Healthcare Delivery

As Christian physicians and dentists, we believe God commands Christians to attend to health care needs of people. Jesus taught, and His life demonstrated, that caring for people includes providing for their spiritual, emotional, and physical needs. Values inherent in God's Word and Jesus' teaching include kindness, compassion, responsibility, impartiality, stewardship, and the sanctity of life. Therefore, Christians should work toward a system of health care delivery consistent with these values.

We affirm the following guidelines for health care delivery:

- Society as a whole should seek a basic level of health care for all.
- Purchase of additional health care not covered by the basic plan should not be prohibited.
- Public and/or pooled funds should not be used to finance the taking of human life.
- Institutions, clinicians, patients, and their families should share responsibility for good stewardship of medical and fiscal resources.
- The Christian community should share responsibility for health care, especially of the poor.
- All clinicians should strive to deliver health care to the poor.
- The clinician's priority should be the best interests of the patient. Clinicians should not make allocation decisions at the bedside that violate this priority, nor should clinicians allow health care delivery systems to coerce them to do so. Patient care decisions should never be influenced by clinician income considerations.
- Individuals should be responsible for their own and their dependents' health, including lifestyle choices.
- Individuals should provide for their own and their dependents' health care to the best of their ability.

If competent physicians and dentists practice the love and compassion of Christ toward all patients, recognizing that in the eyes of God each individual has intrinsic worth, good health care delivery will be enhanced.

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Passed with 79 approvals; 1 abstention.
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Explanation

Background

Prior to World War II, most medical care in the U.S. was delivered by individual physicians and paid for by individual patients. Costs were not often prohibitive, physicians and patients were not very cost conscious, and most physicians were generous with the provision of reduced fee or even free care to those in need. Technological advances led to the availability of more treatments for more conditions, at increasing cost. This increasing cost, combined with the efforts of organized labor, led to the implementation of indemnity health insurance policies which continued to pay professionals on a fee-for-

service basis. Most health insurance was paid for by employers. At about the same time, many physicians began to share night and weekend coverage and/or practice in groups. Medical care was more readily available, and paid for by someone else. Both patients and physicians were perfectly happy to receive and give more medical care.

In 1966, the federal government stepped in to pay for health care for those over 65 and for the poor, still paying on a fee-for-service basis, though sometimes on a reduced scale. This led many physicians to curtail the practice of giving free care to those in need. It encouraged some patients and some physicians to overuse primary and referral services, further adding to the escalating costs.

Skyrocketing costs subsequently led to the re-structuring of healthcare finance. Prospective payment plans were instituted which often paid on a capitation basis. In effect, physicians were now rewarded for doing less. Physicians were forced to be more cost conscious, and patients often felt they were being denied care which they had been used to receiving without question.

Similar changes are taking place in the practice of dentistry.

These changes in cost and in payment mechanism have changed the patient-physician relationship. The changes have generated some new potential conflicts of interest.

Secular Perspective

There has been an enormous amount of public discussion of health care delivery and finance in recent years. Much of the debate has focused on economics and whether health care is a right; and if it is a right, who should be responsible for its payment. Health care has become a commodity, professionals have become "providers", and patients have become "consumers".

Secular discussion of this issue has relied primarily on the basic principles of medical ethics: non-maleficence (do no harm), beneficence (do what is good), autonomy (self-determination), and justice (treating likes alike).

Christian Perspective

Much of the traditional ethos of medicine can be traced back to the competence and beneficence taught by Hippocrates and the compassion demonstrated and taught by Jesus and the early Christian church. Clearly this includes more than economics and rights. Clearly it includes compassion and responsibility, as was taught by Jesus (Matthew 25:42, 45). Clearly it includes a concern about conflicts of interest; Jesus also warned that we cannot serve both God and mammon (Luke 16:13). But Christians are not unanimous on what the system should look like.

In 1997, a national conference of Christian scholars was held in Deerfield, IL to discuss issues of health care delivery from a clearly Christian perspective. That conference was jointly sponsored by The Center for Bioethics and Human Dignity, the Christian Medical and Dental Society, the Christian Nurses Fellowship, and the Christian Legal Society. The proceedings of that conference are available in a book entitled The Changing Face of Health Care published in 1998 by Eerdmans (U.S.) and Paternoster (U.K.). Several of the accompanying resources are taken from this book.

