Medical Efficacy and Medical Ethics

Hilton P. Terrell, M.D., PhD.

Dr. Terrell is Assistant Proffesor of Family Medicine at McLeod Regional Medical Center in Florence, S.C.

The pro-life movement has a problem, an undiagnosed illness, as it were, which may cause the movement to self-destruct. It is a problem commonly found among those ardently involved in saving the lives of the unborn, the crippled, the senile and others unable to fend for themselves. The problem is an overvaluation of medical care often taking the form of a valuation of physical life even beyond the great worth God has assigned it in His word.

This article will present some evidence that failure to access all that modern medicine offers may not be the terrible denial some Christians and others make it out to be. The evidence hinges on investigations of the preventive and curative effectiveness of medical regimens. If it can be shown that medicine is not as curative or preventative as most believe, some adjustments in the emphasis of medicine are in order.

However effective medicine may be, it is clear that the focus in the U.S. is on the material aspects of health and disease. We emphasize bacteria, cholesterol, blood pressure, mammograms, surgical techniques, drugs, etc. Far less importance is granted to such intangibles as the patient's comfort, his relationship with others, the compassion of the medical team, or the contributions of the patient's belief system to his condition. If it can be shown that medicine is less effective for cure or prevention than is commonly believed, then the imbalance becomes more pronounced.

Our fixation upon the material aspects of medical care may actually be retarding both our physical health and our performance of the central duty of medicine - to care for the whole patient, body and spirit. One correction needed by the pro-life movement is more emphasis on the spiritual features of medical care. Without a spiritual focus, medical care loses true caring and becomes mere medicine. With too great a focus upon physical features, medical care risks disobedience to God.

LIVING LONGER BECAUSE OF MEDICINE

One of the tasks assigned to medicine today is to extend life. Two things need to be noted about this task at-the outset. The first is that maximum life span has scarcely changed at all in the U.S. during this century. That is, nearly all people who reach old age still die by or before the same maximum limit that they always have (about 85 years). It has yet to be proven that medical care, or anything else, can extend the maximum life span of a population. Failure to access medical care cannot be reasonably blamed for deaths at ages beyond the middle 80's. Medical care still has a decided function at that stage of life, as will be discussed later, but evidence for its effectiveness in extending maximum life span is lacking. The second item to note is that average life expectancy has indeed risen dramatically in the U.S. during this century - the major portion of the rise being due to a decrease in the death rate of infants and children.

The indisputable decrease in the death rate of live-born infants and children may not be due as much to medical care as is usually believed. Whether it is or not though, it is not proper to sum only the credits of the profession and forget the debits. If the aborted unborn are counted as people, then the medical profession has caused a major decrease in average life expectancy in the U.S. since the early 1970's, setting us back more than a century in average life expectancy.

Returning to consideration of live-born people, what evidence is there that medical advances have contributed to the increase in average life expectancy?

A brief overview of several categories of diseases and attendant special, expensive medical efforts will have to suffice.

INFECTIOUS DISEASES

Often mentioned in regard to children is the development and widespread use of vaccines to prevent common diseases. Due to immunizations, most younger doctors have never seen a case of paralytic polio. Red measles is extremely hard to find now. Whooping cough is greatly decreased in incidence.

I was taught in medical school that immunizations were important because the common viral illnesses of childhood were great killers prior to the advent of vaccines.[1] In 1865, over one percent of children who contracted red measles or pertussis would die from the illness. Since large numbers of children contracted the disease, in absolute terms, large numbers of children were dying. The implication from my teachers was that the immunization *caused* the decline in mortality. However, at least with respect to pertussis and measles, it was not so. The death rate from those diseases underwent a steady decline *prior to* the development and widespread use of vaccines effective against them, such that there were practically no deaths from them by the early 1950's. The attack rates did remain high until the vaccines came along, but deaths had virtually disappeared. In a recent year, only four patients died of measles in the U.S., of 3,652 cases. All of these four were immuno-compromised children. Two had AIDS, for example.[2] Likewise, diphtheria cases dramatically increased in England in the late 1970's, due to a mistrust of the vaccine. However, deaths from the disease did not increase.[3] Whatever has reduced the death rates from these diseases, it is difficult to attribute the improvement to vaccination.

