

Euthanasia Versus Letting Die: Christian Decision-Making in Terminal Patients

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Not everyone is a physician, but everyone is a metaphysician (Peter Kreeft).

Introduction and Background

The care of terminal patients is often difficult and ethically challenging. The standards of competent and compassionate care that characterized a previous generation seem to be wavering, replaced by a post-modern mélange of newer conflicting theories and ethical values.

A shift from deontological principles to utilitarianism has occurred in the past thirty years, corresponding with the rise of the modern bioethics movement (Rae & Cox, 1999). Many members of an increasingly aging population are denied their autonomy on the basis of mental incompetence. The most common cause of the loss of competence is Alzheimer's disease, which may afflict up to 50% of individuals 85 years and older (*Alzheimer's Disease*, 2003).

Decisions to withdraw treatment are often based on a lack of higher mental functioning as evidenced by self-awareness and self-control. On such utilitarian ideas of bioethics, there are degrees of personhood as though it were a quantity that one individual could have more of than another. To lose these physiologic parameters means to lose something vaguely called the "quality of life." Such "physiologic personhood" ignores a patient's personal history, and the fact that she has existed for more than a moment of time. Dependency and irrationality, with decisions made by others, would often deny such an individual the right to live.

Utilitarian considerations have even led to a "duty to die" in public discourse, a general sentiment that the elderly should "get out of the way" of the young. A report from a recent medical journal is chilling in this regard: An 85 year-old minister with dementia was abusive and irrational, posing a problem for caregivers in a

nursing home. The minister's wife and children agreed that he was "without quality to his life." Therefore, they and the physicians decided to simply turn off his pacemaker to cause his death. In favoring this practice, the authors of the report made a purely utilitarian argument. Their act was convenient for the family, rather than based on any intrinsic value or personhood of the patient (Rymes, McCullough, Luchi, Teasdale, & Wilson, 2000).

The Christian thus faces a unique dilemma in today's health-care environment: How should he commit to compassionate and competent medical care within the current establishment, yet take a stand for the sanctity of life and respect for human dignity? Where is the balance between a commitment to life and a common-sense willingness to "let go" when the time comes? This paper will explore this balance, utilizing a case history from the author's personal experience.¹ This will provide an opportunity to define and discuss some commonly misunderstood concepts related to end-of-life care.

Case Study

Mr. M., a 72 year-old retired accountant, presented to the emergency room in severe respiratory distress. He had a history of heavy tobacco use, having smoked two packs per day for 50 years. Though he completely quit smoking two years before this admission, he remained chronically short of breath. Mr. M. had three hospital admissions for respiratory failure in the previous year, two of which required short periods of mechanical ventilation. During the four months prior to this admission he required supplemental home oxygen. Three days before admission, Mr. M. began to notice an increase in his usual shortness of breath, a dry cough, and fever. On the day of admission, these symptoms grew worse and Mr. M. was brought to a nearby emergency room by ambulance.

On physical exam, Mr. M. was a thin, anxious, chronically ill appearing man in respiratory distress. His blood pressure was 140/80, respiratory rate 36/minute, and his heart rate was 124/minute. His temperature was 101.4 degrees Fahrenheit.

Admission laboratory studies revealed normal serum electrolytes, except for a slightly elevated potassium level. His serum bicarbonate was elevated at 36 mEq/l. His blood hemoglobin was normal. The white blood count was elevated at 14, 500 per cu. mm. Arterial blood gases (on supplemental oxygen by nasal cannula) were as follows: pH 7.34, pO₂ 46 mm Hg, pCO₂ 66 mm Hg. A chest X-ray showed a flat diaphragm, with hyperinflation of both lung fields and an infiltrate in the right lower lobe.

In the emergency room, Mr. M was orally intubated, and he was placed on a ventilator. He was admitted to the medical intensive care unit with a diagnosis of chronic emphysema, with superimposed right lower lobe pneumonia and acute respiratory failure. Over the next several days, physicians treated Mr. M. with antibiotics for his pneumonia. The lung infiltrate improved, and the patient's temperature and white blood cell count became normal. However, multiple attempts to wean him from the ventilator failed. Off the ventilator, he became restless and agitated, with severe shortness of breath.

