

ShALOM!

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Health Care for All

In these last few years before I retire and become eligible for Medicare, I carry the health insurance for my husband and me through my employer. It's very good insurance, and although it's not free my premium is fairly reasonable compared to what a lot of people pay—about \$250 a month for coverage for both of us, with the balance paid by my employer. We've had our insurance through my employer for more than a decade, so about three years ago when I feared I might lose my job, I was in something of a panic at the possibility of losing health insurance too. As a cancer survivor, I know how expensive health care is and how major illness can happen unexpectedly even if you think you are in excellent health. I also imagine that cancer in one's past is a "pre-existing condition" and could easily make it difficult for me to be able to obtain insurance should I lose what I have.

Fortunately, I still have a job, although it continues to feel a bit tenuous in this uncertain economy. Yet despite whatever uncertainties I face, I know that my situation is so much better than that of many other people who have no insurance at all and are one serious illness or injury away from crippling debt or who pay huge premiums for their coverage.

The topic of health care has been a lightning rod this past year for incredibly acrimonious debate, scare tactics, exaggerations and, in some cases, outright lies. Of course, some of the vigorous debate has been over genuine differences of opinion and philosophy about the best way for the United States health care system to be reformed and over the appropriate role of government in something like health care. Such a complex issue can't be resolved simply, much as we might wish it could.

One of the questions raised during the current debate has been whether health

care is a right. On the one hand, thinking in terms of rights can easily disintegrate into a self-centered assertion of "my rights." However, I can't help wondering what Jesus would say. Jesus never talked in "rights" language, yet he certainly acted as though everyone, no matter who they were, deserved equal treatment. Luke records Jesus healing the servant of a centurion and then immediately raising a widow's son from the dead; later he raised the daughter of the religious leader Jairus from the dead and then healed a woman who had spent everything she had trying to get relief from her affliction. Whether they could or couldn't afford to pay was beside the point; they needed care and Jesus had compassion for them and healed them. That's the model that should inform whatever we do.

This is the third time in 25 years that *Shalom!* has focused on health. There are obvious reasons for reprising the theme again right now, given the health care reform debate taking place in the United States, but the goal is not to advocate for a particular point of view or piece of legislation. Rather, this edition focuses primarily on the perspectives of health care professionals and those who experience it personally. It is by no means a complete perspective, given that I was unable to recruit any articles from the Canadian perspective (something I really regret and for which I apologize to my Canadian friends) or from other countries where there is limited access to quality health care and people die every day from preventable diseases. Perhaps those articles will form the basis of *Shalom!*'s fourth edition on health sometime in the future!

Harriet S. Bicksler, editor

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A Primer in Primary Care

By Rachel Petersen

In preparation for this issue of *Shalom!*, I recently sat down with Paul Wengert, a retired surgeon, and Geoff James, a family physician, who both belong to my home church, Grantham BIC. I had a page and a half of questions to ask each of them, and I left our time together feeling far more informed—and, to my surprise, hopeful—about the American health care system.

Instead of providing a complete transcript of their answers to my questions, I thought it would be helpful to highlight the points on which they spoke most passionately; namely, their perspectives on the shortcomings of health care in the U.S., and their thoughts on how to best address these areas of weakness.

They began with broad strokes, talking about issues of access, quality and expense. Whereas the U.S. used to be on the cutting edge of health care delivery systems in the 50s and 60s, it has since lost pace with the rest of

the developed world. Paul, who has devoted much of his retirement to volunteer medical work in more impoverished nations, can still appreciate how relatively fortunate Americans are in comparison to people in certain developing countries. But when comparing the U.S. with other industrialized nations, our highly advanced health care system begins to look less impressive. In spite of being the most expensive system in the world (nearly twice as expensive as most other industrialized nations), the U.S. continues to fall lower on the World Health Organization's ranking for health care quality. In a 2008 study comparing preventable deaths in 19 industrialized nations, the U.S. ranked last. Likewise, our infant mortality rate—a basic measurement of health care quality around the world—continues to be disturbingly high. In the last 50 years, 17 nations—including Singapore, Japan, Cuba, and Hungary—have surpassed the U.S. in achieving lower infant mortality rates. Such data calls into question the popular perception that America has “the best health care in the world,” and forces us to ask how other industrialized nations are achieving better public health at lower costs.

Cost ≠ Quality

The relationship between expense and quality turns out to be more complicated than we've been taught to believe. And, according to both Geoff and Paul, our society's collective misconceptions about how to obtain the best medical treatment are part of the problem. Paul recalls the days when physical exams, combined with his knowledge of a patient's history, were sufficient to diagnose conditions like appendicitis. “But now, patients don't want to be diagnosed in a doctor's office. They go to the hospital for x-rays and other expensive tests, even though such high-tech modalities are often unnecessary.” Geoff agrees: “This technology is misused excessively in place of clinical care. It's partly driven by the malpractice system. But it's also driven by the attitudes and expectations of the public. We've sent the message that we can

fix anything if we spend enough money on it, so patients want the most expensive tests; they don't want to be diagnosed simply by an examination.” While both Geoff and Paul agree that the availability of superior medical technology is one of the greatest strengths of the American health care system, they also see how our over-reliance on this technology contributes to problematic and costly cycles within the system.

The public's demand for expensive tests and treatments is, in some respects, the by-product of the way we pay for medical care, which economically promotes procedures and volume rather than thorough, evidence-based clinical care. This has contributed to what Geoff calls “the hamster wheel of primary care.” Instead of being paid for the quality of the treatment they offer to their patients, physicians are paid according to the quantity of treatments they provide. “This payment system encourages us to see more and more patients,” Geoff says, “but increasingly the primary health care needs of our patients are complex chronic problems, which require more time for each patient.”

