Living by Bread Alone: Some Myths of Preventive Medicine, Part 2

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"Man shall not live by bread alone, but by every word that proceeds from the mouth of God."

Part 1 appeared in the previous issue.

Conceptually, medicine has slipped into a notion that we are the major locus of control for health and illness. For certain approaches to illness, it is a fairly valid position to hold. An anesthesiologist has some control over blood pressure, hematocrit, partial pressure of oxygen in the blood, muscle relaxation, body temperature, and respiratory rate, among other things. An intensivist has almost as much control, through the use of respirators, monitoring devices, pressor agents, and so on. On a general care hospital floor, there is less control by professionals, but still substantial. Even in the doctor's office with outpatients there is considerable control. These points of control produce in us the illusion that we have much power over illness. Actually, the real locus of control is in the hands of nonprofessionals-the patients. Even if what patients do with and to themselves is not very influential for health or disease (and it almost certainly is quite potent), the fact that they spend most of their lives out of our hospitals and offices gives their actions the power.

While we see what is possible when they are in our clutches, they do not generally live in our clutches. We should not generalize beyond the fragment of time we "have them."

Ulcerative Colitis and Colon Cancer

The wider view of pathology is so slow to correct some of the misconceptions foisted upon our profession and population by the narrow view! For years the dreadful disease of ulcerative colitis was thought to have such a high rate of ultimate genesis of colon cancer that preventive colectomy should be considered. Perhaps the disease has attenuated. More likely, the expert view attained by looking at the output from the narrow end of the funnel appears to be seriously in error. A Danish study of over eleven hundred patients with ulcerative colitis was followed for up to 25 years. Follow-up was virtually 100% complete with regard to the death of the patient or occurrence of cancer. "The calculated cumulative lifetime risk (0 - 74 years) for development of colorectal cancer was 3.5% for ulcerative colitis patients compared with 3.7% for the Danish population."23 The authors of the study note that "many of the hitherto reported results [of increased colon cancer risk] were obtained from specialized referral centers that have a high representation of severe cases and are thus not representative of the disease spectrum of ulcerative colitis. This tends to lead to an overestimation of the colorectal cancer risk for ulcerative colitis patients in general."24 One may be reasonably certain that the intentions of my profession have been good. The information, however, may have been bad.

Cholesteatoma and Prevention of Hearing Loss

The narrow end of the medical funnel is a real factory, churning out advice for both the wider end ("primary care"') and the population as a whole. Dr. Kenneth Grundfast, head of the department of otolaryngology at the Children's National Medical Center in Washington, D.C., advises for example, that "screening for cholesteatoma should be a routine part of well-child visits.'[21] "Your job and my job, working together, is to find cholesteatoma and refer early, before hearing loss occurs..."-' What is the prevalence of this disorder? After 19 years in primary care, I have never seen one.

If there is a trail of missed cholesteatomas behind me, how may I estimate the length of *its* What is the sensitivity and specificity of the screening test Dr. Grundfast recommends, which is to "fully immobilize" the head of the child and then use a good pneumatic otoscope to note an immobile, retracted eardrum and some other topographic features of the eardrum? How effective is the therapy? What is the natural history? Without rather explicit answers to all of these questions, recommendations for primary care screenings are both arrogant and quite possibly harmful. If time in the primary care well-child visit is limited, then time spent looking for this rare disease is subtracted from time spent doing something else. The primary care screener is in a better position, one would think, to make that judgment. If something else is "bumped," the omission of that something else might well be more damaging than cholesteatomas. The Biblical principle of good stewardship of resources commends to us that we consider such trade-offs, and not judge ourselves only on the basis of our good intentions.

Sleep Apnea and Accidents

Dr. William Dement of the Sleep Disorders Clinic and Research Center at Stanford University has more advice for all of the ignorant screeners in the front-line trenches who are not doing things to his liking. He sees sleep deprivation as "America's largest, deadliest, and costliest health problem because everyone is ignorant about its impact.'" Right off the bat, one suspects that he has ruled sin out of contention for these superlative distinctions. Of course, "religion" can't be allowed on the playing field. It would upset the unstated religion that empirical evidence and rationale are all there is. Even within Dr. Demerit's presuppositions, evidence, and rationale, however, there are some wonderments. He at least has a statement of prevalence: 35% of adults in this country experience occasional insomnia, and 24% of men suffer from sleep apnea. Perhaps the reporter misstated Dr. Dement, since another source from the medical "popular press" has the latter incidence as "1% to 4% of the general population.'[28] A science that has a nine-fold variation in its estimates of incidence of disease is in need of more than fine-tuning.

