1980) 764. They define quantitative futility when answering the following question: "What considerations lead to the judgment that treatment is useless or futile? The physician has no moral or legal obligation to provide therapy that will not cure the disease or relieve the symptoms." Cf. also G. Meilander, *Hastings Center Report* 23/4 (July-August 1993) 28: "Recent discussions make clear that, in light of such problems, 'futility' has gradually come to mean something else—and something quite different. If the sense of futility described above is termed 'quantitative' (referring to the improbability that treatment could preserve life for long), a rather different sense is now termed 'qualitative.' Thus, some have argued, treatment that preserves 'continued biological life without conscious autonomy' is qualitatively futile." See also Emergency Cardiac Care Committee and Sub-committees, American Heart Association, "Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac Care VII: Ethical Considerations in Resuscitation," *Journal of the American Medical Association* 268/16 (October 28, 1992) 2283.

[59] M. Buber, *I and Thou* (2d ed.; New York: Scribner, 1958) 28. My thought reflects Buber's statement: "Through the *Thou* a man becomes *I*."

subject as corporeality, interiority and pneumanality. Biological vitality provides the medium for physical expression of psychopneumanal facticity. The ultimate *telos* of this biological vitality is to bear witness to God. The transcendental aspect of this principle is constituted with anthropological notions drawn from man as *imago Dei*, Biblical notions of sanctity, and Biblical notions of life. A synthesis of these aspects results in a view of corporeality as neither an absolute good nor an unnecessary vestige of materiality. QoL criteria, such as excessive suffering or debilitation that are associated with irreversible, irreparable conditions or with imminent death, are acknowledged but do not negate the sanctity of vitality. But they do alter the manner in which that vitality shall be set aside to God. Corporeality in this case will be set apart to God as a ministry to others in showing them how to die well in Christ. We as the believing community must set ourselves apart to God to facilitate that act of martyrdom. The interrelationships of our ministries re-present or image God by means of the common moral attributes he has given us in our innate dispositions.

2. *Constitution of the transcendental aspect of this principle*. The discussion of man as *imago Dei* is a subject that goes beyond the scope of this paper. I would like, however, to introduce some general notions in a construction of the concept of *imago Dei* that are germane to the TSLP. I begin with a semantic consideration drawn from the first Scriptural appearance of the phrase in Gen 1:26–27. The key word in this pericope to denote "image" is *ṣelem* (1:26–27; 9:6). A proposed lexical definition is given as "something cut out, an image."[60] NT Greek uses *eikōn* to connote the idea of "likeness, form, or appearance."[61] The common lexical thread is that in both languages the image in some way represents its original.

The second consideration concerns Scriptural notions involving the image of God. It is unnecessary to reiterate the obtuseness found when seeking Scriptural clarification of the phrase.[62] Although little insight can be gained in regard to the precise meaning of the term, three general concepts are present. The first is that of humanity's shared essence. Since the entire human race was and is created in the image of God, we share that essence. Implications of equality and similarity are associated with this revelation. Second, Pauline references to the image of God bring me into agreement with V. Elving Anderson and Bruce Reichenbach, who

[60] BDB 853.

[61] BAGD 222.

[62] For discussions regarding the nondescriptive content of the phrase in Scripture see V. E. Anderson and B. R. Reichenbach, "Imaged Through the Lens Darkly: Human Personhood and the Sciences," *JETS* 33/2 (June 1990) 198: "As to the problem at hand, Scripture gives little guidance as to how the concept of imago Dei is to be translated into empirical psychology, philosophical anthropology, or biology." Also cf. M. J. Erickson, *Christian Theology: One-volume Edition* (Grand Rapids: Baker, 1987) 512–513: "Having noted that there are difficulties with each of the general views, we must now attempt to form some conclusions as to just what the image of God is. The existence of a wide diversity of interpretations is an indication that there are no direct statements in Scripture to resolve the issue."

posit that such references seem to associate "image of God" with moral content.[63] They base this opinion on their interpretation of the imperative connecting image with choosing to put on righteousness and holiness and a behavior that is compatible with such a choice.[64] We come to a third insight gained when conjoining the moral characteristic and the characteristic of shared essence: The morality conferred on us by the residence of God's image provides for the presence of universal fundamental moral norms. Louis Janssens gives a clear description of my opinion when he states the following:

> Because we are basically similar, we find ourselves in a common situation that can be governed by universal norms valid for each and every person.[65]

This postulation is a basis for the resistance of ethical egoism argued from the vantage point of social pluralism.

