

Advocate Health - Midwest

SHARE @ Advocate Health - Midwest

Historical Documents - Combined

Advocate Health - Midwest History

Bulletin of the Park Ridge Center, 1988, V3 N2, March/April

Advocate Aurora Health

Follow this and additional works at: <https://institutionalrepository.aah.org/alldocuments>

BULLETIN

OF THE PARK RIDGE CENTER

Volume 3, Number 2

March/April 1988

Religious values and the economics of health care discussed at Center conference

What does the future hold for hospitals and health care systems? What is the role of religious hospitals in a competitive market? These and other questions were explored in a four-day conference sponsored by the Park Ridge Center during the last week of February in Phoenix, Arizona.

The keynote for the conference was sounded on the opening day by George Caldwell, president of the Lutheran General Health Care System in Park Ridge, Illinois. Caldwell spoke of "seven realities" of health care and medical economics which must be addressed in any serious discussion of health care systems:

"1. America spends more per capita for health care than any other nation, yet our health statistics are among the worst of the industrialized nations. Health care costs in America per capita are four times those of Great Britain and ten times those of Singapore—yet these places have approximately the same death and disease rates. Even though we spend more than \$1 billion a day on health care, there are 37 million people without health care coverage.

"2. Little serious thought is given to maximizing what our health care dollars purchase. We spend billions on technologically advanced 'specialty' medicine while ignoring the basic health measures—such as preventing disease—that could save far more lives. While millions of Americans don't have access to basic health care, we transplant hearts into smokers,

spend billions on life-support systems, and allow 30%–50% of the nation's hospital beds to remain open but empty.

"3. Wide discrepancies exist in medical practice in various regions of the country. The list of variations is long and, to a large extent, unjustified. In many instances, differences in the rates of operations correlate only to the number of physicians in the community.

"For example, women in Tampa or Orlando, Florida, and Atlanta, Georgia, are 50% more likely to have hysterectomies than women in

tain parts of the country than in others.

"4. The medical health establishment leads us to believe that it represents the only way—or at least the best way—to good health. But many of the great improvements in health haven't come from doctors or hospitals. They've been accomplished through vaccinations, refrigeration, sanitation, and antibiotics.

"America could be healthier if we concentrated on reducing tobacco and alcohol use, on improving our diets, and using our seat belts. We need to reconsider how we allocate resources. Locking up drunken drivers may save more lives than hospitals alone ever will. A \$1-a-pack tax on cigarettes could be more effective than another \$100 billion poured into the health care industry. A national seat-belt law might save more lives than all the CT scans in America.

"5. Health care providers often act and spend money as if they can 'cure' death. We aren't wise or brave enough to turn off the life-sustaining machines we were smart enough to invent.

"Students in American medical schools are taught to consider death an enemy in all instances instead of recognizing that we all must die sometime. The enemy of the health care system ought to be disease, discomfort, pain, suffering, and poor health. Almost a third of Medicare expenditures are spent in the last few

“
*America spends more per capita
on health care than any other
nation, yet our health statistics
are among the worst of the
industrialized nations.*
”

Chicago or Washington. Men in Los Angeles, Atlanta, or Fort Worth have a 60% greater chance of a prostate gland operation than males in Columbus, Ohio, or in Detroit. CT scans are performed seven times more often in cer-

(Continued on page 8)

We note with sadness the death on February 29 of Paul Ramsey, "the most influential American Protestant writer on medical ethics of his generation." An exploration of Ramsey's legacy in the field of theological ethics was published in Volume Six of *Second Opinion* (November 1987).

Medical-journalistic ethics

Two of the biggest medical-ethical news stories of the past couple of months involved America's two largest medical publications:

Which should take precedence: scientists' right to verify and carefully disseminate their findings or the public's right to know about important medical news?

In its January 28 issue, the *New England Journal of Medicine* published the results of a study that found that a

dose of aspirin every other day can significantly reduce the risk of heart disease and heart attacks. The five-year study involved 22,000 physicians as test subjects and was funded by the federal government.

NEJM immediately began receiving criticism for not releasing the data earlier. At issue was the journal's "Ingelfinger rule," named for a past editor and under which the journal refuses to publish findings that have been publicized elsewhere. The stated purpose of this policy is to prevent premature dissemination of inaccurate or incomplete information. Critics charged, however, that in practice the rule deprives the public of timely information about new discoveries in order that *NEJM* can advance its own prestige by having exclusive coverage of important stories.

In a front page "news analysis" in the *New York Times*, Lawrence K. Altman, M.D., the *Times*' chief medical reporter, noted that "many medical experts worry that this single journal, and perhaps a handful of others, exercises undue power over the flow of information on medical research. It is information that influences government policy, promotions, careers, financial markets, science policy, grants, and, not least, the treatment of patients." Altman suggested that the *NEJM* policy was designed not only to protect the public against unwarranted claims for medical findings, but also reflects "the desire for newsworthiness, which in turn is related to the need to make profits."

Medical economist Uwe Reinhardt joined in the discussion by claiming that the Ingelfinger rule makes professional colleagues "reluctant to talk about their work even informally lest they jeopardize their chances of having their work published in (the) journal. . . . the Ingelfinger Rule exists as much to enhance the economic position of the journal as to protect the public." Finally, a physician who had been a subject in the study suggested that enough results were known six weeks prior to publication that publicity about the findings then could have prevented "thousands of heart attacks."

NEJM editor Arnold S. Relman responded that the study was terminated prematurely on December 18, when the significance of the findings was evident. The journal received the manuscript on December 21, devoted two weeks to peer review, and three weeks to production, printing, and mailing. "Physicians needed to study the data in the scientific article before patients started asking about the benefits and risks of taking aspirin to prevent heart disease," Relman said. "Doctors cannot give sound professional advice on the basis of a broadcast or a newspaper story. I believe that our policy of discouraging premature media publicity is approved by the great majority of medical scientists, practicing physicians, and government health officials."

