CARING CONFRONTATIONS

A Christian Physician's Response to the Growing Crisis of Life-Style Related Disease

Michael K. Augustson
308 Oneida Street
Beaver Dam, WI 53916
1-920-885-8537
augie6@powercom.net

Theology of Caring and Health
North Park University
C. John Weborg
Mary Chase-Ziolek
Joan E. Zetterland

August 20, 2001

> "Since the dawn of human history, man's existence has been threatened by famine, disease, privation, affliction, disaster, and the forces of terror. Man has tried to secure himself against these perils in many ways, but in the end only one thing has made it possible for him to survive – the power of love, that love of neighbor, of fellowman and brother, which found its pure and perfect expression in the life of Jesus of Nazareth, the Son of God. Wherever man has been touched by this love, he has been enabled to become the helper, benefactor, and deliverer of his fellowman."
>
> Heinz Vonhoff

Currently in America a large portion of the disease, injury and death is closely related to behaviors practiced by people on a day-to-day basis. These behaviors are in reality personal decisions of life-style and are often made by people despite an awareness of their choice being hazardous to their health. The current worldview of our population along with our health care system's dependency on the medical model fosters this growing crisis. The Christian health professional is uniquely positioned to help people deal with the truth in their daily lives by selectively engaging their patient in a caring confrontation. Such approach may indeed be an effective means to lessen this advancing burden of life-style related disease.

McGinnis and Foege (1993) determined that about half of all deaths in America are due to the decisions that people make on a daily basis. Their conclusions are based on 1990 death certificate reports from the National Center for Health Statistics along with a critical review of literature pertaining to contributing factors of specific diseases. In 1990 2,148,000 people died in America with Table 1 listing the top ten causes. McGinnis and Foege recognized that most diseases and injuries are caused by many factors and that any estimation of a specific factor is at best an approximation. They determined that the most prominent identifiable contributors to the top ten causes of death in America are tobacco, diet and activity patterns, alcohol, microbial agents, toxic agents, firearms, sexual behavior, motor vehicles and illicit use of drugs. The extent to which these factors contributed to the 1990 causes of death is listed in Table 2.

Table 1. Top Ten Causes of Death in America in 1990. (McGinnis and Foege, 1993)

Disease State	Number of Deaths
heart disease	720,000
Cancer	505,000
cerebral vascular disease	144,000
Accidents	92,000
chronic obstructive pulmonary disease	87,000
pneumonia and influenza	80,000
diabetes mellitus	48,000
Suicide	31,000
chronic liver disease and cirrhosis	26,000
HIV infection	25,000

Table 2. Contributing Factors to Death in America in 1990. (McGinnis and Foege, 1993)

Contributing Factor	Number of Deaths
Tobacco	400,000
diet/activity patterns	300,000
Alcohol	100,000
microbial agents	90,000
toxic agents	60,000
Firearms	35,000
sexual behavior	30,000
motor vehicles	25,000
illicit use of drugs	20,000
TOTAL	1,060,000

A more recent analysis of death and associated behavior patterns is found a report on chronic disease from the U.S. Department of Health and Human Services and the Center for Disease Control (1999). Chronic diseases incur more than $400 billion dollars each year or sixty percent of total medical care expenditures. The major chronic diseases causing death are cardiovascular disease, cancer, diabetes and chronic obstructive pulmonary disease. Dr. F. E. Thompson, State Health Officer and Chief Executive of the Mississippi State Department of Health, states in the report, “We as a nation must give chronic diseases the attention they demand. These diseases are the nation’s leading killers, responsible for more than 70% of all

deaths. The real tragedy is that many of the 1.7 million deaths among Americans from chronic diseases are in large part preventable."

Tobacco use, lack of physical activity and poor nutrition are behaviors that are at the root of the premature morbidity and mortality from these major chronic diseases. The prevalence of these health-damaging behaviors as well as use of selected early detection strategies for breast, cervical and colorectal cancer are now tracked by states on an annual basis the Center for Disease Control's Behavioral Risk Factor Surveillance System (USDHHS & CDC, 1999).

According to the BRFSS in 1998 cigarette smoking rates among the adult population varied from a low of 14% in the state of Utah to 31% in Kentucky. Cigarette smoking is responsible for twenty percent of all deaths in the U.S. or about 430,000 deaths per year. Twenty eight percent of the adult population is sedentary (i.e. does not engage in exercise, recreation or physical activity other than regular job duties). Physical activity reduces risk of heart disease, diabetes, colon cancer, high blood pressure, obesity, osteoporosis, muscle and joint disorders as well as reduces the symptoms of anxiety and depression. Poor nutrition is a common occurrence and just over 75% of U.S. adults eat less than the recommended amounts of fruits and vegetables. Approximately 30% of all cancer deaths are due to poor dietary factors. Poor nutrition and insufficient physical activity contribute to 300,000 deaths per year.