Consequently, fewer physicians choose to practice primary care (2 of every 3 doctors in the U.S. go into specialty practices), and those who do have less and less time to spend with each patient. Meanwhile, the health needs of the American population are increasingly chronic in nature; diseases like hypertension, hyperlipidemia, diabetes, and heart disease all require ongoing treatment, unlike the acute health care problems, such as pneumonia and other infections that dominated the medical field 50 years ago. It has been estimated that, following recommended clinical guidelines, it would take a primary care physician 10.6 hours per day to adequately address the chronic health care needs of his or her patients. This figure does not include the additional hours it would take to address health maintenance needs and to provide care for acutely ill patients.

In this climate, the bond between physicians and patients has understandably weakened. Paul remembers a time when family doctors would come into the hospital with



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their patients to “see them through surgery.” Nowadays, a visit from one’s primary care physician seems unheard of in the hospital. But this shift in the doctor-patient relationship isn’t merely a result of doctors having less time to spend with each patient. A significant part of the problem is the lack of communication and information sharing among health care providers.

The economic and qualitative consequences of this lack of communication become especially clear around hospitalizations. In the interest of saving money, patients are often rushed out of the hospital. Under optimal conditions, with proper follow-up care, this wouldn’t necessarily be a problem. But more often than not, doctors are not informed that their patients have been admitted to the hospital until days or weeks after discharge, if at all. Geoff explains: “Part of the problem is that systems are not well developed to ensure that the information about the details of patient care during the hospitalization gets to the primary care provider at the time of discharge.” This communication gap has contributed to what has become one of the largest preventable expenses in our health care system: the re-hospitalization of people who don’t receive the concentrated care they require in the days and weeks following expedited discharge. Compounding the problem is the lack of mechanisms to pay for the close monitoring that would help prevent these readmissions, even though, in the long run, such care would save us billions of dollars.

Ironically, these inefficient communication and funding systems exist at a time when the administrative costs associated with U.S. health care have never been higher. When Paul worked as a surgeon, his practice employed three doctors and three administrative personnel. Today, the same number of doctors requires eight office staff to stay afloat in the increasingly complex marketplace of private health care. According to Geoff, rising administrative costs result largely from insurance companies needing to find ways to differentiate themselves from one another, which they do by creating their own individual rulebooks. Physicians don’t receive payment for services rendered unless they abide by the particular rules of each insurance company to which they submit a claim; hence the need for so many office

staff. But, as Geoff points out, this means “we’re paying for paper shuffling, not medical care.”

Writing a Prescription for the Future of Primary Care

Given the extent of these systemic problems, one could justifiably respond with cynicism and despair. On the other hand, our society’s growing dissatisfaction with the current system could create the climate necessary to achieve meaningful reform.

Those who closely follow the political scene on Capitol Hill no longer hold out much hope that substantial reform will take place wholly (or even partly) through the intervention of our federal government in the coming months. While such large-scale reform may be necessary to achieve a financially sustainable long-term alternative to our current system, the absence of such legislation does not mean that patients and doctors everywhere must resign themselves to the status quo.

Fortunately, some physicians are already forging ahead in the direction they believe health care must head in the 21st century. Geoff, whose practice is committed to such progress, speaks passionately about the future of health care in this country, and the importance of reinforcing quality primary care as the essential foundation upon which any significant health care overhaul must be built.

One solution he cites is the integrated, physician-led health care system modeled by Geisinger Medical Center in Central Pennsylvania. Geisinger received extensive publicity this fall when it was hailed by President Obama as an example of a groundbreaking health care provider that delivers quality care at lower-than-average cost. Doing away with the piecemeal care (and payment system) that characterizes mainstream health care, Geisinger has created an environment in which teams of doctors work collaboratively. Instead of being paid for the quantity of procedures, office visits, or tests performed, physicians at Geisinger are salaried, and their raises are determined according to the health of their patients. Not surprisingly, this has led to increased quality of care for patients, lower costs for Geisinger, and higher retention of the organization’s health care professionals, who can feel good about the services

they provide their patients.

A similar, smaller-scale solution is the concept known as the “medical home” model of health care. In this approach, each patient has a primary care “home” where a team of health care professionals—physicians, nurses, dietitians, health educators, etc.—work together with the benefits of information technology to provide proactive, patient-centered care based on scientific evidence for what treatments work best.

Geoff explains the benefits of such an approach: “When I do an annual physical for a middle-aged patient with a chronic condition like diabetes, there are literally hundreds of factors that I need to consider. Do I even remember them all, much less have time to educate patients about their options, get their input as to what issues they want to address and how, and then implement them all? Not likely – especially when I need to get to the next patient in a few minutes.” By using computer support and less expensive health care professionals to help ensure that the needed clinical data is obtained and basic education provided, doctors can be more focused in working with patients to determine their health goals and how best to accomplish them. “We’ve started developing the infrastructure for providing this kind of care, and it is gratifying to see how energized the staff and patients are becoming,” reports Geoff. “Unfortunately, the systems aren’t in place to pay for this kind of patient-centered team care and that is slowing our progress.”

Ultimately, such systemic change will require a major shift in the way we practice—and pay for—health care in the United States. Though many Americans resist the idea of a federal overhaul of the health care system, the costs of our current system continue to rise at a rate that make the need for some kind of reform increasingly apparent. Thankfully, forward-thinking health care professionals aren’t waiting for the government to fix the problem; they are already finding ways to improve the system from within. Their stories of success, however limited, give us reason to hope for a better future for U.S. health care.

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This I Believe: Health Care for All

by Wanda Thuma-McDermond

One always brings one's worldview to any explanation of assumptions and beliefs. Therefore, as I make this statement on why I believe in the necessity for health care reform in the United States, I will begin by explaining my world view from life experiences. Some may say these are biases, and that would be very true. However, dialogue on issues such as this is important so I say with sincerity: "This I believe: health care reform in the United States is a necessity to ensure better health care for all."

