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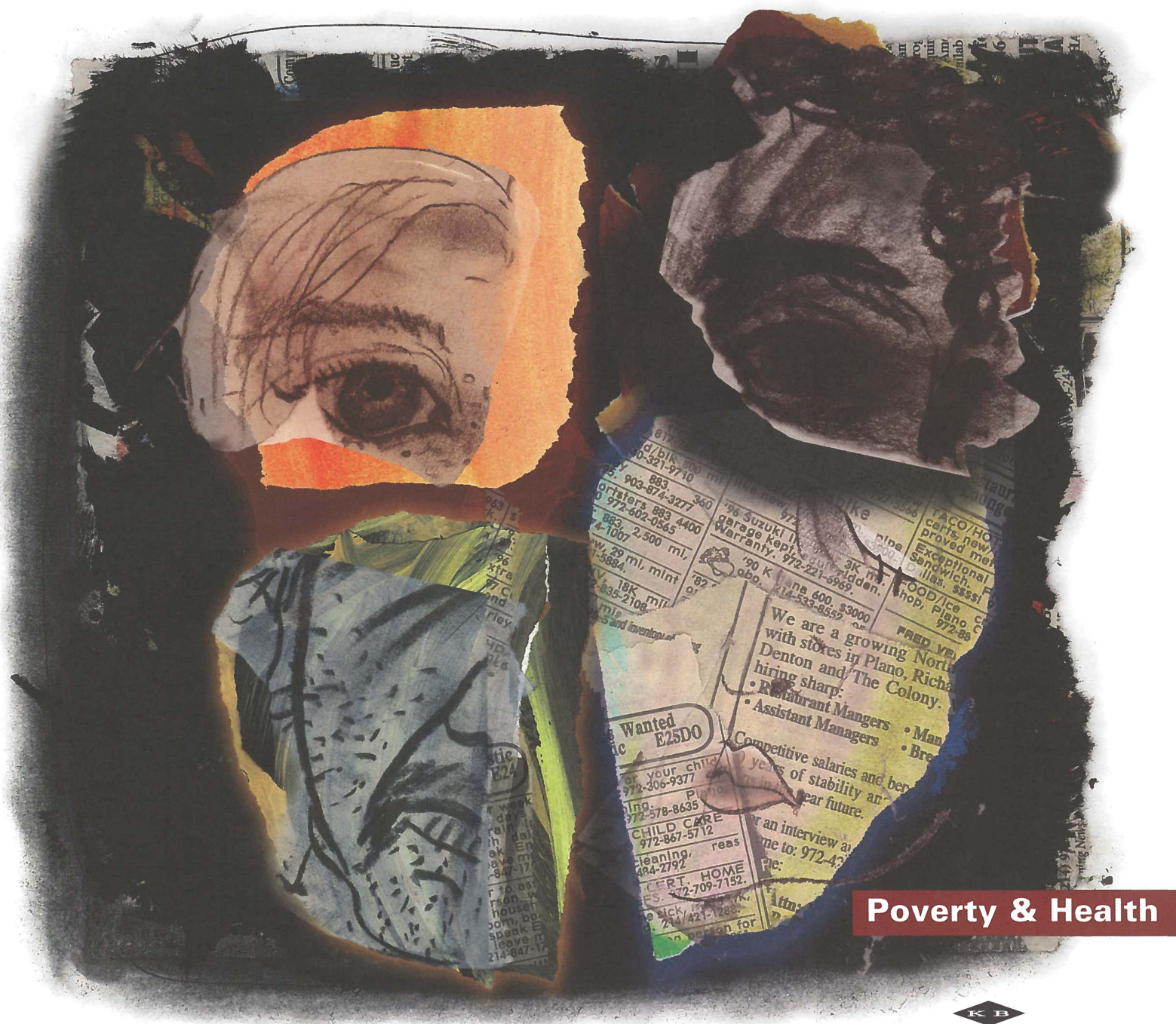
The Park Ridge Center Bulletin, 1999, N10, July/August

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Bulletin

JULY/AUGUST 1999





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The Park Ridge Center explores and enhances the interaction of health, faith, and ethics through research, education, and consultation to improve the lives of individuals and communities.

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Rendering Visible the Invisible

philip j. BOYLE

Moral obligations to care for the sick poor seem, at first blush, to be so straightforward as hardly to warrant analysis.

When we face a vulnerable, sick person needing health care, the simple obligation to "do unto others" ought to compel action.

The Golden Rule motivates us to care for the indigent. Yet if moral arguments were the only obstacle, society would long ago have helped the millions who face unacceptable impediments to obtaining health care.

With a majority of citizens supporting some right to health care, and with economic boom times, why have we been so unsuccessful in supporting adequate health care for the indigent sick? The story of a woman I met named Dorothy might be instructive.

After moving to Chicago I found myself stepping daily over the human gargoyles tucked into the city's doorways and alleys. I found myself timid and torn, not knowing whether and how best to respond to beggars' plaintive eyes. I did nothing.

My perspective and actions changed when a dear friend with whom I frequently walked would-based clearly on religious conviction—stop, greet, and truly engage the street poor by learning their names and stories and literally offering them every last penny he had. Embarrassed, and perhaps annoyed at the number of encounters, I eventually

saw the gargoyles as persons. That's how I met Dorothy.

Dorothy was one of those toothless fixtures that seemed to live in the doorway around the corner. Since she was rendered visible to me—by no action of mine—my friend and I began to worry about her jaundiced coloring, her warmth in winter, and where she was when we didn't see her for days. Economic thriving and strong moral arguments for health-care reform have not changed the plight of Dorothy or her lot. Oddly, Dorothy has changed my perception, but not in the way you might imagine.

Knowing Dorothy has not only motivated me to help her access another program—dental care, nutrition, and drug treatment. Rather, I was invited to cross the line and see her as another person with dignity; we became connected and committed as human beings. The most fundamental element of holistic health care is to help people become part of the human community, and not simply the object of a treatment or social program.

