

Physician and Pastor - Co-Laborers Part 1: A Truncated View of Man and Medicine

Hilton P. Terrell, M.D., Ph.D.

Dr. Terrell is Assistant Professor of Family Medicine at McLeod Regional Medical Center in Florence, South Carolina.

The scene is Vienna, in the Austro-Hungarian empire. The time is the 1840's. The chief character is the legendary Hungarian obstetrician Ignaz Semmelweis. He is self-perceived as an outsider. His German is poor; he does not write well in that language. Obstetrics is a field held in low esteem in medicine at that time. The moment is his "Eureka" experience, in which he has put together evidence that illuminates why so many women are dying from childbed fever in the Vienna General Hospital, where he heads one of the two divisions of obstetrics. Though he has never seen a germ, he has reasoned that some infectious principle is being transmitted from the autopsy rooms up to the delivery rooms, on the hands of the obstetricians. The student doctors are required to do autopsies on all of their patients who die. They do plenty of autopsies. The midwives who deliver in another division in the hospital do not do autopsies. The maternal mortality rate in the midwifery division is about 1%. In the division headed by Semmelweis the maternal mortality rate is 18%. Mothers who deliver at home or in an alleyway have a very low mortality rate.

Dr. Semmelweis institutes a rule: doctors in his division must wash their hands in chlorine water before delivering a baby. The mortality rate falls to about 1.5% or so. Dr. Semmelweis presents his findings verbally, perhaps clumsily. He is presenting the germ theory of disease to the big-wigs in the "ivory tower." His theory competes with other current theories including constitutional causes and seasonal miasmas. His theory is rejected and he ultimately leaves Vienna to return to Budapest where he dies a few years later.

Sherwin Nuland in his book, *Doctors*, in a chapter on the unfortunate story of Ignaz Semmelweis says, "Even

had Semmelweis' explanation of seasonal variations [that is, how they fit into his theory] been generally available, however, it is doubtful that it would have been accepted. No matter the progress that had by then been made in pathologic anatomy and physical diagnosis, Western medicine still lived with various stunted vestiges of ancient theories of disease etiology, like miasmas and vague constitutional imbalances. Concepts of single causative agents, which would enter the arena with the advent of the germ theory less than two decades later, were only barely construed, if at all. There was little precedent for a doctrine that invoked the direct action of invisible particles of putrid organic matter. To many critics, it would take a leap of faith which they were unable or unwilling to make."¹

Not long after his death Semmelweis was proven very substantially correct. The germ theory took root. It is a powerful concept. Great things have been accomplished in medicine by application of this theory. Ask today what the cause of pulmonary tuberculosis is, and nearly every physician will answer, "Mycobacterium TB" or one of the other Mycobacteriaceae. More than just for infectious disease, the germ theory is typical of a set of models which posit a material cause for each disease.

THE MEDICAL MODEL OF DISEASE

Common to these models is the idea that each disease is caused by an unbidden, alien, and usually unseen agent which invades a person against his will. The job of medicine is to find the alien and cut it out surgically or poison it out medically. Preventive medicine is supposed to lock out the alien substance or to lock it up harmlessly - be it cholesterol, elevated blood glucose, uric acid, or a developing nest of malignant cells. The

patient's job is rather passive in all of this. The patient is basically to hold still while the doctor identifies and destroys the invader. The whole idea of prevention or therapy is to change as little of the person as possible. Only the invader needs to be destroyed. The person's attitudes, beliefs, motives, loyalties, or character are largely incidental to the process.

The germ theory has worked!

One and a half centuries later, we have become victims of our success in exploiting these models of disease which feature a "physical causative agent" that comes in willy-nilly on a gene or a germ. Thus planted and matured, this model of physical causation of disease has borne such fruit that people are trying to grow it well outside of its natural range.

