A Needy World—A Needed Word: Scarce Medical Resources and the Christian Story

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A baby in California is denied access to a heart transplant because his unmarried parents are judged unable to provide a stable home environment. The right people learn about it, an uproar follows, and custody is transferred to the baby’s grandparents so that a transplant may be done. The parents obtain appearances on various media programs to plead for an infant heart to be donated, and the parents of a brain-dead but heart-alive infant respond. Meanwhile, the parents of a baby awaiting a heart transplant in Kentucky are horrified as they watch the unfolding drama. Their baby has been on the waiting list longer and should have obtained the heart that went to California.

Who gets the scarce organ transplant? Who receives an intensive care bed when space runs short? Who is given any expensive treatment at all? The answers to these questions are deeply touching the lives of countless people in the United States and around the world today. While the problem has received scant public attention, that picture is rapidly changing. What does the church have to say as people struggle to decide who should live and who should die?

Numerous criteria are being employed for selecting patients to receive treatment when not all can be treated (see Table). Sometimes those judged most valuable to society are preferred; sometimes it is those with stable home environments or the ability to pay. On the other hand those thought too old or living lives of insufficient quality may receive lowest priority. Which of the various criteria are morally acceptable? Does a Christian perspective on the world provide any guidance in these life-or-death decisions?

This analysis is designed to demonstrate that Christians can and must contribute to the debate over patient selection criteria. In order to be motivated to do so, one must first be convinced that there is a serious problem which needs attention. Sadly, there is a popular myth today that a prosperous country like the United States need not worry about the problem of patient selection since there are resources sufficient for all. Some may believe that this sufficiency extends throughout the world. This myth is less than a half truth. The truth in it is that the financial resources exist to eliminate many of today’s scarcities. Will such resources be made available to meet the medical needs of all? Unfortunately, such a development is not likely even within the United States, though it should be aggressively pursued. Other non-financial resources like organ transplants are also

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Table: Patient Selection Criteria

*Ability to Pay:* whether or not the prospective recipient has enough money or insurance to pay for the required services.

*Age:* how many years the prospective recipient has lived.

*Favored Group:* whether or not the prospective recipient is a member of a certain group, identified by geographical location, veteran status, etc.

*Imminent Death:* whether or not the prospective recipient will die in the next week or so without treatment.

*Length of Benefit:* the length of expected survival with treatment.

*Likelihood of Benefit:* how likely is it that the desired medical outcome will in fact occur.

*Medical Benefit:* whether or not the prospective recipient will live longer because of the treatment.

*Progress of Science:* how much scientific knowledge may be gained from treating the prospective recipient.

*Psychological Stability:* the ability of the prospective recipient to cope emotionally and intellectually with the treatment regimen.

*Quality of Benefit:* the quality of life the prospective recipient may expect if accepted for treatment.

*Random Selection:* whether cases are ever such that they should be treated as fundamentally similar and, therefore, recipients selected by lottery or on a first-come-first-served basis.

*Resources Required:* whether or not the prospective recipient will likely require particularly long or expensive treatment.

*Social Value:* how much society, including people individually, will benefit if the prospective recipient is treated.

*Special Responsibilities:* whether or not the physical life of at least one other person—or something equally important—depends upon whether or not the prospective recipient lives.

*Supportive Environment:* how supportive (financially, emotionally, etc.) the prospective recipient’s family, friends, and community are likely to be.

*Willingness:* the expressed or implicit desire of the prospective recipient to undergo treatment.
scarce relative to need. And new scarcities are inherent in the march of technology. In other words, patient selection criteria are desperately needed everywhere today and will continue to be so in the future.

Since the problem involves choosing among medically qualified candidates for treatment, the decision is not a medical one. It must be based upon whatever basic values a society wants to live by. To the extent that the church has insight into those values which are most affirming of people and community as they are at their best, the church must get involved. This analysis attempts to document clearly the seriousness of the problem and to identify the contribution that Christian insight can make to the morally healthy selection of patients. The discussion will be extensively footnoted throughout to enable people to investigate further any of the issues raised here.

THE PREDICAMENT IN THE UNITED STATES

No nation, including the United States, is free from patient selection dilemmas. Health care has always been rationed in the U.S., in that a lack of physicians or the ability to pay for their services has constantly afflicted some.1 There have also been many situations in which particular treatments have been scarce, at least for a period of time.2 Prominent examples include blood supplies in special cases and lifesaving drugs such as insulin, polio vaccine, and streptomycin for a significant period of time after they first became generally available.3 Wars and natural disasters have similarly created situations in which limited resources forced decisions as to who would be saved and who would be left to die.4

The classic high-tech example of a recently scarce lifesaving medical resource in the U. S. is long-term hemodialysis for kidney failure. The first dialyzer, or artificial kidney, was constructed in 1913. It had received some use by 1946, but maintenance dialysis for chronic kidney disease was not available until 1960.5 By the mid-1960s, still only 800 people were receiving hemodialysis although those recognized as suitable candidates for it numbered 10,000 or more.6 Within another year or two as many as 10 percent of those needing hemodialysis in order to live were able to receive it.7 However, this figure probably represents only the ideally suited candidates. Those treated were likely only 3 percent of all those whose lives potentially could have been saved by hemodialysis.8 Estimates of the number of suitable candidates denied treatment grew during the early 1970s, with figures over 20,000 being cited for the year 1972.9

