



TRUE COMPETENCE
in MEDICINE

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PRACTICING BIBLICALLY-BASED
MEDICINE IN A FALLEN WORLD

JAMES T. HALLA, M.D.

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INTRODUCTION

Christian physician, you may remember the Nike ad campaign of several years ago when Michael Jordan was at the top of his game and a household name. The theme of the campaign was simple – *Be like Mike!* The campaign was a winner because every kid in America, both young and old, who played basketball, wanted to *Be like Mike*. Are you satisfied with the way you practice medicine? Does what you do differ from those physicians who have accepted the culture's standard for practicing medicine, and if so how?

As Christian physicians we have Someone Whom we can aspire to be like, both professionally and spiritually. We can be like Christ. He chose Luke, the beloved physician, to write the most complete gospel, and to write Acts, a sequel to his gospel which is a missionary history book. Apparently, the Holy Spirit considered Luke's medical expertise important and made use of it. Luke was a medical doctor who served God first. He was more than a doctor who happened to be a Christian. He was a Christian who was also a physician.

The book in front of you is not about Luke per se, but it is about the faith that he followed. It was that faith that made him stand out from the pagan doctors of his day. His medical expertise gave credibility to the acts of Paul when he healed those who were sick. It is from Luke's observation that we have confidence that Paul really was bitten by a poisonous viper after his shipwreck.

Just as Luke's testimony was used by God to validate and relate the reality of faith to the world, your testimony as a physician can point your patients to the reality of the hope that is found in God's Word. That is the faith that I want to explore with you. In the pages ahead you will see how your faith can become a vital part of your practice. Let me challenge you to consider how your faith can influence the way you practice medicine as you speak to your patients. I am sure that you have thought of how God wants you to be different from the medical world that does not profess the faith that you possess. By God's grace I have found some ways that can help you do just that. Let me begin by telling you about Mary. I will present a "before" and "after" picture of her. Next I will describe *what* was done, *why* these things were done, and then focus on the *results*.

I. THE CASE OF MARY

Mary, a 62-year-old married white female and retired nurse, came to the office at the request of her family physician because of her continuing complaints of pain, functional limitations, and seemingly downhill course. The “before” picture is her condition at the initial visit. The “after” picture is her condition as recorded over the next several visits.

A. THE “BEFORE” PICTURE

Mary’s complaints of fatigue and pain were best described as polyarthralgias, polymyalgias, and axial pain. She graded fatigue as 10/10 and pain as 10/10. These symptoms had worsened over the previous two years and there was greater difficulty getting around.

Additional history included complaints of neck and shoulder pain occurring after an injury years ago. Fatigue of varying degrees had been a complaint for 20 years. She said she had a past history of hepatitis B, hepatitis C with antiviral treatment several years ago, and periodic complaints of a flu-like illness.

She summarized her situation by telling me that life was “the pits — to always be stiff and sore and having difficulty remembering things. I just don’t feel good.” Yet, in spite of her complaints, she considered herself relatively healthy until two years ago. It was at that time that she began to complain of fatigue and pain and eventually received a diagnosis of fibromyalgia (FM). A number of medications had been prescribed, including non-steroidal anti-inflammatory drugs (NSAID) and prednisone, but she reported no helpful response.

She came to the office on prednisone and Zolof, the latter prescribed years ago in hopes that it would “make me feel better.” She said it hadn’t. She painted the picture of being in a black hole and having no way out. Her fatigue and pain were constant reminders of her predicament. She said she was depressed and discouraged, and that only aggravated the fatigue and pain. She blamed her bad feelings and the “black hole” on the antiviral meds and “everything else,” foremost of which was her unwanted hepatitis C and its treatment.

I asked her what aggravated the fatigue and pain. She answered, “It is thinking and wishing I could do things that I have always done in the past without so much trouble — and when I get upset, which has been happening more lately.” She then told me that she was bitter, and irritated at everything and everyone. “That only makes things worse,” she said. She described her situation as a “living nightmare” that began when she was diagnosed as having hepatitis C. She wanted out. She told me she reasoned this way: “I hadn’t asked for the infection in the first place, it happened on the job, I couldn’t get the insurance companies or workman’s compensation to help me, and I have to suffer for someone else’s mistake. Life is UNFAIR.”

“I am used to doing and going, but now I don’t feel like it. I can’t do anything without effort and I can’t do everything I need to do. I am down in this big black hole with no way out. I still go on, but it is harder to do so and it is hard on my husband. My whole life is a mess.”

“What do you mean by ‘down’?” I asked. She told me that she felt bad, didn’t see any hope, was tired of coping and not getting anywhere, and waking up with the same problem every morning.

During that first interview she cried. She told me about her relationship with her mother and her children. She had been married for 29 years, as an unbeliever to an unbeliever, which ended in divorce. Consequently, all of her children and her mother were angry at her and one son remains so to this day. She retired two years ago because she just didn’t feel like going on — “I was worn down, tired, and hurting.” She had married a Christian five years prior and financially could retire. She said that she was a believer, but that “It is still hard to be hurting, to be separated from some of my children, and to try to figure out what is going on.”

She thought of the changes in her life as all bad with no redeeming purpose whatsoever. She believed her occupation (nursing) had harmed her and that the insurance companies had let her down. She told me she was bitter but that she was not convinced that her response had any relationship to her physical problems.

On physical examination, she had a normal non-rheumatic examination including her skin, cardiopulmonary systems, abdomen, and neurolog-

ical system. On her musculoskeletal examination, she had no synovitis, effusions, contractures, or proximal/distal muscle weakness. She did have pelvic and scapular tilts, scapular crepitus (crunching type sounds on the movement of her shoulder blades) with reduced scapular excursion, and paraspinal muscle spasm.

I worked hard at trying to understand her, her problems, and how her approach had failed to offer her any relief. I was moving in the direction to give her hope by establishing a working relationship with her. In doing so, I tried to meet her where she was – to understand her life and struggles as she was experiencing them. I knew she had come to me for help in the physical realm. She was hurting and had bodily problems. But I responded to her as more than a person with a “body problem.” I did address her physical problems, but I understood her as a whole person.

I discussed her history and the physical findings with her. I explained to her that I had two pieces of the diagnostic puzzle: her history and her physical examination. I had detected no evidence of an inflammatory, rheumatic disease, but noted that the prednisone could influence the degree of inflammatory changes in her body. Two other pieces were needed in order for me to complete her clinical picture: blood work and radiographs.

On this initial examination, I found ample evidence for soft tissue rheumatism. I conveyed to her that it was very likely that these abnormalities were longstanding and producing a mechanical inefficiency of her body that was aggravated when muscles were tight and tense. I asked her to read some papers that address pain and rheumatic conditions.¹ I briefly explained the differences between arthritis and rheumatism and encouraged her to read the handouts.² I asked her to read the first four and answer the three accompanying questions. I gave her those papers with the goal in mind of helping her to think biblically about her problems.

I also gave her an exercise program consisting of appropriate exercises (in her case, shoulder shrugs designed to correct her specific soft tissue abnormality) and switched her to a NSAID. I began to taper her prednisone. She left, agreeing to read the papers, do the exercises, and return for a follow-up appointment.

B. THE “AFTER” PICTURE

She returned for her second visit reporting that she had stopped her prednisone with no change in symptoms and no evidence of joint swelling. She said she still hurt but she was “not any worse.” She had begun to read the “Pain Papers” and she understood what she had read. She was thankful that someone had taken time with her and given her information to read. She said she now understood at least four facts: (1) that pain is one problem and her response to it is another; (2) that her response to her situation, including pain, may actually be playing a role in why she hurts; (3) that based on the information she had read, she described herself as a “road runner” (on the go, trying to make things happen as she sees fit); and (4) that she didn’t know what “victory” was.

These observations, and the fact that she was willing to share them with me, indicated that she had made some movement along the lines of rethinking her situation and how she got there. During the visit she became teary-eyed and told me she was an embittered lady. Life had been unfair to her and she tried to right those wrongs but had been unsuccessful and had suffered the consequences.

She told me she was bitter and even angry about a number of things which caused her to hurt more. She told me she wanted to be honest with herself, though she hadn’t in the past. I asked her if she had any plans on how to do so. She said “no.” I asked her if she had any plans to address her bitterness and she said she didn’t. She was not crying; rather she was alert and attentive.

We discussed her laboratory results and her radiographs. These were negative or normal, all of which confirmed that her problem was soft tissue rheumatism. She had begun the exercise program and was taking the medications. I encouraged her to continue the reading and exercise programs, and asked her if she would read some Scripture, give feedback to me about what she had learned, and how she would apply it to her situation. She said “yes,” and I suggested Matthew 18:21-35 and Mark 11:25.³ She told me that she had gone this far with me and she saw no reason not to continue.

She came back for her third visit and reported a major breakthrough: “I am better because I am thinking better. I still hurt, but I understand more

clearly what is happening to me.” She graded pain as 5/10 and fatigue 7/10. I asked how this was so and in what ways. She pointed to Scripture: “I have been studying the passages you gave me.” She did not deny the reality of her physical problems: “I still hurt, but I am better. I am doing my shoulder shrugs. I can function even if it hurts. I am practicing being a good steward.”

She remained on Zolof. I had made no attempt to change it. She said she wasn’t sure why she takes it except that “it was prescribed for me and I am afraid to stop it.” It was a pleasure to see her smiling and bringing me up to date on these things. She said she was viewing life differently and that included both her physical problems and her response to them.

I saw her again for two follow-up visits and each time she graded pain as 2/10 and fatigue 7/10. She said her thinking was continuing to change and she brought several journal entries for my study. She is continuing her exercise program and losing weight, all of which are part of a good stewardship program. Now I see her about every four months.

At each follow up visit, she was excited about becoming a “new person.” She never denied the fact of her physical problems and the need to be a good steward of her body. However, she began to focus on good stewardship of her thinking which changed radically. This change came in the context of her physical problems and her response to them. She had studied the Scripture I gave her and recorded her reaction and thoughts in a journal which she brought to me. She attributed her changed thinking first to the “Pain Papers” which initiated her to think differently about things. And now she understood that her changed thinking was due to studying God’s truth and applying it. She was no longer living a nightmare nor was she in a black hole. She was no longer in bondage to her own feelings or her definition of “fair” and “unfair.” She was beginning to get a grip on the fundamental fact that this was not her world — it was God’s. She was beginning to think and act as a good theologian. This change affected her response to physical problems, and visible benefits were seen fairly quickly. Patients don’t always follow this schedule of improvement as this lady did.

Some of the process of her change was shown in her journal entries which were very insightful. Journaling is a good help for change, but it is not necessary. It was helpful for this lady. She wrote in her journal:

In the six weeks since I read the Scripture for the first time, I have been so aware of how unfair life on this earth is, and how many people suffer huge injustices against them. In this parable (Matthew 18:21-35), I am the servant and Jesus is the master who forgave all my sin. He purchased me with His own blood. I am commanded to forgive. And I know in my mind that it hurts only me to hang on to past hurts but somehow it feels so good to hang on to that injustice. The whole way that it all played out — all the battles with insurances — all the misery of treatment — the decline of my health since the diagnosis, I scream unfair — poor me. I clutch the pain and hold it ever tighter. And the love and truth from God’s Word gently says to me, ‘You can let go child. It’s okay to let go.’ My fingers are relaxing and the weight of it slips. I’ve set it down and it feels so wonderful and free. I’ve picked it up for a hug now and then but it feels too good to let go of my hurt to hold it for long.

In another entry on another day, she wrote (*I was given permission for slight editing*):

Life is unfair. But Jesus whispers. “Peace, be still” — His sacrifice for us in love is the great leveler. I am His. I have been saved, loved, a recipient of untold blessings, tender mercies, and the possessor of hope. Wow! That is unfair. He is sinless; I am sinful. He is perfect; I am so flawed; He speaks peace; my life is chaos. He is the great physician; I need Him desperately. How could He love me? Even notice me? It’s unfair. But I’m glad he loves me anyway!

II. ANALYSIS OF THE CASE

A. WHAT I DID

I entered the patient encounter as a good theologian. I was poised to filter her complaints and physical problems through the grid of biblical principles. My aim was to help this lady get victory defined God's way.⁴ It was obvious to me that what was going on in her inner person influenced the way she felt. But she was coming to me with physical complaints and bodily problems.

I needed to remember that the health problems would be my entry gate into where her real battle was going on: in her inner person where she purposed, doubted, concluded, feared, and was angry and embittered.⁵ I didn't know where the initial visit and interview would lead. So I addressed her physical problems as completely as I could. I wanted to ensure her that as a Christian rheumatologist, I was knowledgeable about the body. I addressed her physical problems always remembering that she is duplex (God designed man as a unit – physical and non-physical – and man functions best when the two are in harmony). Early in our doctor-patient relationship it wasn't appropriate to address her non-material side until more groundwork had been laid.