HOW THE MEDICAL MODEL FAILS US

Physical causation for presenting complaints of patients has been transplanted to problems which do not have a physical cause, though they may have a physical consequence in the body. In addition, though multifactorial models for disease are now in ascendance, all of the multitude of factors examined are physical factors. The spirit of the suffering person is neglected as a factor, let alone as a key factor. The idea of physical agency for medical complaints has pushed the spirit of mankind Out of its proper claim.

I wish to maintain that the spirit of mankind is actually the primary factor in determining health or sickness in the United States, and that the "basic science," as it were, of spiritual matters is Biblical theology. It follows then that Medicine should be functioning from a biblical framework that makes the natural science methodology subsidiary to theology.

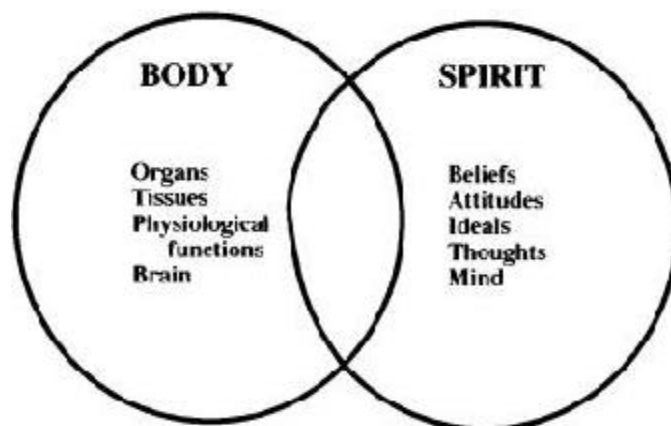


Figure 1

Figure 1 attempts a simple illustration of a bifold conception of human beings. The overlap represents the difficulty we do have in ascertaining the relative contribution of body and spirit in many cases. The spiritual features of human beings cannot be apprehended by the method of natural science. Furthermore, while the Christian may not denigrate the body as do some pagan religions, the spirit is the more important of the two aspects. (1 Timothy 4:8; Matt. 10:28)

Asserting a primacy of the spirit in health may seem to be akin to the invocation of "miasmas" and "vague constitutional imbalances." However, it is normally "true" only presuppositionally that there exist "single causative agents" even for infectious diseases. Why have I never seen *tinea corporis* on my skin, despite having touched it on hundreds of patients? More properly, "single causative agent" should be rendered *sine qua non*. The germs for childbed fever were necessary, but they were not sufficient. They required a steady source, which they found in the autopsy room. They required a portal of entry, which they found in the denuded uterine cavities, or occasionally in accidental cuts on the hands of the doctors themselves. They required a vehicle for transport, which was the hands of the doctors. They required, behind all these physical things, a belief system in what could be going on, and what could not be going on.

Dr. Semmelweis was not dealing here just with powerful, unseen germs. He was dealing with powerful, unseen attitudes in the Vienna medical establishment.

His "solution," after all, was merely one of correcting an iatrogenic problem. Remember that the women who delivered at home or in alleyways in the city had almost zero maternal mortality. In his division of the General Hospital, before he instituted changes, the death rate was 18%. It is illuminating that Semmelweis is today remembered for reasoning out that an infectious agent was "the cause" of childbed fever. It is just as tenable to hold that the cause of childbed fever in Vienna was wrong notions held by doctors, or the idea that babies should be delivered in hospitals because something might go wrong if they did not. Indeed, the fact that something did regularly go very wrong was noted more by the lay community than by the medical community. The latter may well have considered the dangers of childbirth all the more reason to deliver under controlled conditions. It seems likely that we today in medicine are not at all free of such reasoning.² For example, how do we know that it is necessary to treat all patients with acute myocardial infarction in a coronary care unit? Heresy! But, how do we really know? It has now become medical malpractice not to admit all acute MI patients to such places. The British published a series of investigations on this topic about 15 years ago. They presented some interesting evidence that for uncomplicated inferior infarctions patients with an adequate home situation fared as well or better at home than in an intensive unit, for patients over 60 years of age.³

Much has occurred in coronary care in the past 15 years, most notably clot lysis agents, the use of afterload reducers, and transluminal angioplasty. Yet, that is always the way it will be. By the time a therapy is really understood, and its true place understood, it will usually find a considerably reduced scope for application. Also by that time, there is a new therapy making the rounds. We are perpetually in a position in which some new physical treatment is in ascendance. One problem with this situation is that the physical treatment modality also gets ascendance over spiritual features in disease causation and control, and that is not by any proof, merely by presupposition.