My life experiences encompass the following motifs: I grew up as a "missionary kid" in Zambia so my worldview from the beginning was multicultural and international. My professional career choice was nursing and I received my degree at Goshen College, where my Christian commitments and Anabaptist leanings towards justice were definitely strengthened. Soon after that I worked in England for five years for the National Health Service (NHS), and I realized the NHS was not the evil of "socialized medicine" presented by some. Although I had worked most of my career as an "ER" nurse, for graduate work I chose a master's degree in community health nursing. I knew intuitively that emergency care is "Band-Aid" or tertiary care for many preventable problems. Alternatively, community and public health theory focuses on "upstream" thinking with health promotion, risk reduction, and primary prevention. Now as a nurse educator and as I research a doctoral thesis, I am drawn to social justice in nursing and health care, not as an esoteric concept, but as an impetus for action and reform.

Community and public health proponents have long claimed social justice as a historical and contemporary guiding framework for practice. Social justice, as a value for fair treatment to redress social inequities, is espoused by public health and world health bodies as a means to decrease health disparities (Krieger & Birn, 2000; World Health Organization [WHO], 2006). Health disparities, both nationally and internationally, are rooted in inequity and injustice, and impinge on the morbidity and mortality of individuals as well as communities. Consequently, the definition of social justice implies active involvement to ad-

dress and eradicate social inequities (Krieger & Birn, 2000). However, as one looks more closely at how to address eradicating social inequalities, one realizes that social justice is similar to distributive justice; to really eradicate inequalities, sometimes one who has resources now needs to share with another who may not, so that everyone is better off in the end. In other words, do I really need a CT scan to diagnose appendicitis just because we have the medical technology in my town, when the money saved from that test could probably be used to provide numerous basic immunizations for children without insurance in urban poverty?

But what is "health?" Is it just the absence of disease or pathology? Norman Daniels in *Just Health* (2008) develops the idea of health as "normal functioning" with the absence of significant mental or physical pathology. Health care then becomes "promotion" and "maintenance" of normal functioning, and requires a team approach involving the individual as well as the health care community. As a nurse, I have always preferred a holistic definition of health that is inclusive of physiological, psychological, sociological, developmental, spiritual, political, ethical, and economic factors. Additionally, if I believe health is a human right, and that fair and equitable health care is possible for all, then health, health care and other factors affecting health are of "special moral importance" (Daniels, 2008).

If there is an ethical imperative to health, then there should be health care reform in the U.S.. Recently as I have read analyses of social determinants of health - that poor social and economic circumstances affect health throughout life, and therefore social determinants of health account for the majority of health disparities (Daniels, 2008; Institute of Medicine, 2009; Wilkinson & Marmot, 2003), I am more than ever convinced that poverty produces poor health. I am also more than ever convinced from these studies that the U.S. does not have the best health care system in the world. I think we have no moral leg to stand on in the U.S.

if we brag about our medical technology yet cannot guarantee health care to all citizens.

So what does all this mean to me on a personal basis? If I say I am a Christian, do I really believe Micah 6:8 or Matthew 5, and what it means to live that belief? How do I work for social justice and health care reform? Do I work for universal health care coverage in the U.S. as one step towards fair and equitable health care for all? Yes, I believe some form of universal health coverage is necessary for health care reform. I believe universal coverage would primarily decrease health disparities plus help mitigate the fear and anxiety of those without access to health care. Ultimately, better access and decreased health disparities should make for a healthier nation. This I believe: A healthier nation with health care for all is an ethical imperative; therefore I will support health care reform.

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A Quest for Wholeness and Compassion

by Kathy Lehman-Schletewitz

It should go without saying that health care is a basic human right. Every civilized country has the responsibility to see to it that its citizens receive basic medical attention. When we take into consideration the full gamut of choices available to Americans, be it private insurance, Medicare, Medicaid, community clinics, the Veterans' Administration, we find that every American has access of one type or another to health care. The question is: how is that care delivered, in terms of quality, timeliness and human dignity?

I've worked at a county hospital, a Veteran's Administration hospital and various nonprofits and religious institutions. The government-run hospitals extrude hundreds of patients at a time through a byzantine system involving mind-numbing regulations and soul-killing wait times. The message is clear: if you are an important person with money you won't have to take all day to get your antibiotics, but as it is you are an inconvenience to the civil-service workers who have to deal with you. This is not medicine practiced with Christian compassion.

The current climate in medical care is to move away from Christian values and specifically make people more dependent on government and less on each other. For example, I live and work in a state that highly regulates the delivery of health care. In my practice, I must respect the confidentiality of reproductive issues in patients as young as 14. This means a 14-year-old girl who comes to me to be treated for a sexually transmitted disease given her by her 18-year-old boyfriend can expect that I will give her a prescription for an antibiotic, and not enlist the help of her parents in making sure she picks up the medication, uses it correctly, sees to it her boyfriend is treated and takes steps to make sure this or something worse does not happen again. An atmosphere of mistrust between young people and their parents is reinforced. Instead of being able to help find healing for a family, I am complicit with the state as part of the breakdown of the family system.

In addition, Christians can and should bring their unique perspective to end-of-life issues. Fully one-half of a person's lifetime medical expenses occur during the last three years of life. If the last several days to weeks of that life are spent in the intensive care unit, on a ventilator, getting drugs to try to keep a failing heart beating, treating the inevitable complications of heroic life-sustaining efforts, the cost is staggering. More important than the monetary outlay is the emotional price paid on the part of friends and family when a loved one undergoes a frightening succession of more and more invasive procedures to delay the inevitable.

When the secular world gets hold of end-of-life questions, there are two fears: that we will regret not having done "everything" to save a loved one's life, or, conversely, that an accountant will decide the worth of life in terms of dollars and cents. The result is a frantic family demanding that "everything be done," causing a tremendous expenditure of resources for the same ultimate outcome.

