

Medical Services - Our Stewardship

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From my breakfast table at C'est Bon I spied my old friend, Bill, trudging up the sidewalk. It would be good to see him again after an absence of several weeks. He arrived a few minutes late for our rendezvous, and his face betrayed the heaviness in his heart even before he walked through the door.

"Bill, how's it going!" said I.

"Not so hot," replied my friend. "I went to the doctor last week. You know I've been tired for months. He says I've got leukemia. I need a bone marrow transplant."

"Good grief. That sounds pretty serious. What are you going to do?"

He was disconsolate.

"I don't know," he answered. "It's very expensive. They want \$55,000 to do it. That will wipe out a substantial chunk of my life savings. I'm sixty-one and Virginia's just sixty. If something happened to me, I don't know how long she could make it on what would be left. The women in her family are as old as Methuselah.

"My oldest son, John, just got axed in an executive shuffle and I'm helping him by paying my granddaughter's orthodontist's bill.

"Our youngest, Mary Margaret, is just half-way through law school. She was our mid-life surprise, you know. Her tuition runs \$8,000 a year, and that's just the tip of the iceberg. With all the extras I'm chunkin' down thirty grand a year for another two years. And the basics keep getting higher every year. Food, clothing and shelter, you know."

"What'll happen if you don't have the transplant?" I ventured, with fear and trembling.

"Well, I really couldn't pin him down on that one. He just said I probably wouldn't live three years without it."

Deeply disturbed by my friend's plight, I phoned a cancer specialist from my church that afternoon. I knew him from a special project we'd worked on together, and I believed I'd get some straight answers from him.

"Hey, doc. How's it goin'? Say, I wonder if you'd mind giving me a little information."

I told him about Bill. His reply took my breath away.

"The results of bone marrow transplantation after chemotherapy," he began, in his erudite, professional tone, "in adult leukemias, at this point in time, are not substantially better than the usual treatment -- chemotherapy alone. Bill's chances of surviving three years after the standard chemotherapy are about 30 - 40%. Bone marrow transplantation in conjunction with chemo may add a percentage point or two."

"The treatment requires about six weeks of intense hospitalization. There is one chance in four that the transplant will kill him."

I recoiled at this revelation and a sick feeling settled in the pit of my stomach.

"Thanks, doc." I hung up.

Rosy this picture is not, but it is realistic. It portrays the often overlooked truth that individuals, families, and nations must set priorities for the use of finite resources.

The past few years have witnessed the birth of myriad opinions to solve the health care "crisis." Some very thoughtful and bright people have analyzed the situation and published their solutions.

Some, such as Lee Iacocca, see no other way out than total federal control over the health care system. Many others prefer a cooperative effort between the public and private sectors. Most of the latter agree that business must be forced to offer medical benefits to their employees, and that society at large must support the rest. I cannot imagine that either of those approaches will succeed. There are two insurmountable problems.

First, the consumer of personal medical services, the patient, is insulated from the costs of those services. As long as that is the case, the value of those services will never be determined, and where the value is not known, no rational decision can be made by the patient, whether to use the services.

Value is a highly personal opinion. It contains many variables, such as personal life circumstances, costs, and the expected benefits. Because my life differs from yours, I will place more or less value on a given treatment than you will.

How much pain or discomfort is it causing me? What is my threshold for suffering? Is it interfering with my job or my familial relationships? Can it be cured? What will it cost? In money, time and energy. What other obligations compete for those resources, present and future? Are there other things I'd rather spend the money on?

How sick will the treatment make me? What risks will I take? What are the chances of adverse reactions? Of complications? Of death itself?

What will happen to me if I don't have the treatment?

The second insurmountable problem is determining the benefit that can be expected from the treatment. This problem has two parts. The first is that doctors do not know what the likelihood of a "cure" or relief of a symptom really is in many, if not most, cases. The

second part is darker. Even if they knew, they probably would not tell you. Because of the Fall, when Adam's sin was imputed to the entire human race (Romans 5:12,19), every one of us is deeply committed to protecting ourselves. Doctors have bills to pay, too. We deceive ourselves when we imagine a practitioner will pass up the chance to "sell" a treatment if it means his kids will not go back for second semester. Many in our society sell things that people do not really "need", and we think nothing of it.

But, you will object, medical services are different. It's a matter of life and death. Oh, really?