Such scarcity, involving staff as well as machines, rendered inescapable extremely difficult choices with regard to who could make use of the lifesaving resource.10 Since there were no national decision-making guidelines, each facility was left to its own method of deciding. Swedish Hospital in Seattle, one of the largest hemodialysis facilities in the country, received extensive (often adverse) publicity when some of the decision procedures used by its Admissions Advisory Committee were revealed.11 By 1972 enough concern had been aroused that Congress funded the treatment of end-stage renal disease for Medicare patients.12 While most people were thereby covered, seven percent or more of the U. S.
population do not meet the eligibility requirements and others have difficulty gaining access to available resources. Accordingly, medical directors of renal facilities estimate that 1,000 people are still dying annually in the U.S. for lack of dialysis alone. There were a variety of reasons for the congressional funding decision, including the progression of dialysis beyond the experimental stage and the lobbying of the nephrology community. Yet, curiously, no congressional hearings were held and less than 30 minutes of debate took place on the Senate floor. This fact, taken together with the arguments voiced by a majority of the senators during the brief floor debate, suggest another funding rationale. People saw federal funding as a way to avoid uncomfortable life-or-death patient selection decisions altogether, especially where social worth evaluations of people were being conducted. The results, though, included not only a “universal” funding which is not in fact universal, but also a failure to develop carefully-considered approaches to medicine’s inevitable patient selection decisions.

The need for such careful consideration is evidenced by the increasing frequency of life-or-death patient selection decisions. They are becoming virtually routine—a “fact of life.” Many health care settings have found it necessary to establish committees to help them make such decisions. While funding and trained personnel limitations contribute to the scarcity, certain resources themselves are not available to all in need. One major arena where patient selection decisions are commonplace is that of organ transplantation. Kidney transplants are the most familiar of the lifesaving transplant operations, having been done for 50 years and having remained scarce relative to need throughout. Many hundreds—perhaps thousands—of patients a year still die for lack of an available organ.

A more recent development is heart transplantation. According to all estimates there is a significant selection problem here. Public studies place the number of potential recipients at 32,000 to 75,000 per year but the number of available hearts at only 1,000 to 2,000. Even if the extremely strict patient selection criteria employed at Stanford University are applied, over 750 ideal candidates are dying each year for lack of a donor heart. From this perspective, selection criteria would be doubly needed—to identify the ideal pool of candidates and to make the final selections. Considering the diversity of estimates, a National Heart, Lung and Blood Institute study has concluded that no more than one-fourth of the acceptable candidates can receive transplants since the number of suitable organs will always be insufficient. While liver transplantation has not received the same degree of national attention, estimates indicate that the scarcity of organs and need for selection criteria are on a comparable scale.

Another arena in which patient selection decisions have become commonplace is intensive care. When space is not available patients are generally turned away, though sometimes someone is removed to make space instead. Such denial or removal is not always fatal. However, there is always a significant risk, and deaths as a result have indeed been documented. Sometimes the scarcity is a matter of available beds (and the funds for more); sometimes it is due to a nursing shortage. The impact on the patient is the same either way if the resource cannot
be provided. Neonatal intensive care is particularly prone to life-threatening scarcities. Many cases have been graphically reported, with some specialists indicating their awareness of as many as 180 cases per year in their geographical area alone where babies die while waiting for a filled intensive care bed to become available.

Other current examples of scarce lifesaving resources compelling patient selection decisions tend to reflect limitations in dollars made available to health care rather than a shortage of a resource per se. In that sense, they bring into question the legitimacy of the ability-to-pay selection criterion in particular rather than merely establishing a need for a whole set of criteria. Examples of this type include expensive surgeries and special forms of administered nutrition (especially parenteral nutrition). Emergency room room care for poor patients without insurance is another case in point. The refusal of such care to the poor creates major risks to life and health, and numerous cases have resulted in premature death. The need to select patients and to develop criteria for wise decisionmaking, as we have seen, is striking. Before looking at what the future will likely hold, though, we would do well to place the U.S. predicament in broader perspective. The ethical dilemmas involved have long been around. But the advent of lifesaving health care has magnified the problem vastly. How is the church speaking to this issue?

A WORLDWIDE PROBLEM

Through the centuries, the need to decide whose life to save when not all can be saved has arisen in various settings. Cicero for example, records an early Stoic discussion of the case where there are two floundering men and a floating plank large enough to support only one of them. Lactantius mentions a similar dilemma posed by Carneades in ancient Rome where one man is stronger than the other. Such questions also troubled the early Christians. As Ambrose notes, they were concerned about the presumption that a wise sailor ought to take away a plank from an ignorant one. In Jewish tradition the somewhat different case of two men traveling through a desert with enough water to sustain only one of them seems to have been a major paradigm.

From the seventeenth to the nineteenth century, numerous shipwreck cases requiring life-and-death decisions received wide publicity, particularly where legal trials followed. The best known case, United States v. Holmes, involved the sinking of a ship near Newfoundland. When it became apparent twenty-four hours after the disaster that a leaking lifeboat carrying survivors could not remain afloat unless it was significantly lightened, fourteen people were selected and thrown overboard by the crew. In The Queen vs. Dudley and Stephens three men and a boy were similarly stranded in a small boat far from land; but their dilemma involved the apparent necessity of three killing and eating the fourth if the three were to have enough food to survive. During the trial, earlier parallel cases were introduced and debated, especially a Dutch account of a Caribbean disaster.