As Christians we understand that death is not something to be put off at every cost, but a natural transition from this life to the next. Death can be welcomed as relief from pain and entry into an eternity with our Savior. The last few days of a person's life do not need to be a firestorm of technology, but can instead be a peaceful time of saying last goodbyes.

The growing prominence of giant, centralized medical payers breeds mistrust in the system, which causes a chain-reaction that only worsens the problem. For instance, recently the U.S. Preventive Services Task Force came out with recommendations on mammograms: advising against routine mammograms in most women under age 50, and then only every other year. This caused an immediate backlash on the part of a suspicious public, accusing government penny pinchers of putting women's lives at risk to save some money. Now, these recommendations are actually nothing new: for years, I have been explaining the

rationale behind this to my patients when we talk about preventive health care. We talk about relative risk, the potential advantages and disadvantages of starting mammograms earlier than 50, or doing them more frequently than every other year. Coming from me, my patient understands and accepts the explanation, and we together can come to a conclusion that makes sense to us both. We can save money on unnecessary procedures, avoid excessive radiation exposure, and still be sure we're pursuing excellent preventive care. Coming from a giant centralized entity, there is an immediate backlash of accusations of a cavalier attitude toward women's lives in the interest of economics. The upshot will be laws passed that require payment for early and frequent mammograms. They will be medically ill-advised, but politically necessary. Medicine becomes that much more expensive and harder to obtain. Resources are wasted that could have gone to establishing a more equitable system for all.

Recognizing the infinite value of every human being, as Christians we must see to it that people made in the image of God are granted dignity. What can we do as Christians to ensure that affordable health care is available to all? We can call for the return of health care to local control back to the communities who use it. We can resist being shut out of the dialogue and maintain a voice in medical decision-making, regarding issues like end-of-life care, family systems, communication, and resource allocation. We must return to the values of honesty, trust, caring and appropriate stewardship of resources. As the politicians, the lawyers, the insurance companies and the drug companies all jostle for their piece of the pie, we can remind them that health care must be, in the end, a quest for wholeness and compassion. Used wisely, our current resources are more than enough to deliver medically appropriate care to every citizen.

Kathy Lehman-Schletewitz is a family practice physician working in Southern California and serves as a deacon at New Community BIC Church, Pomona, Ca.

Malpractice—Neither Peaceful nor Practical

by Nancy Crowder Huerter

I've had a good deal of experience on many sides of the physician/patient relationship. I trained and practiced several years as a physician, sometimes in consultation to improve the relationship between a family and their child's physicians. I developed a chronic illness that took years to diagnose and, for over 20 years, have spent a lot of time as a patient with multiple diagnoses. I have several physician friends and am married to a radiologist in a private practice group; otherwise, I have no health care connections to influence me and no current employer or patients to avoid offending.

Everyone should have access to good health care, not because it's a right, but because it's a need, and those of us who can help will be diminished if we don't respond to the need with love. Healing the sick was extremely important to Christ. It's tragic when illnesses destroy a family's financial stability, and it could happen to any of us. It's also tragic when people spend their time complaining about politics instead of doing what they can to make a difference. We are all responsible to help make this work.

Our health care system is very cumbersome and complicated. The ramifications of most any intervention are unpredictable. There will never be agreement on how to draw lines between reasonable costs and care and extraordinary ones. Most of us would like our physicians to order only reasonable tests on everyone else, but cover every possible angle when we're the patient. Having major decisions about health care restructuring dominated by big business and polarized politics does not bode well for patients or doctors. We must find a way to do what's best for the patient, both individual and collective. One huge cost (monetary and human) not addressed at all in the current legislation is medical malpractice.

In Pennsylvania, malpractice is a huge problem in terms of frequency, magnitude of awards and settlements, and as the cause of significant decline in physician morale. Doctors have left our state and young doctors choose not to come here because of our medical liability climate. The costs of malpractice cases and insurance contribute

in many ways to our total medical costs. While physicians live in fear that any patient encounter could result in an attack on their character and reputation, they will order more tests to cover more bases than necessary, and will be less fulfilled, focused and effective in their profession. Cases often drag on for years, causing serious emotional strain for physicians and their families. A distracted, anxious physician can't function optimally. Malpractice lawyers tell clients they're not suing their physician, but the insurance company; that's not how it is for the physician.

Most physicians choose medicine because they truly care about helping people. Their temperaments are not well suited to defending themselves or their profession. Many physicians I know have been named in malpractice suits. They can't share details with anyone, so they suffer fear, shame, depression, and self-doubt alone, isolated even from their colleagues, most of who have had similar experiences. Most physicians I know give all they have to give, doing their best for their patients. Knowledge expands so rapidly that, even in a specialized field, no one knows it all. But despite relentlessly demanding schedules and human frailty, doctors are expected to always be right and never make mistakes. Additionally, many American patients feel entitled not just to health care, but to health, and when life doesn't work out that way, many feel someone should pay.

We have a curious mix of respect and disdain for our physicians. We want so badly for them to be able to fix us, we unconsciously give them superhuman powers and have unreasonable expectations of them. And yet we love to "cut them down to size." Who hasn't talked with glee about having proved their doctor wrong? Upset or disgruntled patients sometimes threaten their doctors with lawsuits to get what they want. It is especially heart-rending when Christian patients sue Christian doctors who have loved and cared for their families for years, particularly in a denomination with peace as a core value. We don't need

legislation to make a difference. All of us can show appreciation for care we receive, respect for physicians as people who trained hard to help make our lives better and routinely give us their best advice and care, acknowledge their humanness and fallibility, and not blame them for our illnesses. Our culture has become hypercritical of many professions, but in medicine, we're all paying a huge price for it. As it becomes more difficult to practice effective medicine, more of our most caring physicians will leave medicine, and young people who might have chosen medicine as a career will look for other ways (or places) to serve.