Due to the magnitude of the problem, LSRD has definitely received the attention of our society. The chosen method has been primarily technology with the public and researchers calling for more. $50 billion will be invested in US biomedical research from public and private sources (Nathan, Fontanarosa & Wilson, 2001, p 534). The opening sentence to this introductory article in the Journal of the American Medical Association for which the issue was entirely devoted to medical research states, "The ongoing revolution in biomedical science is of an

unprecedented magnitude, is accelerating dramatically, and promises almost unlimited opportunity for the betterment of humankind." National weekly newsmagazines frequently offer the promise of technology to the public. Newsweek (2001) states, "The most dramatic and profound impact of the technological revolution will be on your health…These astonishing leaps are changing medical understanding and practice in ways that could hardly have been imagined. Their result is clear: for millions of Americans, the gift of longer, healthier lives."

The title on the cover page of this Newsweek was "How Technology Will Heal Your Heart". The lead article "New Heart, New Hope" described in over five pages the great promise of an artificial heart called the AbioCor. It referred to its great need on account of the 300,000 deaths each year in America from the chronic disease, congestive heart failure. Only a portion of the article referred to some of the problems of this artificial heart and said nothing of the health destroying behavior practices that are at the root of the disease for which the heart is used.

Cancer treatment is an area in which we perceive medicine has been more effective than it actually has. While there are frequent reports of cures, these are often for select cancers and highlighted by the telling of individual case stories. An analysis of data however indicates America has not been effective in its approach to cancer. Our War on Cancer in this country began in 1971 when Richard Nixon signed the National Cancer Act. This act released large amounts of federal dollars for cancer research and provided the National Cancer Institute with sufficient authority to make the conquest of cancer a national crusade (NCI). Nixon called for a 50% reduction in the death rate from cancer by the year 2000 and many had even hoped such efforts would bring about a cure for cancer within five years (Frontiera, 1998 and NCI). In 1973 the death rate from cancer of all causes was 165 per 100,000. By the early '90 it had climbed to

175 per 100,000! In recent years we have started to see improvement to the point that in 1997 the death rate is almost the same as it was in 1973 (Ries et al, 2000).

But now we are on the forefront of another medical revolution through our knowledge of the human genome. Public expectation is high for this to be the ultimate cure for many of our ills, including our ills associated with LSRD. While there is enthusiasm in the scientific community there are also elements of caution not being heard by the public. Medical researchers say that our current advances in understanding the human genome are only a beginning. It will likely be decades before scientific advances result in practical benefits for patients (Nathan, 2001). How gene sequence patenting may impact advances is unknown. Current patent law can give research groups ownership over gene sequences thereby preventing other researchers from building on that knowledge without paying a royalty fee to the original group. Dr. Salk did not secure a patent for the polio vaccine. High cost for genetic related diagnostics and treatments may be another factor limiting its impact. Many illness including atherosclerosis, obesity, lung disease, addictive and major psychiatric disorders have an environmental and non-genetic basis.

There is no question that technology offers and will continue to offer people health improvements, particularly in selected areas. Many Americans – if not every American - have experienced some health benefit from the manner in which technology has either prevented or treated disease. How effective technology has been in helping create a healthier America however is be up for debate. When health indicators of the top thirteen industrialized countries are compared, U.S. citizens fall second from the bottom in which the bottom of the list represents the worst health status (Starfield, 2000). The question before our society now may involve whether we will continue to favor technology in the treatment of disease or whether we will seek a better balance in which all root issues of disease are given *serious* attention.

Medicine's initial and existing strategies for altering destructive behaviors have not been highly successful. Perhaps they results have impacted health professionals to become complacent about the destructive behaviors of their patients and pessimistic about being able to offer a favorable impact. The foremost examples of such strategies are in helping our patients stop smoking and loose weight. Even in the best of specialized programs in which weight loss can be documented over a 16 to 26 period, patients regain one third of their loss in one year with further regain over time (Anderson & Wadden, 1999). We are also not doing well with the prevention of health destroying behaviors. A classic example of this is with the Smoke-Free Class of 2000. This major and popular initiative, sponsored by the American Cancer Society, American Lung Association and the American Heart Association, was launched in 1988. Current outcome measures indicate a disaster for students. According to the 2001 Report of the Surgeon General on Women and Smoking, smoking prevalence actually increased in the 1990s for both girls and boys. For the senior class of 2000, 29.7% of girls smoke and 32.8% of boys smoke.