A leading researcher in the field of health services, author of the term "HMO", Dr. Paul Ellwood, states flatly that half of what the medical profession does is of unverified effectiveness. Any general practitioner will testify that at least half of the people who come to see him do not suffer from true medical disorders. Dr. Steve Allen, Jr., son of the famous comedian, was recently quoted as saying the generally accepted figure is seventy per cent. These people are, rather, afflicted by disorders of the spirit, bred by the shame and disappointment that accompany every life. Psalm 38 states the case eloquently:

*O Lord, do not rebuke me in your anger
or discipline me in your wrath.
For your arrows have pierced me,
and your hand has come down upon me.
Because of your wrath there is no health
in my body;
my bones have no soundness because of
my sin.
My guilt has overwhelmed me
like a burden too heavy to bear.*

My wounds fester and are loathsome
because of my sinful folly.
I am bowed down and brought very low;
all day long I go about mourning.
My back is filled with searing pain;
there is no health in my body.
I am feeble and utterly crushed;
I groan in anguish of heart.

All my longings lie open before you, O Lord;
 my sighing is not hidden from you.
 My heart pounds, my strength fails me;
 even the light has gone from my eyes.

Such cases simply do not respond to drugs, surgery, or chiropractic. Psalm 38:15 points to the only cure:

"I will wait for you, O Lord;
 you will answer, O Lord my God."

In experiments designed to measure the impact of various interventions on the health of the population, researchers studied villages in an undeveloped country. One village received modern medical care, another better nutrition, and a third got both. Medical care made a negligible impact; nutrition, substantial.

Another researcher, Charles Stewart, independently concluded that education and clean drinking water had a greater impact on health than personal medical services did (diagnosis and treatment of individuals as opposed to public health measures). In spite of these findings, the medical establishment has fostered a profoundly dependent public which searches in vain for cures that do not exist. Headaches, back pain, and depression head an imposing list.

I would argue that, on the whole, medical services are a commodity. They are, with some obvious exceptions, such as severe injuries, serious infections, and some early cases of cancer, optional for most of us.

I would also remind you that all of us, except those who are alive when Jesus returns, are going to die sometime. More than three quarters of the \$500 billion spent on health care in the U.S. in 1989 was expended on people either in their first or their last year of life. This suggests that the bulk of health care expenditures in our country goes to keep people with incurable diseases on life support systems in intensive care units - where Americans go to die in this Age of Enchantment with Science. Those who are Christians are detained from the bliss of heaven where their husband, the Lord Jesus Christ, eagerly awaits them.

We have a de facto system of socialized medicine in this country. The patient does not have to place a value on every encounter in the medical marketplace. What else is this than socialism? The experience of twenty-five years with Medicare offers visible and tangible proof that, when government oversteps the bounds set for it in the Scriptures, disaster occurs. The fund verges on bankruptcy and threatens to enslave us and our children economically for decades to come. Will the Congress, just as every individual and family must, finally wake up to realize that we possess finite resources and admit that clean air and water, good roads and bridges, and a strong military must take priority in its budget?

Just as the Berlin Wall came crumbling down after decades of decay under a totalitarian, socialistic economy, so must the health care system in the United States. Cracks can, even now, be seen, and they are becoming wider and looming larger. The word on the street is that the Feds are searching doggedly to find a way to shift to the states the burden of paying for the medical services of an aging populace. That's like rearranging the deck chairs on the Titanic. Unless the freedom that comes with informed choice, as envisioned by the framers of our Constitution, is re-established, the fall will be complete and inevitable.

Someone will argue that medicine is too technical, that mere lay people cannot really make an informed choice. The same could be said of education and legal services, but we do make those choices. Medicine stands alone among American institutions as the last bastion of cultural authority. The Cat scanner and the stethoscope have assumed an almost sacramental character, and we assume that professional judgment always outshines personal judgment. The evidence presented above will, I hope, cause us to question that assumption.

Realistically speaking, a return to privately paying for medical care has about as much chance of success in the current political environment as re-instituting capital punishment for homosexuality. What place, then, in a free market system for insurance? With some radical reforms, there is no reason that a free people should not be able to pool their risks against catastrophic events in their lives. One of the cardinal rules of insurance, however, states that insurance should not increase the

hazard. That is, the number of claims should not be increased simply because the policy holder has insurance. Clearly that has happened in health care. The current system of insurance, with its co-pays and deductibles, does not deter the use of services with marginal effectiveness or value. I think the out-of-pocket amounts at each encounter are too low to have an impact. If a person or couple had to pay an amount equal to their adjusted gross income on IRS form 1040 times 11.5% (the proportion of our wealth we spent as a nation on health care last year) before the first insurance dollar was reimbursed, I believe they would shop as carefully for medical care as they do for a car. They would still enjoy protection against catastrophic events since insurance would kick in when the bill exceeded 11.5% of their income.