There are, of course, physicians who are grossly negligent or even criminal in their behavior. There must be a system for dealing with those problems, but that is not what most malpractice suits are about. As a psychiatrist, I was threatened with lawsuits (and worse things), but fortunately never named in one. As a physician/wife-of-physician patient, I've been treated better and worse than other patients—with everything from careful, thoughtful compassion to cavalier bravado, suspicious snobbery and paternalistic brusqueness. I've had exemplary care, good care, and frankly negligent care with serious omissions and dangerous commissions. My children and I could have died from medical misjudgments, mistakes and accidents. But I might not have lived to have children without the wonders of modern medicine. Any intervention has risks; not intervening has risks—that's how medicine is; that's how life is. We try to do no harm, and if we were God, it would work—but we're not, and it doesn't. My practice was not without mistakes, but I gave my patients my best. My doctors are doing the same thing. When it comes to malpractice, I won't be throwing any stones or taking my brother or sister to court.

Nancy Huerter taught and practiced child psychiatry at Hershey Medical Center, consulting at Harrisburg Institute of Psychiatry and University Hospital Rehabilitation Center. She has been active in music and children's choirs at Elizabethtown (Pa.) Brethren in Christ Church and is in her last of 14 years homeschooling her two children.

The View from Both Sides

by Lynsey Davis Granger

Health care is a hot topic right now. There is much debate and discussion around the country. I have heard a lot about the subject and I have listened to both sides of this argument. The big question today seems to be whether or not the government should provide, or help to provide, a national health care system—a system that would allow everyone the ability to afford quality health care.

I have been on both sides of this issue. Growing up, I was covered by health insurance through my mom's employer. This was a huge blessing since I had three major surgeries during my teenage years. Without that health insurance I would be in a wheel chair today. Throughout college I continued to have access to her policy. Three months after graduation, I was no longer covered and went without coverage for almost a year.

My first years of marriage, I lived overseas in Thailand. There we had access to low cost health care that was excellent and affordable (even for the national population, which is saying a lot considering Thailand is part of the "developing world"). Upon returning to the U.S., I was an adult, married and without health insurance. I had to seek employment that would give me benefits immediately. I found such employment and was able to have my first child, who then qualified for the Children's Health Insurance Program. Thankfully the insurance company did not consider pregnancy a pre-existing condition, which some companies do if you are already pregnant before getting a plan with them.

We moved overseas again, this time to Hong Kong, a country of seven million with free government-provided health care for every resident. Emergency care costs are minimal if you don't go through your regular doctor first. Even as an expatriate visa holder, I had access to high quality health care via the government system. Yes, it was a very different system than what is common in the States, but it was more than adequate. I gave birth to our second child there (via C-section, with a hospital stay). At no time was my health at risk. In fact, my husband spent more on taxi fare to visit me than we did for my entire stay of three days (the total was \$26 U.S.) Two

days after, my daughter had to be readmitted for jaundice and her stay in the NICU was completely covered for \$13 U.S..

Upon our return to the U.S. we were once again without health insurance or full time employment that would provide such coverage. We were headed to Massachusetts for graduate school. I applied for the state health insurance program. Our family of four with one on the way all qualified. During our time there, the state passed a law that every person had to have health insurance. Those already on the state program would stay, but everyone else had to secure a plan either through their employer and/or the state. If the employer's insurance was too costly there was low cost insurance provided on a sliding scale based on income. No matter the income level, everyone could afford health care.

I hated moving from Massachusetts. We took a job in Texas where our employer did not offer health benefits as part of our compensation package. We were without insurance for more than a year with four kids age 4 and under. Thankfully, our children qualified for the CHIP/Medicaid program and were covered. But neither I nor my husband had any health insurance.

I have experienced first-hand how government run health plans work. They are no different than private companies. None of my care was different in any way from other patients who had private insurance. I had no co-pay, no extra charges and an incredible prescription plan (generics were free, and name brands were \$1). I knew that no matter if it was a cold or major surgery I would have great medical care by well-trained doctors.

Now, as I listen to the discussions and debates I hear a lot of people shutting down the idea of any government intervention for health care. What I hear is people afraid of change and something different. People fear that things will be taken away from them, or that they won't get the same care they once did. What some don't see is what this would do for so many without any health care.

If I need to go to the doctor it will cost me around \$80-120 just to walk in the door. That does not include prescriptions, tests or a follow-up appointment. That scenario is workable with a decent salary and some disposable income. What about those who are making less than what I did, or are unemployed? What about those who had insurance, are being treated for an illness, lose their jobs and insurance and can no longer be treated? Or get another job, but new insurance won't pick them up because of a pre-existing condition?

My biggest concern—my biggest question—is why is America so far behind the rest of the world on this issue? If Thailand can have a system in place, if Hong Kong can do it, if all of Europe can manage to provide quality health care for its citizens why can't America do the same thing? We all need health care that is affordable. I think that we all need to take a step back and understand what both sides of the argument really mean. As a Christian, it is my hope and prayer that any person can get the health care they need without having to worry about the cost.

Lynsey Davis Granger has been in youth ministry with her husband for more than 10 years, most recently in Texas. She grew up in the Grantham Church where she is still a member.

Dealing With the Stigma of Mental Illness

by Jeremy Ritch

I know a lot about mental health and mental illness. Not only does my wife work in the mental health field but I was diagnosed with bipolar disorder about three years ago. At first I was scared to face the truth about it because of the negative stigma associated with these types of disorders. People tend to equate mental illness with images of shock therapy, straightjackets and serial killers. They are uncomfortable because they associate mental illness with instability. These stereotypes have caused many people to avoid diagnoses or hide them to prevent alienation.