Here in sleep apnea, at last, is the demon behind automobile crashes, cardiovascular disease, and who knows what else. Let's do a little computation with his numbers, however. Let's assume that under the heading of "men" would fall about 100 million Americans. Twenty-four percent of that number would come to 24 million suff=erers from sleep apnea. If there are 50,000 automobile deaths per year in this nation, and if all of them involved male drivers at fault due to undiscovered sleep apnea, then the annual probability that a given sleep apneic man would cause an automotive death would be abut 0.2%. Can sleep experts efficiently sort out the more significant sleep disorders? Would we order polysomnograms on 100 million men? Could we afford that Would we treat them all? Are the treatments safer than the sum of the dangers of untreated sleep disorders? Would the money used for the screening, diagnosis, and treatment of all these men purchase more health than the same money expended in other channels? Dr. Dement, et al., have some more work, it would appear, before his revelations in this respect can bear substantial fruit. Another expert, Dr. Michael Thorpy, director of the Sleep-Wake Disorders Center at Montefiore Medical Center in the Bronx, plunges ahead, nonetheless, with the opinion that, "it is a primary care physician's role to be instrumental in dealing with this."

Immunizations

One of the most sacrosanct dogmas of the rigidly empirical, mechanical approach to prevention has been that immunizations are one of the success stories of modern medicine. Perhaps. On the other hand, "many [vaccines] were developed and introduced after the target disease had spontaneously declined.'" Two examples are the vaccines for whooping cough and measles, which as recently as 150 years ago together caused the deaths of about 2.6% of all children, not all children who contracted them, but of all children. From that fearsome toll, these two diseases fell off as causes of death to about 0.001% of all children by the time the immunizations for the diseases were available. j' There is still no good treatment for either disease. Something very powerful was active in bringing about this precipitous decline in deaths. That something very likely was not medical. The immunizations have accomplished

a great decline in the attack rates of these illnesses, just not the deaths. Yet, it is the diminished deaths for which they get so much credit that these vaccines now are mandated by law for every child entering school in the United States, whether the parents of the child agree or not. It is considered actionable child abuse for parents not to assent to the injections.

In a nation which already has a dreadfully low sense of parental responsibility for children, particularly for fathers, is the net effect of such a theft of parental responsibility really positive for the health of children? Some Christian parents are aware of some of the questions hovering over the safety of the vaccine for whooping cough and seek to have their children evade the shot for that reason. The actual risk of the whooping cough vaccine is so low as to drop into the "background noise" that afflicts all measurements seeking to find very low rates of occurrence. The latest information appears to exonerate the vaccine, as well as a new form of it which is said to be safer. To argue immunizations on narrow grounds of their marginal safety is to yield implicitly the choice of the field of battle to the opponent. The larger issue is the more general one of attenuation of parental authority and responsibility. If immunizations were the only such attack on parental authority, it would be negligible, but there are many such assaults by the civil authority on the family, in the name of health, and the effects on the family are additive.

Sudden Infant Death Syndrome

To the extent that medicine is an enterprise based on empirical data, we are stuck with our severe limitations on data. Good information is hard to come by, and expensive. It is easy enough to rummage through the literature and find that it provides at best a thin basis for our practices. We all find ourselves working largely on rationale, not empirical evidence that a particular practice works to the desired end. As is so with empirical evidence; however, rationale tends to rule where it is empirically or theologically wrong. For years physicians and others reasoned that it would be better for infants if they were positioned on their stomachs for sleep, lest they spit up and gag on vomitus. In Holland physicians even campaigned to teach parents to put infants down on their abdomens, resulting in an increase in SIDS. For whatever reason, however, it is becoming clear that such positioning actually increases the incidence of one of the leading causes of death in infancy.[32]

Rationale vs. Empiricism vs. Revelation

Medical rationales for prevention which violate Christian doctrine abound. Widespread medical support of legal abortion to prevent damage from clumsy back alley abortion or poor pregnancy outcomes lead the list in lethality. By itself, abortion reduces average life expectancy of all Biblically defined persons (that is, persons conceived rather than just those allowed live birth) from the reported 76 years to about 44 years. So far from being a preventive measure, abortion is the leading cause of physical death in the United States today, and the leading cause of years of potential life lost, since it kills at the earliest time in the life span. As a manifestation of spiritual death, only God knows the extent of abortion's ravages.