Several questions entered my mind:

1. Could I establish a viable relationship with her so that I would be in a position to help her get victory God's way?
2. What were her medical problems and what should my treatment plan be?
3. Would she be willing to continue consulting with me until we came to some conclusion about them?
4. Would she accept and act upon the solutions we developed, hopefully together?
5. She had to find a way to address her bitterness, and angry, hopeless spirit. How was I to help her do that?
6. Would she be willing to understand the influence of the non-material side of man on her body?

In my history taking, I was a *learner* as I gathered data. I asked questions

about fatigue and pain, but always with the purpose of moving to her response to it: What made it worse? What made it better? What were her views of having a body that she didn't like or didn't work like she wanted? What were her fears, hopes, and expectations? Like most patients I see, she was more than willing to answer questions. Such data gathering is essential in ministering to patients. While I learned data gathering in medical school, it was not in the context of a whole-person ministry and certainly the goal was not to filter medicine through the biblical grid of God's truth. Now I don't gather facts simply to make a diagnosis that pertains to the body. I know that the patient is a whole person and not simply "a physical problem with legs on it."

As an added benefit, she perceived me as someone who was taking an active interest in her. She perceived me as trying to understand her and her situation. That in itself gave her hope. Moreover, because she was in trouble and her way of responding to her bodily problems had *not* given her the relief that she so desperately desired, she was open to my data gathering in hopes of finding help.

What could I speak into this lady's world in the limited time I had for a patient interview? I needed to be not only a data gatherer but also an *interpreter* of those facts and an *implementer* of a plan to help her get victory.⁶ Initially she had some inkling that her handling of her problems had left her in a black hole, but she did not understand or did not want to accept the role that her thinking played in her bodily feelings. Even as she began to read the papers, she still wasn't sold on the connection between the physical and non-physical, and between her thinking and feeling associated with her responses to life and her view of her bodily problems.

At the second visit, I was able to encourage her in the progress she had made. I pointed out her major changes as I understood them. She was beginning to practice good stewardship of her body and thinking. She had read and begun to answer the questions in the "Pain Papers." The fact that she had shown some interest in reading the papers indicated that she might be interested in solving problems God's way. I asked her to complete her answers. I encouraged her in the simple, yet effective, exercise program. She had opened herself to the point where I was able to seize the opportunity, and I asked her to read Mat-

threw 18:21-35 and Mark 11:25. I chose these Scriptures because they succinctly and clearly addressed her underlying problem.⁷

At her later visits, she produced entries from her journal and asked me to read what she had written. Her insight into the Scripture was a blessing and a breath of fresh air in a life previously filled with self pity, bitterness, and anger. She had gotten the message of the cross and applied it to herself. That is victory! As a result she viewed her bodily problems from a different perspective. She had discovered that her real battle was in her heart and the Word of God had the only answer for victory.

B. WHY I DID WHAT I DID

This lady was functioning as a poor theologian and it had cost her dearly. As a consequence, her body was suffering. She required a radical metamorphosis. When she began to look at the physical aspect of her life through the grid of the Bible, she started to become a good theologian. She was beginning to understand the relationship between the physical and non-physical, and, more than that, what the Creator has to say about life in general and her body in particular.

There are basic truths and presuppositions that are necessary for practicing true and correct theologically-based medicine. By those words I mean practicing medicine from a biblically-based perspective. These truths can be summarized as follows:

1. All of life is theological and everyone, both the practicing physician and the patient, is a theologian. By theological, I mean that all men live in relation to God whether or not they acknowledge it. Every person is created dependent on the Creator. All men everywhere know God as a good and powerful Creator and Judge, though unbelievers suppress that fact (Romans 1:18-20). Only the believer knows God as His Father and Jesus as His Savior and brother.

By the term "theologian," I am not referring to someone one who has received formal theological training or simply reads and studies theological books. Rather, I mean that daily every person determines truth and lives either correctly using biblical principles or incorrectly using some non-biblical stan-

dard including his own reasoning, experience, feelings, or observations. A person lives in response to his view of God and his relationship to Him. The issue is whether or not one sees or refuses to see all of life from God's perspective. A true biblical theologian, then, is one whose view of God impacts his thinking and acting in every situation of life including the practice of medicine.⁸

In addition, every person gives himself an identity and functions from it. He may accept the identity given to him by someone else. But everyone lives by what he thinks he is. If he hears often enough that he is a victim and not responsible for his thoughts, desires, and actions, he will live as a victim. That is what had happened to Mary. As a corollary, a person will set himself an agenda — that which he deems most important to have, and he will pursue it. The key is understanding that a change in identity will motivate one to a different agenda and his pursuit of it (Romans 6:11-13).

For these reasons, it is clear that everyone has a theology — and it matters. Since all of life is theological and everyone is a theologian, it is impossible for anyone to live in a morally and ethically neutral manner. Originally, man was created in perfect relationship to his world and to God because God was in perfect relationship to him. This dual relationship (God to man and man to God) required man to function as a God-pleaser again emphasizing that all of life is an ethical matter. Man is obligated to respond to God's revelation with undivided allegiance. As a by-product, living as a good theologian is in man's best interest.

Now, when anyone attempts to do otherwise, there are consequences. Mary experienced some of those consequences. She was burdened, almost overwhelmed; she was living a nightmare and in a black hole. She was full of unrest, discontentment, bitterness, resentment, self pity, and bodily difficulties.

Mary told me she was a believer. When faced with that statement, I had two alternatives: accept it at face value and begin applying biblical principles to her problem, or attempt to discern more clearly the level of her spiritual maturity, not accepting her statement at face value. The two options are not mutually exclusive. I chose the former because of some of her answers to the questions in the "Pain Papers" and during our conversations in the office. It was clear she was willing to listen to something that could afford her relief and help. And she

was especially open because she hadn't previously heard that victory was possible and how to get it. The gospel message and her relationship with Christ had not impacted her thinking and her response to "I don't like" situations.

2. Just as man is either a biblical or non-biblical theologian, so too is he a good or bad steward. Viewing and living as a theologian and a steward are interrelated since stewardship is also a theological issue. Man was created a steward (Genesis 2:15). Yet, God did not leave man to his own devices. Stewardship involves not only the body but also thinking. Man is to be a good steward of his body and his thinking. Good stewardship is one reason for seeking medical care. God does not guarantee health, pain relief, and healing to anyone. In fact, an inordinate emphasis on and desire for these will result in futility, dissatisfaction, and bondage. Therefore, these shouldn't be ends in themselves, but by-products of pleasing God (Matthew 6:33). Good stewardship is a central issue for all of life (2 Corinthians 5:9,14-15).

Adam was not created autonomous but as a revelation-receiver, revelation-interpreter, and revelation-implementer. Adam *received* counsel and direction from outside of himself. God blessed man and gave him specific instructions: Be fruitful, multiply, fill the earth, subdue it, and rule it (Genesis 1:28). God expected Adam to *understand* what He had said and His revelation was to be Adam's guide for doing so. Moreover, God expected Adam and Eve to *apply* what He had said to the task of living. They were given instructions in principle. Except for the specific injunction of not eating from the tree of knowledge of good and evil, they had liberty and ability to consider how best to apply God's marching orders.

So it is for man today. He is to be a good steward as prescribed in the Bible. Stewardship involves both the inner and outer person. It requires returning to God what He has entrusted. In order to help Mary get victory in her situation, I had to address the issue of stewardship.⁹ She had failed to do and to think right. And as we shall see a little later in detail, because we are whole persons, stewardship involves taking care of both the immaterial and material sides of man.

Most people focus on "doing" and are willing to change activity in order to "get better." Mary told me she was a "road runner" which is a pattern of life

characterized by "going and going" like the "Duracell bunny" irrespective of her physical condition. I have labeled it *learned drivenness*. When it hurt to do so, she tried all the harder, and when she couldn't function without pain she became frustrated (angry) which only heightened the pain, further reminding her of her "I don't like" situation.

It was apparent to me, but not to her, that she needed a "whole person" approach to stewardship. She had to change not only what and how she *did* things but also her motivation and thinking for that change. When I first see patients, most of them are not ready to become good stewards for several reasons. One, the concept of stewardship is foreign to them. Second, they are not convinced that they have been bad stewards. Third, patients are usually motivated by the desire for pain relief and good stewardship doesn't fit into that agenda. Fourth, they don't know the "how to" of good stewardship. And fifth, sometimes they have practiced bad stewardship so long that they literally "don't know any better."

So how was I to help her become a good steward? There are several ways to do so - and fairly quickly. She came with a preconceived diagnosis and she acted upon that fact. Any patient can "learn" almost anything about any subject on the Internet as well as from professionals. She had done so and I needed to disabuse her of some ideas that kept her from getting victory (see footnote 3). The secular approach to treating patients with ill-defined rheumatic conditions and chronic complaints can be summarized as: you are what you are and the only hope you have is to take care of yourself, focus on relief, and get others to help you. Victory is not available.

I had her read the "Pain Papers." I summarized the difference between arthritis and rheumatism and explained to her the results and potential significance of her physical findings. In terms of the previous diagnosis of FM, I was able to help her better understand that entity through the lens of the term "soft tissue rheumatism."¹⁰ She had physical problems but most importantly she had a body she did not like and a situation created by that body that she didn't like. Stewardship required her to change her thinking as well as her doing. And the far superior manner of doing so was to replace her wrong system of truth with biblical truth.

3. A third truth that I mentioned previously requires emphasis. It is the fact that God created man a unit consisting of an outer and inner person. By God's original design, man not only has a body – he is body. Yet he also has an immaterial side. The Bible uses various terms to describe the immaterial side of man including heart, mind, spirit, soul, conscience, and will (see footnote 5). While the term “heart” is the most common, each term expresses a distinct functional capacity of the inner person. It is in the inner-person that he thinks, purposes, hopes, fears, doubts, considers, plots, and decides on courses of actions. It is also where the conscience is active.

The culture's view of man's “anatomy” is incorrect when it speaks of the brain and mind as synonymous. There is no word translated “brain” in the original language of the Old and New Testaments. That is because the brain is material – it is part of the body that goes into the ground and rots and is included in words such as *soma* and *basar*. The brain not only receives, interprets, and acts on nerve signals from the rest of the body (physical), but also on data from the spirit of man (non-material). Therefore, thinking is a spiritual-physical process.¹¹

And it is in this inner person (spirit of man), not the brain, where changed thinking must occur. This is the purview of the Holy Spirit, not drugs or professionals. Science would have us believe that man's moral compass is located in the brain. Therefore, secular thinking encourages medications to change man's behavior, thinking, wanting, and motivation. However, these are inner person activities that require God's grace to bring about specific long-lasting change. This change requires God's truth in a fertile heart rather than medications or psychological endeavors.

The creational fact of Mary's duplexity meant that if I could move her to a proper interpretation and understanding of her struggles, I could introduce her to the only treatment option that brings true relief. There was no question that I could use a purely secular approach to address her physical problems. However, she had not improved using that approach and, in fact, had grown increasingly hopeless. If I followed in the same manner, I would have functioned as I had in the past – as one who failed to understand and apply biblical truth to my practice of medicine. I could have simply prayed with her, made sure she

was saved, and encouraged her to take her “faith” seriously. However, I would not have truly ministered to her. God's truth was the only hope she had in addressing her problems. I chose to be vigilant and sensitive to opportunities to present biblical truth in a way that was appropriate, meaningful, and palatable to her.

Biblically-based medicine acknowledges that man lives in a fallen world with a fallen body because of Adam's sin and his relationship to Adam. The Fall affected man from the inside out: man's desire is not to please God, but self; his thinking is not in accord with God's thoughts but is self-centered, and his actions are opposed to God. Suffering and disease are part of the curse. Yet every person doesn't experience the effects of the curse in the same way. Since man is duplex and thinking is affected by the curse, wrong thinking can bring on symptoms that in the medical profession are labeled “disease”.

Also wrong thinking can worsen symptoms even if there is provable disease. Since feelings are affected by sin, bad feelings can result from wrong thinking. Furthermore, a wrong response to those feelings and the use of feelings as a motivation to do (or not do) usually results in a continuing downward spiral of more bad feelings. And wrong uses of the body (for example, smoking, drunkenness, too little or too much sleep, or too much or too little exercise), as well as wrong thinking, do bring about disease or aggravate that which is already present. Such was the case with Mary. She had a mechanically inefficient body for a number of reasons, and she aggravated that inefficiency by her wrong thinking.

4. Close on the heels of the creational fact of man's duplexity is the truth of the influence of the inner person on the outer person and vice versa. As I said previously, biblical stewardship involves taking care of both. This dual emphasis expresses itself in several ways. Inner-man functions of wanting and thinking will be expressed in bodily actions and feelings. That fact is summarized as follows: You feel what you feel because you do what you do and think what you think; and you do what you do because you think what you think; and you think what you think because you want what you want.