Millions of people suffer from some form of mental disorder and are normal members of society. While there are more serious cases that require extensive treatment, most of us are able to manage with medication and other coping skills.

In the church it is sometimes even harder to talk about mental illness. There are many false claims about mental illness and what causes it. Many times Christians simply ignore the health issue and look for a spiritual reason for a person's condition. Studies have shown that when Christians approach their pastors about a mental health problem, they are often told it is merely a spiritual matter. One study showed that 32 percent of the time this was the case.¹ It is also disturbing to me that people often consult clergy more than doctors when it comes to depression, anxiety, paranoia and other such disorders. While spiritual counsel is an important part of Christian life, it is important to realize that mental illnesses are often caused by chemical imbalances and require treatment by a doctor.

Of course, it is always a good idea to seek spiritual help as well to aid in the healing process. Spirituality and the mind are often a confusing mixture; therefore, science and faith are both very important in sorting things out. The key, however, is not to dismiss a doctor's diagnosis and assume the issue is a demonic or spiritual matter. We must gather as much information about the person's condition before deeming it an is-

sue of faith. The church needs to continue to learn about mental health and the ways it can be a positive force in the pursuit of treatment. Mental illness can be a lifetime thing that can take over a person, and without a loving, nurturing community to help, mental illness can kill. We can no longer assign people with mental illness to institutions and forget about them. There is too much research on causes and effective treatments and supports to look the other way.

Luckily many in the church are aware of the issues surrounding mental illness and are doing something. Places like Paxton Ministries in Harrisburg are prime examples of Christian organizations that recognize the importance of both spiritual and psychological healing, participate in the recovery and daily lives of people with mental illness and advocate for better treatment. In addition, more churches have outreach programs to people who suffer from mental health problems. And there are many Christians with a diagnosed mental disorder who live full lives. We work regular jobs, have families, and many of us serve God in ministry every day. We are creative, passionate and have a desire to have lives that are filled with joy despite our suffering. Though there are no cures or concrete causes for many of these disorders there are effective treatments, and while medicines can be the most effective way to manage the illness, the love and support of a Christian community are equally important.

For me, having bipolar disorder has been a blessing and a curse. I have found the cause of years of depression and manic behavior. I am able to empathize with other people who share my illness both as a pastor and a friend. My eyes have been opened to the harsh treatment people with mental health issues often endure. I have become an advocate for not only those with disorders but for those who treat them. On the other hand, I still suffer. These days my good days outnumber my bad, but the dark times still are there. To feel the weight of



depression crushing down is not something I wish on anyone; it is painful and I often feel helpless. Fortunately, for me and many others like me who know Christ as our Savior, we know that one day we will be healed. Our darkness will cease and our pain will go away. That hope can lift me from a deep depression or a manic state. The idea that God loves me the way I am is why even when it seems hopeless I know he will be merciful. So while mental illness is my diagnosis it does not define me. I am not bipolar; rather, I am a loving husband, a pastor of a church, and most of all a beautiful child of God.

1 "Church Pastors Dismiss Mental Illness": livescience.com/health/081015-church-mental.html

Jeremy Ritch directs Holdfast Ministries in Harrisburg, Pa, and attends the Harrisburg BIC Church.

Zambian Brethren in Christ Church Members Support Those with HIV and AIDS

Every three months, people with HIV and AIDS in rural Simwaanda, Zambia, take a two-day journey to get checkups and refill their supply of anti-retroviral medication.

To get to Choma, the closest place to obtain treatment, they hop aboard a truck or take a bicycle ride of 45-kilometers (27 miles) on a one-track cow path to the paved road. They may wait there for hours until a bus or truck driver comes by and is willing to transport them to Choma.

“This could easily take the better part of a day,” said Kathy Fast, an MCC representative in Zambia who visited the area last summer. “Thus they tend to arrive at the clinic after closing time. This means they have to sleep at the gate or find someone to take them in, then head to the clinic early the next morning and get on the next transport back to Simwaanda, hopefully by that afternoon.”

Although the anti-retrovirals, which stop the progression of the HIV infection, are free, drivers expect a payment. One HIV positive woman in another village works a full week for a neighbor every time she needs to raise \$3 for transport to the clinic. Meanwhile she leaves three seriously handicapped daughters behind while she works and travels.

Staying home would be easier and cheaper in the short term. Home-based care workers from Compassionate Ministries, an MCC-supported ministry, know this, so they encourage people to make the trip in spite of its hardships.

If the patients do not take their medicine regularly, they will get sick, even sicker than they were before they started anti-retrovirals, said Maureen Mundia, coordinator of Compassionate Ministries home-based care in an e-mail.

“Ever since I became a caregiver, I had nine cases where clients stopped their medicine and they all died,” Mundia wrote. “When it [HIV or AIDS] is not seen, they think they are cured and then stop taking

the anti-retrovirals. They fall sick and die.”

Compassionate Ministries’ home-based care workers are volunteers from Brethren in Christ churches, who minister to people in their churches and in their communities. The workers are trained by Compassionate Ministries through an MCC grant.

Since Compassionate Ministries began training workers in 2001, more than 200 people have been trained. The home-based care ministry is active in several dozen communities throughout the southern province of Zambia.

Through the training, the home-based care workers learn about the effects of HIV and AIDS and issues of stigma, which can cause families and communities to reject people with the disease. The workers use this information as they encourage people in their communities to go for testing and counsel families dealing with the disease.

“Not only do they give of themselves by going to visit ‘clients’ in their communities one or two days a week, but they also bring foods from their own gardens and home to supplement the diet of the HIV and AIDS clients,” Fast said.