Today, vital allocation decisions must be made throughout the world with
respect to various resources, but in no case is the decision-making problem more widespread than in the case of medicine. Scarce lifesaving medical resources must be allocated in more- and less-developed countries alike. However, the resources to be allocated are somewhat different in the two settings. In many less-developed countries, the most pressing problem is a lack of "basic" (from a U.S. perspective) drugs and doctors. For instance, hundreds of thousands of children die each year in Africa alone from malaria because they are not given the necessary preventive drugs. A similar predicament exists there regarding measles. Measles, in fact, has been labelled one of the main killers of children in less-developed countries. Documented examples include Nepal, Bangladesh, Chile, Thailand, and, on a larger scale, India, where yearly deaths and belated deaths (all ages) due to measles have been estimated in the hundreds of thousands.

As for health care personnel, they persistently remain in short supply all over the world. The tragedy of this shortage was graphically portrayed by one doctor whom I interviewed in Kenya recently. She confessed that at least one night every week she is caring for a critically ill child when another critically ill child is brought in for treatment. She is working alone—the only intensive care available. If she leaves the one she is with long enough to care for others more than superficially, he or she dies. But if the new arrival does not receive almost constant attention throughout the night, the latter dies instead.

In more developed countries intensive care units have been introduced to help avoid such crises. But the technology involved is quite expensive and not always available for everyone in need. There are numerous examples of such technologies which are becoming increasingly available, sometimes creating patient selection dilemmas where none existed before. (All in need simply would have died.) Natural and artificial organ transplantation are typical instances, as is expensive surgery. This is not to imply that technological shortages do not plague less-developed countries as well. The resources just noted—not to mention such widely applicable technologies as fetal monitoring equipment—could meet a great deal of need there. But it is often the case that a recently invented resource in a more-developed country will not even exist in a less-developed country.

A good example of a more-developed country where advanced technological capability has collided with financial constraints is Great Britian. Daily and systematically people there are denied lifesaving resources available to some. Intensive care, coronary artery surgery, and total parenteral nutrition are cases in point. The epitome, though, seems to be resources for the treatment of renal disease. Annual "unnecessary" deaths due to renal failure are estimated in the thousands. Part of the problem is the lack of transplantable kidneys. But part is also the result of government decisions to restrict funding (thus staff as well as equipment) for dialysis.

THE DAYS AHEAD

The massive number of life-or-death patient selection decisions identified in the preceding pages is just a foretaste of what is to come. Will the church be ready?
Consider, for example, the future confronting the U.S. in such areas as organ transplantation. While legislation has been passed to help increase the supply of available organs, cultural barriers to organ donation and the great cost of transplantation remain as imposing obstacles. In fact, improvements in transplant technology, particularly the control of organ rejection, will continue to swell the ranks of patients judged medically suitable to receive a transplant. In fact, the drug cyclosporin as well as a family of drugs, monoclonal antibodies, have already had this effect. With better success rates, more physicians will refer their patients for transplantation, and increasing numbers of facilities performing transplants will make them accessible to patients who would refuse or could not afford to travel great distances. Persistent shortages are also likely regarding intensive care space, artificial organs, and newly developed drugs—not to mention the treatment of massive casualties in natural disasters such as the long-anticipated San Francisco earthquake. The need for acceptable patient selection criteria will only become greater with time.

As previously suggested, some of the resource scarcities will be due to financial constraints. Demands upon available resources are expected to be unusually great for decades due to the atypical swelling of the ranks of the elderly. Meanwhile, the cost of new technologies will continue to escalate—such treatments as dialysis, neonatal intensive care, and coronary bypass surgery already annually costing over $2 billion each. This mushrooming of health care costs will not be confined to the United States; nor has it ever been. Yet rarely has another nation allowed health care costs to consume more than 10 percent of its gross national product. Such a prospect has concerned some since this rise cannot continue indefinitely.

Nevertheless, by 1985 the figure for the U.S. had already reached 10.7 percent ($425 billion), with the rate of medical inflation far above that for other goods and services and starting to rise toward the end of the year. It has indeed been possible to avoid many patient selection dilemmas in the past by funding treatments for all in need—an approach still worthy of every effort. However, in the face of increasing medical costs, this solution is likely to become less and less available.

The financial pressures have become so great that even funded treatments such as those for renal disease are being subjected to cutbacks. Some limited restrictions upon the availability of dialysis resources have already been imposed. Moreover, physicians themselves indicate that patient selection decisions have again become a part of their dialysis practice. While the abandonment of the entire federal funding program is not likely, current cutbacks do suggest that more may follow. To make the observations is not to encourage such developments but to call attention to a trend. The United States is not alone in this resource problem, for many countries are evaluating their level of funding for the treatment of renal disease. Patient selection decisions will become more and more commonplace, and acceptable criteria are desperately needed.

Part of the problem in the U.S. is that the costs of the end-stage renal disease program were greatly underestimated during the planning stage. As it is, they skyrocketed in the first decade of funding from $229 million (for 11,000 people) in 1972 to $2 billion (for 73,000) by 1983—and they continue to climb.
suggest that the present growth curve will continue into the next century. As early as a year after federal funding in 1972, official reports were acknowledging that patient selection decisions for other lifesaving resources could not possibly all be avoided through similar funding. The same conviction has repeatedly been voiced since that time—"once burned, twice shy." To make matters worse, many of the technological developments ahead are likely to be even more costly than treatment for renal disease.