This understanding (and presenting it to the patient) is a necessary tool for practicing biblically-based medicine. Mary wanted relief and had sought to get

it in a way that seemed wise in her own eyes. She had reaped the consequences of an angry spirit that resulted in her refusal to acknowledge her sin and forgive as she had been forgiven.

Everyone functions out of his own functional belief system and functional motivational system (FBS and FMS). By FBS, I mean, his thinking about life, himself, his situation, others, and most importantly about God. By FMS, I mean, what he desires in life and what motivates him to have what he thinks he needs and believes he must have. So, too, did Mary. She wanted a hassle-free life – which is not in itself wrong. But she wrongly thought that she deserved it and that her life would be better if she had what she wanted. That's where her problem lay. But when she didn't get it and received the very opposite, she considered herself living a nightmare down in a black hole. Her world had caved in and she saw no light to guide her way.

Even though wanting, thinking, feeling, and doing are not the same thing, they are so interrelated that changed thinking and motivation will result in different feelings and actions. The inner-person influences outer-person function because man is a unit. Therefore, anger, bitterness, and resentment are produced by inner person activities and are expressed as certain feelings (sometimes called emotions) and actions. Consider Cain in Genesis 4. In verse 5, we read that his face fell. God asked him why he was angry (verse 6). His outer person expression was a function of activity in his inner-person. He did not answer God, but it is clear that he had no inner-person change because his downward spiral of rebellion against God continued, culminating in murder (1 John 3:11-12).

The book of Proverbs contains a number of passages concerning the duality of man. A person's body is influenced by his attitude or "state of mind" (see appendix A). Guilt from unconfessed sin can produce significant outer person symptoms and signs. A case in point is what David writes in Psalm 32 (verses 3-5) and Psalm 38 (verses 2-8):

- v.3: When I kept silent my bones wasted
away through my groaning all day long.
- v.4: For day and night your hand was heavy upon me;
my strength was sapped as in the heat of summer.

- v.5: Then I acknowledged my sin to you and did not
cover up my iniquity. I said, "I will confess my
transgressions to the Lord" – and you forgave the guilt of my sin.
- v.2: For your arrows have pierced me, and
your hand has come down upon me;
- v.3: because of your wrath there is no health in my body;
my bones have no soundness because of my sin;
- v.4: My guilt has overwhelmed me like a burden too heavy to bear.
- v.5: My wounds fester and are loathsome because of my sinful folly.
- v.6: I am bowed down and brought low;
all day long I go about mourning;
- v.7: My back is filled with searing pain; there is no health in my body.
- v.8: I am feeble and utterly crushed; I groan in anguish of heart.

Here David vividly sets forth the agonies of inner struggles. Today, the Holy Spirit uses David's rebellion against God to highlight the bodily consequences of guilt and unconfessed sin.

Similarly, the outer person also influences the functioning of the inner-man. Inner person issues of motivation, wants, fears, and expectations are often exposed when the body is not working well; that is to say, when the person is sick or not feeling well. Often the words "bad feelings" are used to explain away sin. There is no question that bodily problems tend to make it easy for a person to sin, but they are never a justification for it. Consider Job (1:13-22), Paul (2 Corinthians 12:7-10), and Christ. The Bible records significant times in the lives of these men in which there was hardship on top of hardship. Yet the biblical record shows that the sinless Jesus *never* sinned, that Job did not sin in his early trials (Job 1:22; 2:10), and that Paul even rejoiced in his troubles. In 2 Corinthians 12:7-10 God answered Paul's prayer with a resounding "no." Often God honors good stewardship by giving varying degrees of health. But sometimes His answer is "no." How one responds to His "no" can have a great deal to do with a person's response to his treatment regimen. Paul looked at his physical problems as a gift from God to grow and change. The life of Elijah as

recorded in 1 Kings 18-19 also demonstrates the fact that the condition of one's outer-person influences inner-person activity and function (see appendix B).

Early on, I was able to help Mary understand the influence of wrong thinking and wanting on her body and her feelings. She was able to see the connection. Even secularists understand this truth but do not give credit to the Creator God. Knowing the biblical relationship between the inner and outer-man enabled me to use her physical problem as my entry gate into moving her toward addressing her problems from God's point of view.

5. Another truth that must be clearly stated and emphasized is the fact that Mary is a whole person. This truth follows from the fact that man is a unit of two parts - a duplex. Feelings and emotions such as pain, fatigue, anger, bitterness, sadness, and discouragement are whole person activities. In the area of pain, it follows that it is inaccurate and misleading to speak of "emotional pain," "psychological pain," or "mental pain." Rather pain is physical (something material). "Emotional," "psychological," and "mental" describe the non-material and are usually used to convey feelings of unpleasantness and discomfort. Further, these terms are thought to indicate that only part of man is being affected and are used to dictate therapy by a "professional."

But the key is understanding that feelings are a function of thinking and wanting, both of which influence a person's response to his situation. Such was the case with Mary. Much of her treatment had been directed at her feelings. Her feelings were not the problem. In fact, one could say that they were working just fine. Rather, she had a physical problem (soft tissue rheumatism) which had been worsened by her inner-person conflict. She had failed to resolve her problems God's way and, in fact, had functionally excluded Him from her thinking and desires. She was functioning like an *atheist*.

6. Another truth in order to practice biblically-based medicine is two-fold: Symptoms and signs differ and may or may not indicate that something is wrong in or with the body. Symptoms are what the patient tells the health care person: "I hurt;" "I am fatigued;" "I am depressed." They are personal, subjective and, therefore, not measurable except as a person quantifies: "I hurt a lot," or "I am very tired and fatigued," or "my pain is 10 on a scale of 10." When symptoms are reported, there may be discoverable and specific abnormalities.

For instance, the symptom of "my heart is beating fast" (a fast pulse rate is a *sign*) may be the result of fever (*sign*) in a patient with pneumonia, or from worry and fear. The first scenario indicates something wrong *with* the body and the other indicates only that something is wrong *in* the body. In either case, a rapid pulse rate may be noted, but from entirely different causes.

Signs, on the other hand, are physical findings that may or may not be reported by the patient. They are measurably objective, and demonstrable on physical examination, laboratory examination, and/or radiographic studies.

Consider feverishness. The patient will say, "I have a fever." However, that statement only describes a symptom based on what he says. I can verify whether he has an elevated temperature using a thermometer, but I can't verify whether he feels feverish. There is no feverishness gauge or instrument. A temperature of 101 degrees is a sign and is indicative of a bodily problem whether the person feels feverish or not. A fever is a sign whether or not the patient says he is feverish.

Too often in medicine (and characteristically in psychiatry) the diagnosis of a condition or disease is based on subjectivity - what a patient tells the doctor about how he feels or how he is acting, not about what can be measured objectively. Such is the case with FM. There are no demonstrable abnormalities by physical examination, laboratory findings, or radiographic studies. So-called "trigger/tender" points are based on what a person says in response to pressure by the examiner. Subjectivity has become the authority taking center stage both, in terms of diagnosis and in terms of treatment. And as a corollary, a patient is judged "better" because he says he is.¹²

The cause of the patient's symptoms always relates to the curse of sin and may be due to something wrong *with* the body or something wrong *in* the body. Symptoms develop because the human body is not flawless. It is sin-cursed and will never be symptom-free in this earthly life. In addition, there will always be more complaints (symptoms) than causes discovered. This is in part related to limited technology and scientific knowledge. On the other hand, actual tissue damage (disease) may be present producing abnormal cell and organ function that may result in symptoms. Lastly, a person's evaluation of and response to circumstances in life may produce symptoms felt in his body.

It is very important to explain to patients the difference between the two terms — *with* and *in*. The cause of symptoms may or may not be discovered. Determining which of these is the problem and explaining this concept to the patient helps him understand the problem. It may open the door toward helping him develop a spiritual interest for addressing physical problems.

Something wrong *with* the body describes a disease such as rheumatoid arthritis or cancer that is likely the cause of symptoms. The diagnosis of such diseases is based on known pathology that may be responsive to treatment regimens. Something wrong *in* the body relates to physiological (not pathological) changes noted on examination such as a rapid heart rate or rapid breathing rate. A rapid heart rate may be a reflection of anemia, hyperthyroidism, or fear and worry in response to a certain situation. The rapid heart rate is measurable and indicates that something is wrong *in* the body, but not necessarily something wrong *with* the body.

I believe it is important to help patients understand the above differences. Otherwise, as happened here, Mary's sole goal was pain relief and the less it came, the more intense she experienced pain. This often leads patients to misjudge the significance of their symptoms believing that there is something seriously wrong with them. Further, it often results in a downward spiral of pain, discouragement, *learned helplessness*, or a more vigorous display of *learned drivenness*. Either way, symptoms invariably worsen resulting in the opposite of what the patient desires.

Therapeutically, a patient too often focuses on relief of the bad feelings. That is what had happened to Mary. The approach to her medical care had been non-spiritual and amoral, but it was not non-theological. In fact, she had received medical care that, in effect, said God has no useful place in it except, perhaps, as an adjunct to help her through the "rough" spots. The term "victory" had no place in her vocabulary and the victory at the cross had no significance. She was embittered and that came out loud and clear. Apparently, no one had challenged her in regard to her response. I had to be alert because she came to me regarding her physical problems. She didn't come with anger and an embittered spirit as major complaints. I didn't minimize her struggles or her description of them.

7. Another truth necessary to practice biblically-based medicine is to re-label the patient's description of his response using biblical language. I make it a habit to couch a patient's description of his thoughts, wants, and actions in response to situations and people in biblical terms. Such was the case with Mary. When I summarized to her my understanding of her medical history, I highlighted the words "frustration" and "upset" as she told me about her response to what she considered was undeserved wrong. I asked her how those were different from anger. She ultimately agreed that she was an angry person and her response had worsened her physical problems.

It is important for the patient to clarify what he means by his terms and, from his perspective, what triggered that response. Another example is asking the patient what he meant by "panic attack." I asked him what he feared or worried about. Using the terms "worry" and "fear" in place of "panic attack" often allows me an entry gate to open up other ways of thinking biblically. The same approach should be taken for such phrases as "I am depressed" or "It is stress-related" or "pain caused me to think and feel this way." I have done this in the "Pain Papers" (see footnote 2).

8. The first of two other truths that characterize biblically-based medicine is:

Defining and pursuing one's goals for life apart from pleasing God according to His Word is counterproductive to good health and leads to futility and bondage. The second is: Understanding life from God's perspective simplifies life.

Mary didn't realize these truths, but discovered them when she was confronted by the Word of God. Wanting her body to function better and desiring good health are not necessarily wrong desires. Neither is the pursuit of them. However, the Bible teaches that the way of the transgressor (unfaithful) is hard (Proverbs 13:15). The gist of this verse is that pursuing goals other than the one true goal of life — pleasing God — has consequences. Mary had experienced some of those consequences. When she hurt or couldn't function as she wanted, she remembered previous wrongs done to her, and the body and function that she previously had. This line of thinking led to more hurts and a greater desire and drive for relief. She held a grudge, which meant she had fo-

cused on getting even for these many years. As this downward spiral persisted, she was trapped and in bondage. She had contributed to her bondage. She expressed this bondage by saying she was living a nightmare and that she was in a black hole.

After reading the “assigned” Scripture, she began to acknowledge to herself the fact that she was not God; that the cross levels all people including herself and the people who work in insurance companies; and that the pursuit of what she desired – good health and little or no pain – had actually eluded her. She had reaped the opposite: chaos, more pain and discontent, and a body that wasn’t any better. She was beginning to understand the call of Isaiah and Joseph in Egypt: come to Christ for rest instead of confusion and chaos (Genesis 50:19–21; Isaiah 55:1–2; Matthew 11:28–30). Moreover, she came to realize that the behavior she was engaging in (nursing an embittered spirit) was not only bad for her, but that it was displeasing to God. She reported that she did repent.

III. THE DIFFERENCES MADE IN MARY’S CASE PRACTICING BIBLICALLY- BASED MEDICINE

To begin, she knew that I was willing to listen to her. This helped establish a working relationship. This also helped instill hope. Without hope, no one will persevere (1 Thessalonians 1:3).¹³ She needed hope to endure, to run the race with vigor and enthusiasm, and to gain victory. Her definition of hope had merely been a “hope-so” thing, and victory was not part of her mindset. “Hanging on,” “accepting,” “coping,” and trying to get out of her mess consumed her. It was the best she could do. I knew all of this, but she didn’t.

She was surprised that someone would listen to her and gather data by asking questions that she had to think through to answer. I have heard this sentiment expressed so many times by many different patients that it must have validity. Being a learner by gathering data is a must for practicing biblically-based medicine. It has so many pluses that I can’t recommend it strongly enough. There is a contrast in data gathering as part of practicing biblically-based medicine as opposed to practicing secular medicine. In biblically-based medicine gaining facts always has a goal, which is to diagnose and solve the patient’s problems God’s way. My data gathering covered many aspects of Mary’s life as I tried to “enter” it from as many directions as I could in my limited time.