Outside Leonard Sintumbi’s home in Simwaanda hangs a blanket, made by MCC volunteers in Canada or the U.S., and delivered by home care workers in 2006 when he and his wife were both very ill because of HIV. His wife died, but Sintumbi was able to get started on anti-retroviral medicines that year. Now he is well enough to farm and support his household of This kind of self-sustenance is important for people who have the disease, said Mundai. Often the onset of the disease causes people to lose much of their

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property. Recovering victims need to be empowered with financial support to start their own small-scale businesses, she said.

The blankets and AIDS care kits, which include a variety of hygiene products, help people to recover, thus breaking down the stigma held against people with the disease, said Fast. The gifts also introduce people to the church, said Ginwell Yooma, director of Compassionate Ministries. He accompanied Fast, her husband Eric, and a Brethren in Christ pastor from Kalomo on the trip.

“People have said that if this is what the church does for others, beyond themselves, they want to be a part of that church,” Yooma said.

The Brethren in Christ church has grown because of the work of the home-based care workers, Yooma said. Not only have their present congregations swelled in numbers, but new church plants have also taken place, he said.

Reprinted by permission from Mennonite Central Committee. More information about MCC’s HIV/AIDS work in Zambia appeared in the Winter 2009 edition of In Part. Check it out at BIC-CHURCH.ORG/INPART/2009WINTER/INPART_WINTER09.PDF

BOOK REVIEW

Just a Thought Away

by Harriet Sider Bicksler

During the last months of my mother's life as her cognitive function declined, I often thought about what was happening in her brain that would help her remember certain things from long ago but not something that happened the day before. At the other end of life, watching my grandchildren, I've been intrigued with the development of language in young children and how their brains are able to process what they observe and experience to make the connections between words and sounds and what they mean. Truly, the brain is an amazing thing!

My Stroke of Insight: A Brain Scientist's Personal Journey, by Jill Bolte Taylor, is a book about the brain. A neuroanatomist, Taylor had been working at the Harvard Medical School doing research on the human brain when she suffered a major stroke in the left hemisphere of her brain in December 1996. The book is the story of how she experienced the stroke and recovered completely; it is also a layperson's guide to how the right and left hemispheres of the brain work and a story of self-discovery and personal choice following a life-threatening illness. It was literally and figuratively a "stroke of insight."

The most interesting parts for me were Taylor's account of the first minutes after the stroke itself and her analysis of the functions and characteristics of the left and right hemispheres of the brain. She describes the morning she woke up feeling odd and slowly came to the realization she was having a stroke:

I felt as though I was suspended in a peculiar euphoric stupor, and I was strangely elated when I understood that the unexpected pilgrimage into the intricate functions of my brain actually had a physiological basis and explanation. I kept thinking, *Wow, how many scientists have the opportunity to study their own brain function and mental deterioration from the inside out?* My entire life had been dedicated to my own understanding of how the human brain creates our perception of reality. And now I was ex-

periencing this most remarkable stroke of insight!

As she struggled to "orchestrate her rescue," she somehow managed to make a phone call to a colleague at work and communicate, albeit in a very garbled way, that she needed help. And then, "Even in this discombobulated state, I felt a nagging obligation to contact my doctor. It was obvious that I would need emergency treatment that would probably be very expensive, and what a sad commentary that even in this disjointed mentality, I knew enough to be worried that my HMO might not cover my costs in the event that I went to the wrong health center for care."

Because the stroke damaged the left hemisphere of her brain, Taylor learned to rely on her right brain. She gives this easy-to-understand explanation of some of the differences between the two hemispheres: "Just opposite to how our right hemisphere thinks in pictures and perceives the big picture of the present moment, our left mind thrives on details, details, and more details about those details." After the stroke, she consciously chose to reinforce what she had experienced when her right brain took over as her left brain healed: "My right hemisphere is all about *right here, right now*. It bounces around with unbridled enthusiasm and does not have a care in the world.... In contrast, my left hemisphere is preoccupied with details and runs my life on a tight schedule. It is my more serious side.... It defines boundaries and judges everything as right/wrong or good/bad."

Taylor also gives valuable advice from the point of a view of a recovering stroke victim to caregivers about what is and is not helpful and she praises her mother's excellent care. She spends a fair amount of time at the end of the book describing how she discovered that her "deep inner peace" was just a deliberate and intentional thought away. Many Christians would probably be uncomfortable with the emphasis she puts

on relying on personal rather than divine power; however, her experience is a good reminder of how we can choose to think differently and how something as potentially devastating as a stroke can be a source of great insight and emotional healing.

Editor's Notes

Subscription renewals: By now you should have received the subscription renewal letter for 2010. Thank you for responding with your renewals and extra contributions to help sustain the ministry of *Shalom!* The basic subscription rate remains at \$15 per year for four issues.

Upcoming topics for 2010:

- Spring, "Heroes"
- Summer, "Human Trafficking and Exploitation"
- Fall, "Movies"

Please contact the editor if you or someone you know would be interested in writing on any of these topics.

The More Things Change, the More They Stay the Same

This year, 2010, marks the 30th anniversary of the publication of the first edition of the *Peace and Justice Newsletter*. Five years later, in 1985, the name and format was changed, making 2010 also the 25th anniversary of *Shalom!* To mark those significant milestones, each edition of *Shalom!* this year will feature some relevant reprints from those 30 years.

The first edition of the *Peace and Justice Newsletter* was published in January 1980. It was a simple typewritten and copied one-page piece and began with this sentence: “This is an occasional newsletter for those who participated in a Consultation on Peace and Justice Education at the Grantham Church on November 15-17, 1979.” Edi-

torial responsibility for the first year and half was shared by John Stoner and Harvey Sider on behalf of the Brethren in Christ Church’s Commission on Peace and Social Concerns. I took over as editor with the June 1981 edition.

In 1985, a denominational restructuring created the Board for Brotherhood Concerns which absorbed the responsibilities of the former Commission on Peace and Social Concerns. The board changed the name of the Peace and Justice Newsletter to *Shalom! A Journal for the Practice of Reconciliation* and decided to focus each edition on a single topic. The first edition in the new format was published in Winter 1985 and was on aging, entitled “Do Not

Cast Me Away When I Am Old.”