A good example of an upcoming resource that is not likely to be fully funded in light of the renal experience is the artificial heart. The idea of an artificial heart has long captivated the public imagination and received much attention in the medical community as well. Research began on it as early as the 1950s. By 1963 the National Advisory Heart Council had already decided to give its development a high priority. Within three years the National Heart Institute had established a full-fledged Artificial Heart Program to define goals and to coordinate research activities. In other words, an extensive history lies behind the present use of the artificial heart.

Such an investment of time and money has created a powerful momentum for the program to continue to move forward. Yet, the costs are expected to outstrip by far those of the end-stage renal disease program. A federal study has suggested the annual price tag could approach $5 billion, while other estimates have been even higher. In addition to costs, the availability of specialized medical personnel is expected to limit the number of qualified patients who will receive an artificial heart. Add to these constraints the arguments of some that limits on the supply of artificial hearts are to be welcomed in the face of higher medical priorities, and it is easy to understand why the artificial heart is typical of tomorrow's limited resources. Since such scarcity relative to need is likely to persist indefinitely with regard to the artificial heart, the importance of developing acceptable patient selection criteria cannot be over-emphasized.

Indeed, technological advance insures that selection decisions will remain unavoidable. Sometimes discoveries solve scarcity problems by eliminating the need for a particular treatment. More often, though, new technologies create new access problems and the ethical dilemmas that go with them. The technologies themselves are often wonderful. Uncomplicated cancer cures, artificial lungs, and cell modification to enable the body to grow new organs, for example, would be spectacular even if expensive. But the expense is not irrelevant in the face of the entire range of human need and desire. "Prometheus has met Malthus. Unbounded aspirations must confront scarcity."

Again, to acknowledge this clash is not to welcome or approve it. The United States and other more developed nations arguably have the wealth to meet the basic life-threatening needs of their people. Yet priorities are such that even now people are left to die while massive resources are devoted to goods considered frivolous by most. How much more will this be so as the costs of medical technology escalate? Another worthy goal besides expanding the health care budget is to eliminate waste. This, too, has delayed the full impact of resource limitations; but there is only so much waste to be trimmed.
patient selection decisions have already become a fact of life, and the magnitude of the problem will necessarily grow for the foreseeable future as technological capability expands.\textsuperscript{101}

Even if there were no monetary constraints whatsoever, acceptable criteria for distributing scarce lifesaving resources would remain a critical need. Whenever there is a major technological development, there is an extensive period of time during which the treatment is genuinely scarce.\textsuperscript{102} This period ranges from the point at which a treatment is no longer experimental to that at which enough of the resource in question has been produced and distributed so as to be available to all in need.\textsuperscript{103} Dialysis followed this course, and the same is anticipated (though distribution to all may never be realized) with such resources as the artificial heart.\textsuperscript{104} Where lag periods are brief, difficult patient selection decisions will still be necessary for a while.\textsuperscript{105}

Wealthy countries like the United States are between two technological eras, though really already crossing the threshold of the second. The first was a “low-tech” era, still experienced by many nations of the world, in which people must be left to die for lack of such medical resources as vaccines and antibiotics. The need for patient selection criteria under such circumstances is apparent. Upon largely emerging from this first era, a nation understandably rejoices that these agonizing choices—perhaps never faced publicly or systematically—have been left behind. But the reprieve is short-lived. A “high-tech” era of equally tragic patient selection decisions is at hand. The National Heart Transplantation Study paints the picture starkly:

Instead of an unidentified mass of individuals being denied access to a needed resource, persons whose names have become known to the public will be declared ineligible for a treatment or service they are known to require. Perhaps this scenario is inhumane, but it is undoubtedly a true representation of reality.\textsuperscript{106}

These decisions will not go away if they are not recognized. Rather, they will demoralize and undermine a nation unprepared to meet the challenge. So every effort to obtain needed resources must be joined by the crafting of sound patient selection criteria to equip people to make the unavoidable decisions that lie ahead.

A CHRISTIAN PERSPECTIVE

The present lack of agreed-upon criteria presents a special opportunity for the church. So often Christians have only become actively concerned about an issue after it has been so long in the public eye that the basic direction of public policy has been set. In fact, policy decisions are sometimes the very instigator of Christian concern and involvement. But the church should be playing more than just a reactionary role in society. If Christians are to take any part in shaping the policies that critically affect the lives of everyone, they should get involved at a point when they can help set the course society will follow. Whereas this point has long been
passed with regard to many of the popular issues of our day, the time is at hand regarding criteria for deciding who will be allowed to live when medical resources are limited.

In the currently developing debate over patient selection criteria, a wide variety of moral terms are being employed. Most, such as “responsibility” and “the human,” are commonly employed in discussions of ethics—so much so that their meaning is generally assumed without further thought. Yet, such assumptions may be based upon a Judeo-Christian heritage which has lost its standing in the public arena. If a patient selection proposal is to stand on a purely rationalistic foundation, without support from God, then it must give its own account of common moral terms. Alternatively, it can adopt a theological foundation.

Consider, for example, the notion of responsibility. Proponents of randomly selecting recipients of scarce lifesaving resources have argued that other approaches such as leaving all to die are irresponsible, while opponents have responded that it is random selection which is really irresponsible. What does responsibility mean in this context? The word itself suggests a story—that at some time in the past certain people have done certain things or in some other way have become “responsible” to someone or something for some sort of behavior. No such account is generally provided by those engaged in the patient selection debate.