Corporal Punishment, Sexual Orientation, Depression, Alcoholism

Physicians join with others in attacking all forms of corporal punishment of children as an effective preventive." God says otherwise (Prov. 13:24; 23:13, 14; 29:15; 17; 1 Sam. 3:13) The American Medical Association "bylaws now specifically bar discrimination in membership based on sexual orientation,'" thus supporting a moral evil which helps propagate the AIDS calamity. The mainstream of medicine, Christians included, persists in supporting the unbiblical teaching that alcoholism is a disease.35 Depression is considered only and primarily as a biochemical disorder by the mainstream in medicine. Spiritual considerations, inputs, and outputs are out of bounds. In an essay describing attempts at secondary prevention, Chris Raymond writes of a "psychological Calvinism: a belief that a strong character can defeat depression." Dr. Raymond's implication is clearly that the belief by people that "they should just be able to control themselves" is fatuous. Character and self-control are off the playing field, in the stands, under an ancient religious banner.

Interestingly, the direct annual financial costs of depression were cited in Dr. Raymonds essay as $16 billion, the same that Dr. Dement estimates for sleep apnea. Perhaps the dice that estimators roll only have 16's on their face.

If attempts to prevent disease by attention to empirical data and rationale have all these problems, then is the whole issue moot? Not at all. most of the above-listed problems with empirical data and rationale can potentially be overcome by accumulating information on a wider array of outcome measures than the narrowly disease-focused ones presently in use. Beyond empiricism, however, is God's revelation to us in His Word.

A Biblical Basis for Prevention

The Scripture is not a textbook on health, but where it speaks to health, it is accurate and useful. Clearly revealed in Scripture is the teaching that the key health feature in human beings is our spirit. For example, God tells us in Proverbs 4:20-27:

"My son, give attention to my words; Incline your ear to my sayings. Do not let them depart form your eyes; Keep them in the midst of your heart; For they are life to those who find them, And health to all their flesh. Keep your heart with all diligence, For out of it springs the issues of life. Put away from you a deceitful mouth, And put perverse lips far from you. Let your eyes look straight ahead, And your eyelids look right before you. Ponder the path of your feet, And let all your ways be established. Do not turn to the right or the left; Remove your foot from evil"

The right ordering of our spirit internally and in its relationships to God and man is most important for health. "For bodily exercise profits a little, but godliness is profitable for all things, having promise of the life that now is and of that which is to come" (I Tim. 4:8). What we do with the body is not a zero with respect to health. It is, however, decidedly secondary to Godliness. The complaint is immediately raised that physicians are in practice to minister to the body, not primarily as evangelists. Further, few of our patients will be interested in hearing about "spiritual" things. Such teaching is even offensive to some. Consider, however, whether it is possible-or even safe-to minister to someone's body without engaging his mind. It is possible to minister that way to the extent that our ministry is strictly surgical. A physician and patient have to share very few beliefs and attitudes in common for surgery to take place. But, as we move from surgery to chronic complaints and problems treated medically, it is more often essential that the physician and patient have some kind of "meeting of the minds." For ongoing medical issues, the body mechanic image of the physician can actually be dangerous. As to the disinterest of patients in spiritual matters, that can be acknowledged near the beginning of a relationship. If the physician becomes convinced that the patient's beliefs, attitudes, and habits are going to be central, he or she may then relate that to the patient. If the patient demurs, the physician may proceed to such "body mechanic" work as may be reasonably safe after having apprised the patient of the limitations of that approach.

My early concern with this approach was that patients would leave in puzzlement or disgust. That has rarely been my experience, even when it seems to me that they either do not understand or do not agree. It seems, rather, that they appreciate the effort to achieve a comprehension and an approach from the spiritual side of the matter, even if the effort falls flat.

Cervical Cancer

Specifically, what kinds of Scriptural teachings are there that might apply to preventive medicine? With respect to cervical cancer and other STDs there is Proverbs 5:7-13: "Therefore hear me now, my children, And do not depart from the words of my mouth. Remove your way far from her, And do not go near the door of her house, Lest you give your honor to others, And your years to the cruel one; Lest aliens be filled with your wealth, And your labors go to the house of a foreigner; And you mourn at last, When your flesh and your body are consumed, And say: `How I have hated instruction, And my heart despised reproof? I have not obeyed the voice of my teachers, Nor inclined my ear to those who instructed me!" I find the quaint concept of honor, even when disparaged as "unrealistic" often finds its mark in patients when reminded of their marriage vows. I

Corinthians 6:15-18 is also very instructive in this respect.