Twice before in the last 25 years, *Shalom!* has focused specifically on health care—in Fall 1994 (“Just Health Care”) and again in Spring 2005 (“Health and Wellness”) and two additional editions have highlighted mental health issues. The Fall 1994 edition was published in the midst of the Clinton administration’s failed attempt to achieve health care reform in the U.S. Reading my editorial introduction again more than 15 years later, I was struck by how I almost could have used it again this time and no one would have known the difference! Check it out on the back page.

Excerpted from Shalom!, Spring 2005

Treading Water

By Patrick Cicero

A few months ago, a couple came into my office because their house was being foreclosed. When I inquired about why they had missed their payments the answer was simple: James got sick and they could not afford for him to go to the doctor; because he did not get primary medical attention, his situation worsened and he ultimately had to have emergency surgery that laid him up for month. James lost his job and without it they were unable to keep up with their mortgage payments. Because they did not have health insurance, they also faced an astronomical medical bill. Because they did not have health insurance, James could not get the primary care that he needed to diagnose his illness. Because they did not have health insurance, James and Ann faced the potential loss of their home.

I have heard this story countless times and it varies very little. James and Ann are like millions of other individuals in the United States. They both work full-time

jobs earning barely above minimum wage. They work long, hard hours which means that they are too “rich” for Medical Assistance (the name for Medicaid in Pennsylvania – the federally subsidized health insurance for the poor), but also do not receive health insurance benefits from their employers. They are the working poor and they have nowhere to turn when it comes to health insurance. It is only getting worse for people like James and Ann....

Though the lack of health insurance hits the poor particularly hard, they are not the only ones who are treading water; many middle class families are one catastrophe away from being in the same situation as James and Ann. Think about it. Two-thirds of all Americans get their health insurance from their employer or their spouse’s employer. What happens when the employee providing the health insurance gets sick, really sick, so sick that they cannot go to work for months? How long will the em-

ployer allow the employee to stay on the health insurance plan? Federal law protects employees for a modest period of time, but there is a limit. It is a Catch-22. A person who is too sick to go to work can’t get the treatment they need because they lost their health insurance when they lost their job. The unfortunate reality of health care in this country is that until and unless we develop a system where one’s access to basic medical care does not depend on the generosity of one’s employer we are all treading water and hoping for the best.

When this article was written, Patrick Cicero was working as a legal aid attorney. He is now a senior law clerk to Judge Sylvia H. Rambo of the United States District Court. He and his family attend the Harrisburg (Pa.) Brethren in Christ Church. You can read the entire Spring 2005 edition from which this was excerpted at

BIC-CHURCH.ORG/CONNECT/PUBLICATIONS/SHALOM/2005/SPRING2005.PDF.

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Editorial reprinted from the Fall 1994 edition.

Just Health Care

Five years ago, our son broke his arm. It was a relatively bad break, requiring general anesthesia, an orthopedist and an overnight stay in the hospital. Two months and \$3,000 later, his arm had healed. Today he suffers no ill effects of the break. Our health insurance covered most of the cost. Small scale though it was, our emergency encounter with the United States health care system illustrates several things.

First, even for relatively simple things, the cost seems outrageously high. In Derek's case, many people who had to be paid were involved: x-ray technician, our family doctor, an orthopedist, an anesthesiologist, nurses, other support personnel, paramedics, bookkeepers and other paper handlers.

Second, because we had insurance we took for granted that we could and should do everything necessary to make sure his arm was treated properly. Had we been responsible to pay for everything ourselves, we may have asked more questions and made choices about what we could afford (for example, we may have decided we didn't want him to stay overnight in the hospital).

Third, we were treated well. Because we were able to pay, no one made us feel like second class citizens. Fourth, we had easy access to state-of-the-art health: with 20 miles of our house there are six hospitals, including a university teaching hospital.

Contrast our situation with people who

have no insurance and don't qualify for medical assistance, or who live where access to health care is a problem or in underdeveloped countries with few hospitals and doctors and primitive or non-existent equipment and medicine.

Too much of the argument over health care reform in the United States has come out of self-interest, with not enough regard for justice for everyone else. We who already have access to good health care want to continue to be able to choose and we don't want to risk losing any benefits. Never mind those who have little or no choice and often cannot afford even basic health care. At what point will we agree to give up something in order to get something better, in this case, an equitable distribution of health care resources to all people? Justice isn't the only issue in health care, but I think it ought to be a central one for Christians.

This edition of *Shalom!* was conceived in the context of the health care debate in the United States but it goes beyond the question of which health care bill is best. The broader scope of health care issues includes the story of one family's experience with catastrophic illness and the Canadian health care system, and a comparison/contrast of North American health care with that available in underdeveloped countries.

Underlying the issue is the question of the role of Christians in health care.

In an article in *Christianity Today*, former U.S. president Jimmy Carter said: "Unfortunately, the debate over health care reform has too often been dominated by concerns about money and privilege. People of faith have not yet succeeded in putting moral issues into the center of the debate. But churches have a wonderful opportunity to make their voices heard and their actions count" (June 20, 1994, p. 30). Specifically, he calls for the church to focus on prevention, justice and partnership.

Carter might also have cited the example of Jesus as motivation for Christian involvement in health care issues. Jesus performed many healing miracles, and cared about sick and hurting people, whether their illnesses were physical, emotional or spiritual. His entire ministry demonstrated concern for health.

Jesus, however, did not limit his concern to those who could afford health care nor were the desirable members of society. His healing of the woman with the bleeding disease showed that even those with few resources and considered unworthy by society's standards deserve quality care. Should we do any less?

Harriet S. Bicksler, editor