Before moving on to theological considerations, I would like to draw some inferences from Scripture regarding man and the image of God. The first is that the image of God is not to be taken lightly. There is a strict prohibition against making images to represent God. According to orthodox Judaism, this included images of man. One author observes that the closest thing to the image of God that the Israelites of the Hebrew Scriptures had was his empty portable throne in the Holy of Holies. This throne was not occupied by something so static as an image, but supposedly by the omnipotent Shekinah Glory of God.[66] Extrapolation permits me to draw a correlation between the portable temple of the Hebrews and the portable temple known as the body of man (1 Cor 6:19–20). Albeit obtuse in Scriptural definition, it seems apparent that man uses his body as a reflection of God's presence or absence in the moral sphere of human behavior. The use of body is a medium of the message of God's presence in relation to other persons and the presence of God in relationship to the totality of the individual person. The image is, in a sense, signifying a re-presentation of God.

The third and perhaps most important consideration in the constitution of our notion of *imago Dei* is theological. It is based on a synthesis of three historical views: substantive, relational and functional. The medium of action and relation in man is his corporeality.[67] Without corporeality, the human imperative to glorify God is not realized in the phenomenal sphere of relationship with the "other." Thus in a sense the dominant his-

[63] Anderson and Reichenbach, "Imaged" 198.

[64] Ibid. Cf. Eph 4:24; Col 3:10; 1 Cor 11:7.

[65] L. Janssens, "Artificial Insemination: Ethical Considerations," *LS* 8/1 (Spring 1980) 13.

[66] G. Kittel, "εικών," *TDNT* 2.381–387. Cf. Ezek 10:1–19, which describes the departure of the glory of God from the temple. Cf. also 2 Cor 3:18.

[67] This concept echoes that disclosed in *Gaudium et Spes 14*: "Man, though made of body and soul, is a unity. Through his very bodily condition he sums up in himself the elements of the material world. Through him they are thus brought to their highest perfection and can raise their voice in praise freely given to the creator." Cf. *The Documents of Vatican II* (ed. A. Flannery; Grand Rapids: Eerdmans, 1978) 933–934.

torical view of "image of God" as substance has some merit.[68] The concept of "image of God" is inextricably bound to substance. As Janssens attests: "The body is a necessary medium for all our relationships."[69] But as Janssens intimates, being, and surely being in God's image, suggests more than mere corporeality. To focus only on the material is to reduce the image of God to constructs of mere post-Enlightenment positivism. Such a reduction is difficult to verify in Scripture and leaves transcendental realities wanting.

The relational views fill a void left by a material reduction of the image of God.[70] As discussed previously, "image of God" as represented through the medium of corporeality expresses itself in relationships, both with God and with the "other." It is in the corporeal sphere that the I-Thou relationship manifests itself to humanity. The relational element, however, is not the totality of the image in my construct as it is in the relational views. Quite the contrary. To reduce the image to the relational sphere is again to leave the richness of the notion wanting. An expression of the richness of human relationships cannot be achieved without human actions. Thus the place of the functional view is established in the discussion.

The functional view has a long history. It emphasizes the place of man's action, particularly dominion, giving content to man's relationships.[71] Emphasis on action provides the necessary manifestation of the *telos* of being created in the image of God, and that is his glorification. The functional view alone, unfortunately, attenuates the vista of "image of God" by denying the place of relation and substance in the manifestation of image as action.

It should be apparent that I am striving toward a synthesis of the three views in my construct of the image of God in relation to corporeality. The relationship of corporeality with "image of God" is constructed with the following content. God created man in his image to re-present him, both in relation to the material creation and in relationship to himself. This representation of God in man is part of every aspect of man's being. Corporeality, as one of these aspects, provides a material medium for the representation of God. Corporeality is the most tangible aspect, both in the sight of the individual himself and of others relating to him. It is by means of corporeality that the human person has the potential to relate the presence of God, through his being and actions, to the Other and the others. Actualizing the potential to represent God as his image introduces a su-

[68] Erickson describes the substantive view as follows: "The common element in the varieties of this view is that the image is identified as some definite characteristic or quality within the make-up of the human. Some have considered the image of God to be an aspect of our physical or bodily make-up" (*Christian Theology* 498).

[69] L. Janssens, "Personalist Morals," *LS* 3 (1970) 12.

[70] A short truncated description of a relational view rejects that God's image is something present in man's nature. Relationists, like Brunner and Barth, are said to suggest that man is said to be in the image or to display the image when he stands in a particular relationship. In fact, that relationship is the image. Cf. Erickson, *Christian Theology* 502.