Secondly, she was at ease and comfortable in telling me her struggles because I had listened and showed an interest in her. She knew I was addressing the reason why she had come to see me. The “Pain Papers” that I gave her to read also were perceived as helpful and showed my interest. All of this helped to establish a working relationship.

Mary had been exposed to the secular model of medicine (see Appendix C) which affirms several major tenets including:

1. All symptoms have a definable organic cause, and deserve treatment even if no pathology can be demonstrated;
2. Behavior and feelings alone are sufficient criteria from which to make a diagnosis and institute treatment;
3. Subjectivity is the standard for both a diagnosis and for determining treatment success or failure;
4. A patient is labeled as a victim who is not responsible for his response to outside pressures and requires treatment with medication;
5. Newer technology is needed to demonstrate alleged/putative abnormalities, thereby justifying treatment.

In medicine today, science works hard to uncover any and all abnormalities with the hope of explaining behavior and symptoms. Whether physical and pathological abnormalities are found or not, the idea remains that symptoms indicate that some bodily abnormality must be present, is responsible for the symptoms, and can and should be treated. Treatment approaches have taken on new proportions since medicine has developed and applied new technology in an effort to pursue so-called evidence-based medicine (EBM).¹⁴ The newer technology is purported to uncover abnormalities often alleged to produce symptoms. Using this rationale, treatment is then prescribed. However a significant number of these people with abnormal MRI are asymptomatic. Yet some physicians say that every symptom deserves treatment!

The new technological methods are so sensitive in detecting presumed abnormalities that abnormal readings are detected in normal people. One case in point is the results of Magnetic Resonance Imaging (MRI) of the lumbar spine in normal people.¹⁵ The MRI was read as abnormal in more than 50% of patients. Another instance of trying to improve diagnostic sensitivity involves the use of MRI of the hands in patients with rheumatoid arthritis (RA). About 7% of normal people have what seems to be typical erosive changes that look like RA (I learned this by personal communication).

In addition, since some patients with an abnormal radiographic study such as the MRI have symptoms, it is often assumed by some physicians that the patient's symptoms are related to the "abnormal" finding. If one believes that

there is a bodily problem behind every symptom, it follows that the symptom deserves some kind of treatment.

As an outgrowth of this model, those physicians who agree are quick to label a patient a victim to that which is outside of him, and treat him accordingly. Empathy becomes the major focus of the doctor-patient relationship. When this occurs, important information will be left out or reinterpreted during the physician's history taking. Gathering data and asking questions in order to determine the fears, hopes, expectations, and motivation of patients is either not done or it is understood in the framework of "things outside of me," or "that is just the way I am." The ideas of hope and victory are not part of the vocabulary for physicians and patients with this mindset.

Physicians under the secular influence of practicing medicine are inclined to remove any responsibility for good stewardship of the body. They are inclined to re-label the patient's response to his condition as a result of his problem and are quick to use various medications.¹⁶ Treatment including medications is directed toward relieving unwanted feelings and behavior as a means of "coping" and "accepting" what a sovereign, providential God has brought into the patient's life. "Coping" and "accepting" are never defined and there is no standard for them except patient subjectivity. Moreover, "coping" and "accepting" are politically correct terms for something defined and arrived at by the patient. So whether he is "coping" or "accepting" (by whatever standard), if medications help a person "feel" better, that is the definition of "victory." Alleviation of symptoms including pain is what drives many therapeutic decisions rather than directing attention to the whole person.

In addition, the physician frequently re-labels a patient's response while in the midst of hard times. For instance a patient's anger and bitterness are framed as "normal life responses" or "irritation" and "frustration" because of that which was "done" to him. The physician will seek to remove bad feelings by medications and/or getting rid of that which is thought to have produced the bad feelings by what is often called "stress management." A patient's desire to "punch out of life" and become a "couch potato" because things didn't go his way is labeled depression, fear, or anxiety and assumed to require medications.

Further, a secular mindset assumes one response fits all. A good example is the so-called five stages of grief as recorded by E. Kubler-Ross in *On Death and Dying*.¹⁷ Any person experiencing hard times will respond as so many others do. Therefore, since one person may become discouraged, hopeless, angry, or anxious when facing death or a chronic illness, it is assumed that all will, at least to some degree. Accordingly one's relationship to Jesus Christ is of little benefit to the grieving and dying. The process and the pressure of life take center stage and not the individual person's response or his responsibility in responding to it.

Another feature of practicing medicine from a secular viewpoint includes a focus on the "now." A "now" theology means that one is focused on that which he appreciates with the senses rather than through the eyes of saving faith. This conflict is an ever-present one and I termed it as a *sensual vs. suprasensual* approach to life. Therefore, the created, the material, the temporal and finite, the present, and the personal take center stage in contrast to a future eternal focus which includes growing and changing into Christlikeness. This "now" emphasis promises the hope of that which is unattainable on this earth – reversing the curse of sin and God's judgment on the outer person. That awaits heaven.

Early on, we worked together to help Mary change her definition of hope and ultimately her identity of herself as a victim and a loser. She had put her trust in changing circumstances and people, getting even, pain relief, and hope of God giving her a new body. I had to help her change her definition of hope. The question was how to do that?

I had to convince her that God's answers were radically, surpassingly, and overwhelmingly superior to her own. We were face to face with the sensual vs. the suprasensual approach to life. She had felt more pain over the last few years, and perceived her ability to get around and function was much less than in previous years. She reasoned that life had been significantly changed for the worse. Therefore, how could something so bad ever be changed, and how could she possibly use it for good? What is good about having a ravaged, hurting body and bosses and insurances companies that have been unkind and unhelpful? She considered them as having "done her dirty." Her senses told her that there was nothing good about her situation. She expressed it as "being in a

black hole" and "living a nightmare."

However, when she used her eyes of saving faith, she studied God's Word and found that it told a radically different, life-changing story. Further, walking by faith and not by physical, sensual sight, she was able to acknowledge, cultivate, nurture, and apply God's truth to herself. Her journal entries indicated that she had gotten a handle on where her conflict lay and how she had put down her weapons of warfare against God. She came to realize that He had laid aside His wrath at the cross and she was to do the same toward others. She was to move from being a grudge holder to being a peace maker and lover. And because she was a Christian, she had resources at her disposal that she hadn't considered.

The breakthrough came when she grasped the enormity of her position as a grudge holder. I had not only instituted an appropriate treatment plan directed at her physical abnormalities, but also at her as a whole person. Her journal entries indicated that something else had happened. Her view of her bodily problems was different. She no longer took her body and its function for granted. She took biblical stewardship seriously along with the proper goal of pleasing God whether or not her health returned (2 Corinthians 5:9). Pleasing God by good stewardship seemed to be a far better goal than what she had previously imagined. And she was beginning to accept the fact that everyone's body will fail and that the question was how would she respond (2 Corinthians 4:16-18). See footnote 1 regarding paper 9.

Part of her profound metamorphosis centered on her acceptance of the biblical principle of sowing and reaping (Galatians 6:7-9; Proverbs 13:15). She had sown *discord* in her life and the lives of others. She was at war because she had placed her own desires ahead of God's plan. Her ultimate conflict was with God. She had lived out of her FMS and FBS. Her lifestyle of *learned drivenness* superimposed on the reality of a failing body that she thought she didn't deserve had taken its toll on her physically.

As we have seen, Scripture plainly teaches that what goes on in the inner person affects the outer person. She was a perfect example of this truth, but hadn't realized it.

A later journal entry showed her changed thinking:

How silly is that! Companies and systems can't be hurt by bitterness but I can. Unforgiveness can separate me from fellowship with God. I can honestly say I have a new way of looking at my situation now. The pity parties are over! No more victim mentality. I feel free and empowered to look forward instead of behind.

She wrote that she has continued to meditate on those Scripture verses (Matthew 18:21-35; Mark 11:25).

Her physical problems are still with her, but she is continuing to function as a good steward. When she began to focus on what she had gained through the pain, she was able to use her trouble to grow rather than focus on the pain and its relief. She continues as a patient, but I see her only every four months or so when we address stewardship issues including her exercise program, her medication dosage and schedule, her thinking, and her goals.

She continued on low dose analgesic medication. She remained on Zoloft which she had received elsewhere. She said she knew why it was prescribed – to help her feel better. It hadn't. She continued it out of fear that she might feel even worse. I didn't consider stopping the Zoloft because I hadn't prescribed it. Clearly the drug was not playing a role in her care. However, Mary had come to me with much on her plate and she had difficulty in responding biblically to what a providential God had provided for her. Helping her do so was my major concern. As she gains confidence in the application of God's truth in her life, she will be less controlled by feelings. The desire for drugs such as Zoloft will become less and less. In fact, she recently told me she had stopped the Zoloft saying she just didn't need it.

Antidepressant medications such as Zoloft are directed at changing feelings. Her problem was not bad feelings but the cause of those bad feelings. Medications did not address that issue because she had an inner person conflict which she failed to resolve God's way.

Applying biblical principles is the best help that a physician can provide for his patient. However, too often both the physician and patient consider the physician as the "feeling expert" and both equate "better feelings" with improved health. Therefore, the goal is to improve feelings rather than please God by good stewardship of thinking and the body whether or not good feelings come.

IV. YOU CAN DO THE SAME

There are certain qualifications and requirements to practice biblical-based medicine. Obviously you must be saved. Only believers can minister God's truth. Second, you recognize that something is amiss in your practice of medicine. Third, you are seeking God's answers for the practice of medicine. Fourth, God is sovereign. He ordains the opportunities and the fertile hearts of patients on which to minister His truth. I am forever reminding myself of these facts. I am responsible for being a good steward of these moments and preparing for them. It takes time and effort to understand and correctly apply biblical truth. I am the Holy Spirit's instrument in using His sword – the Word – to give patients such as Mary real hope and victory in handling a failing body. Fifth, you and I need to remember that not all patients will respond as Mary did. However, your job is to plant and, perhaps, water the seed of biblical truth in every patient who is receptive to it. Healing his medical problem, as good as that is, pales when you compare the overwhelmingly and far superior privilege of helping a patient use his physical problem to see and act on the truth of a good God for him.

With this brief introduction, let's look at some of the "ifs" more closely.

A. IF YOU ARE UP ON THE BIBLE

Being "up" on the Bible means being a biblical theologian with the theology previously defined (see section II, B). It means acknowledging and acting upon the truth that caring for patients is a theological issue. The physician must answer: "What is the place of God and biblical truth in my practice? How does my relationship with Christ impact my life, including my care of patients?" The real issue for the physician is this: "What kind of theologian am I and what theology do I bring to patient care?" The way to determine this answer is to compare your theology to God's Word because the best answers for caring for patients are found in God's Word.¹⁸

Consider the physician as a theologian. According to the Bible, a good

theologian is one who is a *learner* who wants to grow and change into the likeness of Christ so as to help others do the same. Learning God's truth for those purposes is the essence of being a good theologian.

One of the first questions to ask yourself is this: "Whose world do you say it is? And how do you live in it?" The Bible says it is God's world, and He has something to say about how to live in it (see footnotes 8 and 9). A good theologian will act on the fact that God, the Creator, designed the whole person (body and soul), and has provided an owner's manual (the Bible) to enable every man to be a good theologian and good steward of the whole person. The Bible teaches that God is "for the body" — being a good steward of the body His way by serving Him — so, too, must His people be (1 Corinthians 6:12-20; 7:20). The wrong use of the body was prevalent in the Corinthian Church. Paul taught that the body could only legitimately be used for what it was designed: to serve the Lord (Romans 6:6; 12:1-2). The believing physician is to be in the business of helping patients become good theologians so as to be good stewards of their bodies. Because the believer's body is not his own — it was bought with a price — he must give an account of how he took care of it. The Christian physician will find multiple opportunities to minister God's truth in the arena of physical problems as a good theologian enabling patients to be good stewards.

In the area of medicine, the significance of being a good theologian is whether the physician filters medicine through the grid of the Bible or whether he filters the Bible through medicine. If the believing physician chooses to filter the Bible through medicine, he will follow the current wisdom of the age. It is impossible for anyone to be theologically neutral. He will take his stand on one side or the other.

How will a poor theological physician practice medicine? (see Appendix C.) He will function more as a body mechanic attempting to find a physical cause behind most, if not all, symptoms. Even if none are found, medications will be first-line therapy. Based on the pragmatism of "anything goes" for the purpose of feeling better, he will be quick to use medications. When they fail to provide relief, the pragmatism of "anything goes" may even include things as alternative medicine. The patient may well continue to seek "healing," sometimes no matter the cost. And of vital importance, the Bible will be distorted either to fit

one's view of health and his body — or ignored. Such was the case with Mary. She was seeking relief and a better functioning body without reference to God.