Relman also suspended for six months advance delivery of the journal to an international news agency, Reuters, charging that Reuters violated the Ingelfinger rule by prematurely releasing the aspirin study results. (*NEJM* alleged that Reuters had based its story on an advance copy of the journal; Reuters claimed its information came from a scientist involved in the study.) Reuters responded by vowing to get the publication through other sources and told Relman that for stories affecting the stock market (such as pharmaceutical successes) its "first responsibility was to investors" and thus it would not wait for clearance from *NEJM*. According to the *Boston Globe*, editors of the *Wall Street Journal* said they, too, will honor the Ingelfinger rule only so long as a story does not have implications for the stock market.

Relman was interviewed in *Second Opinion*, Volume One (March 1986).

Can mercy killing be justified? Should a medical journal publish an account of a mercy killing to spark debate without verifying the authenticity of that account?

In its January 8 issue, the *Journal of the American Medical Association (JAMA)* published an essay in its weekly "A Piece of My Mind" column entitled

Bulletin of the Park Ridge Center March/April 1988 Volume 3, Number 2

The *Bulletin of the Park Ridge Center* is published bi-monthly and sent to all Center Associates. Its purpose is to present accessible, useful information in fields related to health, faith, and ethics, and to provide Associates with a forum for interaction with each other. We welcome contributions from all Associates in the form of letters to the editor, research suggestions, and manuscripts for review and possible publication in the *Bulletin* or in the Center journal, *Second Opinion*. Additional copies and back issues of the *Bulletin* (if available) may be purchased for \$3.00 each, \$2.00 for Center Associates (write or call about quantity discounts). The editor of the *Bulletin* is Micah Marty; the copy editor is Sandy Mathai. Other contributors are Kathleen Cahalan, Martin Marty, David Stein, and James Wind. All material copyright 1988 by the Park Ridge Center.

To subscribe to the *Bulletin* and *Second Opinion*, Associates pay a single annual membership fee of \$35 per year (\$65 for two years, \$95 for three). In addition to the *Bulletin*, published six times per year, and *Second Opinion*, published three times per year, Associates receive discounts on Center books and periodicals; advance notice of forthcoming events and publications; and a greater opportunity to contribute to the Center's conversation on health, faith, and ethics. Editorial correspondence, research suggestions, and manuscripts should be sent to the Park Ridge Center, 1875 Dempster Street, Suite 175, Park Ridge, Illinois 60068. The phone number is 312/696-6399. To become an Associate or request more information about the Center, please write to the Park Ridge Center Membership Division, P.O. Box 1347, Elmhurst, IL 60126.

"It's Over, Debbie." The author, who claimed to be a gynecology resident, described intentionally administering a lethal dose of morphine to "Debbie," a 20-year-old, 80-lb. woman who was apparently dying of ovarian cancer (the author had never seen the patient before the night of the fatal injection).

"I could not give her health, but I could give her rest," wrote the author, who signed the essay "Name withheld by request." "I injected the morphine intravenously and watched to see if my calculations would be correct. . . . With clocklike certainty, within four minutes the breathing rate . . . became irregular, then ceased."

Although AMA officials have said they "oppose mercy killing in general and deplore the 'Debbie' case in particular," *JAMA* editor George Lundberg said he agreed to publish the essay to spark debate over what he sees as an "important and controversial situation in medicine." Responding to questions as to whether the incident actually occurred, neither Lundberg nor Dr. James Sammons (executive vice-president of the AMA) could be certain, although both believe the case described is real.

Ethical debate centered around two questions: was the physician's action justified, and should *JAMA* have published the essay? Editor Lundberg said "the mail is running 80 to 20 percent against publishing the piece at all, and the vast majority is running against the physician's action," although in a subsequent TV interview Dr. Sammons said that the responses were shifting. Sammons predicted that the debate over publication "will soon die down," and attention will be focused on the implications of the case itself, such as how often such incidents occur and what physicians should be doing to alleviate the suffering of terminal cancer patients.

In addition to raising ethical concerns, critics also charged that laws had been broken and that legal action should be taken to find the author. Cook County State's Attorney Richard M. Daley agreed and sought a subpoena in early February to force the AMA to name the author. "It was important to seek the identity of the per-

son who authored the 'Debbie' essay, because the article appears to be a confession to murder," Daley said. "Even more disturbing, it is an unrepentant confession by one who justifies the murder of another human being." On March 18, however, a Cook County Criminal Court judge ruled that no such subpoena would be issued until the State's Attorney's office had exhausted "all other means" of identifying the author.

In a related development, the California-based "right to die" group, the Hemlock Society, said it burned all records of a recent physician survey on euthanasia. The destruction of the data was apparently designed to preclude legal inquiries such as those initiated against the author of the "It's Over, Debbie" essay published in *JAMA*.

The Hemlock Society said it received 588 responses from a mailing to 5,000 California physicians. Seventy-nine of the respondents said they had practiced euthanasia at least once, and 29 physicians claimed to have practiced it more than three times.

Euthanasia in Asia

The United States isn't the only country struggling with questions of euthanasia. According to the news agency Reuters, two articles published recently in mainland China showed support for permitting the killing of terminally ill patients. One magazine, *Chinese Women's Journal*, published a survey of 199 people in a northern province and reported that 89% "favored euthanasia for terminally ill cancer patients." The magazine noted that "as euthanasia is against Chinese traditional concepts and morality, the result was a surprise." (In volume 4 of *Second Opinion*, ethicist Ren-Zong Qiu, of the Chinese Academy of Social Sciences in Beijing, noted in his discussion of the increasing acceptability of euthanasia in China that "the long hospital stay of patients in irreversible comas . . . is maintained through the sacrifice of other curable patients.")