The value of these vaccines to extend life, therefore, is debatable. They may serve to prevent a recurrence of widespread death, though that too is speculation. They do prevent the nuisance of suffering the diseases, and in the cases of rubeola and rubella, even today they prevent congenital deformities. On the negative side, the majority of the few cases of paralytic polio that occur today in the U.S. are *caused by* the vaccine.[4] Pertussis causes serious, permanent sequelae once in about every 300,000 shots administered. These problems with the vaccines are being addressed to augment the tenuous balance in favor of immunization.

Tuberculosis deaths have been plotted over a century and a half for England and Wales and for a slightly shorter period for Massachusetts.[5] Once a major killer in **the Western world,** it underwent a decline that antedated anything which would today be regarded as an effective treatment. The specific bacteria necessary for the disease to occur was not even discovered until *after* the death rate had fallen by about half. By the advent of antibiotics active against the germ, the death rate was quite low and the disease was demonstrating a decided association with alcoholism. Further progress against tuberculosis in eastern S.C., where the rates are relatively high, could be as well or better accomplished by reducing alcoholism and its attendant living conditions as by direct medical assaults upon the mycobacterium. The steady slope of decline of the death rate from tuberculosis shows no influence from discoveries about the disease and antibiotics. One would be hard-pressed to construct an argument that the decline in tuberculosis deaths was due to anything medical.

In addition to TB, measles and pertussis, plots of the death rates for other infectious diseases have been constructed for the U.S. from 1900 to 1973.[6] Showing similar significant declines *prior to* the advent of effective antibiotic remedies or preventive vaccines are: scarlet fever, typhoid, pneumonia, diphtheria, and polio.

CANCER

Pro-life Americans, in concert with many others, would take a dim view of failure to treat cancer patients. If treatment means providing patients with a prognosis and other information about their disease, with relief of symptoms associated with it, with postponement of death, with companionship and with cure where possible, then the dim view is warranted. We must be careful, however, not to assume that everything that intends cure or postponement of death will effect it.

Though some cancers that were inevitably fatal 30 years ago can today be cured, overall, cancer is as big a killer now as it ever was.[7] Failure to access treatment devoted primarily to cure is a problem only when the treatment offers a reasonable hope of a cure. Otherwise, it is as much a benefit *not* to access medical treatment so defined. Patients not treated for cure miss the endless blood testing and other procedures, the nausea, cystitis, hair loss, or amputation of a body part. They miss the expense, the hours spent in medical facilities, and the roller coaster emotions of negative scans followed by rediscovery of a nodule. Advocates for life must be willing to make distinctions and accept palliative treatment as a Godly choice in *most* cases of life-threatening cancer. There is a time to die (Eccl. 3:1-8).

HEART DISEASE

Heart disease has been declining as a cause of death in the U.S. for about 20 years.8 Most preventive measures and treatments for heart diseases today were not in widespread use before the decline began. The temptation of many inside and outside the medical profession to ascribe power to preventive and therapeutic approaches to heart disease is poorly justified.

Christians too quickly complain of "ageism" or some other discrimination if the elderly or some other group is denied access to high technology treatment. `Ageism" it may be, but the outcome of the discrimination may not be all that bad. For example, Reznik, et al., found no real differences in mortality between coronary care units and ordinary medical ward treatment for patients with an acute myocardial infarction.9 Others have found that the majority of heart attack victims do as well at home as in a coronary care unit, especially if they are over 59 years old. '°

CRITICAL CARE

Some Christians think it criminal if a patient fails to "access" medical care because of inability to pay. A substantial portion of the high cost which creates such barriers is due to high tech procedures of extremely doubtful utility and considerable danger. For example, the use of pulmonary artery catheters, often inserted in intensive units, has steadily increased over the 15 past years. I was taught that failure to use them in certain settings was failure to provide the appropriate "standard of care." That standard of care, however, has been found to be erroneous in many applications. Gore, et al, reported that pulmonary artery catheter use is not beneficial for hospitalized patients suffering from acute myocardial infarction." After reasonable attempts to establish similar groups for comparison, patients who had the tubes threaded into their chests actually did worse than those who did not. They were more likely to die or, if they survived, to stay in the hospital longer.