One of the major results of bad theology in any area of life is that God and biblical principles are considered unimportant or non-entities. If physicians continue to observe and evaluate symptoms and signs, define disease, and implement treatment apart from God's truth, what follows is distortion of the patient's real problem and consequently, the solution. This distortion will be descriptive (e.g., a patient is considered a victim and not a morally responsible being), definitional (e.g., anger is really "irritation" and "frustration"), and directional (e.g., the course of treatment is medication to control feelings rather than changed thinking and motivation). As we have seen in secular medicine, symptoms are considered organic even if no abnormalities can be found. Symptoms are considered legitimate and deserve to be treated and removed irrespective of physical and laboratory examinations. The prevailing thought of the practice of medicine is that subjectivity reigns. Subjectivity in diagnosis and treatment has become the standard for both diagnosis and for determining the success or failure of some treatment program. "Treatment" is given irrespective of what is going on in the *whole* person. The patient is pictured as a victim and, therefore, not responsible. Treatment goals are couched in such terms as "relief," "healing," and a better "quality of life."

Another result of bad theology focuses on the "power of things outside" a patient. In medicine today (and especially in the field of psychiatry), things and people "do it" to the patient. What happens outside the patient is thought to be a determinant of feelings, and responsible for symptoms. Accordingly, treatment is directed at symptom relief, is pragmatic, and the patient's feelings take center stage. Again, the physician is in the position of dispensing medication and not God's truth.

In the course of bad theology, treatment may include "spirituality" of a brand in which Jesus Christ is not involved. This definition of "spirituality" is contrary to Scripture which defines "spiritual" as indwelt and directed by the Holy Spirit. The reasoning goes something like this: man is more than body, and since religion is a private matter and faith affects the body and feelings, "spirituality" should be used in the office only so long as the patient is willing

and the physician is willing to espouse his own beliefs.

People with this mindset believe anything goes in defining "spirituality." They recognize a "spiritual" side of man but misuse this God-created fact. Rather than worship God, they use Him to provide yet another treatment option. They assume religion is religion and that one is as good as another. In this mindset, the overriding consideration is to try to ensure that the patient is comfortable. Jesus Christ and His relation to a person carry no more significance than any other religious figure or no religious figure at all. Jesus Christ is just one of many alternatives and may not be as good as some of the others.

Many others claim that religion is a private matter and it shouldn't be allowed into the practice of medicine. This claim is itself a theological statement attempting to exclude God from a segment of life. Still others contend that the practice of medicine is non-spiritual, non-moral, and non-theological, which is also a theological statement. A physician who follows either of these lines of thinking has no place for God in his care of patients.

However, some believing physicians may move beyond their secular counterparts and pray with their patients, and even evangelize them. They may encourage the use of faith as a tool, attempting to manipulate God and His healing by it. Patients may feel better and even respect these physicians. It is possible that bodily problems may improve. As good as all this sounds, the real test is whether the patient's thinking is conformed to God's thoughts about life and bodily problems. This requires understanding on the part of the physician that all of life is theological and that living must be considered in biblical terms. Only then will the influence of one's relationship with Christ impact favorably on the practice of medicine. Living out one's relationship with Christ results in victory for *both* patient and physician — even if physical healing doesn't come.

In contrast, and it is worth repeating, the physician as a good theologian is compelled to filter medicine through the Bible. When he does so, he learns that good theology helps to demonstrate to the patient the significance of God's relationship with him. Victory comes as the patient understands and acts upon the significance of that relationship in responding to physical problems. The patient in the midst of problems may not acknowledge or act upon the fact of his relationship with Christ. The physician who looks at his Bible first, and then

at the practice of medicine, will help the patient acknowledge and act upon the reality of that relationship. He is able to do so because he is confident that the sufficient and superior Word of God, rightfully applied, brings God's truth to the patient. He is then moving toward victory biblically defined (see footnote 3.) Such was the case with Mary.

In addition, a biblical view of medicine always sifts scientific facts through the grid of the Bible. Application of the facts to personal health and the delivery of medical care require using biblical principles in patients who present with symptoms and bodily problems. For instance, in the example of the patient who presents with so-called "panic disorder," the biblical theologian knows that the Bible speaks frequently about fear. Therefore, guided by biblical thinking about fear and not secular views, he will try to learn what is going on with the patient.

The practice of biblically-based medicine holds that healing is not a matter of more faith as opposed to more medicine but a synchrony of both. It is never medicine *or* faith. Science and faith are not contrary to each other for each has come from the hand of God. However, not all that is called science or faith are such. And even the secular world knows that science is changing. Being a good theologian means properly understanding and applying the two.¹⁹ In order to do so, the interpretation and use of scientific principles must always fall under God's guidelines as recorded in Scripture. The two will never compete when placed within this framework. And unlike science, Scripture is the unchanging Word of God.

Failure to properly understand the harmony between medicine/science (discovered fact) and God's revealed truth in the Bible results in the creature attempting to assume priority over the Creator. The Creator/creature distinction will be distorted and even inverted.²⁰ By excluding and/or distorting God, the Creator, medicine has positioned itself in the place of true biblical theology. It ventures to speak about the human condition — health, disease, and its treatment — while ignoring what God has said. A physician who assumes this position is functioning as an unbeliever. Therefore, the practice of medicine can never be divorced from God's gift of saving faith.

Further, consider Van Til's concepts applied to the physician who practices

medicine using a secular approach. He would say the doctor is using the practice of medicine to deny the existence of God. How so? Consider this example: Any scientist knows that apples come from trees and are normally good to eat. The secular scientist says apples are due to evolution. In other words, apple trees were not designed by God. Thus, for him, apples and apple trees are Creator-denying material that the scientist uses to deny the Creator. In the same way, practicing medicine as if God has no place in medical care is tantamount to denying God.

Another aspect of being “up” on your Bible centers on the simple yet profound fact that life is all about glorifying God and enjoying Him forever. Adam’s sin didn’t derail God’s original design. God’s judgment served only to point toward and to magnify the Good News of salvation in Christ. The believer’s hope and victory were secured at the cross by the only true Victim and true Victor. “Hope” and “victory” should always be part of the vocabulary of the believing physician. These replace the culture’s poor and wholly inferior substitutes of “coping” and “accepting.” Therefore, pleasing God is always possible even when relief and cure don’t come. This means that living for the “now” – the visible, created, temporal, the physical, the personal, and the material – is futile and counter-productive since one’s body and this world are passing away (2 Corinthians 4:16-18; 1 John 2:15-17).

Rather, Scripture teaches that the eternal destiny of man should influence and motivate him to consider the “how” and “why” of his life. Mary had lost sight of the eternal perspective of life much like the psalmist in Psalm 73. He was brought to his senses when confronted with the Word of God. That is what happened to Mary (see Psalm 73:16-17; Luke 15:17). This made all the difference.

The superiority of the biblical view of medicine is evident only when you understand and apply the basic Scriptural concept that something bad (misery and sickness) is to be used for good. This is the very essence of what happened on the Cross and it is the foundation by which to judge all of life, including pain and any other bodily problem. A major result of doing so is that all of life is simplified. Life is simplified in terms of a person’s goal. He will be either interested in pleasing God or himself. In addition, his approach and agen-

da for life will be focused in living out his relationship with Christ rather than getting “what I want.” And his method of fulfilling his agenda will center on responding to physical problems in order to become more like Christ rather than to achieve pain relief no matter the cost.

B. COMMITMENTS FOR CORRECTLY INTEGRATING THEOLOGY AND MEDICINE

Be encouraged! You can practice biblically-based medicine. First, you must make a commitment to approach the practice of medicine as a true biblical theologian. This means that you will view the patient as a whole person, realizing and understanding that his outer-person problems will influence his inner person and that his inner-person activity affects his body. People live out of their hearts.²¹ Therefore a good theologian will be more interested in moving patients to approach their bodily problems from a biblical perspective rather than simply removing their pain or enabling them to function better.

Second, you must commit to approaching a patient’s physical problems as an opportunity to minister God’s truth to him. In order to do so, you need to develop as a *listener* as you gather data. The patient has something on his mind. He has hopes, fears, expectations, and desires. He lives out of who he thinks he is (an identity). He has an agenda designed in his mind to obtain his hopes, and he pursues his goals. He comes to you with all of this and isn’t aware of the fact that he is a theologian and that theology matters.

Biblical data gathering requires that you ask appropriate questions that “look below the surface” of the bodily problem. Otherwise you will function only as a body mechanic.

Third, you must commit to being an *interpreter* of the data. Seeking to apply God’s truth in your medical office means that you must understand what the patient has said biblically and reframe his response, both in his thinking and action, as well as the problem, using biblical terminology. God’s solution will be discovered only if the “diagnosis” is correct. The purpose of proper interpretation is to help the patient get victory God’s way.

Fourth, data gathering questions should be directed toward the patient’s heart in order to develop and implement a therapy plan that moves toward vic-

tory. You will do this by helping the patient see the beauty of applying biblical principles to his problems.

C. EXAMPLES THAT FURTHER ILLUSTRATE THE PRACTICE OF BIBLICALLY-BASED MEDICINE

People ask me how I use the Bible as I take care of patients. Since I became a Christian, my world view has changed and with it my view of practicing medicine. I now consider taking care of patients a ministry of the gospel either in terms of salvation or in the use of biblical principles to help Christians grow and change. I have come to realize that bodily problems are part of the pressures and "heat" of life. They serve as the context in which a patient's allegiance to Jesus Christ comes to the forefront. When a patient presents to me, he is more than a symptom describer or a bodily problem. He is one in need of physical and spiritual help. But that help must be given in the context of the whole person, his spiritual maturity, and his willingness to hear and apply biblical truth. He needs Jesus Christ, the Truth not only for salvation, but for daily living with a body he may not like or that has even failed him.

I have not always thought this way about life and the practice of medicine. It was only when I began to understand that all of life is theological that I realized the best thing anyone can do is to have a relationship with Christ and apply its benefits to his life. The Bible is not a textbook of medicine, but it is the Owner's manual for life and it has much to say about bodily (outer-person) problems. Now I practice medicine by attempting to apply biblical truth in every case given the constraints of whether the patient is a believer and his willingness to accept and apply it.

Medical history taking is part of taking care of patients. I learned it as a fact-finding mission in medical school. However I now gather data not only about the patient's symptoms and complaints, but about the patient himself. Understanding his fears, hopes, expectations, resources, and concerns will help understand his agenda and the reasons he comes to see me.

As part of listening to patients, I ask questions in order to understand where they are coming from. For instance, I ask smokers the reasons for their smoking and continuing to smoke. The answer is helpful to me in becom-

ing aware of what drives a patient. The answers to the question of "why do you smoke" are manifold but generally boil down to the fact that "I like it" and "It is a habit." "What is it that you like about smoking?" is my next question. Most, if not all, say it is because it makes them feel better and relaxed. In other words, they believe it helps them handle life. From answers like these, I learn a great deal about patients that I can carry over into a diagnosis and treatment program for their rheumatic problem. They have told me that they seek to handle the problems of life by doing something that makes them feel good irrespective of whether it honors God, or is bad for their body, or addresses the reasons for the bad feelings, or even gives any other hope.

Patients on antidepressants, when asked why they are depressed, will tell me any number of things such as: "I don't know why," "I didn't know I was," "I am depressed about everything," "Life," and "I can depress myself about anything." Here again these patients have told me a lot about themselves and how they handle and respond to life. For a rheumatologist who is familiar with patients and their complaints of pain, an understanding of what makes a patient tick is a valuable tool for developing a ministry program of treatment for these patients.

So, asking questions is an important aspect of my practice of medicine. However, I must do something with the data that I gather. I am forever inundated by patients who complain of pain and have no hope. They have no hope because they have defined hope in a manner different from God's definition of hope (Romans 8:24-25). Hopeless patients will endure poorly or not at all. Hopelessness further pushes the spiral of wrong thinking downward. Depression is allowing bad feelings to guide and control behavior. This contrasts with the culture's definition of depression. Bad feelings may result from any number of causes: a specific bodily disease, a sin-cursed body unrelated to a specific disease, a sin-cursed body as a result of a specific sin (a hangover from too much alcohol or a hand that hurts because of a fracture that occurred when striking an unmovable object when angry), medication, or unbiblical thinking about any number of things including bad feelings.²²

As a rheumatologist, when I find a patient as described above I get excited. When a patient is at the end of his rope and doesn't see relief spelled his way, he

is more willing to change his definition of hope. When he does this, I am able to provide appropriate biblical principles for his particular case which gives both me and him true hope. In order to do so, I will help him understand the connection between the inner and outer person. I explain that since man is a duplex, thinking and wanting are linked to feeling and activity. Hope is related to understanding, and right understanding fosters hope. It is the Truth that sets you free from the bondage of sin (John 8:31-36). I can begin to bring the truth to him as I bring truth to his treatment regimen.

