The Frustration of Fallibility

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"... ***Ye shall be as gods, knowing good and evil,"*** the serpent promised Eve. Mankind wanted godhood and believed Satan's half-truth. As eternal existence without the power to have eternal health is no blessing, so is knowledge of good and evil without the power to enforce the good. Pretenders to God's throne must have all the divine qualities in full measure. One of God's attributes is infallibility. Anyone who wants to be God will be pressed toward this unattainable goal and will realize only frustration. Medical practice today reveals frustration arising from a pretense of infallibility.

Our nation has progressively disowned God and legitimate human authorities whom He has appointed. Thus, we come under increasing pressure to manifest God's powers personally. Though we want His autonomy, we lack the ability and despise the responsibility which goes with it. An escape from our dilemma is to anoint some human institution with improper authority in order to displace responsibility from ourselves.[1] But no sooner has an entity been charged with authority than we rebel. We resent authority whether it is legitimate or not. Medicine is an institutional target for today's rebellion because of its legitimate and illegitimate authority.

Physicians' actual authority over free patients is quite limited and is wholly derived from our patients' responsibility for themselves. Our duty is to encourage patients' accountability to God as it relates to health. We should not accept responsibility for the patient's self, governance nor can we properly be held by patients to possess God's powers on their behalf. There is a difference between being the patient's adviser, educator and assistant and being his warden. "Am I my brother's keeper?" Cain asked God. Cain's question was wrong because it was a devious answer to God. Had Abel carelessly or deliberately injured or killed himself despite Cain's advice to the contrary, Cain's question would indeed have been a defense. We physicians are responsible to help the helpless within our means but we lack the power to be ultimately accountable for the illnesses or deaths of others unless we ***deliberately*** harm them or commit grossly ignorant or careless acts. As helpers, we represent a facet of God's nature. There is a difference, though, between being God's ***representative*** and being ***God***. Our patients want us to be their keeper whenever their own autonomous acts have gotten them into difficulties. They often want us to provide the godlike powers they lack while yet safeguarding their autonomy. Christian physicians must learn to reject this contract.

Though the medical profession is not uniquely a recipient of this generation's rebellion against God's authority, the physician does provide a personal focal point onto which patients project their frustration with the results of their own autonomy and fallibility. Focusing blame away from one's self is an ancient practice .z Ostensibly possessing great knowledge and the power of life, supposedly always available, physicians are increasingly required to be error free. Both the public and physicians often behave as though the profession's standards ought to be omniscience, omnipotence and omnipresence. The power of the state is used by patients to pressure physicians toward divine infallibility.

Decisions bearing on treatments near the end of life, for example, were once left to patients, their families, elders and physicians. This arrangement made for some errors even though these are the proper authorities for such decisions. Since man is infallible, such errors should be tolerable within broad limits before state authority should have access to the decision. Should these proper authorities decide to shoot the patient to "put him out of his misery," for example, this improper decision would give the state legitimate access. Since abortion is murder, this, too, is a state concern. Most medical decisions, however, do not enter the state's domain of authority and erroneous decisions made by patients, their physicians and other advisers do not automatically open the case up to the state. Only if authority granted by God to the state is usurped by the patient and his advisers is the state legitimately involved. The general view, however, has progressed to the position that state authority must be injected whenever fallibility of any sort by other authorities is disclosed. Someone must be called to task for errors, using state power; it is often the physician.

Ethics committees and courts review end of life decisions. Treatment decisions regarding any patient are reviewed by standing hospital committees. The need for hospitalization is reviewed by those third parties who pay the bill. With so many eyes on us, actual or imaginary mistakes are sure to be exposed. If man is required to be infallible, discovery of error is tantamount to proof of guilt. Ordinary errors are not distinguished by any sure criteria from gross negligence, patterns of carelessness or exercise of inappropriate authority. Failure to return a telephone call is held to have caused a late diagnosis, for example. Treatment is delayed. The patient suffers. Since God does not forget telephone calls (and can distinguish the crucial ones from the trivial), the physician-god must account for himself. It is of no consequence that the injured person has, equally often, forgotten phone calls.