INFANT MORTALITY

Yet another way to look at the effectiveness of U.S. medicine is to compare it to similar nations. One area of legitimate concern for pro-life Americans is that medical care be provided for premature or congenitally-handicapped infants. The effectiveness of the host of surgical and other interventions for premature and handicapped infants will not be challenged, though it could be. Rather, it is interesting to compare on a macroscopic level one measure of our attempt to reduce infant mortality - producing more physicians. The perceived physician shortage in the U.S. of the 1960's has become the physician glut of the 80's. Be it shortage or glut, the intention of producing more physicians was to improve the health of the population, neonates not excepted. It turns out that there is a marvelously linear relationship between infant mortality and the number of physicians in 18 roughly similar developed nations, after controlling statistically for the variation in gross national product (GNP) per capita. 'z The problem is, the relationship is in the wrong direction. The developed nations which have the most physicians per population, have the higher infant mortalities!

I don't mean to suggest that the added physicians caused the added infant deaths, but such data certainly don't support a simple relationship between infant deaths and a prolific medical educational system. What the upside down relationship might imply is virtually never mentioned by medical ethicists, Christian and

otherwise. The control for gross national product was done because of the strong positive relationship known to exist between GNP and health.' 3 In an indirect way, the GNP might be causally related to health and longevity, neonates included. If so, then whatever we do in the name of life and health, we'd best be careful that it not adversely affect the national economic output. To do so in the event the connection is even circuitously causal, would be counterproductive. If we support, for example, government-mandated medical insurance paid for by employers to the extent that the economy suffers, we may have done medical harm despite our good intentions. Christians, especially, have a responsibility not to isolate any single aspect of the world for manipulation. We are stewards not only of what is beneath our noses at the moment, but of everything at once.

Of course, the world is too complex for us to comprehend scientifically everything in it, let alone everything at once. Yet, we are not without practical soundings in Scripture. (II Tim. 3:16,17) We are ministers of God's Word, and are to speak it out even when it applies to problems not in our direct control. Though the relationship of money and other resources in medical care is not very much under any individual Christian's control, we do have opportunities to speak God's word on the topic to those who do have control. In providing for health care and longevity, we simply cannot assume that money is a secondary consideration. God's world is a connected world, and He has revealed to us the essential connections. It is wrong to obtain money wrongly, even to sustain life (Prov. 6:30-31). If we persistently obtain money for this purpose wrongly, one of the results could be that life is shortened! To do such a thing in the name of being pro-life would be doubly disastrous.

A FAMILY HISTORY

Multiplying evidences that medical care is not clearly efficacious for extending life won't convince the true believers in medical -efficacy. Some doubt, however, is healthy for the patient and practitioner alike. Unfortunately, some of us learn only from personal experience. This bit of understanding comes slowly as we see cherished treatments fade into obscurity or become disreputable. I inherited my great-grandfather's medical diploma and keep it hanging on my office wall. He graduated 100 years ago. I know little about him, but have often reflected upon the medical accomplishments of his generation. Judged by today's standards, he had little of value for cure. No potent diuretics, no anti-arrhythmics, no anti-hypertensives, no injectable local anesthetics, no non-steroidal anti-inflammatory drugs and no antibiotics. Probably his surgical tools alone put his therapies into the positive column insofar as cure was concerned. On the negative side, he may have inadvertently poisoned someone with his whole-leaf digitalis, bismuth or arsenicals.