Despite our lack of success at impacting health-destroying habits, there continue to be voices in favor of addressing root causes of LSRD. McGinnis and Foege in their concluding sentence of their landmark article on LSRD state, "If the nation is to achieve its full potential for better health, public policy must focus *directly and actively* on those factors that represent the root determinants of death and disability…Behavior change is motivated not by knowledge alone, but also by a supportive social environment and the availability of facilitative services." One can also obtain some encouragement in the developing field of community-oriented primary care. This field of medicine, yet in its infancy, is a systematic approach to health care based on principles of epidemiology, primary care, preventive medicine and health promotion (Longlett et

al, 2001). If we are to really focus *directly and actively* on the root determinants of disease as these researchers and new fields purport, we must help our patients understand who they are but to a level deeper than we have customarily achieved or currently propose through our preventive and intervention approaches. In order to reach that level we must help them come face to face with some truths in their life that involve the very nature and origin of their health destroying behaviors. We must be willing to enter into caring confrontations.

Confront comes from the Latin word *com* which means together and the word *frons* which means forehead or front (Morris, 1973). To confront, means "to come face to face with; stand in front of; to face with hostility; to face defiantly; to bring close together for comparison or examination; compare. Physicians are used to confrontations in their practice of medicine as they help their patients confront disease all the time. They help them define it through history, physical exam and laboratory testing. Then they help them treat their problem through methods that may even induce pain. This pain is accepted as part of the healing process. Good results are often achieved and generally both the patient and physician feel satisfied.

A caring confrontation is of a different order. A caring confrontation to affect the health destroying habits chosen by the person themselves is sometimes a confrontation with the essence – at least in part - of who a person is. It is not helping a patient confront an unexpected injury or foreign disease. It is helping the patient confront their own inner most parts. These parts may be person defining for themselves or others. They may also be hidden and protected. It is for this very reason that an effective confrontation needs to be so caring.

Caring is a more difficult concept to define. Care is caution; heedfulness; protection; supervision; charge; attentiveness to detail; painstaking application; and conscientiousness (Morris, 1973). Roach (1992) states that caring is the human mode of being. The difficulty in

understanding this later definition offered through the discipline of nursing may be related to the difficulty of humans placing in human terms a concept that is so defining to who we are as a human being. Physicians would be wise to consider this definition the human mode of being because the tone of their interaction with a patient too often stems from their drive to efficiently make a clinical diagnosis and efficiently invoke a technological treatment on the problem. As the physician approaches the bedside or the exam room of the patient with their professional skills and tools, they should not leave the essential components of who they are as a person at the door. It is the combination of these person and professional components that have such power to induce healing. Helping a patient taking on the tremendous challenge of a caring confrontation with their inner most parts of their person will require such a combination

Understanding Roach's most fundamental definition is helped by her categorizing various manifestations of caring. While she admits that this is not an exhaustive list, she presents the key attributes to caring as the FIVE C's, which include compassion, competence, confidence, conscience, and commitment. Compassion is a sensitivity to the pain and brokenness of the other. It stems from a Latin word that means to suffer with. Roach quotes Henry Nouwen, who says that compassion involves us going "where it hurts, to enter into the places of pain, to share the brokenness, fear, confusion and anguish". Competence is having the "knowledge, judgment, skills, energy, experience, and motivation to respond adequately to the demands of one's professional responsibilities". Her use of the term "adequate" is of concern as this implies mediocrity rather than the more desired quality of excelling. Conscience is "a state of moral awareness; a compass directing one's behavior according to the moral fitness of things." Commitment is "a complex affective response characterized by a convergence between one's desires and one's obligations, and by a deliberate choice to act in accordance with them."

While Sister Roach says that caring is synonymous to being human and that humankind has survived because of its humanity she notes some difficulty in her definition as there are many examples of human uncaring, e.g. violence or indifference to others. Roach is rather short in her scriptural and theological support to her perspective and seems to imply that man is basically good. Caring as a characteristic of humanness could be more readily established if one views the person as created by God, in the image of God, and continually connected and nurtured by God. She also acknowledges the words of Paul as he reflects on his own humanness in Romans 7. "It seems to be a fact of life that when I want to do what is right, I inevitably do what is wrong. I love God's law with all my heart. But there is another law at work within me that is at war with my mind. This law wins the fight and makes me a slave to the sin that is still within me. Oh, what a miserable person I am! Who will free me from this life that is so dominated by sin?" [a] But Paul has an answer to his question at the end of this chapter. "Thank God! The answer is Jesus Christ our Lord." Mother Teresa shares this perspective with Paul in her words, "Pray for me that I might not loosen my grip on the hands of Jesus under the guise of ministering to the poor." Perhaps the perspectives of Paul and Mother Teresa is not only pertinent to the physician seeking to advance their level of caring but to the patient seeking to alter their health destroying behaviors.