V. POTENTIAL OBJECTIONS AND THEIR SOLUTIONS

HERE ARE SOME POTENTIAL OBJECTIONS TO PRACTICING BIBLICALLY-BASED MEDICINE.

A. Some may say “It isn’t ‘right’ to bring religion into the office.” As I said earlier, that statement itself is a theological statement because everyone is a theologian and all of life is lived in or out of relationship to God. “Right” must be defined according to some standard and doing so is a theological endeavor. When a standard other than the Bible is used, it is bad theology. Apart from the God-given standard, one has no absolute standard by which to make such a statement. Scripture alone is such a standard.

B. “The Bible is not a medical textbook; therefore, it has no place in guiding the care of patients.” Clearly the Bible is not a medical textbook or a plumbing text or even a cookbook. No matter. The Bible is what it says it is. It is God’s owner’s manual that describes blessings and curses for how we live as worshipping creatures. This includes taking care of the body that God has entrusted to each person as an act of worship. Life is about relationships (God to man, man to God and others) including practicing medicine. And since the Bible is about relationships and worship, it addresses how a physician should practice medicine.

C. “I am too busy. I don’t have enough time. I have too many constraints on me. I have patients to see and paperwork to do. I need to have an income by which to support my family.” There are consequences of approaching medicine and the care of people as a disciple of Jesus Christ. Jesus urged His disciples to count the cost of being His disciples (Luke 9:57-62). The believing physician is faced with the task of seeing patients and running an office. He may not see any way to approach medicine other than the way he was taught. In addition, patients may object to the use of biblical principles in their lives, and colleagues may disapprove of this “religious thing.”

The ultimate issue is commitment to God or to the wisdom of the age – and for what motive. The wisdom of the age offers no true hope to doctor or patient and is, in fact, an attempt to steal from God. Stewardship of one's body and helping in that stewardship activity is a basic foundation of biblically-based medicine.

D. **"It is easier to make a patient feel good so I can be productive, move on to the next patient, and keep things peaceful. Disgruntled patients disrupt the office. I will lose patients."** Again this comes under the rubric of counting the cost of discipleship. I am not underestimating the concerns of physicians. However these concerns must be placed under the Lordship of Christ as an answer to the question: "Whom do you serve?"

E. **"There may be legal factors or responses from the county medical society that make it hard for me to talk to patients about their relationship with Christ."**

Disgruntled patients, and perhaps colleagues, may bring their grievances to certain boards. However, often it is not the message as much as it is the messenger that leads to this. Biblical truth must be presented in such a way that God is glorified, not slandered. Presenting biblical truth is not the problem. Rather, it is the manner in which it is done. The physician must remember that he is not the patient's Holy Spirit or the Heart Knower. He is God's instrument to bring God's wisdom to the patient.

If there is conflict, the conflict should not be between the physician and patient but between the patient and God. Therefore, the physician must reflect the Master (Jesus Christ) in terms of his message and manner of presentation. He is an ambassador for Christ (2 Corinthians 5:16-21).

F. **"Giving biblical truth is the job of the pastor and the church not me."** This statement is partially correct. It doesn't follow, however, that the physician is not required by his God to practice biblically-based medicine as an individual believer. In addition, even many pastors have been sucked into the seduction of "the expert" and have functionally rejected the sufficiency and superiority of Scripture for living all of life.

G. **"I don't know how, and I don't know my Bible well enough."** This statement makes clear that the one making it is a poor theologian. And the

remedy for that is discussed in the section of "being up on your Bible."

H. **"Medical science says something different. I read in the medical journals and textbooks that people are victims, circumstances and people cause things in people, and medications help correct these 'diseases.'"** As I said throughout, practicing medicine is essentially the issue of Joshua 24:15: Choose this day whom you will serve. Practicing medicine is service and the issue is to Whom? The physician who filters the Bible through medicine and practices accordingly has mixed God's truth with man's discoveries. He is acting as if man's discoveries are tantamount to God's revelation. When something else is mixed with truth, truth will always be diluted. In essence, what usually happens is that practicing medicine is according to the wisdom of the age. That means that medical science trumps God's written Word.

I. **"'Spirituality' is what one thinks it is" and "Any faith will do, so it makes little difference which one a patient has."** These statements clearly express the inclination of every man to be autonomous. Defining "spirituality" and faith apart from the Bible and without direct reference to the Holy Spirit is the height of man's folly.

J. **"If I pray with and for a patient that is all I need to do."** Some believing physicians view the office as a place of evangelism and getting people saved. Some pray with patients and patients may feel better after that is done. However, in addition, the Bible calls all believers to grow and change. The arena of physical problems is the place where every practicing doctor is able to bring God's truth to bear in a personal and concrete manner in order to help his patient grow. The Christian life is much more than getting people saved. That is only the beginning. Life is about becoming what God originally designed all believers for: Christlikeness (Ephesians 1:4). Physical problems are one of God's instruments they are to use in order to change, and the physician who practices biblically-based medicine is able to function as God's instrument in this process.

VI. A SIMPLE PLAN WITH WHICH TO BEGIN

A. Consider the material presented here and elsewhere such as in Dr. Bob Smith's *Medical Desk Reference* and my book entitled *Pain: the Plight of Fallen Man. God's Prescription for Persevering*. These resources will allow you to begin to see medicine with a biblical eye. These resources are not necessarily exhaustive, but they do lay down a foundation by which Christian physicians can practice biblically-based medicine.

B. Discuss the situation with your pastor. This can be tricky. Many pastors delegate. Even though "spreading around the responsibility for pastoral care" is a function of the church, too often delegation is tantamount to abdication (Ephesians 4:11-14). Pastors need to form a working relationship with physicians who are motivated to practice biblically-based medicine. The pastor and physician can forge a working plan by which they jointly minister God's truth to hurting people.

C. Begin to filter medical problems through the grid of the Bible. This will require a major shift in the thinking of the physician. Functionally, the temptation is to side with science over the Bible. Physicians tend to be "medicalized" rather than "biblicalized."

The "demedicalization" of medicine is a call to apply biblical principles to the practice of medicine. Physicians can begin this process by learning what the Bible says about man's goal for life, health, disease, and even specific physical problems. The Bible is never silent about any aspect of life. It gives principles that theologians may apply in proper context and proper ways. We saw that clearly in the case of Mary. Biblically-based medicine is the tool God used to turn her from a miserable life to one in which she joyfully serves the Lord even when her body doesn't feel good.

D. Next, as a practical exercise, take the five most recent medical problems and review them using the guidelines given here. Compare your handling of them with the results. Not every patient will respond like Mary did.

And yet God has plans for every patient He brings your way. You need to redeem the opportunities by taking advantage of bringing His truth to hurting patients. The patient's referring physician will take notice of the results. You will have opportunity to influence at least two people.

As you review your approach to the practice of medicine, remember to tailor your approach to your specialty or subspecialty and the type of patients you see. As a rheumatologist, I am a consultant and I see patients who generally have chronic complaints. The basic principles, however, are the same for every physician who is practicing biblically-based medicine, even though they must be adapted to each practice.

E. Begin to be a data gatherer of a patient's presumed motivation, identity, agenda, efforts in pursuing that agenda, and the results of his efforts. As you interview a patient, be thoughtful that he is a whole person and functioning, perhaps, as a poor theologian. Minister to him physically, but don't settle for an incomplete job. You might be surprised by what you uncover. That just confirms that man's way of handling life is no match for God's direction. When Mary took hold of this fact, her whole life changed radically.

F. Include a place in your history taking that asks for a patient's status as a believer. If he says he is a believer, then develop ways that help you determine the influence of that fact on his response to life in general and physical problems in particular. Many who claim to be believers function as if their relationship to Christ was only a fire escape out of hell.

G. Develop a set of papers that address common problems of patients that you see in your office. They should provide current medical knowledge. Some subjects may include sleep problems, so-called "irritable bowel syndrome," and so-called "restless leg syndrome." These subjects are well advertised and are based on subjectivity. In other cases, the person's response to his proven medical condition aggravates his symptoms. Provide information that helps a patient distinguish between the bodily problems and his response to them. This is your entry gate for bringing God's Word to the patient.

H. Help a patient to re-label his thinking and response to his situation using biblical terminology. The goal is to always point him to God's solution as the only means of victory in this earthly existence.

APPENDIX A

Proverbs 12:25: “Worry in a person’s heart makes it sink; but a good word makes it glad” (*The Christian Counselor’s Commentary: Proverbs*, or *CCCP*). “An anxious heart weighs a man down; but a kind word cheers him up” (*NIV*).

- *A person can worry himself sick. Worry is an inner-man activity and is bad for the body, but words of encouragement are good for the body. Worry leads to fatigue and depression. It is a wrong view of God, self, circumstances, and responsibilities.*

Proverbs 14:30: “A healthy heart is the life of the flesh; but envy leads to rottenness of one’s bones” (*CCCP*). “A heart at peace gives life to the body, but envy rots the bones” (*NIV*).

- *The effect of the inner man was well known in Biblical times. An inner man agitated by unrest, bitterness, and envy affects the outer-man. Such was the case with our patient.*

Proverbs 15:13: “A joyful heart makes one’s face pleasant, but an aching heart breaks his spirit” (*CCCP*). “A happy heart makes the face cheerful but heartache crushes the spirit” (*NIV*).

- *Attitude which is an inner man function affects the body and feelings.*

Proverbs 15:30: “Shining eyes rejoices the heart, and a good report fattens the bones” (*CCCP*). “A cheerful look brings joy to the heart and good news gives health to the bones” (*NIV*).

- *What is outside a person influences his whole person, both inner and outer-man.*

Proverbs 16:24: “Pleasant words flowing with honey are sweetness to the soul and healing to the bones” (*CCCP*). “Pleasant words are a honeycomb, sweet to the soul and healing to the bones” (*NIV*).

Proverbs 17:22: “A joyful heart brings about good healing, but a crushed spirit saps the bone” (*CCCP*). “A cheerful heart is good medicine, but a crushed spirit dries up the bone” (*NIV*).

- *A person’s body is influenced by his attitude and state of mind.*

APPENDIX B

Elijah was famished after a strenuous and exhausting day's activity. He had prepared a sacrifice, took on the prophets of Baal, led the killing of the prophets, and then ran some 20 miles. Yet faced with the threat from Jezebel, he ran for cover out of fear and from a sense of being overwhelmed. He was "wiped out." He was physically exhausted. He well could have been given a diagnosis of depression.

What was going on with Elijah? He ran but it wasn't to the Lord as his refuge and help in time of trouble (Psalms 18; 46). His fear was not fear of the Lord. What had happened to this man of God? He ran from God because he feared man. He had allowed bodily problems to affect the functioning of his inner person. He considered himself without any source of strength, refuge, safety, or security. His solution was to abandon his responsibilities and withdraw from life. He prayed that God would do it for him (1 Kings 19:3-5).

However, God ministered immediately to his material side, but also to his immaterial side as well by confronting Elijah about his wrong thinking. God restored his body, but He did not use drugs. Instead He used ravens — birds considered unclean in the Hebrew culture — to bring him food. In meeting his physical needs, God was continuing to demonstrate His presence and power. Elijah had lost sight of Who God was and who he was. God revealed Himself mightily — His power and His compassion — in the wind, the earthquake, the fire, and ultimately (personally) in the gentle whisper. This personal God was concerned about individuals. After coming face to face with the Living God, Elijah was sent on his way.

APPENDIX C

Typically, disease has been defined as a bodily problem that is objectifiable by physical examination, laboratory studies including blood tests and biopsy reports, and/or radiographic studies. Today, this is not always the case. The influence of subjectivity on medicine is especially seen in the so-called "mental disorders," but it crosses all medical disciplines (irritable bowel syndrome in gastroenterology; FM in rheumatology, restless leg syndrome and various headaches in neurology, just to mention a few).

Illness is even more loosely defined as an unhealthy condition. The medical jargon used for this is "symptom expression." Therefore, when the words "disease" or "illness" are used, a condition that is judged "not normal" is based on "symptom expression," meaning it is based on subjectivity and not pathological changes. What is "normal" and "healthy" has been blurred.

When medicine terms "disease" or "illness" as an impairment or deviation of the "normal," a standard for normal and healthy should be in place. When subjectivity is that standard, science is blurred and symptoms and their "control" take center stage. It is no standard. It is like a rubber ruler that may be stretched as one sees fit. This is especially true in the pseudo-science of psychiatry which deals in the subjective — thoughts, feelings, and behavior — and then categorizes so-called "disease" based purely on subjectivity.