I also speculate on the financial aspect of his practice. If he accomplished few cures, judged from the hazy perspective of a century, was he justified in charging anything? Was he a fraud on the public? I think not, when I compare him to modern physicians. First, he could probably predict the course of many diseases. That has value for patients and is a proper function for a physician. In fact, since he could not intervene in many things, he was probably better acquainted with the natural history of many diseases than I am. It may have served him well. Today we forget that most episodes of illness are self-healing, usually within a few days. We intervene, often with only a marginally favorable benefit-to-risk ratio, always at some expense.

Secondly, he could comfort, both with his presence and opiates. (I hope he used them judiciously.) We have more options today for relief, not only with analgesics, but with such things as diuretics for the unsightly discomfort he would have called "dropsy." Even if my edematous patients do not live any longer on diuretics, they can live more comfortably. Many things we do today for cure, are more defensible as palliation. Recognizing the distinction would help us rein in our efforts when they pass the point of providing comfort for our patient.

Third, he could counsel patients. What is today disparagingly called "moralizing" was a respectable part of medical care then. He could point out to a husband that the fatigue of his wife was perhaps related to his relationship with her. We can still do that much, though we often cloud a clear Biblical message by using

Behavioral Science concepts and are supposed to promote only popular morality, not Biblical morality. He could unequivocally promote industry, frugality, chastity, fidelity and sobriety because they relate to health and longevity. Today, only sobriety remains as uncontested ground for physician promotion, and only because it has had a conversion experience - from classification as a sin to that of a disease.

Fourth, there were no necessarily large economic barriers to his patients. He did not have to charge an exorbitant amount. (Judging by the family fortune, he either did not do so or had spending habits equal to his charging habits). Medical school required only two years. There was no internship or residency required. Consequently, personal indebtedness did not drive him to higher fees. Competitiveness by those whom we would call "quacks" also served to restrain in his fees. State licensure to practice medicine came in to being while he was a medical student. Those who were already in practice were licensed irrespective of their lack of approved formal training. These "grandfathers" would be around for years to come. Whatever harm they may have done, they probably kept his fees somewhat lower and hence kept physicians more accessible.

Inappropriate expectations of his profession, resentment over high fees, and the anonymity of medical care had not yet combined to cause defensive medicine and malpractice insurance premiums, further raising fees. While not promoting a return to mythical good old days of medicine, characterized by ignorant physicians, we seem to have recently passed the point of a good return of health and longevity for our investment in expensive formal training. More formal training leads to more expense. Higher fees are barriers to care. Resentment lead to lawsuits and laws which hinder medical care.

Fifth, there were fewer incentives pulling him toward unnecessary visits or procedure-oriented care. Not only was there no $40,000 debt from medical school acting on his conscience, there was also no medical insurance code book with its reimbursement package enticing him to do things. Surgery was inherently more dangerous due to primitive anesthesia and lack of antibiotics to bail you out if infection occurred. Modern anesthesia and antibiotics have made safer not only necessary surgery, but also marginal or unnecessary surgery and millions of abortions.

It is apparent that some things have been gained in the past century. No one would want to return to a time without lidocaine, beta blockers and cephalosporins. Some things, however, have been lost in the rush to obtain more of the material features of medicine. Physicians would like to see again fewer malpractice lawsuits, to have more time with patients, and to accommodate the poor patients without being consumed by their sense of entitlement. Most would like to counsel more freely, but are inhibited by the teaching of recent decades that we are to be "nonjudgmental" and to limit ourselves to "medical facts." (The term "medical facts" thus used means that we should stick to a materialistic diagnosis and treatment plan and ignore the spirit of the patient or the moral context in which the problem lies.)