To do nothing but offer another institutional response is to keep Dorothy as "other," to keep her invisible. Vincent de Paul suggested we ask the poor to forgive us for our charity. I take this to mean that our charity can be as oppressive as our good intentions, if in the process we render the poor's humanity invisible.

Perhaps the problem of the poor and health care is not as much a matter of being convinced about rights to health care as it is seeing the poor in the first place. This issue of the *Bulletin* is one step toward rendering visible the invisible. ■

Poverty Kills

For Want of Resources, Millions Face Early Death and Ill Health

meredith MINKLER

In 1993, a landmark survey calculated the leading causes of premature death and disability in the United States not by disease—cancer, heart disease, stroke, and so on—but by actual cause.

Smoking topped the list, accounting for more than 400,000 deaths annually, followed by poor diet, lack of exercise, and alcohol.

Although this article, written by public health leaders William Foege and Michael McGinnis, and published in the *Journal of the American Medical Association* provided a refreshingly frank look at the prominent role of socio-behavioral factors underlying health problems, it unfortunately missed one of the most important. Poverty increasingly is recognized as perhaps the single most important risk factor for premature death and disability. Indeed, even the pronounced race differences in health in the U.S. appear to be very largely—though not exclusively—a function of class.

The pervasive impact of poverty on health is evident regardless of how poverty is measured. David Williams and his colleagues at the University of Michigan thus found that people with annual incomes of under \$10,000 had more than three times the risk of dying in a given year as those who made more than \$30,000. Dozens of other studies have produced similar findings, regardless of

whether income, education, or occupation was used as the marker of low socioeconomic status. Finally, and moving the unit of analysis from the individual to the community, the now-classic Alameda County Study in California demonstrated that residence in a poor neighborhood itself, regardless of the individual's income, resulted in a risk of dying 40 percent higher than would be expected on the basis of age, gender, and even smoking history.

But might not most of the high mortality and morbidity among the poor simply be a reflection of the high rates of smoking, poor dietary habits, and other unhealthy behaviors in this group? The answer appears to be no. One recent national study found that of the threefold excess deaths among the poor, at most just

13 percent could be accounted for by higher rates of smoking, drinking, diet and exercise, and other traditional risk factors. Other studies have corroborated such findings, suggesting that there's something about poverty itself that is decidedly bad for one's health.

Chronic Deprivation

Public health experts debate just how poverty “gets under the skin” to so dramatically worsen health, but researchers have identified several plausible pathways. For Harvard's Richard Levins, these include, but are not limited to:

- chronic deprivation and limited access to resources such as food, housing, and education
- exposure to environmental toxins



CORBIS

- physical threats to health and safety
- unsafe jobs, or those involving high demands and low resources for coping
- chronic psychological stress

Two other possible reasons deserve special mention. One of these, elucidated by scholars in many parts of the world, suggests that the adverse effects of poverty on health are magnified in countries where there is a high degree of income inequality. It's not just being poor, but being poor in a country where many others are rich, that seems to exacerbate the effects of poverty on health. A raft of studies demonstrates that the very fact of being around others who are higher on the socioeconomic ladder causes individuals to experience elevated stress, lower feelings of control over their lives, and a lack of trust in society and their surroundings. Researchers theorize that these factors contribute to ill health, and that the greater the difference between rich and poor (or even rich and middle class), the more these factors are exacerbated.

Still another possibility suggests that

people at progressively lower levels of socioeconomic status have correspondingly less opportunity to control the circumstances and events that affect their lives. In the words of epidemiologist S. Leonard Syme, this lack of "control over destiny" may be the mediating concept that helps explain why the poor are less healthy in almost every disease and disability category, regardless of their particular habits and behaviors.

In stressing the profound impact of poverty on health, it is vital not to underestimate the importance of other factors, such as racism. Racial discrimination's impact on heart disease, depression and other illnesses has been well documented, and disturbing studies continue to demonstrate the persistence of racism in medical

decision-making about who gets what kind of care, even when all other factors are controlled for. It was in light of these facts that when preparing the criteria for the next edition of the nation's "health report card," public health officials set as twin goals reducing health inequities by race *and* class. Neither poverty nor race should predict who lives and who dies, who gets ill and who remains well in this most blessed of the world's nations. ■

1999 Intensive Courses

The Park Ridge Center will hold a series of intensive courses on a variety of topics in the bioethics field:

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|---|--|
| ◆ Organizational Ethics in Faith-Based Institutions
August 18 - 20 | ◆ Theological Reflection in Faith-Based Organizations
September 23 |
| ◆ Retrieving Spiritual Traditions: Training the Trainers
September 15 | ◆ Organizational Ethics Intensive
October 18 - 22 |
| ◆ Spiritual Wisdom for Parish Nurses: Stories and Strategies
September 18 | ◆ Ethics and Alzheimer's Disease: Attending the Person and the Spirit
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Training Package

- ◆ *Religious Perspectives on Aging Handbook*
- ◆ *Leader's Guide*
- ◆ *Participant's Workbooks* (10)
- ◆ 2 videotapes
- ◆ Cost is \$229 plus shipping. 10-day money back trial period.

A workshop to train group leaders is scheduled on September 15, 1999. Cost is \$150. To register or to order the program, please contact Bernice Chantos at (312)266-2222 or via e-mail, bmc@prchfe.org. Continuing education credits available.

Healing the Homeless

*Interfaith House Promotes Dignity, Spirituality,
and a Holistic Approach to the Ill and the Injured*

dan PERRETEN

Ron Wright is living a better life. In conversation, he goes out of his way to say that he's not just *trying* to fly right.