Moreover, psychology and psychiatry attempt to cover the same territory as the Bible. They both study human behavior, values, interpersonal relations, attitudes, beliefs, pathology, marriage, the family, helping, and multiple problems such as worry, fear, and loneliness. There is then competition. How can they coexist? The answer is only if the Bible is diminished. God doesn't bless His competition (Isaiah 42:8; 48:11).

When subjectivity rules, "improvement" of the condition will be couched in subjective terms: "I feel better." This direction and emphasis is taking place in traditional medicine as well. Therefore, it is important and helpful, even mandatory, to distinguish between signs (objective) and symptoms (subjective), and the phrases: "something wrong *with* the body" and "*in* the body."

A symptom is that which a patient tells you about his body. It is subjective. Feverishness is a symptom but it is usually presented as a sign: "I have a fever." There is no "feverishness" gauge, but there is a thermometer by which one can determine a fever. The fever is a sign and is objective. Signs and symptoms may indicate something wrong with or in the body. However a symptom is less reliable than a sign because it is totally subjective whereas a sign requires an objective measurement.

The distinction between something wrong *in* the body and *with* the body has become blurred when "symptom expression" is the major focus in practicing medicine. This leads to confusion in understanding what is going on with the patient. Something wrong *with* the body refers to a pathological finding that is either structural, such as thrombosis of the coronary artery, or functional such as hyperglycemia or hypoglycemia. On the other hand, something wrong *in* the body may be a physiological response, such as a rapid heart rate when one is fearful – the so-called "panic attack," or when one is anxious – so-called "stage fright," or when the patient may have hyperthyroidism. Clearly the two are not the same. It is most helpful to help patients think clearly about what is going on in and with their bodies.

It is important to understand the various theories of disease and symptoms expression. Basically there are three:

1. Medical Model (MM): In part, it is a legacy of Koch and Pasteur who ushered in a then novel concept of medicine. They related the cause of disease to a specific etiologic agent and ushered in the microbial or germ theory of disease that stood in sharp contrast to the religious atmosphere of the age. Based on this theory, it is presumed that the body is sick and that symptoms, as well as signs and behavior, are caused by an abnormality in some organ or tissue causing malfunction (molecular model of disease) of the body.

Under the framework of the MM, disease is diagnosed when discoverable abnormalities are present by some objective testing and symptoms can be explained on the basis of these abnormalities. A person's thoughts, beliefs, and desires are considered to be independent of the diagnosis and management of the patient. Some call this a "mind-body" dualism. A therapeutic rationale is developed as a result.

The MM has been quite successful in the diagnosis, assessment, and management of certain diseases, especially those that are acute. In those cases, the focus is usually on a single, acute medical problem, e.g., streptococcal pharyngitis or lung cancer. However, there is no room for God in this model. In fact, the model developed as a reaction against the mysticism and superstition of the age.

2. Biopsychosocial Model (BPS): Since the early 1990s, medicine has moved toward a more inclusive BPS model of disease and patient care, emphasizing the role and importance of biology, "psychological" factors, and "environmental" factors on health and bodily function. These factors are considered determinants of the condition. People with the right or wrong genes and biology, and things on the outside of them "do it" to a person on his inside so that he feels and acts a certain way.

"Biological" refers to a person's genetic make up: genes and biochemistry.

"Psychological" has to do with one's psyche which is generally defined as one's mind, how he feels, and his *deep inner self*. "Psychological disease" and "mental illness" then are claimed to indicate that something is wrong *in* or *with* the brain and mind which are considered synonymous. "Social" (or environmental) is used in relation to "pressure" outside the person "causing" something within a person even though "it" is not always measurable. What is measurable is the person's bodily response which is attributed to that which is outside the person. But the fallacy is that the individual is never seen as a responsible responder, but as a victim.

This model allows for compartmentalization of the person and has led to the development of "experts" who believe their area of expertise is where the person has his problem. That area is thought to have a determining influence on the production of bodily problems. They call this "disease" and "illness." This assessment sets in motion a compartmentalized treatment program.

3. Biopsychosocial Spiritual Model (BPSS): This model adds a "spiritual" dimension to the presumed cause of symptoms, conditions, and disease. The proponents of this model suggest that at the very least, spiritual variables – *however defined* – are fundamental determinants of "psychological" variables which, in turn, are determinants of physical and social factors. The ma-

major thought is that all these factors play a role in producing or aggravating disease in the person.

The failure to address "spiritual needs" has been linked to patient dissatisfaction and poor clinical outcomes despite advances in technology and breakthrough treatments. However "spiritual needs" were defined non-biblically as a need to make sense, purpose, and meaning of illness; as a desire to acknowledge and cope with the notion of death and dying; and as a desire to feel in control (or give up control), be connected, and cared for. The standard for spirituality is never defined by Scripture and the term is used relationally in the context of a person's "connectedness" with self, others, a higher being, or the universe. It is a user-friendly word that is all-inclusive irrespective of one's theology.

Each of the models excludes God, His judgment, His grace, and His providence. They are theologically incorrect. The MM originally attempted to give an accurate description of an observed phenomenon. Now it has been used to explain any and all behavior even though no pathological findings are demonstrated. The BPS and the BPSS are attempts to "fill in the gap" left by the MM, but move further down the path of wrong theology.

In light of these theories, consider Mary. She presented with "bad feelings" which were attributed to everything except her unbiblical response. It seems that many physicians are prone to focus on the material and physical to the exclusion of the non-physical. And when they have exhausted their diagnostic possibilities physically, they are ready to speak of the influence of the immaterial on the body. This influence is generally called "psychosomatic," is shifted to the realm of psychology and psychiatry, and is partially responsible for the patient being treated with medications which are directed at changing feelings. A "spiritual" dimension may be added, but it is a spirituality using non-biblical standards for the purpose of "feeling better." The call of practicing biblically-based medicine includes the understanding that God's truth has answers for a believer's health, that there is a connection between the indwelling Holy Spirit and how one views his body, and that one's relationship with Christ affects feeling and thinking.

The only way for Mary to be a victor was to apply God's truth to her prob-

lem and resolve it God's way. A physician who firmly believes in the sufficiency of God's Word and is willing to apply biblical truth in his practice of medicine is the physician who offers true hope and great victory for his patient. God provided Mary's fertile heart so that once her thoughts and desires were brought in line with biblical truth, she gained victory.

APPENDIX D

Depression is produced when a person focuses on the bad feelings and the desire to have them removed and chooses to allow them to control his activities. In response to the bad feelings, he ceases to fulfill his God-given responsibilities. The feelings of depression are the result of how one has handled many different aspects of life including “small” as well as “big” problems. That person allows bad feelings – from whatever cause – to control how he functions. In response to bad feelings, wrong thinking (about the body, a particular bodily problem, life, self, and ultimately God) and wrong actions result in further bad feelings.

“Depressed” patients have never been taught (or have rejected) the principle that wanting, thinking, feeling, and doing are related. If they are believers, they have not been taught (or have rejected) the principle that Christ in them is their hope of glory (Colossians 1:27). Perhaps a patient can never have the body he wants, expects, and thinks he deserves. However, the believer has something far superior. The believer who has been re-created in the image of the living God and indwelt by the Holy Spirit has resources beyond measure to live a satisfying life. He doesn’t have to depend on any number of variables such as whether he doesn’t get older, he gets cured, he gets changed, people around him change, or medicine finds some cure for his problem. The best thing this side of heaven is developing the character of Christ (1 John 3:1-3). And the believer who understands what the Bible teaches about hope will use his bodily problem as a God-given tool and instrument to grow in Christlikeness.

FOOTNOTES

¹ Over the past ten years of practicing rheumatology, I began to develop and use a set of papers (a total of nine now) that came about because I was not helping hurting people. The papers are entitled: 1. Pain is a Problem; 2. Arthritis and Rheumatism; 3. Treatment of Rheumatic Conditions: an overview; 4. Does Your Attitude Help You Deal with Your Pain? 5. Is there a Connection between Pain, Depression, and Stress? 6. What is the Best Way to Produce a Changed Attitude and Thinking? 7. Is There Anything Superior to Positive Thinking for Pain Relief? 8. Is Pain Relief All There is? 9. What Do You Do When Your Body Fails You? Dissatisfied and disenchanted by the way patients were doing (or not doing), and my role in trying to help them, I was looking for a better way. After I became a Christian I discovered that better way. It meant using biblical principles to help get victory in life, especially one marked by a failing body. What would be my plan to implement that theology? It was, in part, to use the above mentioned papers which are designed to move patients to a theological understanding and interest in gaining victory in, not necessarily out of, their problem (Romans 8:35-37). Reading the papers effectively extends my time with each patient, and his response is his communication to me. After reviewing that response, I am in a better position to effectively minister God’s truth to him.

There are three questions at the end of each paper which when answered serve to gather more data, help me gain involvement, and give helpful information. The questions are: What did you learn? How did it help? What changes do you think you need to make?

The papers do several things for me and the patient: They make clear a number of rheumatic problems and how they differ. They give a core set of information which helps clear the air as to what one has or doesn’t have. Those who read the papers and answer the questions are usually more interested in changing their thinking about their body and treatment options. The answers provide me with more information regarding the person’s relationship with Christ, his view of faith, prayer, healing, and where I as a physician fit in.

² The second paper spells out the difference between arthritis — both inflammatory and degenerative — and soft tissue rheumatism (STR). I categorize STR as local, regional (another name for this condition is myofascial pain syndrome — MPS), and general (fibromyalgia: FM). Over the years I have found very little use for the term FM. Most patients I see who have received that diagnosis have many of the following findings: scapular tilts, pelvic tilts, tight hamstrings, and a functional leg length discrepancy. In addition, they are mechanically inefficient.

I illustrate the connection between the soft tissue and bone/joint by drawing a schematic of a *nerve* which innervates the *muscle* which is joined by the *tendon* to the *bone/joint*. It is important that patients understand the connection and interplay of each of the parts to the whole. In that way I can help them focus on the whole system, not just a part of it.

Too often, I find that the diagnosis of FM entices both patient and physician alike to focus on the term FM rather than the mechanical problems that can be corrected or improved by an educational program, commitment to good stewardship of the body and thinking, and a regular, home exercise program that emphasizes reeducating the patterned muscle function, reducing specific muscle fatigue, improving range of motion, and improving strength. Based on the criteria established by the American College of Rheumatology (ACR), patients with scapular and pelvic tilts and tight hamstrings would not fit the criteria of FM. In the patients that fit the above physical findings, the bodily area of interest is the soft tissue just as in FM (see footnote 9). I have chosen to group all soft tissue problems under the rubric of STR as it seems illogical to do otherwise.

³ Matthew 18:21-35:

v.21: Then Peter came and said to Him, "Lord when my brother sins against me, how many times should I forgive him? As many as seven times?"

v.22: Then Jesus said to him, "I don't tell you seven times but seventy times seven!

v.23: Therefore the kingdom from heaven is like a king

who wanted to settle accounts with his slaves.

v.24: and he began settlement, one was brought to him who owed ten thousands talents.

v.25: But since he couldn't repay the debt the lord commanded that he, his wife, his children, and everything that he owed be sold to repay the debt.

v.26: The servant fell on his knees and begged him, "Be patient with me and I'll repay you everything."

v.27: And the lord took pity on his slave and released him and forgave his loan.

v.28: But when he went out, the same slave found one of his fellow slaves who owed him one hundred denarii and he seized him and throttled him, saying "Pay whatever you owe."

v.29: So his fellow slave fell down and begged him, "Be patient with me and I'll repay you."

v.30: But he wouldn't. Instead he went and threw him into prison until he paid the debt.

v.31: When his other fellow slaves saw what had happened they were greatly upset and went and told their lord all about what had taken place.

v.32: Then his lord called him and said to him, "You wicked slave, I forgave you your entire debt because you begged me.

v.33: Shouldn't you also have shown mercy to your fellow slave as I showed mercy to you?"

v.34: And his lord became angry and handed him over to the torturers until he paid his entire debt.

v.35: So also will My heavenly Father do to you unless each of you forgive his brother from his heart.

Mark 11:25: And when you stand praying, if you have something against anyone, forgive him so that your Father in the heavens also may forgive you your trespasses.

⁴ Victory is defined as being *controlled* by biblical principles rather than

a person's wants and the agony of the condition. It means *pleasing* God rather than seeking relief. It is *using* the condition to put self to death and to become more like Christ as a supraconqueror (Romans 8:35-39; 1 Corinthians 15:54-57).

⁵ The Bible teaches that man lives out of his heart (Matthew 12:33-36; 15:16-20; Mark 7:18-20; Luke 6:43-45; Proverbs 4:23). The Bible uses various terms to describe man's immaterial side or inner person. These include heart, mind, spirit, soul, will, and conscience. Each term used serves to express a distinct functional capacity of the inner person. "Heart" is the most common term used to picture man's inner person activity. The Bible doesn't view man's behavior as isolated and unrelated to his inner person. Rather he is a whole person who thinks, desires, and acts. A person can be compared to a sponge or a pitcher. Only what is inside will come out when the sponge is squeezed or the pitcher is poured. Both hard and good times squeeze a person so that his beliefs, convictions, wants, desires, and motivation are expressed in response to outside pressure.