A physician fails to inquire of a pregnant patient the details of her husband's "rash" during her prenatal visit. The physician's lapse leads to failure to predict a serious genetic disease in their unborn child, "preventable" by abortion. God knows every rash and the significance of every utterance of every patient (though in this instance He must forget the unborn child's life). The hapless physician-god is required

to answer in court for his fallibility before State officials (who in the very act are rejecting their own proper responsibility to protect the unborn child's life). Patient autonomy is preserved by the technique of setting one divinity (the state) against another divinity (the physician). We physicians are a convenient addition to humanism's pantheon.

Nationally, we are denying God's sovereignty across the board. A maritime loss is blamed not on the storm but on the weatherman's carelessness in forecasting.' We are shortening the list of occurrences which are "acts of God" by adding them to the list of human acts (any human but ourselves). We, at least in the Bible belt, have heard families after a loss console one another with, "God doesn't make any mistakes." A trite statement it is, but theologically correct. More often now we feel in the families' comments a search for some human agency to blame. Acts of God are transformed into acts of physician demigods. Consistent with the patient's desire to escape blame, there is no recognition of his own fobbed responsibility. An autonomous patient can have a paid scapegoat when his fallibility is revealed. A patient who routinely undertakes a voluntary health risk such as smoking, working in a coal mine or overeating can hold a physician liable for failure to recommend an annual PAP smear, if harm comes of the omission. The three voluntary risks listed above are, respectively, 560, 245 and 260 times more dangerous than missing the PAP test.[4]

Why have we physicians allowed ourselves to be hooked into demigod status? We have risen to the baits of power, social esteem and money. It feels good to be approached as a god. In recent years it has also paid well. We can complain about the unfair expectations of infallibility but we will not be free until we release the baits. We like the autonomy and perquisites of divine power just as much as our patients. Only if we return to our proper limits of authority and power will be able to help divest ourselves of expectations of infallibility.

In order to avoid the issue of the patient's and physician's responsibility to God, our profession has been accepting responsibility that should adhere to the patient. It is quicker and more profitable to inject penicillin than to explore erroneous beliefs which led a fornicating patient to contract gonorrhea. Even introducing the issue of sin into the medical encounter is now considered "judgmental." In a sense we thus tacitly pretend with the patient that the disease is the only judgment and the medicine the full atonement. Antidepressant medication is abused when it substitutes for a search for underlying sinful life habits. We have chewing gum to help you quit smoking. It is supposedly an adjunct to a behavioral modification program to break the habit. Such programs are probably honored in the breach but even if they aren't, what do we teach our patients with programs limited to technical interventions?

We teach the error that there exist technological solutions for problems of moral import. Technological "answers" are a characteristic of our nation. We have

breath-analyzers to detect drunken drivers, as if detection were the problem. We have burglar alarms, dead bolts and security lights in lieu of courts that righteously manage their God-given authority to punish evildoers swiftly. We have birth control pills for adolescent females whose parents have abandoned discipline and supervision to teachers who do not know God.

The public looks at physicians as those who have the power to deflect the consequences of their own autonomy. To the extent that we physicians allow such a belief to go unchallenged, we are undertaking responsibility that belongs to our patients. We shoulder a burden properly theirs when we deal only with the physical features of the problem and reinforce misconceptions that there are no other features, no connection to spiritual choices. We dress the wounds of our people as though they were not serious. If we do not relate disorders to patient's autonomous sins, as we have the opportunity, we can expect potential retaliation whenever the consequences of autonomy aren't deflected by us. What is the purpose of a humanist's god but to give out goodies on demand and humbly take blame when the goodies cause trouble?

TELL-IT-LIKE-IT-IS MEDICINE

Physicians must correct patients' expectations that we can bear responsibility for the consequences of original sin or of their particular sin. We must learn to insert this correction as a part of diagnosis and treatment. We must be willing to say such things as, "you are anxious and depressed because you: (1) are pursuing the possession of too many things, (2) neglecting your wife, (3) holding a grudge against your co-workers, (4) directing your thoughts toward the calamitous, (5) shirking the preaching of the Word, the sacraments, prayer and the fellowship of the saints, (6) etc.

These habits may have produced a nest of crooked molecules somewhere in your brain that has become the chemical expression in your flesh of your disobedience. Giving you an antidepressant chemical may straighten out the crooked molecules but unless we address the life patterns we will only encourage you to believe that the consequences can all be chemically nullified. Confess these sins and let us get about a plan to reconstruct your life according to God's outline. . ." A plan may include a chemical, surgery or any other physical modality.