"I really don't like saying 'trying' because when you say that, you've got an excuse built right in. But I am doing my best to continue to grow spiritually, to grow physically, and just to give something back. I'll never forget where I've been, but now I'm concentrating on where I'm going."

Where he's been is the streets, drug-addicted, with an injured leg and sick with debilitating asthma. The building he'd been living in burned down, he couldn't find another place, and then he was hit by a car. He wound up in the emergency room, but had no place to go when they patched him up.

Where he's going, he hopes, is a life built on the ten months of sobriety he's already got, a life with a job and an apartment and a faith in God that builds every day, a life whose outlines he can barely make out beyond the work he has to do every day just to get by.

What makes Ron Wright hope for his future is, in fact, his present. Since last October, he has been living in a place called Interfaith House, a rare refuge for a too-small percentage of Chicago's poor. Created in 1994, the same year Ron

Wright originally found himself living on the streets, Interfaith House helps homeless men and women who are ill or injured, providing a bed, transportation to hospitals, help in finding a job and a home, as well as spiritual sustenance if the resident chooses to partake. It's a consciously holistic strategy that staff and residents alike are convinced is the key to the facility's unique approach.

The connection between religion and health care for the poor has a rich history. Jews have usually included treating the unhealthy destitute in the injunction to care for "widows and orphans." Jesus' work often entailed healing the outcast and indigent. And the impulse to build hospitals for the poor reaches at least as far back as St. Basil, a Greek Father of the fourth century who constructed a huge facility and frequently berated his wealthy parishioners for not giving enough.

The Sickest of the Sick

One contemporary result of that religiously based motivation to care for the poor, Interfaith House responds to a specific problem: what do homeless people do when they are discharged from the hospital but have no place to go to heal?

When they go back on the streets, they are likely to recover slowly, badly, or not at all. Homeless people like Wright have to be constantly on the move and can't rest properly. Their medications are often stolen, they can't afford to travel back to

the hospital for follow-up, and they often end up back in the emergency room.

In fact, even among the poor, whose health is generally worse than the rest of the population, the homeless have significantly greater health problems. Ron Wright's respiratory problem and leg injury turn out to be much more common among those who live on the streets than among the rest of the urban poor, to say nothing of the wealthy, according to a study released last year in the *New England Journal of Medicine*.

In addition to trauma and lung problems, other ailments with extraordinarily high rates among the homeless include skin disorders and parasites, all resulting from simply not having a clean, dry place to wash off and sleep safely. Other commonalities include extremely high rates of mental illness and substance abuse, both conditions that exacerbate still other health problems.

The study, sponsored by the United Hospital Fund, also focused on the high costs to society of health care for the homeless, who stay in the hospital an average of 4.1 days longer than low-income patients with homes and cost nearly \$2,500 more per hospital stay. Those treated for psychiatric problems cost an added \$4,000 per stay because doctors and nurses are often reluctant to release a homeless person onto the streets when he is not fully recovered (whereas someone going home usually can rely on

The Goddam Street

robert COLES

I know her children,
have seen them getting ready
for what she calls
“the goddam street.”
Each child has been held
and breast-fed in ways
well-nourished mothers might envy.
In the cold rat-infested flat
there is lively warmth
between mother and babies,
songs, smiles, sighs.
“I don’t know how to do it,
how to keep my kids
from getting stained, ruined
I keep them close to me.
they can tell how much
I want for it to be good,
so, I hope they’ll make it,
and I stop, say a prayer –
not expecting prayer to be
answered, not around here.”

“The Goddam Street” by Robert Coles,
©1978, appeared in *Blood and Bone:
Poems by Physicians*, the University of
Iowa Press. It was originally published in
*A Festering Sweetness: Poems of American
People*, reprinted by permission of the
University of Pittsburgh Press.

family or neighbors for ongoing support).

Advocates for the homeless point out that the way American society effectively turns its back on the poorest of the poor guarantees a cost-inefficient healthcare response to their needs. *The Wall Street Journal* quoted one of the report’s authors as pointing out that “the extra costs for a single hospital admission are as much as the annual welfare rental allowance for a single individual in New York.” In fact, a Minnesota study demonstrated that providing housing and social services to 180 homeless people saved the state \$9,600 per person, money that would ordinarily have gone to emergency and punitive services like hospital treatments and jails.

Though staff members at Interfaith House are happy to point out that their organization is cost-effective (they are, after all, a non-profit forever scrambling for money to keep the doors open), the institution was founded more as a direct, compassionate response to changing conditions in urban America.

“Homelessness in the 1980s,” says Jeff Pickering, assistant development director at Interfaith House, “was an enormous crisis that people were trying to get their arms around in terms of what were the real causes, what were the real needs, and at first, the response was simply housing, you know, give these people a place to live, which often led to warehousing,” providing shelter only without any other

supportive human services.

“We began to see that it wasn’t just a roof over someone’s head that they needed, that there were certain characteristics among the homeless population that required additional assistance and supportive services,” says Pickering. In the early ’90s, the ecumenical, Chicago-based Interfaith Council for the Homeless began looking around for innovative ways to respond to the problem of illness and injury among the homeless, eventually discovering an abandoned, 60-bed nursing home in a run-down neighborhood on Chicago’s West Side.

A Menu of Services

Interfaith House was founded with singleness of purpose: not political advocacy, but service, not long-term housing, but short-term recovery. While advocacy and long-term solutions aren’t ignored—staff members are painfully aware of the larger structural causes of homelessness, and in some sense their very presence is a form of advocacy—the focus here is on helping residents, one individual at a time, though always within the context of community.

Residents receive intense attention. After arriving at the two-story 1960s-era brick building in the middle of a tree-lined residential boulevard, each resident is welcomed by a volunteer receptionist and assigned a case manager to facilitate



Interfaith House Resident Ron Wright

their overall care, which comes from a team of social service and health professionals. They offer, at no cost, food, housing, employment and substance-abuse counseling, educational and financial advice, permanent housing facilitation, transportation, and spiritual sustenance. Residents can even get a little green therapy by helping out in the garden sponsored by the Chicago Botanic Garden (and overseen these days by a former resident, Sally Peterson). There's even an art therapist who volunteers her services.