Giving as General Prevention

Occasionally I will perform a service for which I do not wish to charge. However, I believe that patients who do not pay almost automatically devalue the service. In such instances I sometimes ask the patient to make a contribution through a church to a person whom I know has a financial need. The church is able to preserve the confidentiality of the recipient and the giver and is usually not the church of any of the persons involved. This maneuver provides an opportunity to relate Psalm 41:1-3: "Blessed is he who considers the poor; The Lord will deliver him in time of trouble. The Lord will preserve him and keep him alive, and he will be blessed on the earth. You will not deliver him to the will of his enemies. The Lord will strengthen him on his bed of illness; You will sustain him on his sickbed." At a time when we are nationally engaged in an orgy of self-protection through medical insurance, the preventive health virtue of giving may well have been overlooked. Though I do not "police" the giving, the feedback I have is that the giving does occur. The givers are intrigued by it. It is nearly always a novel idea to them and to the churches involved.

Spiritual Inventory as Prevention

In the longitudinal relationships which primary care provides, it is sometimes possible to acquire a deeper insight into a patient's desires and motives. A "problem list" is widely considered an essential part of a primary care medical record. When the problem list is long and filled with merely symptomatic diagnoses from several body systems, e.g., headache, abdominal pain, back pain, fatigue, the patient either has an undiscovered underlying explanatory problem (rare) or what Dr. Thomas Szasz would call "problems in lining (common). It is a risk, but I sometimes display the problem list to the patient with the comment that there is sometimes information to be found in the pattern of illnesses that is not clear from any one of them taken by itself. I ask if there might be some problem that is not medical that they have been dealing with. Usually, I already have some idea. Some patients will agree and elaborate a little bit. From some of those a conversation can be opened which can include Biblical advice.

Common features include loneliness, bitterness, unforgiveness, marital discord, and envy. Scripture is replete with teaching on each of these problems. For example, Proverbs 14:30: "A sound heart is life to the body, but envy is rottenness to the bones." Such a passage would not be employed by me as a magical diagnosis of bone disease, per se, but rather as indicative of the influence of the spiritual life on the physical life.

Biblical Parenting as Prevention

"Well-child" visits are usually full of agenda based on rationales and rather poor empirical data. Parents who may be vitally interested in fluoride, vitamins, or immunizations may be neglectful of simple discipline. The Fifth Commandment is "the first commandment with a promise" (Eph. 6:1-3). The promise is long life. There is more risk in addressing parenting matters, so filled are parents with unbiblical teaching regarding child-rearing. (Compare, for example, Dr. Spock with Prov. 23:13.) Nonetheless, the primary care physician may choose to take the relationship risk inherent in raising discipline as a health matter. At a time when children in some locales are more likely to die from accidents or homicide, a disciplined, obedient child is much more protected than one whose fluoride and vitamin intake is within the norms set by consensus groups. There may be time for both in the "well-child," visits. If not, a focus on the latter may be a failure of Biblical prioritization.

Other situations into which some Biblical preventive advice may be useful include reducing stress through prudent financial practices, observing the Sabbath day of rest, being an example to children, study of Scripture, and regular prayer.

Prioritization in Prevention, an Example

Not long ago a man in his early forties came to me at his wife's insistence, seeking "health maintenance." He had no symptoms as a hidden agenda which had prompted him to come. Testing for cholesterol, prostate specific

antigen, and sigmoidoscopy all hung heavily in the expectant atmosphere, along with a possible exercise treadmill test. The family had been exposed to the medical profession's narrow view of preventive maintenance. I had been treating him and a large number of his extended family for years. In conversation with him I confirmed that he is happily and faithfully married, loves his wife and children, enjoys his work, and is in no financial indebtedness. Indeed, he did not even buy a house until he could pay cash for it. He disciplines his children, maintains a good example for them, and attends church regularly. He is actively involved in keeping his elderly parents active and themselves engaged with life. He is a generous man with his employees. His family history is one of extreme longevity and health into old age as the norm. He engages in no destructive habits such as smoking, gluttony, or excessive alcohol drinking. He wears seat belts and engages in no dangerous pastimes. These features of his life took only a few minutes of conversation to discover or confirm from prior knowledge.

If all the preventive measures known and recommended today were applied to such a man, how much would his probability of an untimely death or crippling illness be diminished? As one who is majoring in majors, is the net effect of all the technical preventive measures now marketed even positive for him? Is it not possible that the sum of the false positive results of the screening and preventive measures available makes their application to such a man neutral or negative?

Conversely, if a man who was his polar opposite came in, and that tribe is more numerous, is the net effect of all the technical preventive measures now marketed not a distraction from the issues that are really nearer to the heart of health? When all the available technical preventive measures are applied to one who is living out an unrighteous and destructive mindset, is the benefit worth mentioning?