In comparison with the latest gorillacillin or prosthetic organ, this kind of medicine seems plodding and unfruitful. It is more difficult and less scientific in the narrow sense. Much pre-evangelism and evangelism is involved. Money does not flow in, since this kind of practice is not procedure-oriented and is time-consuming.

One of the first responsibilities a physician should encourage is that the patient be responsible for medical costs. Physicians who themselves deal directly with third parties regarding payment should consider whether they are treating their competent patients as objects rather than as the architects of their own health. Patients have

learned to be financial objects in one generation; physicians are now being taught this same lesson and finding it painful.

In addition to an assured payment physicians must surrender other godlike perquisites if the infallibility trap is to be escaped. We must alter our notions of "keeping up" with medicine. While we would not be so brazen as to claim knowledge of all that is in our medical field, we like to feel that we keep abreast of all that could be important. We subscribe to modified omniscience for ourselves.

Consider. . . that over two million articles related to medicine are published annually.[5] If we assume that 99% of these can be ignored because of redundancy, irrelevance to our field or discernible inaccuracy, we still have a full-time job mastering the remainder. If we could manage that task we would be ignoring our work and other priorities. We should not cease learning in despair over this limitation but should recognize that a life of learning will not establish our infallibility.

IS SUBSPECIALTY MEDICINE AN ANSWER?

Subspecialization in medicine receives part of its impetus from the frustrations of incomplete knowledge. If you don't know everything then you will make errors. Errors are impossible for a god. As subspecialists, of us may obtain satisfaction knowing more in our narrower field than other local practitioners. Relative mastery can be mistaken for actual mastery. Even in an ultra-subspecialty, however, there will be facts or skills that a single individual lacks. The gap can only widen as knowledge inevitably expands faster than anyone could keep up. Our arts and science are so inferior to the power of God that a doubling of knowledge every day would not move us perceptibly closer to His power. Our so-called facts have utility but are not defensible as the absolute representation of nature our patients take them for. We must be careful lest we tacitly concur with our patients this false conception. "Facts" in medicine have a short half-life. There is a definite place for medical subspecialization but too large a representation may reveal our profession's anxieties about incomplete knowledge more than it relieves our patients' ills. We need to examine our personal motivation for entering subspecialized medicine. Frustration with incomplete knowledge is a non-durable motive for entering a subspecialty. Special to interests and opportunities are more enduring reasons.

The self-serving promotion of medicine's potency also needs correction if we will escape the shackles of infallibility. We cannot cure a common cold. The usual ***maximum*** life span of people in developed nations is little different from what it is in third world nations or in our own country three generations ago.6 The increased average life expectancy of developed nations would almost disappear if we counted all those people conceived but not allowed birth. Economic advancement of a nation correlates at least

as well with improved life expectancy as does medical care.[7] Wide variations in medical practices among developed nations do not result in life expectancies equally divergent."

New treatments carry new complications and prices which are nationally unaffordable, if widely applied. We physicians should be more often humbled by our own impotence in the face of disease than exalted by our control of it. News media carry stories routinely extolling treatments, physicians or hospitals. Those reports that criticize adverse effects, costs or effectiveness fail as a counterbalance. Their tenor is more of a personal or institutional failure to keep pace with the supposed inexorable advance of medical science than an exposure of our general ignorance.

One medical practice which pushes us closer to godhood than most others is that of psychiatric testimony in criminal court. Psychiatric testimony is given special credence as if our training afforded us a window into the spirit of man. Psychiatrists are allowed to express opinions in court as to the state of an accused felon's mind when a crime was committed. Lacking even the buttress of a physical lesion on which to lean speculations, physicians thus intrude on authority given by God to the state. The state is thereby assisted in dodging its responsibility by such highly doubtful advice. Christian physicians (and judges) should try to remove psychiatric testimony from special privilege of this kind. Courts must judge on physical evidence and the testimony of actual behavior in relation to the alleged crime. Interpretations that track back into the nonmaterial part of man are not provable by our medical arts. The general condition of the heart of man is well described in scripture,9 if the court wishes to know. A particular spirit is opaque to science and medical expertise '° and physicians should refrain from being paid spiritual Peeping Toms.

We have mentioned only a few of the functional manifestations of infallibility in medicine. We can help our patients and our profession if we work to restore a more limited role for medicine in these and other areas.

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