Abstracts

Pellegrino ED. The Good Samaritan in the Marketplace: Managed Care's Challenge to Christian Charity. Chapter in The Changing Face of Health Care. Grand Rapids, MI. William B. Erdmans Publishing Company, 1998.

The author argues that the current profit driven health care system is fundamentally inconsistent with the Christian perspective of health care delivery. As Christians we are called to emulate the life of Christ and the actions of the Good Samaritan. The author believes that a system which delivers health care with scorn, disdain, and little room for the poor, the marginalized, and the undereducated is incompatible with fundamental Christian principles which value and place preference on the needs of these people. The author unequivocally states that medical knowledge is not a commodity, but a gift to be shared with Christ-like compassion and love.

Pellegrino argues that by placing a priority on profit over charity, and investors over patients, we so fundamentally skew the relationship between healer and healed, that we risk destroying the foundations that our faith plays in our practice of medicine. He vigorously urges Christian health care professionals to refuse to participate in health care schemes (including cost containment) that overthrow the supremacy of the patient's needs. "There may well be times in this era of commercialized medicine when all physician, nurses, and especially those who are committed Christian will have the responsibility of collective refusal to serve the plan." His arguments against managed care are not based on opposition to the efficiency drive which is presumably central to managed care schemes. In fact, he argues that efficiency is central to being able to provide the most service to as many people as possible.

Dougherty CJ. Ethical values at stake in health care reform. JAMA. 1992;268(17):2409-12

The author argues that a universal health plan would satisfy six key ethical shortcomings not being addressed by the current health care system. He states that both our Judeo/Christian heritage and post-enlightenment concepts of the dignity and intrinsic value of each individual compels us to provide a basic level of health care to all. He believes that providing a basic level of care to all will allow us to address the problem of the uninsured, and it will revive the now strained patient-physician relationship. The author further states that such a system will improve the common good and streamline administration, thus containing costs and simplifying organization.

Moore GT. Let's provide primary care to all uninsured Americans - Now! JAMA. 1991; 265(16):2018- 9

Moore implores Americans to give up attempting to provide all costly and specialized health coverage in a universal health plan, and simply provide much needed primary care coverage to all. The author states that it is not feasible to provide universal access to the most expensive and advanced health care system in the world. He says that by providing everyone with access to primary care physicians, measures can be taken to prevent disease and necessary expensive procedures can be provided to the poor through charity.

Council on Ethical and Judicial Affairs, AMA. Caring for the poor. JAMA. 1993;269(19):2533-8

This report outlines the traditional responsibility that physicians have had for taking care of the poor, the historical shift of this responsibility from private charity to the national government, and the shortcomings of the current system. Recognizing the extraordinary privilege the practice of medicine is, and the immense social cost involved in the training of physicians, the Council call physicians to return to the practices of yesteryear --- providing 50 hours of free charity care to the poor (versus debt forgiveness). Furthermore, it asks leaders in the field to provide better systems by which physicians can serve the needs of the poor.

Wheeler S.E. Broadening our view of justice in health care. In The Changing Face of Health Care. Grand Rapids, MI. William B. Erdmans Publishing Company, 1998.

The author examines the biblical commands on justice, and concludes "there is the basic equality and dignity of every human being, founded in their common origin, and their shared states as the bearers of God's image and the subjects of God's care". In addition, as stewards of God's material realm, we have a responsibility to ensure that, regarding the basic needs of life, there is not an extreme disparity between those with the most and those with the least. She laments that we are the only major industrialized democracy does not provide universal coverage to all of its citizens, which she believes is the best way to provide coverage to the poor. The author then urges us to be careful stewards of scarce medical resources, not by judging the merits of individual lives (microanalysis), which she believes Christians cannot do by the virtue of their faith, but by carefully controlling large scale expenditures of these resources (macroanalysis).

Rutecki GW. Guidelines for gatekeepers: A covenantal approach. In The Changing Face of Health Care. Grand Rapids, MI. William B. Erdmans Publishing Company, 1998.

Rutecki details the differences in care for different socioeconomic groups and health care programs (HMO, PPO, etc.). He argues that the relationship between physician and patient is above that of the contract, and is covenantal. In this light, he believes that the physician's primary responsibility is to the

patient, not to society. He advocates the "unswerving commitment" of the physician to the patient, increased activism on the part of physicians, and increased access to physicians for the poor.