The primary physician, a specialist in the intensive management of respiratory diseases, discussed the various options with Mr. M. and his family. All agreed that continued long-term reliance on the ventilator was burdensome, and that his condition was terminal. Mr. M. was fully alert and competent; he and his family understood fully the implications of his illness. A "do not resuscitate" (DNR) order was entered in the chart, with the agreement of Mr. M. and his wife. After a night of rest, the physician removed the endotracheal tube and had the ventilator taken from the room. A strict "do not intubate / do not resuscitate" order was given, and the patient was left on supplemental oxygen.²

Twelve hours after discontinuing ventilator support, and with his family present, the patient died.

Questions:

1. Was the cessation of therapy for Mr. M. justified?
2. Could this be an example of assisted suicide or of euthanasia?
3. What ethical principles are involved here?
4. What insights can be applied from a Christian perspective?

Definitions:

This discussion will be more clear by first defining some important terms. A *terminal condition* is a disease or process that will result eventually in a patient's death, no matter what treatment is given. Of course, this may include cases where death is inevitable but far off, as in patients with cancer who live for years with their disease. On the other hand, the expression *imminent death* is used when death is expected within a short time, usually days or weeks (Kilner, 1992). The word *euthanasia* comes from two Greek roots: *eu* for "good," and *thanatos* for "death." Thus the term means a "good" or "gentle" death (Feinberg & Feinberg, 1993). *Active* euthanasia is the overt, deliberate killing of a patient, e.g., by injecting an overdose of morphine or by giving potassium chloride to stop the heart. *Passive* euthanasia refers to the withdrawing or withholding of treatment, while the disease process takes its course to cause death (Kilner, 1996). In other words, the distinction is between killing and letting die, but the *intent* in both is the patient's death.

Most would condemn active killing. The biblical command is: "You shall not murder" (Exodus 20:13, NASB). The term "murder" refers to the taking of innocent human life, and therefore does not include acts performed during a justified war, self-defense, or capital punishment. The intuitive nature of the injunction against taking life goes beyond the Decalogue to a shared consensus of the secular community as well (Budziszewski, 2003). Furthermore, this principle has been an integral part of the Hippocratic Oath from the

fourth century B.C.: “I will not give poison to anyone though asked to do so, nor will I suggest such a plan” (Cameron, 2001, p. 27).

The proscription against the taking of innocent life is so compelling as to admit of no exceptions, even if requested by a patient. Leon Kass has said that “killing patients – even those who ask for death – violates the inner meaning of the art of healing” (2002, p. 250). Whether performed by a physician or a common thug, active killing is always wrong.

“Letting die” may seem to be more acceptable, though it can be just as unethical as active killing. James Rachels gives the following illustration: two men stand to benefit from a large inheritance if their six year-old cousins die. The first drowns his cousin in a bathtub of water. The second sees that his cousin has hit his head on the edge of the tub, and has fallen in the water face down. He stands by and watches the boy drown. Both men committed murder, one by an act of commission, the other by an act of omission (Rachels, 1978). By analogy, Rachels would thereby argue that there is no morally relevant distinction between active and passive euthanasia.

However, this oversimplifies the reality of medical care. “Letting die” can be morally justifiable in medicine if a particular intervention is truly futile, or if a patient or her authorized surrogate refuses it.³ In other words, the analogy to murder is unwarranted. Thus, the medical cause of death does have moral relevance, though not in and of itself. Beauchamp and Childress have said: “Killing, of course, may be wrong and letting die only rarely wrong, but, if so, this conclusion is contingent on the features of particular cases” (2001, p. 141). As discussed later, the term *passive euthanasia* has only added confusion to the ethical debate.

Another way to look at euthanasia involves three categories: voluntary, nonvoluntary, and involuntary. *Voluntary* euthanasia is the act of bringing about a competent patient’s death at his request. *Nonvoluntary* euthanasia means ending the life of an incompetent patient, usually at the request of a family member, as in the Karen Quinlan case: in 1975, the New Jersey Supreme Court granted Miss Quinlan’s father the right to

authorize removal of the respirator in his permanently comatose daughter (*Karen Quinlan*, 2003). *Involuntary* euthanasia means taking the life of an competent patient who does not wish to die (Beauchamp & Childress, 2001). A moment's reflection will demonstrate that these are not morally helpful distinctions. As mentioned earlier, the active taking of a patient's life is usually considered wrong, even if a patient requests it. The focus here is on the agent who gives consent, rather on the ethical merits of the act of killing or letting die. *Physician-assisted suicide* is a variation of voluntary active euthanasia, where the agent that causes the death is the patient herself, with means provided by the physician.