Despite the great need and value for caring confrontations to impact LSRD, significant barriers exist. The first one most would mention is the barrier of sufficient time. While this may be a more real barrier for the physician in communities with a low physician to population ratio as in rural America or in the inner city, physicians in many communities have the capacity to control their patient schedule. One reason physicians don't choose to reduce their patient load is that their personal income will be reduced accordingly. Millions of health care dollars by

[a] All scripture text is from the New Living Translation.

physicians and their organizations are spent on marketing campaigns to compete with other clinics to maintain or advance patient bases. Yes, managed care organizations can make demands on physician time and productivity but part-time positions exist and physicians can choose to not work for organizations that design a system of care that is contrary to patient well-being. Additional, physicians have frequently resisted through legislative lobbying efforts that would enable other professionals like physician assistants or nurse practitioners to assist in the patient workload. Such lobbying is done under the umbrella of preserving patient safety, but in reality it generally driven out of a desire to protect and maintain the exclusivity of their service. The words of Jesus, "The love of money is the root of all evil", are pertinent words for both the Christian and non-Christian physician.

While initial attempts at caring confrontations may be time intensive, additional study and trial may make them more time efficient and the value of a series of brief interventions may be established. This might be more likely to happen if medical students were encouraged and given the opportunity to be creative in their chosen field of study. While the schools are great at imparting knowledge, they are short at imparting wisdom. Kenneth Bakken (2000) quotes Carl Jung's statement time and busyness, "Hurry is not of the devil; it is the Devil."

Competing worldviews also permeate our society of which the physician and the patient are members. The post-Christian era and post-modernism are worldviews that threaten our culture and negate the basis for caring confrontations. America currently is in the post-Christian era. Our country "no longer relies on Judeo-Christian truths as the basis of their public philosophy or their moral consensus"(Colson, 1999, p 22). Colson also states that our society is becoming post-modernistic. Members of our society are "rejecting any notion of a universal, over arching truth and reduces all ideas to social constructs shaped by class, gender, and

ethnicity." Caring confrontations will involve discussions not only of right and wrong, but whose right and wrong. The confrontation will involve conversation of how personal behaviors of choice injure the person and their community. Such conversations are difficult in post-Christian and post-modernistic society.

Another barrier is that physicians have been trained in the medical model whereby they are called to fix the problem (Evans, 1999, p22). As physicians go deeper into lives of people with LSRD, they will encounter root problems they are unable to fix. Like the attorney who never asks someone on the stand a question to which he/she does not know the answer, the physician is the professional who may never pursue a problem of which he is unable to fix or promptly refer to a colleague. While many people come to a physician for a fix to a problem, many also are interested in knowing the cause. It is our obligation to tell them the cause – even the deeper root causes - but to tell them in a way that they receive it well. While there is a risk involved, it is possible to be truthful with our patients yet maintain them as a "customer". Jesus was able to speak the truth in his personal encounters. As in the story of the woman at the well, He was a master at confronting the sin and not the sinner.

Christian health professionals will frequently look to the healing stories of Jesus to model their approach to practice and to discover his ideas on health and healing. Our search for evidence of a caring confrontation with someone with LSRD will begin here. While this might seem quite logical, the healing stories are not a series of comprehensive demonstrations on health or healing (Wilkinson, 1998). First of all, while Jesus did come to earth to teach, preach and heal (Luke 4:16-19 and Matthew 4:23) his activities did not center on healing people of their disease. Healing was carried out in the context of Jesus' main task of teaching and preaching. While Jesus said in Mark 1:38 and 39, that his primary reason was coming was for preaching he still

ended up getting involved in a healing. “We must go on to other towns as well and I will preach to them, too, because that is why I came. So he traveled throughout the region of Galilee, preaching in the synagogues and expelling demons from many people.” The majority of his recorded activities were also in teaching and preaching (Wilkinson, 1998, p 93). For example, in Mark’s gospel fifty-five percent of the space is devoted to His teaching and twenty percent to healing. In Matthew, seventy-five percent is devoted to teaching and nine percent to healing. It is interesting that of the twenty-six separate recorded healings of individuals, only 4 seem to be initiated by Jesus himself. The rest were initiated by his disciples, opponents of Jesus, the sick person themselves, or relatives, friends or master of the sick person (Wilkinson, 1998, p 91). In those instances where the initiators were the opponents of Jesus, they both occurred on the Sabbath and it appears from the text that working (or healing) on the Sabbath, rather than the restoration to health of the sick person, was the main object lesson or test with the Pharisees. If we narrow our focus on the healing acts of Jesus to learn from him on issues of health we probably will miss his main health message. The following verses illustrate how His teachings speak to our health:

- “God blesses those who realize their need for him.” Matthew 2:3
- “God blesses those who are gentle and lowly.” Matthew 2:5
- “God blesses those who are merciful.” Matthew 2:5
- “You have heard that the law of Moses says, ‘Do not commit adultery.’” Matthew 5:27
- “But I say, love your enemies!” Matthew 5:44
- “So I tell you, don’t worry about everyday life – whether you have enough food, drink and clothes.” Matthew 6:25

The Search Institute (2000, p 26) studies the high-risk behavior patterns of youth as listed in Table 3 and the developmental assets as listed in Table 4 for interested communities. A recent report of one such community demonstrated that for the student who had 31-40 assets, they engaged in an average of 0.8 risk taking behaviors. The student who had 0-10 assets engaged in an average of 8.8 high-risk behaviors.

Table3. Twenty-four High-Risk Taking Behaviors (Search Institute, 2000).

Behavior	Behavior
Used alcohol in the last 30 days.	Got into trouble with police in the past year.
Got drunk in the last 2 weeks.	Hit someone in the past year.
Smoked cigarettes in the last 30 days.	Hurt someone in the past year.
Used smokeless tobacco in the last year.	Used a weapon to get something in the past yr
Sniffed substances to get high in the last yr.	Was in a group fight within the past year.
Used marijuana in the last year.	Carried a weapon for protection in the past yr.
Used other illicit drugs in the last year.	Threatened physical harm to someone past yr.
Drove after drinking in the last year.	Skipped school in previous 4 weeks.
Was passenger with a drinking driver in last yr	Gambled in the last year.
Had sexual intercourse	Engaged in bulimic or anorexic behavior
Shoplifted in the past year	Felt sad or depressed most of the past 4 wks.
Vandalized in the past year	Attempted suicide in the past.

God wants us to be healthy and it may be that the most important health message from His son comes through his teaching and preaching, rather than through His examples of healing disease. The high-risk behaviors and assets as listed in Tables 3 and 4 impact our health, and the teachings of Jesus have much to say about each of these. Consequently, if we are to model our health ministry after that of Jesus, we should consider His general teachings extremely pertinent to the well-being of our patients. While physicians may not opt for directly proclaiming the teachings of Jesus, they could point to their importance for their health and encourage their faith development through a community congregation.

Table 4. Forty Developmental Assets (Search Institute, 2000).

Family Support	Achievement motivation
Positive Family Communications	School engagement
Other adult relationships	Homework
Caring neighborhood	Bonding to school
Caring school climate	Reading for pleasure
Parent involvement in schooling	Caring
Community values youth	Equality and social justice
Youth as resources	Integrity
Safety	Honesty
Family boundaries	Responsibility
School boundaries	Restraint
Neighborhood boundaries	Planning and decision-making
Adult role models	Interpersonal competence
Positive peer influence	Cultural competence
High expectations	Resistance skills
Service to others	Peaceful conflict resolution
Creative activities	Personal power
Youth programs	Self-esteem
Religious community	Sense of purpose
Time at home	Positive view of personal future

Life-style related disease, almost by definition is disease caused (at least in part) by sin, both personal and corporate sin. The New Testament and Jesus do comment on personal sin related to illness but more often than not, there is a statement that sin was not a cause for the illness in the particular instance at hand. It is possible that the reason for this is that they were trying to balance the prevailing attitude of the Pharisees who held that all illness was due to sin. Paul even goes so far to say that his disease, i.e. the thorn in his flesh, prevented him from committing the sin of spiritual conceit and pride. One of Wilkinson's (1998, p 244) concluding statements to his analysis of James 5: 13-18 is that some illnesses are due to personal sin and some are not. In such cases of sin, James calls the person to confess to others and to pray for each other, so that the person may be healed.

Another reason the New Testament does not speak directly to the issue of LSRD is the great difference between the Mediterranean society of the Bible and current American society. LSRD is really in part a collection of diseases that stem from the nature of our society. These differences are clearly apparent in respect to features of privacy and community. According to Pilch and Malina (1998, p xxxii) there is in America an "unwillingness to enter the private lives of others or to have others enter one's own private life. In Mediterranean society, there is an unwillingness to leave alone the lives of others or to have others leave alone one's own life." Our unwillingness to enter the private lives of others may have enabled the explosion with LSRD. In America we have to freely join communities. We tend to have broad, shallow relationships. In Mediterranean society people have no choice but to fit into inherited communities. They have few relationship within those communities but the relationships they do have are deep (Pilch and Malina, 1998). Deep relationships among people facilitate a connection with our deeper, inner struggles.