Buckley D. Gatekeeper ethics: The primary care physician in the era of managed care. Ethics and Medicine.1997;13(2):39-42

Buckley reviews the current state of affairs in the managed care arena, and finds provisions of managed care to be "a direct threat to Christian and Hippocratic traditions of healing." He worries about the precedence that economics takes over ethics, and the development of two classes of patients, those of HMOs, and those with fee-for-service plans. He reiterates earlier calls for the primacy of the patient, and calls Christian physicians to "work for the reformation of managed care as it exists now in its formative stages."

Light DW. The practice and ethics of risk-rated health insurance. JAMA. 1992;267(18):2503-8

The author argues that health insurance in the United States is driven by competitive risk rating and is promoted in ways to give policyholders optimal value for their money and to be fair to those of lower risks. He finds that in practice however, competitive risk rating costs more than noncompetitive universal health insurance, and it erodes the basic goal of spreading large losses over a wide base. This article describes not only how risk rating covers least those with the greatest medical bills, but also how it has spawned a labyrinth of complex manipulations by insurance companies to charge more or pay less than actuarially fair risk would justify. The final section shows that even if risk rating were done fairly, it contradicts moral fairness. Many of the leading proposals do not discuss these practical and ethical issues. The medical profession and policymakers need to discuss them and take a stand on them.

Payne E. The right to medical care: A biblical construction. CMS Journal 1987;XVIII(3):12-5

The author believes that our humanistic culture greatly over-values medical care. He discusses the question whether medical care is a basic right. He states that individuals and families should bear the cost of health care primarily, although he recognizes that this financial burden has increased so that it is beyond the means of almost all families. The church, rather than the government, should be the primary backup for this short-fall. However, he does not call for the immediate cessation of government welfare; the burdens would be too great. He does believe that our biblical goal should be to transfer welfare programs from the state to those upon whom God has placed the obligation.

Bibliography

Lundberg GD. Fifty hours for the poor. JAMA; 258(21): 3157

The editors of JAMA and the ABA Journal urge physicians and lawyers to return the gifts and the respect society has bestowed upon them by providing 50 hours of free service to the poor.

Brown RE. Health USA: A national health program for the United States. JAMA. 1992;267(4): 552-8

The author advocates for a managed-competition, single-payer health care system.

Greenberger, N.J. et al. Universal access to health care in America: A moral and medical imperative. Annals of Internal Medicine. 1990;112(9):637-661

The American College of Physicians proposes and discusses in detail a national universal health program.

Eddy DM. What do we do about costs? JAMA. 1990;264(9):1161-70

The author calls us to recognize the costs of our health care, and openly and honestly discuss methods and practices to lower these costs.

Brody H., Bonham VL. Gag rules and trade secrets in managed care contracts: Ethical and legal concerns. Arch of Inter Med. 1997;157:2037-43

The authors argue for the elimination of trade secrets and gag rules from managed care because of the ethical problems inherent in them.

Glasson J. et al. Council on Ethical and Judicial Affairs of the AMA. Ethical issues in health care system reform: The provision of health care. JAMA. 1994;272(3):1056-62

The Council advocates a universal health care, citing ethical precedence for such, with provisions for the purchase of additional coverage beyond the basic plan.

Simmons HE. et al. Comprehensive health care reform and managed competition. New England Journal of Medicine. 1992;327(21):1525-28

Universal Coverage and Individual responsibility are advocated in a plan which embraces the free market via the 'managed competition' plan.

Burstin HR, Lipsitz SR, Brennan TA. Socioeconomic status and risk for substandard medical care. JAMA. 1992;268(17):2383-87

This study finds that the poor are more susceptible to substandard medical care.

Pellegrino ED. Allocation of resources at the bedside: The intersections of economics, law, and ethics. Kennedy Institute of Ethics Journal 1994;4(4):309-17

The author explores the ethical issues that confront physicians faced with treating patients who have insufficient financial resources, including a comparison of the way law and ethics interpret the physician-patient relationship.

Ashley BM, O'Rourke KD. Personal responsibility for health. Chapter 3 in Healthcare Ethics: A Theological Analysis. St. Louis, MO: Catholic Hospital Association, 1989

After explaining in earlier chapters that the community is responsible for the full personal development of each individual, including his health, the authors state that the primary responsibility for a person's health belongs to the individual. They explain the implications of this responsibility for daily life as well as the meaning of stewardship.