Finally, the omission v. commission argument is frequently cited in making a distinction between *withholding* treatment, i.e., not starting it, versus *withdrawing* treatment, i.e., stopping an intervention already begun. Historically, the latter has always been more difficult in medicine than the former, though this is probably more psychological than real. Beauchamp and Childress call the distinction "both irrelevant and dangerous" (2001, p. 121).

Was Cessation of Therapy Justified?

With these definitions in mind, consider the case study presented earlier. Was the cessation of therapy for Mr. M. justified? Yes, in that this is the withdrawal of *futile care*. The patient's condition was terminal, and his death was *imminent*. There is no reason to second-guess the physician's judgment here. There is no doubt that he was in respiratory failure and ventilator-dependent from an irreversible disease process (emphysema). He had received the best of aggressive medical therapy. This assumes medical competence on the part of the physicians, and assumes that the patient was maximally cooperative with his treatment.

One reason that this case seems difficult is that the doctors withdrew an already utilized treatment (the ventilator) as opposed to withholding it. Some might argue that the doctors in the emergency room should never have intubated Mr. M. and placed him on a ventilator in the first place, yet this would have been a denial of any

attempt to treat him, and clearly inappropriate. Having established that further ventilator support was futile, the decision to withdraw it seems justified.

It is worth noting that medical personnel may abuse the concept of medical futility, often on arbitrary or utilitarian grounds. For example, treatment may be withdrawn because of a vague perception that there has been a loss of personhood (as in the case of the 85 year-old minister cited earlier). However the case of Mr. M is an example of the best kind of doctor-patient relationship. Out of respect for his personhood and aware of his dire medical condition, the physician communicated openly with the patient and his family. Full and informed consent was sought and given by all parties. Ethicist Christopher Hook has expressed it well:

The real source of power in medicine . . . is in the relationship, the coming together of the afflicted and the healer, the blending of needs and goals with knowledge and skill, so that they may come to as good an outcome as possible. There can be no true healing without this relationship (Hook, 1996, p. 92)

Assisted Suicide or Euthanasia?

Could this be an example of assisted suicide or at least of “passive euthanasia?” The answer is no to both questions. First of all, this was not physician-assisted suicide because the agent was the physician, not the patient. Is this therefore “passive euthanasia?” Not all, because the *intent* was to relieve suffering, not to cause death.

An important guide in this instance is the *principle of double effect*. This is the concept that intentions have great weight in moral decision-making. For example, caregivers are obligated to preserve life and at the same time to relieve pain. If a physician were to inject a massive overdose of morphine into a terminally ill cancer patient, with the intent of active euthanasia, this would be morally wrong.

However, a physician should endeavor to treat the pain of a suffering patient with adequate doses of analgesics, even narcotics. This assumes that other medications have failed, and that *imminent* death makes

addiction irrelevant. If such treatment hastens the death of the patient, but this was an unintended consequence of the intent to relieve suffering, then the act may be morally permissible (Jochemsen, 1996).

This principle applies to the case of Mr. M. As stated earlier, neither the patient nor his physicians intended his death. They did, however, intend to relieve him from a burdensome and futile treatment; his death was an unintended consequence. According to the principle of double effect, the action was justified.

Robert Orr and colleagues would not even call this act euthanasia: “Withdrawing or withholding treatment or artificial means of life support in someone who is dying is not euthanasia at all – not even ‘passive’ euthanasia – but acceptable, humane, and an often necessary part of everyday medical practice” (Orr, Schiedermayer, & Biebel, 1990, p. 152). More succinctly, Jochemsen has said: “Stopping disproportional medical treatment has always been good medical practice” (Jochemsen, 1996, p. 166).

The term *passive euthanasia* is confusing and should be discarded from medical ethics discussions.