The same difficulty surrounds the notion of “the human.” In the Holmes-shipwreck legal case noted earlier, arguments are given by the judge and Holmes’ counsel for and against random selection. The standard of acting in a humane way is invoked on both sides of the argument. Random selection has also periodically been berated as inhuman in the context of patient selection decision making. But what is the basis for this intuitively recognized and commonly employed normative standard—“the human?” Again, there is an untold story here, concerning what “the human” is and why it has normative significance. The same applies to the notions of justice and freedom which appear so frequently in discussions of patient selection criteria.

At first glance it may appear that the idea of a story here is being used to signify merely any sort of explanation—but perhaps more is required. The explanation, that we intuitively know that all people are fundamentally equal, for instance, may be too much at odds with our perceptions of the innumerable differences among people. Or, the explanation, that acting responsibly towards others means acting on the basis of carefully considered moral principles, does not touch the deeper issues of to whom and why are we responsible. Explanations can be given for justifications and then further justifications can be given for those explanations until some ultimate account—or story, if you will—must be given of the way things simply are in the moral sphere.

In Western culture people do not often tell the stories that ultimately lie behind their moral outlooks—much less tell stories to provide immediate justification for specific practices or actions. In this respect, contemporary Western ethics (and Westerners in general) may have something important to learn from other parts of the world. I was alerted to this afresh during a year-long study of patient selection
decisions among the Akamba people in Kenya.\textsuperscript{110} But the approach is characteristic of the Bible as well.

The Akamba tend to think in terms of stories rather than mere explanations—at least more so than Westerners—because of their integrated view of life. Just as a story integrates a moral idea into an entire life-context, so one sphere of life is almost invariably interconnected with another for them.\textsuperscript{111} In particular, they are always alert to the relationship between medical problems and other aspects of a patient’s life.\textsuperscript{112} This alertness led Akamba healers to an appreciation of the interaction between the physiological and the psychological aspects of the human being much more readily than ever could have been expected in the case of Western medical practitioners.\textsuperscript{113}

Today, Western medicine is more open to incorporating psychological and social considerations into its area of concern, but there is still a strong reluctance to incorporate the spiritual dimension, as do the Akamba.\textsuperscript{114} The Akamba share the so-called “African” view that “the natural is supernatural (and) the supernatural is quite natural.”\textsuperscript{115} Spirit, body, and mind are conceived of as a whole, and the state of one is always reflected in the others.\textsuperscript{116} Accordingly, treatment by a traditional Akamba healer may involve not only administering therapeutic agents, but also providing the means for confession, atonement, restoration into the good graces of family and tribe, and intercession with the world of the spirit.\textsuperscript{117}

As noted earlier, the Akamba find stories best suited to convey moral truths in a complex but highly integrated world. They serve excellently as “mirrors of life” and often suggest the foundational place of God or other spiritual entities (if any) in the moral issues of life.\textsuperscript{118} For example, one of the most basic and widely told stories among the Akamba is a story about the creation of people. From it can be gained insights into the Akamban perspective on life, justice, freedom, and the relation of God to all of these.\textsuperscript{119}

Western ethics is impoverished and ultimately unconvincing to the extent that it lacks a story to explain and ground its concepts. In the past it has had such a story, though with increasing secularization the story has suffered neglect (important exceptions notwithstanding).\textsuperscript{120} With the fading of this story has faded its wholistic, integrated perspective on people and life. The results have included the narrow, materialistic focus of much modern medicine noted earlier as well as a broad range of ethical views which often argue past one another, with few points of contact. The Akamba do not have these difficulties, for they have a nourishing story. It may not be the best story; in fact, it is being supplanted among many of the Akamba by the Christian story. But it serves a purpose in its culture which is not being fulfilled in the West as it needs to be.

There is a story readily available to the West—the Christian story—which makes sense of much of the discussion going on today in medical ethics. Nowhere is it more instructive than with regard to the bewildering array of criteria proposed for making patient selection decisions. Those who suspect that people have some sort of definitive special value (as compared with, say a stone, plant or dog) but have no way of accounting for this intuition will find this story particularly illuminating.
The Christian story begins with the creation of all things by God. The creation of people in God’s image as the climax of that process suggests the unique and special value of human life. There is a clear affirmation that God is the one responsible and that people are the special recipients of God’s attention and love. The garden of Eden setting in which they are placed suggests that the life God intends for people is one that is thoroughly fulfilling physically, psychologically, and spiritually. As the story continues, people decide that they would rather be gods themselves rather than trust in God’s love; and God endows them with the freedom to go their own self-destructive way. History then becomes the story of people periodically trying to return to God, as well as people remaining and turning away to seek their own glory.

God is not happy to see people suffering in their self-centeredness, so in response to their need God provides a way by which all can return to a right relationship with their Creator and one another. God is just and has created a world in which evil must be punished, so the only way to forgive people for their divine treason is to pay the penalty for them. People are so precious in God’s sight that God stoops to become a human in the person of Jesus Christ, suffers every kind of temptation and trial there is, and is humiliated in a death by crucifixion. Christ is indeed resurrected to new life afterward, but the gruesome price of forgiveness has been paid through the very real suffering of the God of the universe. People are free to accept or reject the forgiveness and new life that God offers. They will remain free to do so until this world has run its course and Christ returns—an event which could take place at any moment. So goes, in part, the Christian story.