Not included in that list is direct medical care. Interfaith House is not a medical facility. Two nurse practitioners, and soon one doctor, occupy a small corner examining room tucked away on the second floor. But that office is, officially if not spatially, a separate entity, run by outside medical institutions.

Keeping the medical treatment separate and in some ways subordinate has many advantages, not least of which is avoiding the myriad regulations with which medical facilities have to contend. Most of all, though, it allows an entirely different, more caring and humanistic milieu to prevail. Program director Art Bendixen tells the story of a visit from a Boston doctor who came to Interfaith House to offer his advice. He ran a state-of-the-art homeless health clinic, "the best in the country," says Bendixen.

"He gave us some good advice on how

to improve . . . but one of the things he told us not to change was the healing, communal atmosphere that he did not have because his is a medical model. There, doctors and nurses rule, here you don't have any of the disciplines rule—it's not a substance abuse treatment or mental health or medical facility. So the model is more holistic. It's the lay people who run the place. Then we can focus on treating the whole person with dignity."

Dignity Rooted in Faith

That word, dignity, is a keystone of Interfaith House's philosophy. It affects everything, according to Bendixen, "even the way we call people over the PA system. We say 'please come' rather than 'please report.' We are very intentional about calling each individual by name." In addition, when residents are discharged, they are always given choices as to where they would like to go. Given the tattered state of the social safety net, they are rarely good choices, but still, it is vital to have options. Indeed, as Bendixen greets the day by walking through the halls, talking to residents, calling them by name, a collegial atmosphere prevails.

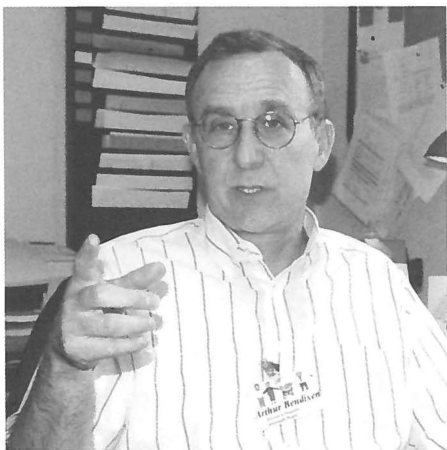
The focus on each person's dignity has, for many staff members, a religious basis, Bendixen, a former Catholic priest, says. "My theology is based in the incarnational mode of Christianity. I really do believe that the closest place you can get

to God is through other people. I very much believe that God identifies in a special way with those who suffer most in society. I do find that God is very much present in them. When I participate in morning prayer with them, my whole faith gets challenged. Their commitment, their hope, their faith challenges mine. I used to celebrate mass every morning in the parish church, but I find morning prayer here more uplifting, and I think it's because a lot of our residents are struggling with so many issues, that it makes their faith even stronger."

The residents, says Bendixen, "are encouraged to integrate their spiritual life into their healing experience so that it's not a fragmented experience of the body healing here, the psychosocial side healing there, and the spirit healing over there, but an integrated approach."

Indeed, the words "spirituality" and "holistic" fill the speech of both staff and residents alike. "We focus on the whole person," says Tony Hollenback, the social services manager. "We focus on each individual's faith preference, asking them where they're at spiritually, because if you miss that, you're missing something crucial. It helps to understand, for instance, why does that person not take their medication? Why does this person not follow up with the resources available to them?"

Hollenback says that while many resi-



Program Director Art Bendixen



Social Services Manager Tony Hollenback

dents report their belief in God has been a source of comfort through the most difficult times of their lives, some forms of quietistic belief can be an obstacle. "Sometimes I get residents and I want to tell them they need to look for housing and avail themselves of services, and they say, 'God will provide' as if it's magic, as if a discharge plan will suddenly appear for them, and that's not the way it works. But that's where they're at, and we need to work with them from that point."

Indeed, personal responsibility and the

self-help model—residents staying after they have physically recovered to serve as leaders of the community—are major themes. Ron Wright speaks the language of recovery when he says, "I'm just doing what God's will is today. I'm learning how to be patient, how to be responsible and faithful, and how to listen. When new people come in, I can show them around and show them how this place has helped me, and if they really want it, they can help themselves."

Interfaith House does not require its

residents to attend the daily prayer sessions or the impromptu Bible study that takes place most mornings. Respecting each person's dignity requires avoiding coercion. Still, most residents participate, and the gentle, surprisingly upbeat atmosphere of the place seems to result from such constant reminders of God's presence. As Wright says, "A lot of people from here go to church every Sunday. It helps me just to really be uplifted, to be honest with myself, and helps me to help others."

Falling Through the Cracks

This Homeless Man Doesn't Fit the System's Rigid Categories

Lars EIGHNER

*Lars Eighner's 1993 book *Travels with Lizbeth* traces his three-year journey as a homeless person scraping by with his dog, Lizbeth. In the following excerpt, Eighner has checked into a hospital for a pain in his leg and is visited by a social worker.*

He came right to the point: "How many fifths do you drink a day?" I explained that if I drank a fifth of whiskey in a week I would be drunk the whole week. . . .

It would have been greatly to my advantage if I could have admitted to being an alcoholic or a drug addict. The social workers have no way of assisting someone who is sane and sober. My interview with the social worker made it clear that only three explanations of homelessness could be considered: drug addiction, alcoholism, and psychiatric disorder. The more successful I was in ruling out one of these explanations, the more certain the others would become. Professional people like to believe this. They like to believe that no misfortune could cause them to lose their own privileged places. They like to believe that homelessness is the fault of the

homeless—that the homeless have special flaws not common to the human condition, or at least the homeless have flaws that professional people are immune to. They are glad to go through the motions of helping the homeless—and some, like the social workers, depend for their livelihood on there being homeless people to pretend to help—but on the ladder of being, homeless people are not quite up to the level of professional people.