Compared to my great grandfather's generation, we are kings of technical therapy. Why, then, do we read of the "paradox of health" today, which describes increasing dissatisfaction of people with their health despite ample empirical evidence that health seems better for more people today than ever before?" Are our patients inarticulately expressing something we refuse to articulate? Are they asking that we address them also as spiritual beings? Psalm 33:16, 17 might be paraphrased: "No king of therapy is saved by the multitude of antibiotics; A mighty clinician is not delivered by great acumen. A hospital is a vain hope for safety; Neither shall it deliver any by its great surgical staff." In the Psalm God disparages neither armies nor their horses, but rather the use of material means of delivery without regard for the spiritual features of the dilemma. We are cautioned thereby neither to disparage medical materials nor to look to them alone to deliver us from disorders with spiritual causes.

American aggressiveness against disease is not found in other technically advanced nations whose life expectancies approximate our own." Our aggressiveness to sustain life is too often at the expense of the comfort, the remaining resources or the productivity of the afflicted, with no compensatory

benefit in duration of life. Even when life can be prolonged by medical treatment, to lay down *everything* under one's stewardship in order to seize the extra life span needs careful consideration. One runs the risk of worship of his or her body.

IMPLICATIONS

Speaking of total mortality from all diseases, the McKinlays state: ". . . the beginning of the precipitate and still unrestrained rise in medical care expenditures began when nearly all (92%) of the modern decline in mortality this century had already occurred.[16] If it is true that we are obtaining very little increased duration of life in return for the exorbitant outlays we are making for medical care, then several implications may be drawn: (1) We are freed to turn more medical ministrations toward palliation and relief. (2) We can see more clearly the need to connect a man's spiritual condition with his health and the health of his nation. For example, Eph. 6:13 recounts the first commandment with a promise. It was a promise of health and longevity. It was not the last commandment with such a promise. (3) We are relieved of much of the agony over allocation of scarce material resources. We can look more clearly at the issues of justice in how these medical resources are obtained. We do not necessarily have to balance a need for justice in the acquisition of medical resources against a need to preserve life. The two needs are not necessarily at odds. A nation which unjustly seizes resources to distribute in the name of health, may actually be damaging its own health in the long run, despite the good intentions. (4) We may see the necessity for medical care to be compassionate in order to be effective at its full purpose. A typical American attitude, shared by Christians, is something like the following: "If you really cared about someone's illness, you'd do something to cure it." We have, however, mistaken our admirable intentions for our ability to cure. Many attempts at cure are imprudent, and therefore, less than compassionate because the eager provider was unwilling to accept a role that did not include curing.

CONCLUSION

Christianity historically stands apart from other religions by its balance of emphasis between the physical/temporal world and the spiritual/eternal world. As post-Christian societies have progressively denigrated physical life, Christians have increasingly responded with a merely pro-life strategy. It is merely pro-life because it is an incomplete, reactionary response. Push harder for abortion and we push harder against it. Claim that the unborn are not fully human and we may run beyond our evidence to ascribe wondrous capacities to the unborn. Let a humanist callously calculate the economic cost of keeping the retarded or elderly and we insist that the cost is affordable in a nation which expends X dollars in dog food, lawn care and entertainment. Such tactics have a certain pragmatic attractiveness but are too poorly conceived to sustain the pro-life effort through all the twists Satan may arrange for us.

A pro-life movement thus conditioned will ultimately be coerced into an awful admission by those who do not honor God. There is not enough medical care to go around! We would do well to admit this fact now and understand its implications. Though God is infinite, the physical universe we inhabit is finite. We are God's representatives, His stewards. We are not God. We do not create medicines or anything else *ex nihilo*. Our task is to obtain and allocate physical resources as He would have us to do it. In medicine, as in everything else, our imaginations have overreached our resources. Some quote Psalm 50:1, "[God owns] the cattle on a thousand hills." The inference is that His means for providing our material needs are limitless. True. It is likewise true that He has ordained limited means by which the title to the cattle is transmitted among men. Violation of His will to secure access to material goods, be they cattle or medicines and hospital beds, is not a proper option. One result of violating His will in this regard may actually be poorer physical health for a population.