[71] Ibid. 508.

pernatural metaphysics into treatment discussions in a balanced way. A full-orbed view of "image of God" provides a corrective for both vitalistic and utilitarian univocities.

3. *Notions of sanctity and life*. The constitution of a TSLP requires an understanding of the terms "sanctity" and "life" in the framework of our previously constituted notion of *imago Dei*. This will be done through lexical and contextual considerations. The term "sanctity" can be lexically constituted with the meanings "to set aside, to devote, to give over, or to consecrate."[72] It is the English translation of the common lexical meaning from the NT Greek term *hagios*. This term denotes that which is "dedicated to God."[73] I have chosen to constitute the word "life" with content from the NT Greek term *zōē*. The breadth of the term intimates both "the natural life of man" and "life future and present," lived through the transcendence and power of Jesus Christ.[74] The preposition "of" signifies the description of sanctity attributed to life. These three ideas can be combined to form the following lexical signification. SL signifies the "giving over" of the "natural and transcendent human existence" to God.

Expressions of Biblical experience found in Scripture lend some clarity to the extent to which this concept can be applied to corporeal notions of sanctity. For instance, an interpretation of Matt 8:22 supports the aforementioned lexical signification. The context of the Matthew passage addresses the decision of a disciple of Jesus to put in order the affairs of his family after his father's death. According to one commentary, this would include "burial, arranging family affairs, distribution of inheritance, etc."[75] Whatever the hidden reasons, it was apparent that Jesus believed such an endeavor would divert the disciple from a total commitment to following him. Jesus responds by suggesting that this disciple permit those who are spiritually dead to bury the physically dead: "When Jesus saw the crowd around him, he gave orders to cross to the other side of the lake. Then a teacher of the law came to him and said, 'Teacher, I will follow you wherever you go.' Jesus replied, 'Foxes have holes and birds of the air have nests, but the Son of Man has no place to lay his head.' Another disciple said to him, 'Lord, first let me go and bury my father.' But Jesus told him, 'Follow me, and let the dead bury their own dead'" (Matt 8:18–22). The application here is that, although the community surrounding the dead father had vital biological life, their true existence was considered dead in the present and in the future. This was due to their focus on corporeality and materiality. By this I mean that not only was their spiritual life dead but also their biological life was as good as dead, since that physical medium (biological vitality) was not disposed to re-present the attributes of

[72] *Cassell's Latin Dictionary* (5th ed.; ed. D. P. Simpson; New York: Macmillan, 1968) 533.
[73] BAGD 9.
[74] R. Bultmann, "ζωή," *TDNT* 2.861, 863–865.
[75] A. B. Bruce, "The Synoptic Gospels," *The Expositor's Greek Testament* (ed. W. R. Nicoll; Grand Rapids: Eerdmans, 1979) 1.143.

the One who gave it.[76] The correlation between this passage and my reconstruction of the SL principle is found in the giving over of the person's spiritual disposition to God. The giving over of the biological vitality represents the allegiance of the person's spiritual life.

A Pauline notion of "life" affirms the relationship of the biological life with the transcendent life in the now and in the future. This is exemplified in Paul's discussion of a life once dead, but now made alive in Christ: "Like the rest, we were by nature objects of wrath. But because of his great love for us, God, who is rich in mercy, made us alive with Christ even when we were dead in transgressions—it is by grace you have been saved. And God raised us up with Christ and seated us with him in the heavenly realms in Christ Jesus, in order that in the coming ages he might show the incomparable riches of his grace, expressed in his kindness to us in Christ Jesus. For it is by grace you have been saved, through faith—and this not from yourselves, it is the gift of God—not by works, so that no one can boast. For we are God's workmanship, created in Christ Jesus to do good works, which God prepared in advance for us to do" (Eph 2:3–11). This pericope emphasizes the difference made when vitality is empowered by the loving, saving presence of Jesus Christ. It is communicated through corporeality by means of good works that are sourced in a human disposition given over to God and thus emulating harmony with the Creator.