Ethical Principles

What ethical principles are involved here? The classical general principles of bioethics are autonomy, nonmaleficence, beneficence, and justice. The actions in this case are certainly compatible with these principles.

The principle of autonomy can be stated as follows: Rational people should be allowed to be self-determining and to make their own decisions (Munson, 2000). Contrast this with *paternalism*, where health-care providers make decisions independent of the patient and his family. In the case of Mr. M., full consultation with him and his family respected his autonomy.

Autonomy is not absolute, however. Patients must respect the integrity of the medical profession, and the ability of caregivers to say no to unreasonable requests for inappropriate or futile treatment (Hook, 1996). Patients who disagree with available treatment options are free to seek a second opinion.

Nonmaleficence means that a physician should never “by carelessness, malice, inadvertence, or avoidable ignorance” do anything to cause harm to a patient (Munson, 2000, p. 32). This principle is one of the oldest in medicine, and relates to the covenant between physician and patient. It dates back to the time of Hippocrates: “As to diseases, make a habit of two things -- to help, or at least to do no harm” (Strauss, 1968, p. 625).

Certainly, assisted suicide and active euthanasia would violate this rule. The utilitarian case for physician-assisted death requires that “harm” be equated with the continuation of life. Such a claim seems difficult to justify, especially in view of new treatment modalities to cope with pain and suffering. According to Stoddard, it is a false assumption “that seriously ill people must expect agonies and humiliations from which death itself is the only merciful release” (Stoddard, 2000, p. 241). Death with dignity does not require that physicians overtly intervene in a natural disease process.

However, this principle does require that burdensome treatments not be imposed on the terminally ill in whom death is imminent. In the case of Mr. M., further treatment was futile. Keeping the patient on a ventilator against his will would have been maleficent and hurtful, thus violating the principle.

The principle of beneficence is the moral obligation to act in the best interest of others (Munson, 2000). It is difficult to claim that euthanasia accords with this principle. So how does the cessation of ventilator support fulfill it? In the case of Mr. M., the physicians went beyond mere nonmaleficence and were overtly concerned about his benefit. Their compassionate interaction with the family and patient was consistent with beneficent intent.

Admittedly, the idea of beneficence would be more difficult to prove if the patient or family had opposed the treatment plan suggested by the physicians. However, even that eventuality would not violate beneficence if the case for futility were strong enough. As Beauchamp and Childress point out, “A justified claim that a medical procedure is futile removes it from the range of otherwise beneficial acts among which

patients or their surrogates may choose” (2001, p. 192). Beneficence would also be suspect if the care team had acted out of strictly utilitarian concerns, e.g., “We really need this ventilator for the guy in 2B, so we ought to let Mr. M. die.” Such a cold calculus would go against the Hippocratic tradition of medicine.

The principle of justice has at its heart the idea that “similar cases ought to be treated in similar ways” (Munson, 2000, p. 38). While this is not quite as important for Mr. M in the immediate context, terminal illness should be handled equitably for all patients. This assumes, for example, that medical staff members have thought through the implications of terminal respiratory failure. This is just good medical practice, and ensures that an “ethical standard of care” is followed with all patients who enter the intensive care unit.

Christian Principles

From a Christian perspective, three principles for end of life care seem evident:

Principle #1: Human life is sacred

Psalm 8 is David’s lofty hymn of praise to the Creator God: “You (God) have made him (man) a little lower than God, And You crown him with glory and majesty.” This wonderful valuing of man is expressed in creation as the “image of God,” described in Genesis 1:26-28. Man resembles God, yet not in any physical or visible characteristics. Though there has been considerable historical debate over the meaning of this concept, it is clear that this is some quality or aspect whereby created man is like God. This makes man distinct from animals, for the Bible declares that only man is made in God’s image.

A thorough discussion of the image of God is beyond the bounds of this discussion. There is, however, a great danger in attempts to derive a list of characteristics that define the image of God. This may open up a real temptation to declare some human beings “non-persons” when they cannot fulfill all the elements of such a list. On the contrary, the image of God in man must surely be an *intrinsic* feature, wrapped up in the very essence of what makes him a person, and not separable from his humanness.