In summary, there is unheeded evidence that the increase in life expectancy of live-born Americans of this century is due to factors other than medical care, one of the more remarkable associations being with a nation's economy. From the middle years of this century the effort devoted to medical care dramatically increased. The necessarily pro-life stance of Christians

has made us susceptible to the common erroneous interpretation that the increases in medical care caused the increased life expectancy. As a group, therefore, we are likely to resist any efforts to cut back or suspend medical care, in the belief that such actions are anti-life.

On the contrary, many such cuts probably will not hurt our ability to cure much, if at all. The resources released from what is *supposed to* improve the quality and duration of life could be turned toward non-medical endeavors which actually have more power for life than medicine. A million mothers released from the work force to spend time with their small children could probably improve the health of the nation more than a dozen new neonatal intensive care units supported by their taxes or medical insurance premiums. Families with increased discretionary income, released to them by lower health insurance rates (due to acceptance of lower benefits for themselves), could heed the invitation in Ps. 41:1-3.

According to the Psalm, discriminant use of true individual and church-supported charity could not only improve the health of the recipients, but also of the giver! What a turnaround that could be from the usual excuse that higher medical insurance premiums are partly due to the fact that the insured are actually paying the way of the un-insured in the medical care system. We also need a reemphasis upon the caring aspects of medicine. An essential ingredient of caring is voluntarism. We must not continue to ally ourselves indiscriminately with those who believe that medical care is a service which can be coerced by law, or who believe that the chief pathway to good health is through materialistic medicine. If we do so, we may find ourselves in an anti-life posture, the opposite of what we intended.

References

1. Sagan, Leonard, The Health of Nations: True Causes of **Sickness and Well-Being,** Basic Books, New York, 1987, p. 69.

2. Measles - United States, 1987, MMWR, Vol. 37, No. 34, p. 527-531.

3. Sagan, Leonard, op cit. p. 68.

4. McLendon, Cheri, "Current Concepts and Controversies in Childhood Immunizations: Part I," Continuing Education, February 1986, p. 74.

5. Sagan, Leonard, op cit. pp. 29, 69.

6. McKinlay, JB & McKinlay, SM, "The Questionable Contribution of Medical Measures to the Decline of Mortality in the United State in the Twentieth Century," Milbank Memorial Fund Quarterly, Summer, 1977, pp. 405-428.

7. Bailar, John C. & Smith, Elaine M., "Progress Against Cancer?," New England Journal of Medicine, Vol. 314, No. 19, May 8, 1986, pp. 1226-1232.

8. Brody, Jacob A., "Prospects for an Ageing Population," Nature, Vol. 315, 6 June 1985, pp. 436-466.

9. Reznik, R, et al., "Differences in Mortality from Acute Myocardial Infraction Between Coronary Care Unit and Medical Ward: Treatment or Bias?," British Medical Journal, Vol. 295, 5 Dec. 1987, pp. 1437-1440.

10. Eggercson, SC & Berg, AO, "Is It Good Practice to Treat Patients With Uncomplicated Myocardial Infarction at Home?," J, Vol. 251, No. 3, Jan 20, 1984, pp. 349-350.

11. Gore, JM, et al., "A Community-Wide Assessment of the Use of Pulmonary Artery Catheters in Patients with Acute Myocardial Infarction," Chest Vol. 92, No. 4, October, 1987, pp. 721-731.

12. St. Leger, A.S., Cochrane, A.L., & Moore, F., "The Anomaly That Wouldn't Go Away" [letter], The Lancet, November 25, 1978, p. 1153.

13. Cochrane, A.L., St. Leger, A.S. & Moore, F. "Health Service `Input' and Mortality `Output' in Developed Countries," Journal of Epidemiology and Community Health, 1978, Vol. 32, pp. 200-205.

14. Barsky, Arthur, "The Paradox of Health," New England Journal of Medicine, Vol. 318, No. 7, Feb. 18, 1988, pp. 414-418.

15. Payer, Lynn, **Medicine & Culture, Henry** Holt & Co., New York, 1988.

16. McKinlay, op cit., p. 414.