Another magazine, *Health News*, described what it termed China's first court case on euthanasia. The case dealt with a woman whose son and

daughter convinced a nurse to administer a lethal injection when they found their mother could not be cured. After the woman died, two other daughters went to court and the son and daughter were charged with murder. The court freed the siblings pending further investigation.

The same magazine reported that euthanasia also received surprising support from the 83-year-old widow of former premier Chou Enlai. Her support came in a letter to a central radio station and endorsed the conclusions of a scientific conference in December in which a number of Chinese physicians came out in favor of mercy killing.

Euthanasia is translated in Chinese as "peace and happiness death."

Surrogate motherhood

Back on the American legal scene, in a unanimous decision the New Jersey Supreme Court ruled that commercial surrogate-mother contracts are illegal. In the February decision, the court allowed the father of "Baby M" to maintain custody of the child but threw out last year's lower court ruling that the father's wife could adopt the baby, ruling instead the child's biological mother was "not only the natural mother, but also the legal mother." The court then ordered a new hearing on visitation rights for Baby M's biological mother, Mary Beth Whitehead-Gould.

Experts on surrogate motherhood noted that the ruling is legally binding only in New Jersey, but suggested that lower courts in other states would base future decisions upon this precedent. In its decision, the New Jersey high court left room for surrogate motherhood arrangements only if the surrogate mother receives no money for the process and only if she has the right to keep the child after birth if she changes her mind. Lawyers involved in writing of surrogate-mother contracts suggested that few women would be willing to be surrogates if no money were involved, and few couples would want to sign a contract if the biological mother had a right to ignore the contract and keep the child.

BOOK NOTES

In lieu of our usual "Book Notes" format, we are printing the discussion of one book, Eli Ginzberg's *American Medicine: The Power Shift* (Rowman and Allanheld, 1985). That discussion took place at the Park Ridge Center's annual meeting in Phoenix the weekend of February 28 and expanded far beyond the boundaries of the book, becoming a symposium on health care in America today. The participants are identified the first time they speak.

Glen Davidson, Chair, Dept. of Medical Humanities, Southern Illinois University School of Medicine: Professor Ginzberg is regarded by and large as the father of medical economics. It would be hard to find anyone in the country who has made more of a name for himself looking at the economic forces that drive the health care system. We need to keep that in historical context—20 years ago there were no specialists in medical economics. Then in 1981 and 1982 there was an effort at Columbia University to introduce ethics to med students. The faculty turned to Ginzberg as someone they could entrust to wrestle with the issues of how economic concerns affect access to medicine in a just society. One entire chapter of the book is based on that experience with the med students.

Thus Ginzberg has gained a wide reputation for the ability to understand the "mystical forces" that seem to be driving the health care system. Of course there are many critics of his perspective and even of his methodology, but no one criticizes the kinds of questions that he is raising. The book itself is a bit dated, but I would be hard pressed to identify a better one and the issues are still as relevant as ever.

A theme of our conferences over the years has been, What does a work like this have to say to the faith traditions? as well as, What do the faith traditions have to say to specific issues (such as the trend toward ambulatory care instead of inpatient care) that we're looking at? Is what's going on in health care shaping values, or is it a reflection of values already existing in the culture?

What in the various faith traditions

has allowed us until very late to assume that the main arena for care should be an inpatient setting, or what I have referred to before as the "hospital in the role of the cathedral." What within the church, the synagogue, the mosque, or any other sacred place

“

*Is the health care system
shaping values or is economics
shaping the values and
determining the health
care possibilities?*

”

allows a shift to an outpatient trend; is it simply a matter of economics? *American Medicine: The Power Shift*, although it was published three years ago and undertaken a couple of years before that, still poses these crucial questions for the faith traditions.

Martin E. Marty, President, The Park Ridge Center: Why do you say the book is "a bit dated"?

Glen Davidson: One of the biggest changes has been in the realm of reimbursement to the "cathedral." Where is the collection plate being passed and who's putting money into it? What tests physicians call for and how far these should be pursued is directly proportional to the amount that will be reimbursed in light of the Diagnostic Related Group formula (which pays the hospital a specified amount regardless of length of patient stay) instituted several years ago. The institution is now rewarded for shortening the stay of the patient whereas in the past decisions about length of stay were based on the condition of the patient.

Judith Swazey, President, Acadia Institute, Maine: I agree. The theses raised by Ginzberg haven't changed so much, but the numbers have. One major locus of change that I hope is going to come—and right now I think is being crippled by reimbursement under the DRG system—is the growing need for home care services, especially for the elderly.

This area of health care is falling between the cracks. It can't get funded and there's a tremendous shortage of personnel. The nursing shortage that Ginzberg just began to see has only been exacerbated and it will only get much worse.

Karen Lebacqz, Professor of Religion and Ethics, Pacific School of Religion: That leads me back to our initial question whether the health care system is involved in shaping values or whether in fact it is economics that shapes the values and determines the possibilities. If reimbursement determines that we get good inpatient care but don't get good home care, what permits us to make a shift from one pattern to another?

Robert Stein, Dean, University of Minnesota Law School: I think economics at least initially drove this change. Health care followed the economic inflation of the 1970s but defied efforts to control inflation that succeeded in other parts of the economy. This caused funding sources to apply more and more stringent tests for eligibility.

On the other hand, I've been struck recently by the desires of families to have the patient die at home rather than in a hospital with all the tubes attached. Maybe the value of wanting to die at home has been there all along and I just haven't heard it expressed, or maybe the economics are shaping the values.

George B. Caldwell, President, Lutheran General Health Care System: My general sense is that the medical/health establishment's delivery of illness care has been reactive rather than proactive. I remember in hospital planning you simply studied the demographics of your community and then

planned to respond to those demographics. Home health care nursing has been unsuccessful because Medicare doesn't pay for it. What has been successful is high-tech care, which the large pharmaceuticals and others have capitalized on very quickly.