Consider the similarity to our view that HIV is the "cause" of AIDS. Since medical science does not, most

vehemently does not, deal with the law of God as it marks out sin for us, it thereby omits the whole aspect of sodomy, adultery, IV drug abuse, and fornication as causative of AIDS. The medical profession, in fact, is coming around in support of sodomy⁴, fornication⁵ and IV Drug abuse in very vocal and practical ways. We are caught in our own reductionism, whereby we reduce the matter to its simplest physical agency. Nationally, we even PAY for condoms for fornicators, "clean" IV needles for drug addicts⁶, food and housing for the willfully idle, Norplant for Baltimore schoolgirls, and "therapy" for liars. We had a Christian Surgeon General recently who instructed the population in how to commit sexual sin more safely. He thought it was his job to do so, and that he could separate his job from his "personal" beliefs. The argument is that since sin is inevitable, and the consequences are so bad, we are best advised to counsel for safety. Note, though, that this argument implicitly places the physical consequences of sexual sin as more important than the spiritual consequences of sin. We must preserve the young people's physical bodies. We neglect their eternal souls.

What we are doing in medicine today - and in the Church and the rest of society - is very like what was going on in Vienna. We do wash our hands so as not to infect patients with physical germs. Yet we carry the germs of deadly spiritual ideas from a misbegotten medical orthodoxy - wrong ideas about the nature of people and their complaints - and bring those wrong ideas into our examination rooms. We are infecting our patients with these wrong notions. We are harming our patients both physically and spiritually by the infectious ideas we bring with us into the medical encounter. We are also harming them by keeping biblically correct beliefs out of the medical encounter.

Like Semmelweis, I would like to try to point out what some of these ideas are, why they are deadly, why they don't belong in our medical care, how we may proceed to wash our hands of them, and with what we may replace them.

As we begin to move from the problem to a solution, we will be moving toward an improvement in the

relationship between physicians and pastors. The tale could be told from either the medical side or the side of pastoral counseling ministry. Both sides have problems. The solution from the medical side prominently includes improved linkages with pastors.

We need to examine, though, a bit further, something of the nature of medicine beyond the Semmelweis story, to see that we do have a problem in medicine (and in the Church) and what its nature is.

NUMERATOR MEDICINE

Physicians deal with numerators. We see those who extract themselves from the general population and present their bodies a living sacrifice for our ministrations. We forget that we are seeing an extract. Even in primary care, we see people for not more than one Out of three episodes of illness. Out of a thousand adults, in a month's time three-fourths will have at least one symptom for which they take some specific action. One out of three of those actions includes seeing a primary care physician. That physician will admit a small percentage of his/her patients to a general care hospital bed. Perhaps half or so of the patients admitted will have a consultation by a specialist. One out of the original one thousand will end up in "tertiary care."⁷

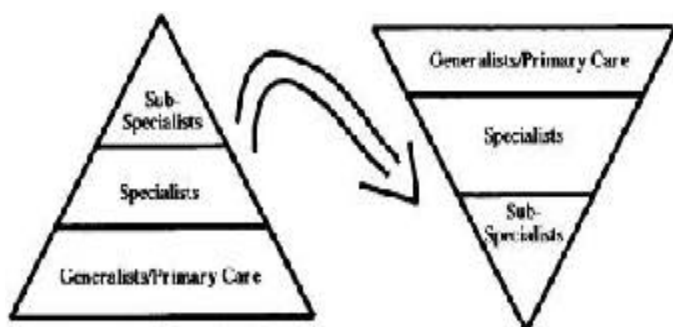


Figure 2

We draw our ideas about health largely from sick people. We do not as often draw our ideas about health from healthy people. Certainly, researchers do study the healthy sometimes, but the experiential basis upon which we function in medicine daily is based upon the sick and complaining. It is more biased even than that. Medicine is operated like a pyramid placed upon its