The Old Testament speaks of health or well being in the word *shalom*. Wilkinson (1998, p 12) states that shalom "denotes the presence of wholeness, completeness and well-being in all spheres of life whether physical, mental and spiritual, or individual, social and national. True shalom or well-being comes from God for only in God do we find our true wholeness and complete fulfillment." God offers a covenant of shalom to his people. Wilkinson goes on to say that the Old Testament described characteristics of people that were healthy, i.e. had shalom. These characteristics include well-being, righteousness, obedience, strength, fertility, and longevity. Obedience is of particular interest in the behaviors of LSRD. Obedience was associated with freedom from disease and disobedience associated with liability to disease. Exodus 23: 25 states, "You must serve only the Lord your God. If you do, I will bless you with

food and water, and I will keep you healthy." Wilkinson states (1998, p 21) that while the Old Testament presents a comprehensive definition of health to include all spheres of existence it stresses the spiritual state of mankind and regard holiness as the supreme description of human health. In other words, it includes human character and behavior in its definition of health. It is also important to remember words of Jesus in Matthew 5:17 on the Old Testament. "Don't misunderstand why I have come. I did not come to abolish the law of Moses or the writings of the prophets. No, I came to fulfill them."

Proverbs speaks of wise living and foolish living. Proverbs 4: 20 states "Pay attention, my child to what I say. Listen carefully. Don't loose sight of my words. Let them penetrate deep within your heart, for they will bring life and radiant health to anyone who discovers their meaning." Proverbs indicates that the fool makes a choice to be that way. The person is not a victim of their neurochemistry causing their unhealthy behavior. The person is a victim of their own choices. In Proverbs, it is not only the individual that suffers but the community as well. The person who is overweight from overeating and consumes a twelve pack of beer a week, personally suffers through heartburn and chest pain. The community also suffers in that his employer pays high insurance premiums. These premiums pay for his $1000 annual cost for his powerful heartburn medication as well as his periodic admissions to the hospital for chest pain to rule out a heart problem that later is found to be only heartburn. While Proverbs might regard some people with LSRD as a fools, we must remember we are to love the fool.

Avoiding the deeper root causes of LSRD is a suppression of the truth, both for the person and their community. The following verses highlight the importance of truth in numerous ways:

- "Put away all falsehood and tell your neighbor the truth because we belong to each other." Ephesians 4:25

- "And you will know the truth, and the truth will set you free." John 8:32
- Love "never rejoices about injustice but rejoices whenever the truth wins out." I Corinthians 13:6
- "I am the truth, the way and the life." John 14: 6
- "All who invoke a blessing or take an oath will do so by the God of truth." Isaiah 65: 16

Roach (1992) says that one of the barriers to caring is deception. Satan is the great deceiver. Physicians are deceived in part regarding the effectiveness of their treatments and that patients can't change their behaviors. Patients are deceived in that they don't appreciate their health problems are rooted in deeper, personal issues. God will honor processes that bring forth truth as this honors God, it honors His son and it honors and heals the person.

Physicians tend to avoid confrontational conversation with their patients on issues related to their LSRD. Except for some instances involving chemical dependency, physicians tend to offer merely brief suggestions and maybe an occasional extended conversation pertinent to the root causes of their LSRD. Physicians may develop frustration, complacency and even inappropriate judgments when patients fail to respond to suggestions or extended conversations. This is especially true when the physician feels there are no alternate strategies to deal with the root causes or the technologic approach has reached its limit and still the disease is not controlled. The following is an interview structure that may assist the physician or other health professionals in conducting a caring confrontation. The outline (see sample in appendix) could be placed on a single sheet of paper in which the physician and patient discuss and document the content of their conversation. Although it may be appropriate to consider, it may not work as well as a take home exercise for the patient. A copy of the document is placed in the chart of the patient for future use and the original given to the patient for their future use. It is

worthwhile to note that timing, tack and tenacity are important whether in a single caring confrontation or in a series over time. “Timely advice is as lovely as golden apples in a silver basket.”(Proverbs 25:11) “Dear brothers and sisters, if another Christian is overcome by some sin, you who are godly should gently and humbly help that person back onto the right path.” (Galatians 6: 1) “And let us run with endurance the race that God has set before us.”(Hebrews 12:1).