FREEDOM AND JUSTICE

Consider how this story makes sense of important ethical concepts like freedom, justice, the value of life, and social well-being. Freedom, first of all, is central to people’s existence. Even where their eternal destiny is at stake, people are free to choose. Those who choose God in this life live with God forever. Just as people are given freedom to make eternal choices, so they are to be given the freedom to make critical decisions that would extend their lives here and now. They should ultimately be at liberty either to forego scarce lifesaving medical treatments or to pursue treatment (hence a willingness criterion). Pursuing life is generally the more commendable alternative in light of the value placed by God upon that life and one’s responsibilities to others. But the example of Jesus also suggests the admirable alternative of laying down one’s life so that others might live. For this valuing of some lives over others to be a genuine expression of freedom, though, the decision must be that of the person sacrificing. It cannot be merely the forcibly imposed judgment of society or its agent Caiaphas, who judges that it would be better for one person to die, because of who that person is, than for others to perish.121

A particular understanding of (distributive) justice is also embodied in the Christian story. There is an egalitarian dimension to the way that people should be
viewed and treated, rooted in the creation of all people alike in the image of God. While it is not clear exactly how far this equality should extend, it appears at least to involve matters that concern the very lives of persons. Where someone lacks the basics necessary for life—food, clothing, shelter—justice demands that these be provided if possible by others. When God’s people are wandering in the wilderness after their escape from Egypt, for instance, God sets the example by providing manna to eat in accordance with the needs of the people.122 In later centuries the prophets were to remind the people repeatedly of their responsibility to the poor and needy. A similar sensitivity is found in the words and actions of Jesus, who came to bring “good news to the poor.”123 Various New Testament writers such as Luke and James reflect this sensitivity, closely aligning the concepts of love and justice.124

The apostle Paul—who more than any other writer in the New Testament applies the Christian story to contemporary dilemmas—champions an equality-and-need conception of justice as well. This conception inspires both his famine relief visit to Jerusalem and his major collection for the Jerusalem church.125 In his discussion of the latter he advocates equality explicitly, with a view toward meeting the life-threatening needs of the poor.126 The same concerns for equality and need are sprinkled throughout his letters.127 That this responsibility for the poor was characteristic of the early church is suggested by Paul’s first major consultation with the apostles, when they assessed his overall ministry. They expressed their approval and added only one exhortation: to continue to remember the poor.128

The Christian story, then, features a special concern for those in desperate need because their lives—equally valuable before God—are in jeopardy. Without such a story, the equality and need dimensions of justice make little sense. Human equality is far from self-evident. In fact, observation would suggest that people are largely if not completely unequal. Similarly, the lack involved in a need does not imply any imperative to rectify it unless this lack is damaging something valuable. But there is little value in persons if only time and chance separate them from other collections of molecules in the universe.

In Old and New Testament times alike the means of meeting life-threatening needs were limited to staples such as food. Today medical care serves a similar purpose. So need and equality are appropriate standards of justice for distributing this lifesaving resource as well. The standard of need entails a medical-benefit criterion in order that only patients who need a particular resource will be given it. If any are in special need—i.e., death is imminent without treatment—then they should receive special priority. Within groups of those equally in need, equality should direct. Since all alike cannot receive treatment, the most equality that can be achieved is giving all an equal opportunity to receive treatment by selecting them randomly. A random-selection criterion protects against the intrusion of comparative evaluations of persons—which conflict with the affirmation in the Christian story that all lives are equally valuable in God’s sight.129
THE VALUE OF LIFE

The value of life is a third key ethical concept, alongside freedom and justice, which emerges from the Christian story. A crucial feature of this Christian perspective is that people's value is measured ultimately by what they are related to above rather than below and around them. Their value comes from God, in whose image they are created, rather than from the world in which they live. If it were otherwise, then ability to function in relation to the world around them would be a critical measure of their value. But because their value comes from their divine creation and is measured by the price God paid for them in Jesus Christ, people have a unique preciousness about them that is not reducible to comparative, functional evaluations. Properly speaking, then, human dignity is not really human per se. It is an “alien dignity”—God's dignity which attaches to people by virtue of their created and restored relationship with God. This relationship is sealed with a covenant which commits people to love and respect not only God but also other people, who are God's.

The respect for human life, grounded in this lofty view of who people are, underlies the practice of medicine—indeed law and morals generally—in the West. For this respect to wither would be disastrous. Yet, that is exactly what is happening as respect for human life is being uprooted from the Christian story which has been its origin and source of nourishment. Whether it is impossible or not for another story to provide the needed support is beyond the scope of this article. But those who doubt the intrinsic value of human life have insisted that it is not possible to ascribe such value to human life without somehow relating life to God. If that is true—and I agree that it is—then the urgent challenge facing every person is to investigate whether or not the Christian story that has given rise to a high view of people's worth is indeed a true and historical account which makes sense of the world as we know it.

One common way of referring to the great value of life is to affirm each person's right to life. This notion has often been rooted in the Christian story. But contemporary usage of the term—in which the expressions “having a right to,” “deserving,” and “being owed” are frequently used synonymously—is somewhat at odds with this heritage.

According to the Christian story, life is not a right in the sense of something deserved although it is one in the sense of something owed. The reason for this is that all people are the creation of God. As such they hardly claim to “deserve” life. On the contrary, they are under obligation to God for their very lives, not to mention the way they live these lives. One requirement upon their lives is to respect the lives of others. This requirement is often stated in terms of not killing one whom God has created in God's image, but the implication elsewhere is that a more active protection is also in view. These negative and positive elements are brought together in the New Testament in the concept of love, which people are said to “owe” other people.