The other thing that's happened is how quickly technology has changed the nature of the cathedral: (a) We're reacting to the financial system rather than planning what we should be doing; and (b) technology is such that it's wham, bam, you're out the door. I like to say we've become a nation of body shops. With the emphasis on technology rather than the broad range of human healing skills, the hospital comes to be perceived as an unpleasant place to be.

Harold Shafter, *Executive Vice-President, Medical and Professional Affairs, Lutheran General Hospital*: One can, however, be on the receiving end of this technology and not feel oppressed but rather feel comforted and reassured. It depends a lot on the attitude of those taking care of the patient.

I think reimbursement has definitely affected most of what we do in hospitals: it has shortened the length of stay, and medical students are preparing for ambulatory rather than extended hospital care. DRGs, of course, were just coming into place when Ginzberg wrote this book.

The other thing I think Ginzberg underestimated was the impact of managed care such as health maintenance organizations (HMOs). He didn't seem to think they would be a major factor, yet in the few years since he wrote the book, HMOs have had a powerful impact not only on patients but also on physicians and physicians' attitudes. The whole notion of the primary care physician as the gatekeeper is a concept that I'm sure will engender a lot of discussion.

Daniel Schechter, *President, American Hospital Publishing Company*: From my perspective, the business of the hospital is the care of the patient, not just businesslike behavior. In terms of publishing we see what's important to the health care deliverers. There's a

new breed of institutional manager, people who have come into the field from different routes than the traditional M.H.A., people who are concerned with share of markets, joint

“
Ginzberg avoids all talk of
values. Economists will tell you
that economics is a value-free
science, although of all the
disciplines it's the least
value free.”

ventures, and productivity. On boards of institutions, those with community service orientations are being replaced by board members with the background to make large and significant financial decisions.

So there are new kinds of managers and new kinds of managerial responsibilities, and more and more investor-owned institutions, which has played a large role in the proliferation of not-for-profit alliances and multihospital alliances. For a while one felt overwhelmed by the business aspect of hospital management, but now institutions are once again talking about the issues pertaining to quality of care.

J. Philip Wogaman, *Professor of Christian Social Ethics, Wesley Theological Seminary*: I have an advantage not enjoyed by most of you in looking at this book, namely, a brain that isn't corrupted by very much actual experience. As a layperson in health care, I'm wondering how you react to chapter 13, "Non-Conventional Views." It seemed that the mountain was laboring and bringing forth a mouse in terms of actual conclusions. Perhaps I picked up the book unreasonably expecting a panacea, but it seemed as though every possible promising op-

tion was raised and then discarded, leading me to wonder where I might find the shift advertised in the subtitle. I'm curious how those of you in the medical field reacted to that particular chapter.

Christine Cassel, *Chief, Dept. of Internal Medicine, University of Chicago Hospitals*: I have enormous admiration for Ginzberg, but I share the sense of still being hungry after finishing this book, because Ginzberg, like most economists, avoids all talk of values. Economists will tell you that economics is a value-free science, although of all the disciplines economics is the least value free. You have all these ideological schools at war with each other. What medical economists do is deal with a very superficial layer of what really matters in health care, such as whether voucher systems, or preferred provider organizations, or health maintenance organizations are going to make a difference. All of that is very transient. Even DRGs haven't made much of an impact in health care spending. Those administering DRGs have announced with some pride that the rate of growth has been slowed somewhat, but that wasn't what they were looking for—they were looking for a flat line.

The problem is that we who work in health care often think that economic manipulations reflect value choices. I question whether Americans really do dramatically shift their values every eight years, because that's what we've seen. In 1972, we were about to enact national health insurance, because we thought it was the right of every American to receive good health care. Then, only eight years later, it was embarrassing in polite circles to even mention national health insurance—people thought you were some kind of wild-eyed radical. Now it's starting to become acceptable to discuss it again. So it may be that the values question really hasn't been asked in a cogent way, at least not by economics.

(Continued on page 6)

BOOK NOTES

Book Notes (from page 5)

Daniel Foster, *Professor of Internal Medicine, University of Texas Southwestern Medical School*: I have strong feelings about what I've been hearing in this room, particularly the pervasive negative tone about "cathedrals" and technology and so on. Modern scientific medicine is one of the glories of

“

Religion and society should decide how we're going to allocate resources. If you want a new aircraft carrier in the Persian Gulf, you may not be able to get a CT scan when you need it.

”

our civilization. And yet to hear the tone of this discussion, you'd think medicine is something we ought to be ashamed about.

I take care of the poorest of the poor, and also the richest of the rich. It's easy to talk about the "burden of oppressive technology" if you've got an 88-year-old mother who's been unconscious for two years and you're deciding whether to do multiple CT scans, and quite another if you're talking about a 20-year-old husband and father of two little babies who has acute leukemia. I object to the idea that limited health care—the comforting physician with an empty black bag and “home care”—is OK for the other, but not OK for me. If death is premature, most people would want tubes and wires and would not find them oppressive.

People outside medicine should take into consideration some very real everyday occurrences that are not just abstract things. It's purely an economic thing: if our country does not want to pay for modern medicine, that's that. I

don't myself like modern medicine that's available to only a fraction of our population.

Religion and society should decide how we're going to allocate our resources. If you want a new aircraft carrier in the Persian Gulf, then that's a political decision you have to make. But then you may not be able to get a CT scan when you need it. And I understand perfectly that CT scans and heart transplants have nothing to do with the health statistics in this country. If you really want to do something about premature death, do something about cocaine, handguns, cigarettes, seatbelts. That's not the doctor's problem. But high-tech medicine does make a difference in individual lives, and in this country we have always decided that individual lives were important. High technology can be humanized.

