AMERICAN BAPTIST CHURCHES USA

THE MESSAGE BOARD
A Newsletter from
A. Roy Medley, General Secretary

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Can We Better the *Better* Health Care Concept? Part 2

(Commentary by Kenneth V. Dodgson MD)

This is the second of a seven-part series on personal responsibility as a part of churches' response to the health care crisis. Kenneth V. Dodgson MD is a retired general surgeon, who spent 24 years with the Board of International Ministries, American Baptist Churches USA, serving at the Jorhat Christian Medical Centre, Jorhat, Assam, India. Dr. Dodgson is a graduate of Franklin College of Indiana, Colgate Rochester Crozer Divinity School, and Temple University School of Medicine. Upon returning from India, he became the Director and Staff Surgeon of the Occupational Medicine Program of the University of Rochester Medical Center. He and his wife, Sally, reside in Rochester, New York.

2. Three Options

Circulating in the halls of government are proposals for a health care system that is underwritten by a combination of privately and/or business and industry financed health insurance, coupled with aspects of a nationalized health care system. However it is ultimately conceived, the full cost of health care, hospitalizations, operations, prescriptions, follow-up care, and rehabilitation services, has the potential to bankrupt the country.

Full tax-based financing for all medical care is tantamount to removing all rules of the road and having the government pick up the tab for all automobile repairs, all medical and injury care, and all hospitalizations, operations, and rehabilitation for the road-inflicted chaos that would follow unrestricted driving. With respect to our present health care system, the similarity resides in the fact that there are no compulsory dietary restrictions, little control of tobacco products, and no mandates with respect to exercise programs. The present presumption is that some system of medical care will finance the overwhelming costs of an over-weight, increasingly sedentary society.

Walt Kelly's *Pogo* had it correctly when, with significant insight, he declared, "We have met the enemy and he is us." Part of the problem lies with two generally accepted assumptions: first, that if one lives long enough one will develop illnesses that require treatment and second, that there will always be medicines available to treat the illnesses. Nowhere in the health care system is there an incentive to remain illness free. There are no financial rewards for disease-free living.

Our right to life, liberty, and the pursuit of happiness permits us to live a life style we choose irrespective of medical consequences. Freedom always imposes responsibility. Health-wise we are individually going to have to take some responsibility for preserving our own health and living by the rules of the game that life has given each of us. There are three options.

Option One—eradicate disease. While the eradication of disease presents a desirable goal, it has been accomplished in only one instance, the elimination of small pox by an international vaccination campaign. It has been tried unsuccessfully, at great expense, with respect to malaria and, more recently, with polio.

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Option Two—diagnose and treat disease. If we cannot eradicate disease, a valid option, now embraced by the vast majority of medical practitioners, is **treatment** oriented. This is the basis for almost all curricula in medical schools. As one of my professors stated, "If a doctor takes a careful medical history and does a complete physical examination, adding up the positive findings will begin to spell the name of a disease studied in medical school." It is this performance that Dr. Gawande would like to see improved. Patients seek medical care because they are ill, injured, have pain, or are bleeding. Doctors treat patients who are ill, injured, have pain, or are bleeding. Doctors learn to diagnosis disease based on symptoms of illness and by recognizing distinctive pain patterns, and they treat those symptoms, correct injuries or diseased body parts, and stop the causes of bleeding. Increasingly sophisticated technology now assists in making diagnoses and the cost of this technology along with hospitalizations, medical and surgical treatment programs, and prescribed drugs account for the expenditure of virtually all of the billions of dollars now being spent for medical treatment programs. Projected expenditures could, if everyone in the country is to be covered, exceed a trillion dollars.

Option Three—prevent disease. Preventive Medicine presents a third way to practice medicine. This is the arena in which all physicians, irrespective of their specialty or practice, should be practicing along with their treatment programs. With the exception of pediatricians, whose responsibilities include providing an increasingly complex set of immunizations to prevent infectious and contagious diseases, almost no other physicians practice Preventive Medicine. The tragedy is that, as currently practiced, Preventive Medicine has become another specialized branch of medical care and much of the effort in this respect is directed toward social and environmental engineering, a necessary part, but only a part, of what Preventive Medicine can and must do.

In the next commentary, the potential for preventative care will be examined in more detail.

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Office of the General Secretary
American Baptist Churches USA • PO Box 851 • Valley Forge, PA 19482-0851
800-ABC-3USA, extension 2274 • Roy.Medley@abc-usa.org
www.abc-usa.org