⁶ By *interpreter*, I mean that I needed to listen in order to understand and evaluate what she was telling me from her perspective. Understanding for the purpose of evaluating what was said was key. And I needed a standard by which to judge what she was telling me as a help or hindrance for moving her toward victory. By *implementer*, I mean that I not only was to be a learner and receiver of data, I needed to understand what she was saying in order to help her apply God's truth to the situation.

⁷ These verses address the issue of forgiveness. Matthew 18:21-35 deals with man's incalculable debt toward God, man's complete inability to pay, man's arrogance in thinking that he can pay, and the effect of failure to or rejection of God's lovingkindness and forgiveness in removing His enmity toward and alienation from man. One result of this failure is grudge-holding which, in essence, is functionally playing God. Mark 11:25 addressed the urgency of a willing heart to grant forgiveness.

⁸ The basis for the statement that all of life is theological and that everyone is a theologian is summarized by these facts. First, God is man's *environment*. This is an inescapable fact. God is not limited by space – He is present everywhere. Therefore, there is no escaping God (1 Kings 8:27; Acts 7:48-49; 17:27-28; Psalm 139:7-10; Isaiah 66:1; Jeremiah 23:23-24). The surrounding presence of God makes it impossible to live morally and ethically neutral. Second, man was created in *relationship* to God. In the Garden, Adam was a revelation receiver, interpreter, and implementer. God gave him information on how best to live in that relationship. Man is no different today except that God has given His direction through the Bible. Third, man is a morally *responsible* being because God the Creator so designed him as God Himself is a morally responsible Being. Fourth, this is God's world and His creation and creatures are His and are, therefore, *dependent* and *obligated* to Him (Psalm 24:1-2; 29; 33:6-11; 50:7-11; 93). Fifth, in the Garden and before the Fall, Adam and Eve were in relationship to God and *knew* Him as Creator and Judge: Genesis 2:15-17. Unconverted man continues to know God only as both Judge and Creator. Converted man, however, knows God as Redeemer and Father. God saves in the context of relationships. His people were chosen in Christ before the foundation of the world (Ephesians 1:4) and His people grow in that relationship as they become more like Christ. This process is called sanctification (setting one apart from sin to righteousness: Romans 8:28-29; 2 Corinthians 3:18; Philippians 2:3-5).

Therefore, all of life, from beginning (creation) to end (man's destiny which is heaven or hell) and all in between (either growing in the likeness of Christ or the likeness of Satan) is theological.

⁹ There are at least six characteristics of biblical stewardship: 1. God owns everything; yet you possess. This is an *ownership* issue (1 Chronicles 29:10-20; Haggai 2:7-8; 1 Cor 6:19-20). 2. God entrusts to you everything you have, including your body. This is a *responsibility* issue (1 Corinthians 4:2-5; Psalm 139:13-16). 3. You own nothing, but what God enables you to use and earn. This is a *user* issue (Deuteronomy 8:16-18). 4. God expects a return on what He has given. This is an *expectation* issue (Matthew 25:14-30; Luke 19:11-27). 5. You must give an account of your care and it may be today. This is an *accounting* is-

sue (Luke 12:16-21; 2 Cor 5:10). 6. The issue is good or bad stewardship and there are consequences for that stewardship. This is a *result* issue (Matthew 25:24-27; Luke 19:24).

¹⁰ The ACR introduced criteria for classifying patients as having FM in 1990 (Wolfe F, Smythe HA, Yunis MB et al: Arthritis Rheumatism 1990;33:160-172). The criteria include the complaints of widespread pain that is reported to persist for longer than three months and tenderness in at least 11 of 18 specific anatomic sites. One of the goals in doing so was to clarify a previously muddy field and to attempt to bring some closure to what for many patients and physicians was an interminable diagnostic and therapeutic journey. Whether the ACR accomplished its goals is open to question. The diagnostic criteria are based totally on subjectivity. Moreover, gauging response to treatment rests solely on the *patient's* subjectivity. Many think the diagnosis of FM has been misused and even abused by patient, physician, and lawyer alike. Consider the editorials in the *Journal of Rheumatology* by three rheumatologists (Drs. G Ehrlich, N Hadler, F Wolfe) who are considered to have expertise on this subject (J Rheumatology 2003;30:1666-1667, 1668-1670, 1671-1672). Each author agrees that the label "FM" describes patients who report pain that is "real" but that the entity itself should not be elevated to a disease status. Each author speaks to the "psychosocial" aspects of the condition and laments the reliance upon subjectivity for both diagnosis and treatment results.

¹¹ James Halla: See chapter 2 in *Pain: The Plight of Fallen Man*, Timeless Texts, Stanley, North Carolina.

¹² There is considerable controversy surrounding FM (see footnote 9). Just what is it? Does it truly exist? There is no question that patients come to the MD complaining of pain that is not joint/bone (arthritis) related nor nerve or blood-vessel related. Mary's symptoms and signs best fit a diagnosis of soft tissue rheumatism (see footnotes 1-2,9). In the secular world of medicine, it is generally agreed that "a large number of patients who carry the diagnosis of FM display high levels of 'psychologic distress'" (Bradley LA, Alarcon, G: Fibro-

myalgia, in *Arthritis and Allied Conditions*, 14th edition, ed: WJ Koopman, Lippincott Williams and Wilkins, Philadelphia). By "psychologic distress," the authors are referring to patients who have been given various psychiatric diagnoses such as anxiety and depression (see below). Thus, it is well recognized that patients who have been given a diagnosis of FM have inner-man issues as well as an outer-man problem. Even the secular world understands that how one responds to life affects feelings including the sensation of pain! In fact, John Winfield, a well known rheumatologist, wrote in his review of FM that "'psychological distress' is central to the pain experience and overall morbidity of Fibromyalgia" (*Rheumatic Disease Clinics North America* 1999;25:55-79; see pages 59-60). He gave five lines of evidence in support of this statement:

1. Increased "psychological distress" is a common characteristic of FM;
2. Higher "psychological distress" in FM is not caused by simply more severe pain;
3. "Psychological distress" is strongly correlated with the number of painful tender points (in this regard, he quoted Dr. F Wolfe, a noted rheumatologist who has written extensively on the topic of FM, saying that the tender point count functions as a sedimentation rate for distress irrespective of a diagnosis of FM: *Ann Rheum Dis* 56:268;1997). In other words, there is a line of research that believes the greater number of tender points acknowledged by a patient, the greater is his degree of "psychological" distress. Dr. Wolfe likened the number of tender points to the level of a sedimentation rate (ESR). A higher level in either instance indicated more distress (high tender point count) or more inflammation (higher ESR).
4. High levels of anxiety and distress together with less certainty that pain is going to resolve and a history of trauma are predictors of who progresses from acute pain to chronic pain;
5. Patients with already established FM and related pain syndromes can be separated by their level of psychological distress and depression into distinct groups ranging in severity from "adaptive copers" who do well clinically to highly "dysfunctional" patients who respond to treatment extremely poorly.

In contradistinction, it is much more helpful to replace the term “psychological distress.” I prefer the term “trouble handling life” which indicates a failure to address and solve both routine and unusual problems of life according to biblical principles. Such was the case with Mary. See Dr. R D Smith’s discussion of this subject in *The Christian Counselor’s Medical Desk Reference*; chapters 2: A Biblical View of Illness, and chapter 12: Fibromyalgia. Timeless texts, Stanley NC.

¹³ Biblical hope is the confident expectation that what God has promised is a reality and a certainty. Hope enables one to see with the eyes of faith rather than the senses what God has in store for him. It would allow Mary to look at the gain rather than the pain and to use what she didn’t like to become more like Christ.

¹⁴ EBM has developed out of the recognized need for objectivity in diagnosis and treatment. To that end, physicians are taught to search for, acquire, and apply appropriate *information – evidence or data* – that directs patient care decisions including screening, diagnosis, and treatment. The source of the evidence or information comes after the physician has asked a focused clinical question. One example may be: which antihypertensive is best in my patient? Depending on the focused clinical question, the physician may consult the particular national professional organization and its website (in our example it may be the Heart Association) and/or he may choose to begin his search for evidence at the National Guidelines Clearinghouse (NGC and its website: www.guideline.gov). After the physician has validated and interpreted the evidence or information, he makes his conclusion and applies it to the care of his patient. However, upon a closer look at EBM, I have concluded that even it has been tainted by subjectivity as a standard for treatment decisions and successes because it has added the clinical expertise of the physician and patient values to the research-obtained information and evidence.

¹⁵ Jensen MC and et al; Magnetic Resonance Imaging of the Lumbar Spine. in People without Back Pain. *New Engl J Med* 1994; 331:69-73

¹⁶ At issue here is not the use of medication per se, but what is the source of the person’s bad feelings. A patient may “feel bad” because he has active RA. I don’t treat the symptom of not feeling well, but the active inflammation and/or the resulting mechanical abnormalities of the disease. A patient with osteoarthritis of the knees may “feel bad” in his knees. Does one treat the bad feeling or the underlying problem? Bad feelings generally motivate patients to come to the physician. It is important for the physician to explore the source of those feelings and the hopes and expectations of the patient. Reducing the inflammation of RA is better for the body and generally results in the patient saying he feels better. If he doesn’t, then the physician must pause and gather more data regarding just what is going on *in* and *with* the patient and his body. OA patients also present with complaints of pain and not feeling well. They have a proven cause for their bodily problem. Usually these patients are mechanically inefficient which aggravates their symptoms and hinders progress in developing and maintaining good muscle integrity and function – such as the quadriceps muscle. And since no joint or bone is better than the muscle and tendon that moves it, analgesics and NSAID have a role in the treatment of these patients.

¹⁷ Elizabeth Kubler-Ross, *On Dying and Death*, Collier Books 1997. Dr. Kubler-Ross died in August 2004. After coming to the United States, she became interested in the terminally ill who had apparently been isolated from the mainstream of patient care. She found that these patients wanted to “talk.” She listened and developed her theory based on her observations and conclusions, not on biblical principles. The Bible says much about death (Hebrews 9:27; 2:14-15; 1 Corinthians 15:54-58; 1 John 4:18; 1 Thessalonians 4:13).

¹⁸ Robert D Smith, *The Christian’s Counselor’s Medical Desk Reference*, Timeless Texts, Stanley, NC, 2000, pages 3-26

¹⁹ Everyone has faith. Only the believer has saving faith which is a gift from God. The believer expresses or exercises that saving faith as a demonstration of God’s grace (Ephesians 2:8-10; Philippians 2:12-13). Saving faith allows

the believer to view life with a suprasensual perspective as Jesus described in John 4:31-34.

²⁰ Cornelius Van Til, *Defense of the Faith*, Presbyterian and Reformed Publishing Company Phillipsburg, New Jersey. Van Til makes the point that everyone argues circularly and starts either with God, the Creator, or apart from God – the creature or creation. Life must be in relation to God, or the creature will attempt to assume the importance that is reserved only for God. This is the great exchange described in Romans 1:18-25.

²¹ One may balk at this commitment and what follows saying it requires too much and in the end will cost someone something. This idea is summed up by the question: “Who pays?” In response, the overriding principle is faithfulness to God. Just consider what would happen if every Christian physician accepted and acted upon the tenet that the delivery of medical care was a theological issue. With that cadre of physicians facing and moving in the same direction, the end result would be far-reaching. We would be speaking about ministry and growing and changing in all of life including the bodily arena.

²² See Appendix D

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THE PRACTICE OF BIBLICALLY-BASED MEDICINE IS JUST WHAT THE DOCTOR ORDERED.

This book sets forth foundational truth that establishes the practice of medicine as a theological endeavor. The author then develops a “how-to” approach to the practice of medicine for rheumatology and calls other physicians to do the same for their areas of practice. The overriding principle in any endeavor is faithfulness to God. This book challenges every Christian physician to act upon the truth that the delivery of medical care is at the core a theological issue which should bring honor and glory to God.

“Once more Dr. Halla has added to our thinking about the relation of Scripture to Medicine. Having written previously to patients about how to handle pain, now he shows his fellow Christian physicians how to minister truth to meet not only that problem but others as well.”

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“Dr. Jim Halla has a heart to help physicians deal with the complete person as they treat their patients. In this book he encourages a different view of the practice of medicine. He presents an exciting and fresh approach to patient care that focuses on an essential biblical source of help which has been almost exclusively neglected in modern medical practice.”—BOB SMITH, MD

“Dr. Halla has encouraged us as physicians to rethink our view of medicine. Jim gives us practical ways to integrate our theology and view of God into our everyday practice of medicine.”—DAN WICKERT, MD

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