James P. Wind, *Director of Research and Publications, The Park Ridge Center*: We selected this book because it gives an overview of the economic realities affecting modern medicine. I'm struck by how secondary religion is to this telling of the story. I feel like we have a diagnosis and then an appeal for help in the book that the economist knows he or she can't provide. Let me illustrate:

On page 18, Ginzberg talks about “ineluctable forces” that have drawn medical care into the vortex of the money economy. When I look at those forces, I ask “How could you ever overcome this?” If you turn the page, Ginzberg replies, “to secure its long-term financial foundation, American medicine will require a combination of political leadership and professional cooperation that is not yet visible on the horizon.”

Similarly, on page 27, he notes that “No innovation could make a greater contribution to cost containment over the long term than an investment by the American people in maintaining their own health through alterations in their personal behavior. This change cannot be effected by legislation; it depends on long-term changes and education reflected in new lifestyles and behavioral patterns.” While Ginz-

berg attempts to be scientific and neutral and avoids all talk of values, he gives himself away in these quotes, which acknowledge these powerful forces out there and end with a weak appeal for help. There's no way

“

I'm struck by how secondary religion is to this telling of the story. We have a diagnosis and then an appeal for help that the economist knows he or she can't provide.

”

economics can provide this; it has to come from somewhere else, from other kinds of resources, of human will, of consensus, of belief, and perhaps that's where religion might become more central.

Judith Swazey: I think there should be both high-tech medicine in the tertiary care hospital and home health care; it shouldn't be an either/or situation. None of us wants to dispense entirely with modern medicine and return to the laying on of hands. It's a matter of when high tech should be applied. If you asked the American people if they are willing to sacrifice the option for CT scans or the option of long-term home health care for the elderly because we're spending too much on health care in this country, people don't say, we want to contain costs no matter what. But I don't think the American people have really been asked that question. We're seeing more and more underserved, underinsured, uninsured people and more and more tiers of health care, and I think the American people are beginning to say “That is not an implicit set of values we're happy with.”

Dennis P. McCann, *Director, Center for the Study of Values, DePaul University*: In response to Phil Wogaman's comments on chapter 13, I'd say that the great strength of this book is also its great weakness. The great strength is that it's very informative—it eliminates a lot

“

We're seeing more and more underserved, underinsured, uninsured people, and the American people are beginning to say, 'This is not a set of values we're happy with.'

”

of quick-fix solutions, especially those dealing with neoclassical economic paradigms. But the net effect of debunking everyone else's bright ideas is very conservative, favoring the current status quo, followed by platitudes like, “Well, we'll just have to find the political leadership to find the resources to keep us keeping on.” If you ask me why this book is out of date, I'd say that the economic picture is even bleaker than it was in 1985. We're going to have make some serious, major choices, and piecemeal reforms are very inadequate.

I'd like to discuss what we're doing to ourselves in becoming so preoccupied with business-oriented considerations in our worries about funding. What is that doing to us in terms of vision, mission, when it really comes right down to the pressures on individuals in health care institutions?

Donald Rippert, *Chief Financial Officer, Lutheran General Health Care System*: There's an underlying assumption here that as a nation we're spending too much on health care. Eleven or 12% of the GNP is said to be “too

much.” Well, I don't agree with that at all. I think 15% might be better. We used to spend 3%, and it was a disgrace. We now spend 12% and it's a disgrace according to a segment of the population. Well, I don't think the American people are unhappy with 12%. Everytime they run a poll, Americans aren't generally unhappy with their own health care, although they perceive everybody else's to be bad, and that's because they are *told* everybody else's is bad. I agree that there are people falling through the gaps, and we should spend more as a country to make sure that they don't. But everybody seems to take as a given that 12% is too much. I don't agree. Let's consider 15%, and if we have to take it out of the armed forces, OK. I'm an old Navy man, but I'll say the disgrace is where our country is spending its money.

Judith Swazey: I agree, but we should compare our health status with that of the Japanese and the English. What are we buying with our health care dollar? Simply pouring more money into the funnel is not going to automatically result in better health care.

Don S. Browning, *Professor of Religion and Psychology, University of Chicago Divinity School*: I'd like each of us to clarify what we mean when we say “national health policy,” an issue that keeps coming up in this discussion. Ginzberg advocated a mixed model of cost containment, some additional spending, and more philanthropy, but he doesn't discuss “national health policy.”

Daniel Foster: I talk about national health insurance because I'm interested in the poor, and I don't think we can have a society where 40 or 50 million people can't get health care. I don't care what anybody says; nobody's going to take care of the poor unless the government does. We take care of the poor quite well in Dallas because they give us millions of dollars to do it. But what do they do in Detroit? What do they do in Chicago, at Cook County Hospital?

Christine Cassel: When people talk about national health care there's fear and panic and everyone thinks about England and its problems. But there's a big difference between insurance and delivery, and the insurance system itself need not be a monolithic thing. It's clear that this country has

“

Nobody's going to take care of the poor unless the government does. We take care of the poor quite well in Dallas because the government gives us millions of dollars to do it. But what do they do in Detroit, or in Chicago?

”

the physical resources to deliver better health care to all citizens if it chooses to, but that's where questions of values and priorities become more important than market economics.

*Coming
in the
May/June
“Book Notes”:
Books on AIDS*

Conference (from page 1)

months of beneficiaries' lives, providing little or no benefit to the dying patient. The money is spent on life-sustaining measures which seem only to prolong suffering, causing patients' families to think of health care systems as an enemy, not a friend.

"6. Defensive medicine costs America an estimated \$15 billion a year. Almost every patient undergoes too many tests and X-rays because of the fear of lawsuits. The legal system in America compounds the problem. The reform of the health care system won't occur until we dramatically reduce the threat posed by lawyers and lawsuits.

"7. Finally, health care has become an economic issue that prevents our American products from competing in the international marketplace. American goods sold abroad are expensive because they contain a hidden health care cost that's three or four times greater than those of our overseas competitors."