The apostle Paul, in fact, employs the specific terminology of rights as well as that of love. His concern is not to provide a vehicle by which people can claim
what they deserve but rather to establish a basis upon which people can be exhorted to do their duty toward others. He does not mean to deny that there is a place for claiming one’s rights, particularly in the political sphere. But he does suggest that rights are abused when they shift the focus of moral concern from others to oneself. People have rights, Paul might have said, but they have no right to rights. In and of themselves they deserve nothing, but God had made them and mandated that they be treated and not treated in certain ways. People must act toward others accordingly.

One way to respect God-given life is to restrict lifesaving resources to those whose lives can be saved by them—hence, a medical-benefit criterion. An imminent-death criterion is similarly justified out of a concern to save today those who cannot otherwise survive, with the hope that additional or new resources will become available to save also those who can wait. A commitment of respecting life leads to two additional criteria as well. A resources-required criterion favors saving two patients requiring fewer resources over one requiring more. A special-responsibilities criterion sanctions giving priority to a patient in the rare circumstance that the lives of other persons literally depend upon that patient continuing to live. In both cases, more lives are saved with the criterion than would be saved without it.

Some people, reacting strongly against the utilitarian propensity to sacrifice the few for the many, oppose the idea of favoring more lives over fewer. While the prospect of jeopardizing the lives of some in order to benefit others in some non-lifesaving way is indeed antithetical to the Christian story, the situation is different where the issue is life vs. life. In such cases, incommensurates are not being compared. Rather, more of that which is uniquely and greatly valued (i.e., human life) is being preferred over less of the same.

Because choosing some over others is never a light matter in view of the importance of equality, the saving of additional lives must be relatively certain in any instance where a criterion under consideration would be applied. Such would be the case regarding the two criteria just mentioned. However, a likelihood-of-benefit criterion, for instance, would not meet this test. In any particular case a person selected due to a greater likelihood of benefit might in fact end up not benefitting, whereas one rejected at the same time might have been saved. Guesses, even educated and well-intentioned ones, are not a sufficient basis to deny someone any chance at life.

Respect for life also informs the particular way that a concern for justice translates into patient selection criteria. As previously noted, from a Christian perspective people are ultimately equal by virtue of their divine creation. This equality could conceivably be realized in the patient selection process by leaving all to die. The value of life, however, requires that the form which equality takes be life-affirming rather than life-denying—hence, a random-selection criterion. Moreover, equality literally encompasses all human beings, rather than being confined to certain “superior” groups, as in some conceptions of equality.
SOCIAL WELL-BEING

Implicit in the preceding is the way that another basic ethical concern, social well-being, is portrayed in the Christian story. In that all human life is from God, people are to love one another by seeking their well-being. This is to be done, though, within the bounds of God’s intentions as established at creation. Those intentions, as we have seen, include the equal value of every human life. The problem with a social-value selection criterion is that it pursues social well-being in a way that contradicts this basic equality. It requires people to do what God has reserved exclusively for the Final Judgment: making overall judgments concerning which persons most deserve life.

Only God is able to make such judgments because God alone is omniscient. Attempts have been made to conduct major investigations into people’s lives as part of social-value assessments.144 But it is impossible to identify all of the important consequences of saving one person rather than another, even if every relevant detail about their past lives could be known (which itself is virtually impossible).145 And even with perfect knowledge, people would lack the wisdom to judge which persons are best kept alive in view of God’s eternal purposes.146 Social-value selection is indeed a vain attempt at omnipotence in the face of death.147 If we cannot keep death from taking all, a social-value criterion would have us at least attempt to make sure that death takes the right ones.

No wonder social-value selection has been widely criticized as “playing God.”148 Even those responsible for it, such as the selection committee in Seattle during the early days of dialysis, worried that they were playing God.149 Their guilt proved so debilitating as to lead to the disbanding of the committee.150 If an enterprise is inherently mistaken, there can be little lasting solace in the fact that a number of committee members are sharing the burden.151 Nevertheless, a social-value criterion, like the other related criteria to be mentioned shortly, is widely supported in medical practice today.152

According to the Christian story, people from the very beginning have tried to go their own way—to take God’s place—to play God. As it was in the beginning, though, the temptation to play God is usually a subtle one, in which the violation of God’s purposes is not very evident to the violator. A sense of the differences between people and God—and between how God has made the world to be and how it might better suit our purposes in the present moment—is so important. With such perspective people can wisely and creatively be people rather than foolishly and destructively play God.153 In any event, there may not be time for the gains sought through social-value calculations to come about, since Christ may return at any time.154 Rather than acting in a way whose justification depends upon various events likely taking place in the distant future, we would do better to be found living in accordance with God’s lasting intentions. Where the two do not conflict, of course, we can do both.

If people are to be God’s rather than gods, then a social-value criterion is unacceptable. For the most part so are many other criteria for related reasons which I have discussed elsewhere.155 The root problem with progress-of-science,
favored-group, and ability-to-pay criteria is that they are primarily productivity-oriented rather than person-oriented. Instead of recognizing the essential value of every life, they seek to achieve other social benefits by favoring some over others. The only exception would be the rare (if even existent) case where more lives would be almost certainly saved if one of these criteria were to be applied to a particular selection decision. Medical and potentially medical criteria such as likelihood-of-benefit, length-of-benefit, quality-of-benefit, psychological-stability, and supportive-environment are similarly invalid to the extent that they merely represent attempts to achieve more with the resources at hand, at the cost of denying all in need an equal lifesaving opportunity. Where they are simply intended to assure that patients will truly satisfy the requirements of a medical-benefit criterion, they are justified not as separate criteria but as components of that criterion.