The social worker had programs for alcoholics, programs for drug addicts, and programs for the insane. If I would admit to belonging to one of these categories . . . then something might be done for me. Unless I were a drug addict, an alcoholic, or a lunatic, the best he could offer me—if I would destroy my conscience to the extent necessary to participate in a religious organization that often refused to agree to principles of nondiscrimination—then he might obtain for me three nights' lodging at the Salvation Army. ■

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The Rare Success Story

Ron Wright is, so far, an Interfaith House success story. And most of the residents leave looking and feeling better than when they walked in. More than half go on to a shelter or better housing opportunities. That's the inspirational part.

The challenging part is that, as the staff members at Interfaith House will admit, many of the 600 residents they take care of each year end up back on the street. "Sometimes we get residents who are doing great here," says Bendixen. "They're working, they're sober, they're saving money, but then they leave this very supportive living environment, go to an apartment all by themselves, and within a couple of weeks we hear they've been drinking again." The known permanent success stories are few.

Still, Interfaith House is making a dent in the universe. If nothing else, it provides a place for homeless individuals to rest up before going out to do battle once again with the forces of an often-uncaring society. And Interfaith House represents a call to fulfill the individual and social responsibilities to care for "the least among us."

And it is not an unwarranted optimism in Ron Wright's voice as he talks about his plans for the future, the calling he says he's got to become a minister. It's possible to hope with him as he says, "Things are going to get better. I believe that. I know that. I'm proud of myself today. I've come a long ways." ■

The Call of the Good Samaritan

How Should Healthcare Practitioners Advocate for Marginalized Patients?

edwin r. DuBOSE

A 78-year-old African-American, Mrs. M suffers from multiple health problems, including congestive heart failure.

Living in a public housing project and relying on Social Security income, she receives some help with household tasks and transportation from her unemployed son. At home, Mrs. M can move about slowly, and even then only with the help of a mechanical walker. Even with the walker and her son's assistance, it is almost impossible for her to leave the house and get around the neighborhood.

A wheelchair would help, though buying one is out of the question with so few resources. One day, Mrs. M's son contacted his mother's Medicaid representative, requesting assistance. The representative refused, saying that Mrs. M's condition didn't warrant such an expenditure, and besides a physician would have to state that she needed it to get around. While they were visiting a local public health clinic, the son approached the medical resident on duty and asked her to mark "yes" on the insurance form, indicating that his mother needs a wheelchair because of her inability to walk.

The physician refused, regarding such "fudging" to be fraudulent because Mrs. M could indeed walk around her apartment. The son became agitated, accusing the physician, who was white, of refusing to help because of prejudice. Upset, the resident suggested that the son call Med-



icaid to appeal the restriction on wheelchair coverage, arguing on the basis of patient welfare and the probability that preventing injury in this case would be more cost effective than denying the wheelchair.

Enter the Parable

The Medicaid rep denied the appeal, saying that if the woman is careful she can do perfectly well with the walker. The doctor then offered to refer the family to other options that might help. The son wasn't mollified: "No one will help us. My mother wants to get out and see people; she needs the chair. You're her doctor, and you could help her now. Why don't you be a Good Samaritan?" Stung by this question, the physician wondered if she should just fill out the form and authorize the wheelchair.

The problems the resident encountered—from dealing with a belligerent

patient to confronting a system that ignores or rejects those it claims to serve—illustrate not only that poor patients but also well-intentioned doctors and nurses often meet frustration and resistance dealing with access to healthcare resources. Bound by a web of policies, regulations, and perhaps prejudices, the system does not successfully address concrete problems surrounding health care for marginalized people; it also seems to inculcate certain attitudes about providing the minimum of services—anything more that supports one's quality of life is unavailable.

Could the son's reference to the Good Samaritan offer guidance in this case? The son's statement about the Samaritan clearly struck a nerve: the resident chose medicine as a way to help people in need, "binding their wounds" and caring for them, as the parable suggests. What would the Good Samaritan do for Mrs. M? How helpful is the parable as a guide?

To begin with, the parable is simpler than the real-life situation. The Biblical story is not complicated by the practical problems of access to healthcare resources faced by the poor and marginalized in a complex, post-industrial society. The Samaritan has no problem meeting the injured man's needs—he has money to offer. Had the Samaritan lacked the means to pay, would the innkeeper in the story have been so obliging? In addition, the resident in this case is not herself a marginalized character, as is the Samaritan in the context of his day. Instead she is a central figure in health care, one who possesses a good deal of power and authority, whose actions can redirect the flow of dollars to provide what her patient needs. But how can the physician be a good neighbor?

The resident is not certain Mrs. M needs the wheelchair to ambulate and doesn't want to fraudulently say otherwise. She tried to help her patient by urging patience and appealing Medicaid's denial. Government programs and social service agencies designed to serve the poor, however, are overwhelmed by demand and are sometimes staffed by uninterested personnel who seem innately suspicious of requests for additional help. After all, there are alternatives: if the son got a job, his employer's health plan might pay for the wheelchair, or he might be able to pay for it out of pocket. Appreciation of what the wheelchair represents—greater mobility and interaction with her community—are lost on the physician.

Beyond Money and Means

Clearly the resident feels obligated to advocate for her patient. She could tell herself that benefiting Mrs. M outweighs her duty not to deceive the insurer. This moral calculation suggests that the physician find a way to game the system to obtain the care Mrs. M wants. One ethical rationale might be that the injustice of the system is greater than the injustice involved in misrepresenting the facts. Besides, the costs of future ER visits or

hospitalizations will far outstrip the cost of a wheelchair; in some sense, then, falsifying the form could result in saving the system money in the long run.