Caldwell's keynote speech highlighted some of the recurring themes of the four-day conference. On Friday, Judith Swazey, president of the Acadia Institute, in Maine, discussed artificial heart transplants as a microcosm of the American health care system. The artificial heart, Swazey asserted, reflects that peculiarly American optimism underlying physicians' difficulty in accepting even inevitable deaths.

On Saturday, J. Philip Wogaman, a professor of religion and ethics at Wesley Theological Seminary, addressed how economic decisions in health care reflect values. Like Caldwell, Wogaman compared life expectancy and disease rates in the U.S. to rates in countries that spend substantially less per capita on health care.

DePaul University ethics professor Dennis McCann called for a renewed "spirituality of institutions," in particular a specification of the moral purpose that guides religiously affiliated health care institutions.

In addition to these three papers (which will be published in volume 8 of *Second Opinion* in July), conference

participants also discussed the following books: *Economics and Ethics*, by Dr. Wogaman; *Six Theories of Justice*, by Park Ridge Center Board Chair Karen Lebacqz; and *American Medicine: The Power Shift*, by Eli Ginzberg (see "Book Notes," p. 4).

To wrap up the weekend conference, the Center sponsored a panel discussion, open to the public, of three questions about modern health care systems: (1) If I am sick, will religion help the system give health care?

“

Students in American medical schools are taught to consider death an enemy in all instances instead of recognizing that we all must die sometime.

”

(2) If the poor and left out need care, will religion help the system deliver?
(3) If medical institutions today are in crisis, can religion help bring about a better tomorrow?

Center president Martin E. Marty was moderator for the discussion and opened by noting that even use of the word "system" could be challenged because many Americans don't have access to health care organized well enough to be called a "system." However, he said, it is a useful word to describe the complex networks of large hospitals, government agencies, insurance carriers, and legal procedures that must be taken into account when discussing American health care.

In response to the first question, "If I am sick, will religion help the system give health care?" Dennis McCann replied, in a word, "Maybe." McCann, who teaches business ethics, said that "healing and the idea of healing ministry is much larger than medical intervention." For religion to help the health care system in the U.S., he suggested, religion must make sure that "the mission statements of religiously affiliated health care institutions are taken seriously and realized through

the programs those institutions implement and the attitudes they convey."

Daniel Schechter, president of American Hospital Publishing, had an answer almost as concise as McCann's one-word reply: "I hope so." Schechter said that this is a particularly "tough time" for the health care delivery system because the public is demanding hospitals that are "more competitive, more cost-effective, less dependent on government, able to provide community services 24 hours a day, capable of caring for the elderly and poor, taking advantage of all new technological advances and making them available to all—and all of this when inpatient care is being shortened or eliminated entirely."

Schechter questioned whether health care institutions would see religion as "yet one more burden" or if religion is in fact intrinsic to the mission of the institution. "For the religiously sponsored hospital this is a double challenge: to create a climate of respect for all individuals and their beliefs while operating in a competitive market and an environment in which there is inadequate government reimbursement for poorer patients. This is a tough mandate for hospitals."

The second question posed to the panel was "If the poor and the left out need care, will religion help the system deliver?"

Karen Lebacqz, Center board chair and professor of Christian ethics at the Pacific School of Religion, answered the question by presenting three pieces each of "good news" and "bad news."

Her "good news":

— Within the past five years, more than a dozen Christian church bodies in the United States have produced statements on economic justice that affirm as a priority the need to help the poor in the U.S.

— The church bodies are moving away from "simple concepts of charity, doing for others out of our largesse or out of what is left over, and moving toward justice, a sense of the entitlement of the poor to services or access to services."

— Poverty is being redefined more broadly to include not simply material

deprivation but also people who have been "marginalized" or excluded from society in some way—again, a move toward "justice."

Lebacqz's "bad news":

— The general ethical principles pronounced by church groups do not always yield specific policy directives, and are thus of limited benefit.

— Even at the level of principle, some churches' statements on economic justice and priority for the poor are not as strong as Dr. Lebacqz would like them to be.

— There is a kind of "paternalism" that manifests itself in "society's tendency to do for the poor rather than to involve the poor and marginalized in actual decision making and access to power."

Daniel Foster, professor of internal medicine at the University of Texas Medical School, agreed with Lebacqz that people who want to change the plight of the poor could "speak to the national conscience [and] be a voice for mercy that political leaders hear."

Foster also stressed that citizens can work within their own communities to meet the needs of the poor. The church he attends in Dallas feeds 250–300 street people daily and, through grants, provides psychiatric, medical, and dental care to many of those homeless.

Third, Foster suggested, the churches and those who practice medicine can use their positions of authority to influence governmental policy. (His church and its diocese are working with various levels of government to get funding for an AIDS hospice that is expected to open this summer.)

The third question on the evening's agenda was "If medical institutions today are in a crisis, can religion help bring about a better tomorrow?"

Judith Swazey took issue with the term "crisis" but said there are both acute and chronic problems in medical care institutions, with a number of possible responses.

Swazey suggested that hospital governing boards take a close look at the mission statements of their institutions, accounting for the community and financial reality, and ask whether the institution adequately embodies the values that undergird it.

In addition, Swazey said, physicians, nurses, and others who work in health care institutions need to examine the professional values that guide their work rather than getting "too wrapped up" in the technical dimensions of care. She also suggested that those who give care and govern institutions need to constantly look at the values of patients, "to see the human beings they serve as far

“

I was very touched by the number of first- and second-year med students who went to the funeral of their cadaver after anatomy ended. They were saying something very profound in that.

”

more than disease entities or interesting cases."

Swazey concluded by challenging institutions with a phrase from Richard McCormick's book *Health and Medicine in the Catholic Tradition*: "If you were indicted for being a religiously sponsored institution, would there be enough evidence for a conviction?" In light of Swazey's contention that the "values" of an institution are best conveyed by those who work in them, moderator Martin Marty asked what physicians, nurses, and other caregivers do with their personal religion when they enter the hospital.