First of all, introduce the topic and receive their permission. Just getting started on the conversation can be a challenge. One might simply state that “Half of all illness in this country is due to the habits people choose to practice on a day to day basis. I am concerned you have one of those illnesses. Can we spend some time talking about that?” Secondly, define the health destroying habits related to the disease. Ask the patient what they think they might be doing on a day-to-day basis that is contributing to their disease. If the patients response in incomplete, the physician may have to offer some possibilities. This is to be done comprehensively and honestly. This names the problem and naming can be therapeutic. Thirdly, discuss what their habit says about them as a whole person in terms of their physical, psychological, social and spiritual dimensions. This complete inventory would contain information related to possible causations and consequences. While all areas are important, it is critical to discuss the spiritual area. Fourthly, discuss an action plan that either modifies the health destroying behavior or attends to at least one of the root issues discussed in the context of their whole person. This may be a good time to remind them of their ability and their responsibility. Finally, conclude with appreciation for them participating in the conversation. “I know it has been difficult to talk about such items. I appreciate you willingness and honesty. You are not alone in this. While this may take some time, I expect some good outcomes.”

Life-style related disease can be impacted. It must be impacted and impacted in a much more efficient way that it has been before. Winston Churchill is reported to have said, "You can always count on Americans to do the right thing, but only after they have tried everything else first." We as a society have tried everything and what really needs to be done can no longer be avoided. We must help our patients with LSRD to look and discover the truth deep within their inner person. Often what we will find are issues that we will not be able to fix. But nevertheless, on behalf of our patient's well-being we must help them look and discover. Healing will likely come with time and will likely be orchestrated not by us but by our creator in heaven. Dr. Konner, a human biologist and medical anthropologist at Emory University states, "Unless we find a balance between the old arts of healing and the new technology, we may lose as much as we gain. And the lose may be irreversible" (Newsweek 2001, p 77). Christian health professionals have something of great value to offer our society right now on behalf of the growing crisis surrounding life-style related disease. The question is whether we have the courage to search our inner person to engage a confrontation involving whether we will choose the ways of God or the ways of the world. If we choose God, we are well on our way to a health care revolution of a different kind. If we choose the world, continued disappointments in health outcomes of value await us. Jesus tells us in Matthew 5:13 that we are the salt of the earth. "But what good is salt if it has lost its flavor? Can you make it useful again? It will be thrown out and trample underfoot as worthless." Jesus also says in the very next verse, "You are the light of the world – like a city on a mountain, glowing in the night for all to see. Don't hide you light in a basket! Instead put it on a stand and let it shine for all." May we choose to be the salt of the earth and the light of the world.

References

Anderson, D. & Wadden, T. (1999). Treating the Obese Patient. Archives of Family Medicine, Volume 8, March/April, 156-167.

Bakken, K. (2000). The Journey in to God: Healing and Christian Faith. Minneapolis: Augsburg. p 149.

Developmental Assets: A Profile of Your Youth. Beaver Dam Unified School District. (Report of April 2000). Minneapolis: Search Institute.

Evans, A. (1999). Redeeming Marketplace Medicine: A Theology of Health Care. Cleveland: The Pilgrim Press.

Frontiera, M., (1998). Cancer Update. CME lecture at St. Mary's Hospital, Madison, WI.

Health and Medicine: Next Front Frontieres. (2001, June 25). Newsweek, 41-77.

Longlett, S., Kruse, J., Wesley, R. (2001). Community-Oriented Primary Care: Critical Assessment and Implications for Resident Education. Journal of the American Board of Family Practice, 14, (2), 141-147.

McGinnis, M., & Foege, W. (1993). Actual Causes of Death in the United States. Journal of the American Medical Association. 270, (18), 2207-2212.

Morris, W. (Editor). (1973). The American Heritage Dictionary of the English Language. New York: American Heritage Publishing Company and Houghton Mifflin Company.

National Cancer Institute. The 1971 National Cancer Act: Investment in the Future. Retrieved August 13, 2001 from the World Wide Web: http://www.rex.nci.gov/massmedia/backrounders/nationalcanceract.HTM

Pilch, J. and Malina, B. (1998). Handbook of Biblical Social Values. Peabody, Massachusetts: Hendrickson Publishers.

Ries, L., Wingo, P., Miller, D., Howe, H., Weir, H., Rosenberg, H., Vernon, S., Cronin, K. & Edwards, B. (2000). The Annual Report to the Nation on the Status of Cancer, 1973-1997, with a Special Section on Colorectal Cancer. Cancer. 88, (10), 2398-2424.

Roach, M. (1992). The Human Act of Caring. Ottawa: Canadian Hospital Association Press.