Some calculations may be done for estimates. With respect to this patient and silent coronary artery disease, for example, a prior (to screening) probability might be 5.5%, maximum. If he has a screening exercise treadmill test with a 2 mm ST-segment depression cut-off criterion, and it comes out negative, his posterior (to screening) probability would be about 1%. While the decrease is five-fold, it also is only a drop from 5% to 1%. If he has a positive test, his posterior (to screening) probability of having silent coronary artery disease would be about 55%. With the issue now raised to this point, would the doctor or the patient be satisfied with intermediate testing such as a stress thallium test? If not, the patient is on his way to the cardiac catheterization lab, with one or two stops on the way, perhaps.

For every one like him who would thus be proven to have silent coronary artery disease, there would be almost one who will not have it. Cardiac catheterization, while very safe in such patients, is not quite perfectly safe. Occasionally, a healthy patient will be sacrificed in the search for those with silent abnormalities. Beyond that, it should not be glibly assumed that coronary artery disease discovered is automatically a life lengthened or improved in quality. The benefits of measures for coronary artery disease, particularly surgical, have been continually in dispute (and in retreat) since the inception of invasive therapies years ago. Lifestyle modification would be difficult to imagine in the (real) patient described. Painting with a broad brush, most studies which promote a particular screening test as advisable limit their outcome measures to particlular modes of morbidity and mortality. Studies which look at all-cause morbidity and mortality are less common, but reflect the better question to be answered. The universe and its relationships are complex. Lowering cholesterol may indeed lower coronary artery disease, but it may also be connected somehow with a raised risk of other forms of disease.

Still, on the surface, exercise treadmill testing, standing in here for many other screening tests, might appear beneficial, on the margin. Recall, however, that it is only one of a very numerous group of disorders for which screening is recommended by some special interest group. Both the risks and the costs of these screenings are additive. Further, while the cardiologic evaluation has focused on coronary events as outcomes, there are other outcomes in the person's life that were deliberately removed from view. Does such screening increase a person's self-absorption? Does it pander to worries that once were assumed as just part of the

providence of God? Does it deflect money and time from other Godly pursuits into a less productive pursuit?

Final Questions

Lastly, in promoting medicine as a source of prevention for health, are we really standing on good evidence that incorporates the whole of health? Have we contributed to a nation's misunderstanding of health as something done to people by experts, rather than done by people to themselves? Have we charged a nation its birthright of individual, family, and charitable responsibility in trade for a mess of pottage called "national health care" which includes a misbegotten promise of preventive health? If national health care severs the connection between a person's spiritual beliefs and attitudes and his health, can any amount of availability of technical resources restore the loss incurred by that severance?

Endnotes

23. Langholz, Ebbe, et al., "Colorectal Cancer Risk and Mortality in Patients with Ulcerative Colitis," *Gastroenterology, Vol.* 103, 1992, p 1444.

24. Ibid.

25. Brown, Scott, "Cholesteatoma: A Major-but Often Overlooked-Threat to Hearing," *Family Practice News,* January 15, 1994, p.17.

26. Ibid.

27. Voelker, Rebecca, "Sleep Disorders Grossly Undertreated, Experts Warn," *AMA News,* August 16, 1993, p. 18.

28. Ibid.

29. Chua, Willy and Chediak, Alejandro, `Obstructive Sleep Apnea,' *Postgraduate Medicine, Vol.* 95, February 1, 1994, p. 124.

30. Sagan, Leonard A., *The of Nations: True Causes of Sickness and Well Being,* (New York: Basic Books, 1987), p. 68. Not written from a Biblical viewpoint, this book nevertheless is a seminal work for those wishing to have a broader view of health and sickness.

31. Ibid, p. 69.

32. Ponsonby, Anne-Louise, et al., `Prone Position and the Risk of SIDS," *NEJM, Vol.* 329, pp. 329-332.

33. McCormick, Kenhelm "Corporal Punishment and Violence," *Archives of Family Medicine., Vol. 1,* November 1992, pp. 203-204.

34. McCormick, Brian: `No Discrimi-nation Against Gays,' *AMA News,* June 28, 1993, p. 3.

35. Pace, Nichlas, "Willful Misconduct," [letter], *Medical Tribune,* August 11, 1988. See also, Szasz, Thomas, 'Bad Habits are Not Diseases: A Refutation of the Claim That Alcoholism Is a Disease,' *The Lancet,* July 8, 1972, pp. 8384, and `The Ethics of Addiction,' *American ,journal of Psychiatry; Vol.* 128, November, 1971, pp. 541-546. It is a shame that a nonChristian is one of the better spokesmen for the fact that alcoholism is not a disease.