Therefore, there is no such thing as a “loss of meaningful personhood,” or a “loss of human dignity.” No matter how much they suffer, human persons have an inherent worth and dignity conferred by God. Christian caregivers must always be mindful of this dignity, and act accordingly.

Principle #2: God is sovereign over life and death

Death is the curse (Genesis 3:17-19) brought about by Adam’s sin. Therefore, it is never to be welcomed; it will always be the ultimate enemy. Christians should never *intend* death, for God is sovereign over such matters (Deut. 32:39). On the other hand, Christian physicians and their patients may *accept* death, bowing to God’s sovereignty, with peace and the joyous hope that good will come out of it (Kilner, 1996). After all, death is a conquered enemy (1 Cor. 15:50-58).

What about those patients who do not know the hope of Christ? This is a wonderful opportunity for ministry. Some of this author’s most precious memories as a physician are those where God’s Spirit led a dying AIDS patient or terminal cancer victim to the Savior. Though it cannot be the only goal of compassionate care of the dying, Christian physicians can share their joyous hope with others.

As already shown, patient autonomy, both in accepting suffering and in choosing one’s own moment of death, must yield to God’s sovereignty. In 1 Cor. 6:19-20 Paul states that a person’s body belongs to God, for he was “bought at a price.” On this principle, patients must recognize that God is in control.

This does not deny, however, that feelings of “losing control” cause many problems for the dying patient, often contributing to psychological depression. As much as possible, care givers should help patients to make their own choices, even in the smaller day-to-day issues. This will help them to feel a little more “in control.”

Principle #3: No patient is beyond Christ’s compassion

Robert Orr has said: “No treatment is mandatory except two: *comfort* and *company*” (2001). In this, Dr. Orr has rightly emphasized two great shortcomings of modern technological medicine.

The first is a failure to adequately manage suffering. Competent palliative care requires a well-integrated approach to supporting the patient. This means adequate use of analgesics, including narcotics as needed, for clearly addiction is not a concern. Adequate doses must be used to control pain, even if an unintended side effect is to speed up the dying process, as discussed earlier on the principle of double effect (Pellegrino, 1996). The modern hospice movement recognizes such an enlightened view, and has helped to promote the concept of a “good death.” Unfortunately this is still the exception rather than the rule (Twaddle, 1996).

The second great failure of modern medicine is abandonment. As ventilators, intravenous lines, feeding tubes, and monitors multiply, the actual patient seems somehow lost amidst all the technology. Caregivers can be so busy managing the devices of life support that they fail to even greet the patient as they walk in the room. This should not be.

Emotionally, dealing with death is difficult for both caregivers and families alike, and a tendency to distance oneself from a loved one is understandable. Many may think, “I don’t know what to say.” But it is not always necessary to say something; mere presence can comfort. In the book of Job, commentators criticize Job’s counselors for their lack of insight, but they did some things right. For example, when they first arrived, they silently joined him in his suffering: “Then they sat down on the ground with him for seven days and seven nights with no one speaking a word to him, for they saw that his pain was very great” (2:13). In the same way, caregivers must be present with patients and loved ones. A simple hug or the holding of a hand is not a departure from professionalism, and such actions may be more valuable than words. The shedding of a tear may be priceless.

Conclusion

This paper has explored the issues of euthanasia, futile care, and letting patients die. The case of Mr. M., tragically afflicted with end-stage lung disease, provided the backdrop for a discussion of secular and Christian principles of compassionate care at the end of life.

Christians must remember that they should not grieve as those who have no hope (1 Thess. 4:13-14), “for if we believe that Jesus died and rose again, even so God will bring with Him those who have fallen asleep in Jesus.” The Christian caregiver has a great privilege and responsibility: to compassionately care for those who are facing eternity.

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Notes:

¹ For the interest of health care students, certain technical details and laboratory values are included. However, a grasp of these particulars is not necessary to deal with the ethical issues.

² For simplicity, this discussion has not included the use of CPAP (Continuous Positive Airway Pressure) or BiPAP (Bilevel Positive Airway Pressure). For more information on newer management modalities, see (Rappard, 2000).

³ The standards for determining who may be a surrogate decision-maker vary considerably from one jurisdiction to another (see for example Orr, 2004).

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