Daniel Foster responded that physicians prefer to be known for their healing and medical expertise rather than for their religion. "People call me up and say, 'Could you recommend a Christian psychiatrist?' or 'Could you recommend a Jewish neurosurgeon?' My reply is always, 'Would you settle for competence?'"

Because he teaches in a state university, Foster explained, the faculty is not allowed to ask about students' religious affiliation, much less seek to

change it. However, he said, religion is there and it's inevitable that the subject will come up—particularly when dealing with seriously ill patients.

According to Foster, patients who are ill often ask a set of questions. The first set is "relatively easy" for physicians to address: "What's wrong with me, and what's going to happen?" The second set, if a serious illness is diagnosed, is "Do I have what it takes to go through what I'll have to go through?" Foster said that most people have "a reservoir of quiet courage," and most answer affirmatively. The third set of questions become more "religious," along three fundamental themes: theodicy ("Why me? Am I sick because I sinned?"); afterlife ("With death will I cease to be?"); and worthiness ("If there's life after death, will I be found wanting in some way?").

Foster said sometimes all the physician can do is be willing to listen and talk, but "it's probably OK" for the physician to share personal beliefs as long as they're identified as such.

Judith Swazey added that in her experience, teaching bioethics to medical students is very difficult until they've had some clinical experience. Partly because our society "views religion as very private," Swazey claimed, med students get "very uncomfortable" if a discussion moves into a value or a moral or a religious dimension. Later, she feels, when students advance through courses in anatomy and pathology, "as they dissect cadavers and watch their first autopsies, very strong values and religious feelings about life and death and illness start coming through. The first years I taught first- and second-year medical students I was very touched by the numbers that went to the funeral of their cadaver after anatomy ended. They were saying something very profound in that."

After medical school, however, physicians usually "deal with it by not dealing with it," according to Swazey. "It's a survival mechanism, what Renée Fox has called 'detached concern.' Those in patient care have to be able to distance themselves to some degree, and any discussions of the role of religion in the mission of these institutions have to keep in mind that the caregivers are already balancing on a very difficult tightrope."

RESEARCH SUMMARY

AIDS

"AIDS: Legal Implications for Health Care Providers," a pamphlet published by the Catholic Health Association (1987), outlines the legal issues health care providers face when they treat persons with AIDS. The legal principles of confidentiality and fair employment are outlined. The pamphlet suggests that confidentiality laws must be maintained in order to protect patients. "Dissemination of such information to those who have no legal or rational requirement to know it may result in the provider's criminal and/or civil liability."

The HTLV-III blood test also raises serious questions about patient and employee rights, and the pamphlet advises against mandatory testing. "Since the test indicates only that the subject has been infected by the virus—not whether the person has or will develop AIDS—widespread mandatory screening is inadvisable because it will lead to unjustified discrimination."

This pamphlet is accessible to the lay reader and would be useful for all employees in health care institutions, regardless of whether they come into contact with AIDS patients. It is available from Catholic Health Association, 4455 Woodson Rd., St. Louis, MO 63134.

Sider, Ronald J. "AIDS: An Evangelical Perspective," *Christian Century*, January 6-13, 1988.

The author considers AIDS from an Evangelical Christian point of view, highlighting the theological and biblical understandings of the human person. Sider immediately affirms the good of all persons: "Our Christian understanding of both creation and redemption tells us that people with AIDS are of inestimable worth, persons so important and precious in the sight of their creator and redeemer that God declares them indelibly stamped with the divine image" (p. 11). While this is the primary response to AIDS by the Christian community, secondary issues require more complex understandings.

Sider denies that AIDS is a homosexual disease or God's punishment of those who have sinned. However, he does argue that promiscuous sexual behavior breaks the moral law of God and any breach of this law is sin and has consequences. The Bible does not support the notion that AIDS is a special punishment, Sider writes, or that specific illness is directed at specific kinds of sins. He does uphold the moral teaching that homosexuality is wrong and that homosexual acts break the law of God. "Evangelicals should be able, however, to condemn homosexual practice as a sinful lifestyle without being charged with homophobia or blamed for many of the problems emerging in the AIDS epidemic. Almost all evangelicals consider homosexual practice (which must be carefully distinguished from homosexual orientation) to be sinful. And I agree, although I want to add that it is no more sinful than adultery, greed, gossip, racism, or materialism" (p. 12). The church, Sider suggests, has several tasks in light of the AIDS epidemic. First it must set a good example, which it has not always done. It must also provide direct ministry to persons with AIDS and their families. It must educate everyone about the medical aspects of AIDS. And finally, it must look at the deeper theological issues around the questions of sexuality that AIDS has raised.

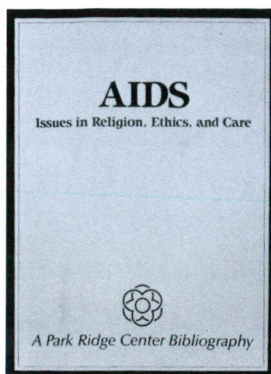
Osborn, June, M.D. "AIDS: Politics and Science," *New England Journal of Medicine*, Feb. 18, 1988, pp. 444-47.

Osborn, one of the leading public health officials in the country, warns that AIDS has only begun to pose problems for society. Several political bodies operate as if AIDS were a short-term problem that can be handled by controlling the groups mainly affected, homosexuals and drug abusers. The author warns, however, that "AIDS is here to stay. It is like the day after Hiroshima—the world has changed and will never be the same again. The new virus will be a fact of life for our children's children; much can be done to moderate its force, but it cannot be made to disappear."

Public education must continue, the author argues, since there is no other way to combat the spread of the disease. This education must assist in shaping long-term public policy that will protect both patients and society.