apex. Figure 2 illustrates the change from a time in which most physicians had a substantial experiential basis in general medicine and were thus in contact with the "denominators" of patient complaints. The pyramid of medical understanding stood upon its base, as physicians moved from the base toward the apex of their understanding in special areas.

Today, physicians initially learn about sickness from the sickest of the sick. The pyramid has been turned to stand upon its apex. "Tertiary care" hospitals collect the rarest of the rare. We have "zebra farms". It is in these holdovers from the time of Semmelweis, these large hospital systems, that we have maintained our fascination and fixation upon physical causation of disease. Hospitals are remarkably efficient for displaying diseases in several stages of development or varying manifestations as well as for studying their response to treatments. On one ward may be collected all manner of cancer or infection or genetic diseases. The benefits we have enjoyed in medical understanding from such collections is not to be underestimated. However, along the way, these collections have helped us to ignore the denominator populations from which they were drawn, as well as the possibility of taxonomies based upon other features than bodily diseases.

We collect and categorize physical ailments, using the medical model. Our field is differentiated largely by disease microorganisms (infectious disease), organs (cardiology), tissues (neurology), age groups (geriatrics), physiological events (obstetrics), and procedures (coronary artery bypass teams).

The whole of medicine is now categorized by reference to these physical features. Imagine a hospital in which the ill were categorized according to spiritual features. There might be a wing in which covetousness was the underlying spiritual feature by which a person came to illness, a ward for idol-worshippers, isolation rooms for those in whom stealing was the spiritual genesis of their problem, whole hospitals for the sexually immoral.

Figure 3 illustrates how important it is for every medical practitioner, generalist or specialist, to be aware of the denominator population from which his/her patients are

drawn. The prior probabilities of disease profoundly influence the decisions of the practitioner in making diagnostic decisions. Generalists look at subspecialists and are tempted to conclude that they are always seeking zebras. Subspecialists are tempted to look back at generalists and conclude that they are always missing things. Our denominator populations are different. Our error rates are not necessarily different. Now, the status in medicine has been (and Semmelweis' experience of the pecking order is an example) for the narrow end of the funnel to tell the wide end how we ought to function. I could argue, from my wide end position as a generalist, against that very vehemently.

Rather than pursue medical internecine warfare, consider that we in medicine as a whole have been turning to the entire population and telling it how it ought to function for health. The estimates of patient self-selection prior to seeking medical attention is probably an underestimation of the self-selection that takes place before any of us in medicine see the patient. Other studies estimate that physicians see patients in only 6% of all episodes of illness.⁸ Not only are we prone to be mechanistically disease-oriented, we see only a fraction of the whole picture!

GENOGRAM EXAMPLE

Perhaps the example of a hospital departmentalized by spiritual features is far-fetched. Consider, however, a household I have encountered that is not all that unusual. A divorced woman in her forties heads the house, one of only two employed persons in the house. Her ex-husband contributes nothing to the support of his one surviving child, who is disabled. The other child died in infancy. The mother has three daughters by other men whom she never married. Two of these three already have illegitimate children of their own, out of numerous sexual liaisons, and the third adolescent is already quite sexually experienced. Educational and vocational aspirations find little encouragement or example in the house.