Mrs. M's case, however, illustrates that money and means aren't always the whole problem. It also speaks to the role of power relationships. The son is urgent and impatient because he is struggling to gain a benefit that his mother needs. And she needs it now. Maintaining patience through a long appeals process is a quality of relative privilege, available to people who can afford to wait. Recommending patience to someone like Mrs. M is tantamount to recommending deference to those with power. Mrs. M's need is now; the physician can help her now. What's wrong with that? Wouldn't it be nice if good Samaritans abounded, freely dispensing resources?

Bending the Rules

And, to be sure, a wealthy patient who needed the rules bent a little could do so. Yet the system resists those at the margins, even when they have an ally or advocate.

But back to the parable. The point of the story is not that the Samaritan has the means, money, and power to dispense care and needed resources. This kind of Samaritan would be hard to bear in at least two ways. First, although merely marking the form to secure the wheelchair is tempting, such an act reinforces Mrs. M's dependence on the more powerful physician, reminding her of her dependence and undermining her sense of autonomy and self-reliance. Such an outcome could reinforce feelings of resentment that maintain an adversarial relationship between those who need help and those in a position to grant it. Second, if patients experience their physicians as deceptive to third parties, even if the result benefits the patient, the effect will be to erode patients' trust in the truthfulness of their physicians.

Finally, the parable simply isn't a precise fit for this case because the story does not offer an anthropological model

of human interaction or an ideological comment on justice and socioeconomic conditions, but a theological perspective. It says that we all live close to the edge, on the road from Jerusalem to Jericho, with our sense of power and control largely illusory, our lives contingent, one stroke away from a wheelchair ourselves.

In addition to duties to the individuals in our care, we also have duties to protect the common good. Responsible stewardship of shared resources means that we should ensure that resources are distributed equitably and fairly. The current healthcare system is fragmented and unjust because vast numbers of persons lack adequate access. Gaming or fudging on behalf of one patient does not make the system more just and violates the duty of responsible stewardship.

The lesson of Jesus' parable, therefore, is not that the Good Samaritan is the neighbor we should expect when we are in need, but that we are all neighbors in need. Fudging on behalf of one patient does not make the current health care system more just, but illustrates the ethical principle of "everyone for him or herself." Since we all someday will find ourselves lying by the roadside of good health, we should work to find ways to distribute health care resources in a way that enhances the qualities of our lives. ■

Racism's Virulence

African-Americans, Economics, and Health

emilie m. TOWNES

In her 1998 book *Breaking the Fine Rain of Death*, theologian Emilie M. Townes examines the socio-economic, cultural, and genetic factors that affect African-American health. She goes beyond the well-known fact that poverty disproportionately affects African-Americans, exploring healing models sensitive to class and cultural context, and providing recommendations relevant to the Black Church and the African-American community.

Regardless of where African Americans are on the socioeconomic ladder, health problems have a greater impact on Blacks than on other Americans. Two key reasons for this are genetic and environmental. Indeed, environment and its attendant living patterns can trigger the manifestation of the genetic potential for disease in any human being. Black folks have their own traditions, experiences, and health risks.

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By 1991, the Health and Human Services Annual Report on U.S. health revealed some sobering statistics: the mortality rate for African-American and Native-American infants was double that of Whites; the life expectancy for Blacks was six years less than Whites; the rate of strokes for Blacks was almost double that for Whites, and within this figure was the alarming statistic that for Blacks between thirty-five and fifty-four, the rate was four times higher . . . [dietitian and author] Barbara Dixon points out that poverty is at the base of most of the health problems of African Americans. More important,



Courtesy of the artist

Untitled by Tricia L. Townes.

she notes that there is more to poverty than low income. There is poor diet, poor housing, overcrowded clinics, and inadequate information about health and nutrition—all these help form the foundation for larger lament about Black (un)health.

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As HMOs emerged, many racial-ethnic providers were squeezed out of practices in areas where they had long ties. African-American physician Randall C. Morgan, Jr. suggests that managed care may ultimately help break down strong doctor-patient relationships as people change physicians, change plans, or see a number of physicians in the same plan rather than have their own doctor who may have generations of experience with the same family.

Morgan is also concerned that there

will be fewer doctors available who know the kinds of indicators that need to be monitored regarding culture and the specific illnesses and diseases that Black genetics can foster. It is possible, says Morgan, that Black physicians may “get outbid for the managed care contract of the patients that are in their practice if they can’t compete, either price-wise or access-wise, with larger groups and organizations. This is due to the fact that many Black doctors are in solo practices or in small group practices.

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Yet as we approach managed care with some caution, we must also evaluate the ways in which the overall current health-care delivery system works or fails to work in the lives of many African Americans.

First, Medicaid has never lived up to its promise to eliminate our two-tiered system of health care. The income restrictions have been and remain so tight that the program currently covers less than one-half of the poor . . . [A 1996 study found] that African American beneficiaries in general and Black and White low-income beneficiaries have fewer doctor visits for ambulatory care, fewer mammograms, and fewer immunizations against influenza. They are hospitalized more often and have higher mortality rates. The researchers also suggest that these patterns indicate Black folks and poor folks receive less primary and preventative care than either White or more affluent beneficiaries . . . Because of the dearth of primary-care services in poor neighborhoods, a tragic adversarial relationship has developed between public health and private medicine in poor communities across this nation. The long history of circumscribing and tight monetary control of these primary-care services has turned some neighborhoods in the United States into medical wastelands.

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Doctors perceive the urban poor as difficult patients. And often the urban poor are difficult cases because their ailments have been made worse by delays in getting care. These folks may show up at doctor's offices with more of what one physician calls "sociomas"—social problems that range from not having a ride to the doctor's office, to drug addiction, to homelessness, to despair. ■

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The Bernardin Factor

The Late Cardinal Continues to Inspire

quentin YOUNG

After the failure of healthcare reform on the national level in the early '90s, it may seem impossible to effect real change in the way society responds to the needs of the poor and underinsured.