"AIDS is the most difficult terrain possible for politicians, for the wisdom of present policies often will not be validated for five or more years, and some of the necessary language of prevention is awkward to use in oratory. But reluctance to embark on difficult programs is predicated on the assumption that the situation is temporary, that it will go away. It won't, of course" (p. 447).

Center's AIDS bibliography available



Research on AIDS has generally focused on the medical and legal aspects of the disease, paying less attention to the profound religious and moral questions that have arisen. To address this oversight, the Park Ridge Center is offering a bibliography, *AIDS: Issues in Religion, Ethics, and Care*. More than 300 citations reference scholarly articles, denominational statements, and various publications that treat ethical and theological questions related to AIDS.

The bibliography is intended for use by students of medicine, ethics, and religion; those engaged in scholarly research; ministers in hospitals and congregations; and counselors, social workers, and therapists who care for persons with AIDS. Cost is \$9.95 (\$7.95 for Center Associates) plus \$1.00 for postage. To order, write to the Center at P.O. Box 1347, Elmhurst, IL 60126.

Cherry, Kittredge, and James Mitulski. "We Are the Church Alive, the Church with AIDS," *Christian Century*, January 27, 1988, pp. 85-88.

The authors are members of the Metropolitan Community Church of San Francisco, located in the neighborhood with the largest gay and lesbian population in the city. The church preaches that homosexuality is a gift from God, and many persons with AIDS have flocked to its doors. At present 30 of the congregants have AIDS, and of course the number continues to rise.

"We have come to understand ourselves as a church with AIDS. This doesn't mean that our church will soon be dead and gone. No, in fact it means that we live more deeply" (p. 86). This article describes the church's ministry to persons with AIDS and their loved ones, as well as the mission of the larger church. Pastoral ministry, healing services, and education are the core of the church's ministry.

Hovey, Gail. "Facing AIDS: Three Duties," *Christianity and Crisis*, February 15, 1988, pp. 27-28.

The author outlines three duties that the AIDS epidemic teaches us: care for those who suffer, the allocation of resources to find a cure, and education against this disease. "The first duty is to care for people with AIDS, people with HIV, and their lovers, families, and friends." Second, we must commit ourselves to finding a vaccine to stop the spread of the disease, which means monies must be raised and allocated for this work. Last, education is the responsibility of all, including the church, even if it involves the difficult issues of condom use and discussion of safe needle practice.

"Sex Education: Information or Formation?" *Origins*, December 31, 1987; "Continued Reaction to AIDS Statement," *Origins*, January 7, 1988; "Public Policy Regarding AIDS/ARC," *Origins*, January 28, 1988.

The U.S. Catholic Bishops' statement

on AIDS ("The Many Faces of AIDS: A Gospel Response," *Origins*, December 11, 1987) fueled considerable controversy. These follow-up statements were published in response to readers' perception that the original statement condoned the use of prophylactic devices. The bishops, however, were not condoning such practices; rather they were seeking to provide the most relevant medical information.

Nursing Ethics

The fall 1987 issue of the *Journal of Christian Nursing* was devoted to the problems that confront nurses who treat patients with AIDS. The articles included a discussion of confidentiality, "AIDS: Should Nurses Honor a Patient's Confidentiality or a Partner's Right to Know?" and follow-up discussions by a person with AIDS, two hospital lawyers, a nurse, and a physician. A gay man tells of his struggle to accept death in "My Name is John. I Have AIDS." His story is followed by a set of questions for nurses concerned about giving "spiritual" as well as nursing care to patients like John.

The Institute of Medical Ethics (London) publishes a monthly bulletin outlining key articles in medical ethics. The January 1988 issue included a supplement on nursing ethics. The topics covered are: shared legal and practical issues for doctors and nurses, disagreements between physicians and nurses over treatment, confidentiality, management and limited resources, and do-not-resuscitate orders. The supplement also includes a list of books for further reading on nursing ethics.

Scanlon, Mary Colleen, and Cornelia M. Fleming. "Nurses Come Together to Face Ethical Issues," *Health Progress*, December 1987, pp. 46-48. The authors, who are both R.N.s, discuss the formation of a nursing ethics committee at Calvary Hospital in New York. The hospital primarily treats adults with

advanced stages of cancer. The forum was designed to explore ethical choices "nurses make daily and to deal with controversies that arise in the care of advanced cancer patients." The goals of the group were to "promote responsible and ethical nursing practice by increasing awareness of the ethical dimensions of nursing, facilitating communication among nurses, and familiarizing nurses with ethical principles and components of the decision-making process."

Infant Mortality

Anderson, George M. "Dying Young: Infant Mortality in the United States," *America*, December 26, 1987.

Each year nearly 400,000 children in the United States die before their first birthday. The infant mortality rate in the United States is worse than that of 16 other industrialized nations. In the District of Columbia the infant mortality rate is double the national rate. A black infant born in Washington, D.C., is more likely to die within the first year than an infant born in Trinidad or Tobago.

These disturbing facts reflect how economic factors cause a radical disparity in health care. High infant mortality rates can be linked to racism, teenage pregnancy, and lack of medical resources for the poor, Anderson writes, and government efforts to alleviate this problem are minimal. The author concludes, "Nationwide change is possible only through the resources of the federal government. Congress has always voiced bipartisan support for the well-being of mothers and children. But the present Administration . . . has been reluctant to consider this group as a priority."

—Compiled by Kathleen Cahalan

Non-profit Org.
U.S. Postage
PAID
Chicago, IL
Permit No. 6531



The Park Ridge Center

**An Institute for the Study
of Health, Faith, and Ethics**

The Park Ridge Center is an interreligious, multidisciplinary institute for the study of health, faith, and ethics. Through research, discovery, and publication, the Center functions as an international forum for experts in health care, religion, and ethics, and as a resource for information on religion and bioethics. The Center aims to fulfill a perceived worldwide need for the study of religious aspects of human well-being, especially as they relate to prevention and treatment of disease, interpretation of illness and health, and similar concerns.