In contrast to a spiritual and physical life given over to God in works is an existence disposed inwardly toward self. This disposition was said to be reduced to materiality and gratification of that materiality alone.[77] An existence of this sort, although having biological vitality and cravings, was said to be in an existence of death (Eph 2:1–2). The death described is a spiritual death that does not represent the image of God but only the image of self. Satisfaction and exaltation of materiality serve as the aim of such a life, and from the view of eternality it is as if the existence had already physically died. This is because all the physical action based upon self expended during biological life brings nothing that would endure in the eternal presence of God.[78]

The difference between a life reduced to material transiency and a material existence sacrificed yet present in the eternal now is reiterated in Rom 12:1–2: "Therefore, I urge you, brothers, in view of God's mercy, to offer your bodies as living sacrifices, holy and pleasing to God—this is your spiritual act of worship. Do not conform any longer to the pattern of this world, but be transformed by the renewing of your mind. Then you will be able to test and approve what God's will is—his good, pleasing and perfect will." These verses come in the context of a doxology that exalts the otherness of God. The exaltation uses verses from Isa 40:13 and Job

[76] A spiritual life not disposed toward God expresses that disposition in an empty expenditure of the biological life that mediates that disposition. In so doing, temporal futurity intended for the human person is truncated and dissipates in the mist of materiality. Furthermore the eternal futurity dissipates in vacuous separation from God.

[77] Cf. Eph 2:3.

[78] Cf. Rev 20:12–15.

41:3.[79] Both of these passages are in the context of the omniscience, omnipotence and benevolence of God. These concepts are part of the Romans passage as well. In view of these notions Paul appeals to the readers to use their corporeality in a manner separated unto the service of God. The rest of the chapter gives content to how this service might look, such as proper conduct in relation to other believers, to civil authorities, and toward the world in general.[80]

The preceding passages support the position that true life cannot be reduced to biological vitality. A corrective to this material reduction can be made through intersecting our postulation of SL with our notion of *imago Dei*. In this intersection the corporeality, representing the image of God, is seen as the medium of humanity. Corporeality is to be set aside or consecrated to the service of others by means of a transformed disposition, a disposition inclined toward God. The melding and giving over of both spiritual disposition and the material means of communicating that disposition, the body, express an unequivocal SL position. The voicing of a transcendental SL permits both biological and spiritual vitality to be heard in harmony.

QoL is part and parcel of sanctity. Biological lives in the end stages of their physical narrative retain their transcendental spiritual worth. The waning of phenomenal vitality provides the final opportunity for a person to re-present God. It is not an opportunity to be denied by resource allocation, physician-assisted suicide, or vitalistic interventions. It is, rather, an opportunity for the person suffering an irreversible, irreparable condition to face his imminent physical death with the witness of Christlike dignity. The curing community and the caring community must facilitate the quality of his witness. As John Dunlop recently stated:

> Quality issues help us determine if we should use aggressive measures to prolong that life. When preserving the quality of life, rather than prolonging that life, is the goal, the result is a commitment to provide loving support and comfort to the patient.[81]

It is by means of this kind of support and comfort that the patient can best represent Christ in his final human act of witness, a last death to the flesh in Christ.

IV. CONCLUSION

The aims of this presentation have been addressed. We have shown that evangelicals reject QoL criteria based upon a utilitarian approach. We have also demonstrated the validity of Kuhse's accusation that advocates of a qualified SL principle, such as many within the evangelical community, use obtuse and unarticulated QoL criteria in their approach to

[79] *UBSGNT* 3.

[80] Cf. J. P. Lange and F. R. Fay, "The Epistle of Paul to the Romans," *Lange's Commentary on the Holy Scripture: Critical, Doctrinal, and Homiletical* (Grand Rapids: Zondervan, 1969) 10.381.

[81] J. Dunlop, "A Physician's Advice to Spiritual Counselors of the Dying," *Trinity Journal* 14/2 (Fall 1993) 206.

life-sustaining treatment decisions. The predominant triad found that quantitative criteria of irreversibility, irreparability, and imminent death were associated with the forgoing of treatment based upon qualitative grounds, suffering and burden. In dealing with this inconsistency we rejected Kuhse's solution to scrap the SL principle altogether. Instead we forwarded a TSLP in which corporeality, representing the image of God, is seen as the medium of humanity. Corporeality is to be set aside or consecrated to the service of others by means of a transformed disposition, a disposition inclined toward God. Part of that service is dying a death in witness to Christ. A consecration of this type permits the voicing of the quantitative criteria of the medical community that is compatible with the qualitative criteria in a transcendent SL principle of the believing Christian community. In order for harmony to exist in these two communities, both must permit the proper voicing of the "other." Harmony can be accomplished by listening to the criticism of the other and, where appropriate, seeking correctives. These come by acknowledging our inconsistencies and, where correctives are needed, boldly saying the unsaid.