Starfield, B. (2000). Is US Health Really the Best in the World? Journal of the American Medical Association. 284, (4), 483-485.

U.S. Department of Health and Human Services and the Center for Disease Control. (1999). Chronic Diseases and Their Risk Factors: The Nations Leading Causes of Death. Retrieved August 11, 2001 from the World Wide Web:http://www:cdc.gov/NCCDPHP/STATBOOK/ PDF/CDRF1999.PDF

U.S. Department of Health and Human Services. Women and Smoking. A Report of the Surgeon General – 2001. Retrieved on August 20, 2001 from the World Wide Web: http://www.cdc/ Tobacco/sgr/sgr_forwomen/Executive_Summary.htm

Vonhoff, H. (1971). People Who Care. Philadelphia: Fortress Press. (p xi).

Wilkinson, J. (1998). The Bible and Healing: A Medical and Theological Commentary. Grand Rapids: Wm. B. Eerdmans Publishing Company.

APPENDIX

CASE STUDY OF A CARING CONFRONTATION

Henry [b]is a pleasant, easy going 50 year-old male. He has several medical conditions consisting of adult onset diabetes, hypercholesterolemia, and mild coronary artery disease as evidence by cardiac angiography. Henry is on approximately four medicines (taken no more than twice a day) that cost up to about $2,000 per year which except for a small co-pay is covered through his insurance. He is not overweight and has virtually no symptoms from his problems. His is very functional, participates in some low intensity leisure activities, is actively employed with an area industry, and is happily married with two adult children.

The difficulty with Henry is that neither his diabetes nor his cholesterol are anywhere near control. His periodic laboratory tests are almost always way off goal. This has been the situation since his diagnoses several years ago. Although he has virtually no side effects from his medicine, it is not uncommon for him to miss several doses per week. He has not modified his diet. He will eat candy bars at work or home and indulge in large juicy steaks at the restraunt. He also drinks some beer but is not an alcoholic.

Office visits have typically been friendly. The results of his labs have been shared with him and he was told quite clearly what goal numbers were and how his numbers greatly exceeded those goals. He was also shown graphs that correlate the severity of complications like blindness and kidney failure against uncontrolled laboratory numbers like his. Medicines were advanced in number and dose. Encouragement was given with statements offered that he would keep trying harder and do better next time.

But our next time for an office visit contained a caring confrontation. My motivations for conducting this caring confrontation were many but what made it happen is that I wanted some experience in doing what I was writing about in this theological paper on life-style related illness. As the office visit unfolded, I became uneasy about actually doing it and approached the topic several times but without getting to the heart of the issue. Finally I was able to preface the topic with, "I am in the process of writing a paper on illness that many people experience but is do in large part because of the personal choices of behavior they make every day and I think you are in that category." His face got red, and he looked at me in a way that I knew I was touching on something that was very personal and sensitive. He admitted he knew he was not making the right decisions and that he was responsible for his medical conditions not being well controlled. I told him that all of us make bad decisions from time to time but that his were going to kill him and that I was concerned for him and his family who would then be without a father and husband. He said that that he was aware of that. As we went round and round on the surface reasons of why he repeatedly does things that are not good for his health, he said "I do these things because it really doesn't matter what I do for my health. When your time is up, your time is up." I did not know much about his faith but I knew he attended a local church. I told him that while I agreed with him and believed that God was in control of this world including its people which included me, I also held to the potentially competing belief that I could influence my future by following the ways of God and through prayer. I told him I recognized the apparent conflict in these beliefs and that probably theologans and philosohpers have debated these very points for centuries. We concluded that longer than usual visit by shaking hands and exchanging smiles. I looked forward to the next visit because now we would have something of

---

[b] Ficticous name for protection of identification.

more meaningful to discuss. Rather than going round and round about uncontrolled lab results and intents to do better, I can't to ask him if he wears seat belts. Because if he does, we will have something to build upon as that would be a demonstration that he is caring for himself and trying to influence his future. Maybe someday his beliefs would be such that they would more favorably make a difference in his behavior.

I telephoned Henry a couple days later. I told him that I hoped he was not offended by our conversation. He said, "Far from it. What it really showed me is how much you cared."

THE TRUTH OF HEALTH DESTROYING HABITS

1. What is the truth of my health destroying habit? Describe completely and honestly.

2. **What does the truth of my habit say about me as a person in terms of…**(How do the following areas contribute to the persistent of my habit? How are the following areas affected by my habit? Be specific.)

   My body…

   My thoughts and feelings…

   My relationship with family and other people…

   My relationship with God…

3. **Given my understanding of the truth of my habit as described above, what will I do next?** Be specific.