An age criterion falls in this last category as well, though some further observations may be added. According to the Christian story, the time frame for viewing life is eternity, not the relatively few years of temporal existence. Compared with 70 years, 35 may seem quite short; but compared with eternity, there is little difference between 35 and 70 years. What God and God’s people are about even before the return of Christ is living out the kingdom of God—which includes healing the destructive results of people’s divorce from God, such as disease and death. Healing will never be complete until Christ’s return, but there can be progress. Medicine’s task is to defeat disease and death at every opportunity. Every challenge to life is ultimately of equal significance—again, with reference to the eternal life which God intended. A person’s age is not the issue, but the fact that a person’s life is in jeopardy and can be saved. People no more have a right to a certain number of years of life than to life in the first place. That we have any life at all is a gift, and those receiving smaller gifts should not begrudge those whose gift is larger.156

To suggest that we must not play God is not to imply that we should refuse to participate in decisions about life and death. Such decisions must be made by doctors and others all the time.157 Rather, it is to draw attention to the way that such decisions should be made. Assessing the value of entire lives is a task best reserved for God on the Judgment Day. Before that time, people would do well to imitate instead God’s provision for the lives of the good and bad alike—for the needy as well as the needed. God provides sun (energy) and rain (water) to all irrespective of their value in this life, for all have a transcendent value in God’s sight.158

MORALS OF THE STORY

Some type of firm grounding is needed by any approach to patient selection; and the high view of persons featured in the Christian story provides just such a foundation. Upon this foundation is built an approach which reserves resources for those wanting them who also have a significant chance of being saved by them, with priority to those who will die first without them. It makes special provisions
where more patients’ lives or the lives of additional non-patients can be saved as a result. And it ensures, where choices among equal numbers of lives must be made, that everyone has an equal opportunity to receive treatment.

Patient selection today presents a profound challenge to medicine, society at large, and the church. The years ahead will probably see the development of selection criteria within many health care institutions—perhaps even more broadly on local, regional, or national levels. This issue is a life-or-death matter for countless numbers of people. If, while certain lives are being saved, life itself is to be affirmed, justice is to be done, and freedom is to be preserved, the involvement of the church is critical. Christians must live as well as tell their story.

Notes

Full bibliographic information for each citation can be found in the Reference List section which follows. Where a sentence in the text contains at least two ideas, each with its own citations, the citations are listed here in the same order as their corresponding ideas in the text. A double slanted line indicates where citations corresponding to a different idea begin.

22. In some cases the committees are established for this purpose (cf. Bell 1981:155). In others, existing committees assume at least advisory responsibility for selection decisions. For example, during the summer of 1986 the Ethics Advisory Committee of The Children's Hospital in Boston devoted significant time to developing expertise in this area. Cf. Page 1977:7 on the trend here.
25. The original research underlying a range of 100-3,000 is described in Kilner, 1986. High figures or generalized statements without figures can also be found in Wallis 1982:100; Harron et al. 1983:150; Lawton 1979:266-7.
31. Diamond 1979:173-4; Treaster 1978:51; R. Sullivan 1982:1, documents the analogous problem which can occur when emergency rooms are full.
41. 311:152.
42. 392:71.
45. 1842. For a visual re-enactment, see “The Right to Live.”
46. 1884.
47. Tulpius 1641.
48. E.g., regarding food, see Greene 1975; regarding vital supplies for cave exploration, see Lon Fuller 1949. Cf. Wilensky 1985:36 concerning non-medical resources in general.
49. Birch and Derr 1979:64.
54. E.g., in South Africa (Rabinowitz and Van Der Spuy 1978:861); Canada (Parsons 1985:468); Singapore (Khoo 1982:5); Japan (Winslow 1982:29); West Germany (ibid.). // Debakey and Debakey 1983:11; cf. Friedrich 1984:72.
70. Thomassma 1982:49.
76. See survey results reported in Waldron 1985 (confirmed by survey results in Kilner 1986).
84. Leaf 1984:718; Clark 1985:121.
90. National Heart 1984: Ch. 43:17.
93. Leenen 1979:162.
106. 1984: Ch. 45:25.
114. Mburu 1977:163ff.; Ndeti 1972:172-3; Tempels 1959:120. This reluctance is also manifested in the anti-supernaturalist bias in critical assessments of the Akamban outlook (e.g., Miller 1980:3-7; Thomas 1975:278).
118. Tempels 1959:117.
120. Notable exceptions would include both those like Paul Ramsey who bring Christian faith explicitly to bear on medical ethics, and those like Stanley Hauerwas who explore the implications of the Christian story in the same arena.
122. Exodus 16:14-21; cf. II Corinthians 8:14-5.
125. Galatians 2; Acts 11. // Romans 15; I Corinthians 16; II Corinthians 8, 9.
129. Thomasma 1982:50-1, 68.
139. I Corinthians 9; II Corinthians 11-12.
152. Kilner 1986. According to this study of 453 medical directors, well over half support the use of social-value and most related criteria where patient selection decisions must be made. With regard to many of these criteria, supporters number above 85%.
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