The increases in out-of-pocket expenses under such a plan could be offset by rewarding employees who live healthy lives. Pegging promotions and pay raises to good health habits would provide a fair and effective incentive to reduce the demand for personal medical services. It is fair because it rewards the more efficient workers. Their costs of production are lower because of decreased medical costs. It is effective because of epidemiologists present convincing proof that smoking, alcohol/drug abuse, and obesity cause premature morbidity and mortality.

Psychosomatic ailments, drug and alcohol abuse, and other problems of a distressed spirit, would not be covered benefits. After all, "free" treatment, by groups such as Alcoholics Anonymous, has proven to be just as successful as "professional" treatment. It warms my heart to see some of the churches now reaching out to their addicted members, causing them to confess their sin and leading them to real healing through Jesus Christ and the power of the Holy Spirit. I hope the churches will take the lead in this field from such semi-spiritual groups such as AA, who have put us to shame by taking care of our business while we have pretended such problems did not reside in the Church.

The liberals who campaigned so hard in the early 1900's for mandatory health insurance did so on the assumption that disease was the leading cause of poverty. That assumption has no basis in fact, but even

the mainline Protestant churches, in their zeal to promote a Social Gospel, denied the primary role of sin and urged the federal government to press for a national health care program. They contradicted the Scriptures (Psalm 14) when they said that man is basically good, and if we can give him an education, medical care and a decent house to live in, he will rise, like cream, to the top, and we will establish God's kingdom on earth.

Another option has much to recommend it, in my opinion, as we search for some middle ground between government health care and private payment for individual services. This option is being tested in pilot programs now. Governments, private sector businesses or individuals and families could pay a fixed amount per head, not to an insurance company but to a group of doctors such as a multispecialty clinic or a hospital medical staff, and, in return, receive all the care they need for a year. This would create great incentives among competing groups to learn what diagnoses and treatments deliver real value, because the more care they prescribe, the less money they get to keep. They would have to keep their bids low, too, in order to capture a fair share of the business.

Such per capita plans flourished in the early part of the twentieth century, but the hospitals and doctors, organized as the American Hospital and Medical Associations, successfully opposed them and garnered a monopoly in the market, preserving the fee-for-service structure that predominates today. Many of the pre-paid plans operating today have reduced costs. The primary reason they are not more prevalent is that government welfare recipients and private sector employees insist they have a right to receive medical care and to choose any practitioner they wish to see. This argument can be circumvented by giving the recipient an amount of money equal to the per capita payment and allowing them to shop for health care in any manner they choose.

A secondary argument, but one just as easily and neatly disposed of, is that doctors under fixed payment plans have an incentive to withhold services from patients so they can pocket more of the payment themselves. The mere threat of a malpractice suit serves as a powerful incentive to provide good care. Serious problems do

exist in the medical liability system, but they are not the focus of this article. Besides, many doctors truly want to take good care of the people who come to them for help. On the hearts of these is the law of God written.

References

1. Pechet, Liberto, "Advances in the Treatment of Adult Leukemias," *Contemporary Internal Medicine*, March, 1990, p. 5.
2. Enthoven, Alain & Kronick, Richard, "A Consumer Choice Health Plan for the 1990's", *The New England Journal of Medicine*, Vol. 320, p. 31.
3. Holoweiko, Mark, "What Cookbook Medicine Will Mean for You." *Medical Economics*, December 18, 1989, p. 120.
4. *The Birmingham News*, September 17, 1990.
5. Carlson, Rick, *The End of Medicine*, John Wiley & Sons, New York, 1975, pp. 26, 27.
6. Kaiser, Leland, *Physicians Management Seminar*, sponsored by the American College of Physician Executives, 1989.
7. Starr, Paul, *The Social Transformation of American Medicine*, Basic Books, New York, 1982, p. 105.
8. *ibid*, p. 290.
9. Singer, C. Gregg, *A Theological Interpretation of American History*, Presbyterian and Reformed Publishing Co., Philipsburg, N.J., 1981, p. 148.
10. Starr, *op cit.*, p. 296.