Yet one man's life, message, and legacy can provide practical guidance.

The late Joseph Cardinal Bernardin was fascinated by the profound similarities between doctors and pastors, and he regularly recalled his own intention to become a physician until the call to the church supervened.

Undoubtedly, the organic links between scriptural imperatives and the vast institutional presence of the church in health delivery compelled his pastoral attention. In 1995, he addressed the Harvard Business School on the topic of "Making the Case for Not-for-Profit Health Care," a provocative title in this era of servile obeisance to market economics.

He quoted Pope John Paul II regarding "the idea that the entirety of social life is to be determined by market exchanges is to run 'the risk of idolatry of the market, an idolatry which ignores the existence of goods which by their nature are not and cannot be merely commodities.'" He went on to assert that healthcare delivery was, in fact, one of those goods.

Elsewhere, Bernardin insisted that

"Health care is an essential safeguard of human life and dignity, and there is an obligation for society to ensure that every person be able to realize this right.

"The only way this obligation can be effectively met by society is for our nation to make universal health care coverage a reality. . . . If justice is a hallmark of our national community, then we must fulfill our obligations in justice to the poor and unserved first and not last."

After Bernardin's death in 1996, his call to action was taken up by supporters who hoped to make the cardinal's vision the law in his home state of Illinois. His wisdom has been recast into legislative language and proposed as a state constitutional amendment.

The so-called Bernardin Amendment, which would mandate the state to provide universal health care, has garnered overwhelming support in a plebiscite and polls held throughout the state. Currently before the Illinois legislature awaiting consideration, it has sparked interest in several other states and become part of the political culture in numerous state coalitions for health reform.

Could Bernardin's legacy—miraculously—become the answer to the panic and disarray characterizing the market-driven American health system today? ■

Charitable Giving to the Poor

Believers Give More, But Why Does Religion Matter?

stephen ELLINGSON

Do religious people give more money to organizations that help the poor than non-religious individuals?

The answer is a resounding “yes” according to a recent article in the *Journal for the Scientific Study of Religion* by three sociologists from the University of North Carolina at Chapel Hill. This should be no surprise given religion’s history of helping the poor.

Unfortunately, the new research provides little help in explaining what accounts for religions’ heightened responsibility, the differences between religious traditions, and why this question is important in the first place.

The three authors, Mark D. Regnerus, Christian Smith, and David Sikkink, analyze data from the 1996 Religious Identity and Influence Survey. One of the questions asked of approximately 2,600 Americans was if they gave a lot, some or no money to an organization that helps the poor. The authors rely on the usual demographic and religious variables to discover who gives more money. Women, those who are married, the elderly, and the wealthy are more likely to report that they give “a lot.”

Individuals who belong to religious organizations, who are active (i.e., who attend at least three times per month), and who report that religion is very important were more likely to report that they give “a lot” than the non-religious.

The researchers’ unanticipated finding is that, contrary to conventional wisdom, Christian conservatives give as much if not more than Roman Catholics and liberal Protestants, and that they don’t hold a strong anti-poor bias. An interesting finding that the authors don’t try to explain is that individuals from “other faiths” (Jewish, Mormon, Jehovah’s Witness) have the highest self-reported rates of giving to poverty-relief organizations.

At first glance this research appears important because it debunks the popular conception that the Christian Right is hostile to the poor. However, a closer look reveals that the analysis doesn’t really tell us much; it fails to reveal why Christian conservatives give at such high rates.

Individual versus Corporate

This failure leaves many unanswered, and more important, questions: Is there something about the beliefs or practices of conservative Christianity that encourages its members to give at a high rate? What does it mean to give “a lot”? How do different religious groups understand the poor, and what are the reasons for giving (e.g., a duty to provide charity vs a duty to do social justice).

These questions are important because they go to the heart of religious rationales for helping the poor and needy. Knowledge of who gives is important only insofar as we understand why they give. For instance, one venerable tradition holds that helping the poor is properly done by individual and private means, and conservative Christians explicitly advance this view.

On the other hand, mainline and liberal Protestantism and Roman Catholicism have championed a more structural or systemic approach in which believers are morally obliged to act collectively in order to remove the enduring, institutional causes of poverty such as the lack of jobs, inadequate education, or limited access to healthcare services. Thus one possible explanation for the findings stems from theological and ideological differences between different religious groups—mainline Protestants may be less likely to give charitably on an individual basis because they are committed to an alternative, corporate solution. Such a solution might emphasize lobbying or protests to influence legislation rather than directly giving money.

Another possible explanation lies in the organizational differences between conservative Protestants and other Christian groups. Roman Catholics and liberal Protestants usually have church offices that attend to the poor, and local congregations often give part of their moneys to these national offices. Many conservative congregations are independent or only loosely affiliated with a national denomination and therefore are less likely to have the opportunity to donate money through the Church.

The relationship between religion and poverty is complex. While the new University of North Carolina study provides some worthwhile analysis, it doesn’t go nearly far enough. We need scholarship that inquires into the theological, ethical, and social factors that shape the religious response to the poor. ■

News & Notes

Prescription for Indignation

In 1996 the California Pharmacists Association adopted a policy allowing members to refuse to fill prescriptions based on “ethical, moral, or religious grounds,” said the group’s interim chief Carlo Michelotti. “A pharmacist has a right to his moral beliefs.” A recent poll of 625 pharmacists revealed that 82 percent believe they have the right to refuse to fill a prescription for a drug such as RU-486, reports *Time Magazine*.