Out of this household has emanated sexually-transmitted diseases galore, depression, one murder, a person with a seizure disorder possibly related to childhood head injuries, severe visual impairment,

numerous infections, premature childbirth, and so forth. Into this maelstrom of medical problems, our profession has hurled, modern obstetrics, Dilantin, antibiotics galore, surgery, tricyclic antidepressants, and vitamins. Not admitted to this arena of suffering, however, is any investigation, let alone challenge, of the erroneous belief systems. What is proper sexual behavior? What is a good basis for marriage? What is the right way to handle anger? Is it right not to work, when you are able to do so, and live off the means of others? These kinds of questions are begging to be asked and answered. Yet, with a vengeance, the medical profession is refusing even to consider them. All lifestyles are now being created equal. The Scriptures have answers to these questions. They are not rhetorical questions. Medicine, however, is halted well short of the etiologies contained in values and beliefs. By means of working connections between physicians and pastoral counseling, we need to make these answers available to patients.

In a subsequent article, these physician-pastor connections will be explored.

Footnotes

1. Nuland, Sherwin, *Doctors: The Biography of Medicine*, New York: Alfred A. Knopf, 1988, p. 253.

2. See as possible example, Guntheroth, Warren & Spiers, Philip, *Sleeping Prone and the Risk of Sudden Infant Death Syndrome*, *JAMA*, May 6, 1992, Vol. 267, pp. 2359-2362. "Before 1971, the Netherlands' SIDS incidence had been one of the lowest in the Western world, only 0.46 per 1000 live births. Following the public campaign to teach parents to lay babies in the prone position beginning in 1972, the SIDS rate rose to 1.31 per 1000." Following publicity to avoid the prone position, once this alarming trend was noted, the SIDS rates in the Netherlands dropped 40% in 1988, in one year's time. Applying figures similar to these from other nations (Netherlands, New Zealand, Britain) to the United States, 2000 infants per year might be spared. Despite this evidence, local pediatricians are not yet making this recommendation.

3. Hill, J.D., Hampton, J.R., & Mitchell, J.R.A., "A Randomised Trial of Home-Versus-Hospital Management for patients with Suspected Myocardial Infarction," *The Lancet*, 22 Apr 78, pp. 837-841.
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Hospital Treatment," *Brit. Med. Jour.* 7 Aug 71, pp. 335-338.
 - Eggerstein, Sam, & Berg, Alfred O., "Is It Good Practice to Treat Patients with Uncomplicated Myocardial Infarction at Home?" [editorial] *JAMA*, Vol. 251, No. 3., Jan 20, 1984, pp. 349-350.

4. Anstett, Richard, Kiernan, Martin, & Brown, Richard, *The Gay-Lesbian Patient and the Family Physician*, *The Journal of Family Practice*, Vol. 25, 1987, pp. 339-344.
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 - Koop, C. Everett, *The Surgeon General's Report on Acquired Immune Deficiency*, U.S. Department of Health and Human Services, undated, p. 17.

5. *Medical Aspects of Human Sexuality*, October, 1989, p.62, "While surrogate partner sex therapy has proved to be highly effective in treating a wide range of sexual disorders and dysfunctions, this method is contraindicated in several situations ... marriage, depressed young men, adult male virgins who are lacking in social skills unless these skills are provided along with the 'surrogate' and in women who have a history of sexual abuse in childhood or who think it is wrong." A good translation for surrogate sexual partner as therapist would be "skilled prostitute" and for the physician who helps arrange the therapy, "pimp." In the name of "health," some of our profession are into pimping.

See also in this regard: Berkovita, Irving, *Health Development of Sexuality in Adolescents: The School's Contribution*, *Medical Aspects of Human Sexuality*, Vol. 19, October 1985, pp.34-49.

6. For Example, Des Jarlais, Don C. & Hopkins, William, "Free" Needles for Intravenous Drug Users at Risk for AIDS: Current Developments in New York City., [letter] *NJEM*, Vol. 313, No. 23, P. 1476

7. McWhinney, Ian R., **An Introduction to Family Medicine**, New York: Oxford University Press, 1981. [The dean of family medicine in Canada, Quotes Karl Popper, "We are not students of some subject matter but students of problems. And problems may cut right across the borders of any subject matter or discipline." Valuable insights into the "denominator" populations of which we physicians are often ignorant and uncaring.]

8. Ibid.