Given these facts, Michelle Crider’s conflict with her pharmacist is hardly unexpected. Crider’s doctor called in a prescription for her, a “morning after” formula: four birth control pills to prevent the implantation of a fertilized egg. But the pharmacy manager at Longs Drug Store in Temecula, California, John Boling, refused to fill the order, citing his moral beliefs. While Boling had the support of his professional organization, he was reprimanded by his employer. “Our policy is that a pharmacist, if he has moral objections, should refer the prescription to another on-duty pharmacist, or to another Longs, or to a competing pharmacy,” said Longs spokesman Clay Seland.

The prescription was ultimately filled at another pharmacy, but Crider was upset. “This was a legitimate, legal prescription,” she said in response. “Is a pharmacist supposed to preach religion?”

Barrio Medicine

One third of the nation’s 31 million Hispanics lack health insurance. In many communities, cultural traditions combined with lack of access to the medical system have promoted a network of alternative care built on religion, ethnic customs, and home remedies, reports the *New York Times*. Curanderas—healers—are called to remove curses believed to cause fevers and other ills. Neighborhood bodegas dispense herbs, teas, incense, charms, sprays, and oils.

While these remedies are often effective, just as often they impede crucial care. The Centers for Disease Control and Prevention says that uninsured people are in danger from untreated contagious diseases and rely on emergency rooms for acute conditions. The much-touted revolution in alternative and complementary health care is driven in part by

simple economics. For those without insurance, there are few alternatives to alternative medicine.

Acupuncture to Zen: New Modalities in Psychotherapy

Synthesis is the latest wave in psychotherapy. Increasing numbers of mental health practitioners are sending their patients to alternative medicine specialists. Therapies once considered fringe—such as eco-psychologists, who “reconnect clients with nature”—are gaining wider acceptance. A recent article in *USA Today* reports an increasing perception among mainstream therapists that traditional therapeutic modalities have their limits.

William Doherty, of the University of Minnesota, describes “functional networks of healers who can work together, referring clients to appropriate healing channels.” Sarah Conn, a psychology instructor at the Harvard Medical School, “takes clients ‘soul tracking,’ on nature walks to ‘help connect what is going on outside with what is going on inside.’” Other practitioners are using approaches from complementary and alternative medicine such as meditation, shamanism, and massage therapy in an effort to “treat the whole person—the soul as well as the psyche.”

The difficulty arises in sorting legitimate approaches from quackery. Since people in distress are often desperate enough to try anything, the possibility of exploitation is real. And while practitioners of dubious modalities may not intentionally defraud their clients, the end result is the same. The road to mental health, like another famous road, is nothing if not paved with good intentions.

—Kirston Fortune

A Safe Place for Unsafe Ideas

The Park Ridge Center announces the re-creation of its academic journal **Second Opinion**. A peer-reviewed, scholarly approach to the role of faith in health care and ethics, featuring:

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The Ever-Present Poor

Truth and Consequences in the World's Richest Nation

laurence j. O'CONNELL

Jesus once said, "the poor will always be with you." Samuel Johnson pointed out the social and moral consequences of the ever-present poor: "A decent provision for the poor is the true test of civilization."

In the United States, we do not provide well for the impoverished among us, especially in the realm of health care. Lack of access to our profit-driven system effectively bars more than 40 million Americans from reliable, timely, and decent health care. How can this be?

Economist Ewe Reinhardt provides an honest, straightforward answer: "The nation's manifest impotence in this area reflects an inability to agree on the ethical precepts to govern the production and distribution of health care." In other words, at present there is no moral consensus—and thus no political will—which can guide the American healthcare system to higher moral ground.

The issue, then, is not money; it is values. Our culture is simply not receptive to addressing the healthcare needs of the poor or near-poor. As Coretta Scott King said recently: "We could provide basic healthcare coverage for half a million people for the cost of a B-2 bomber." Indeed, we might need B-2 bombers, but the decency of our civilization does not depend upon them.

Widespread neglect of the poorest among us is simply not consistent with the American people's good character. We can and will restructure our healthcare system. But first we must give substantially more attention to identifying foundational values and then building a broad ethical infrastructure that will support needed reforms.

The world's religious traditions harbor many of these foundational values and offer fresh perspectives that might energize genuine healthcare reform. We should freely turn to these precious resources. Within the Roman Catholic tradition, for example, we find the "preferential option for the poor." This simple but profound precept is often misunderstood. Sometimes it has been associated with a Marxist vision that encourages violent revolution. Other times, the preferential option has been taken as a put-down of the wealthy.

Yet it is neither Marxist nor classist. It constitutes a call to all classes to cooperate in building a just society by attempting to overcome gross disparities between persons and even nations in terms of power, education, and opportunities, as well as income.

Religious faith and teaching can be very suggestive as we debate important public issues like health care. Each of us can and should explore and exploit our own religious tradition as we struggle to be good citizens. This country's church-state wall of separation does regulate certain public actions; but it does not reach into our personal lives, where we discover the values that we bring to the public square.

Belief in the timely emergence of a renewed and just healthcare system in the United States requires a genuine act of faith and the willingness of the faithful to act. The poor may always be with us, but decency demands that their basic human needs be addressed, even if not completely met. Jesus may have been right, but surely Dr. Johnson had a point. ■

THE PARK RIDGE CENTER

Bulletin

July/August 1999
Issue Number Ten

- 2 From the Editor**
Rendering Visible the Invisible
Philip J. Boyle
- 3 Up Front**
Poverty Kills
Meredith Minkler
- 5 Main Story**
Healing the Homeless
Dan Perreten
- 9 Case Study**
The Call of the Good Samaritan
Edwin R. DuBose
- 11 Reading Room**
Racism's Virulence
Emilie M. Townes
- 12 Law of the Land**
The Bernardin Factor
Quentin Young
- 13 Social Studies**
Charitable Giving to the Poor
Stephen Ellingson
- 14 Media Briefs**
- 15 Last Word**
The Ever-Present Poor
Laurence J. O'Connell



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