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Six years ago as a newly hired (and new to the field) clinical ethicist at a large Catholic medical center, I quickly became aware of the frustration and accompanying feeling of powerlessness when called for an ethics consult long after dividing lines had been drawn, opposing positions were entrenched, and suspicions abounded on both sides of the table. Invariably in those cases, one of the bedside nurses would say, “I could have told you on day three this was going to happen!”

Two questions quickly emerged; What did that nurse see on day three? And why didn’t I know there was a patient here that long with these types of issues?

About that time several articles in the literature discussed the value of ethics consults in the ICU as well as proactive bioethics screening.1 This article will discuss a process developed at the Sisters of Mercy Health System and implemented at a member facility to address some of these common frustrations with the goal of getting ethics resources involved earlier.

Identifying the problem
In an article describing a process for proactive bioethics screening, Leon Morgenstern from Cedars Sinai begins with a familiar scenario, “A fragile octogenarian with advanced dementia and a host of co-morbid conditions is now unresponsive, ventilator dependent, in renal failure, and suffering grade-four decubitus ulcers. Death is expected in the near but undeterminable future. There is no advance directive. Of her remaining kin, her daughter insists that ‘everything be done’; the time has come to consider tracheostomy and feeding gastrostomy.”2 While Morgenstern uses the concept of the “ethically vulnerable” patient, this case can also be discussed in terms of missed opportunities along the way. Questions along those lines might include: What discussions took place around her plan of care when each diagnosis was made? What were the goals of treatment? What attempts were made to discuss this patient’s values and end-of-life wishes? What did the daughter understand to be the possible outcome of placing her mom on the ventilator? Does the daughter truly understand what ‘everything done’ really entails?

There are numerous ways to avoid these missed opportunities. The approach discussed here is just one way to get resources involved further upstream to identify potential ethical issues and rally the appropriate parties’ involvement. With the blessing of the senior leadership of the health system, this task was undertaken concurrently by the Corporate Ethics Committee of the Sisters of Mercy Health System and the ethics committee at the local member organizations. The Corporate Ethics Committee focused on defining the indicators that would trigger an ethics review based on our collective experience on difficult cases, while the local ethics committee addressed how this process might be feasible within its local environment.

Indicators
The Corporate Ethics Committee, which consisted of the ethicists or vice presidents for mission and ethics from the local member organizations along with - for this issue - clinicians, case managers, nurses and a lawyer, developed the following indicators:

1. Patients for whom the goals of treatment are unstated, unclear or unrealistic.
2. Patients for whom there is conflict over the goals of treatment or treatment options.
3. Patients for whom their Durable Power of Attorney for Health Care Decisions or family are requesting that life-sustaining treatment be withheld or withdrawn absent an end-stage disease or when there is reasonable expectation of recovery.
4. A resource utilization outlier, specific to the individual member organization and used primarily as a means for a database of patient cases.

Purpose and development
The purpose of the “Indicators for Ethics Review” process at
St. John’s Mercy Medical Center reads, “For ethics to be more proactive in addressing difficult cases there has been a system-wide effort to identify the characteristics of these difficult cases. In the future when these indicators are identified, ethics resources can be involved at the appropriate level.”

Being sensitive to the primacy of keeping caregivers at the patient’s bedside and reducing the amount of time in meetings, combined with the fact that we did not yet have electronic medical records where these indicators could be triggered electronically, it was imperative that this process tap into systems and processes already in place. Several members of the ethics committee joined with the manager and director of the Care Coordination Department (otherwise known as case management) to discuss how this might work. The chair of critical care, a long-time member of the ethics committee, charged the group to develop a process that is grounded in the practical and is a help, not a hindrance, to the health care team.

Care coordinators, nurses and social workers who work with patients and families on discharge planning, meet weekly to review patients whose length of stay is 25 days or longer. These meetings include the manager and director of care coordination as well as their medical director. This situation met two requirements: a process already operational and a resource utilization outlier which would create a database of patient cases. I was invited to attend these weekly case review meetings.

Team approach

Now that I was invited to the weekly case review meetings, it was important to determine who else should sit at the table. In many of the cases reviewed by the local ethics committee, we found that the patient or family had already contacted the patient advocate expressing concerns over some aspect of their care. Additionally, many of the patients in these difficult cases would have benefited from a palliative care consult; therefore, representatives from patient relations and palliative care were invited to attend. Those now at the table included: ethics, patient relations, palliative care, the nurse and social work care coordinators, leadership from care coordination and their medical director.

Interdisciplinary patient care conferences are difficult to orchestrate in the current health care system; they are time-consuming and often seen as ineffective. The weekly case review is the closest that many services can manage, so while we expanded the number of disciplines at the table, it certainly is not fully representative. Most notably, due to time constraints and staffing requirements, it is not possible to have bedside nurses, chaplains, attending or specialist physicians at these meetings. However, input from those individuals is sought at the unit level.

The process

Weekly case review meetings are a flurry of activity. Care coordinators report individually so that as one exits the room another enters. During the care coordinators’ brief reports, those at the table must pick up on nuances of the case related to their own discipline. They can ask questions and, if potential issues or actual problems are identified, offer suggestions on possible next steps. If the situation has already developed into conflict, the other parties at the table can get involved or, if already involved, become the point-person for resolution. The principle of subsidiarity is at work here: the person closest to the patient and family with the best relationship is encouraged take a leadership role to coordinate efforts to resolve the issue or conflict. When the leader needs assistance, others are brought in. The leader acts as a liaison to physicians, health care team, and patient and family members. Often the situation requires a patient care conference to be followed by a patient and family conference with the health care team. The entire team is active behind the scenes until their personal involvement is required.

Results

Our results to date indicate that there is increased communication among the health care team as well as with patients and families. There is heightened awareness of and sensitivity to ethical concerns which have led to earlier intervention. Individuals who perhaps were not otherwise inclined to speak up have been empowered to have a voice in troubling situations. This process has also facilitated team building, so the coordination of the patients’ care more closely resembles the integrative element of interdisciplinary care rather than merely multidisciplinary. We believe that we have come together to anticipate needs and concerns that result in more ethically appropriate practices in the delivery of health care.

Emblematic of this process, two types of occurrences have become common. In one, a care coordinator will look up
from her paperwork, point at me exclaiming, “Have I got a patient for you!” This turns out **not** to be a patient on the ‘25 day’ list, but rather a patient whose case has raised some ethical concerns. Now the care coordinator can voice concerns, get direction, and not have to answer the (often accusatory) question, “**Who** called ethics?” In the other, while discussing a case, someone besides the ethicist says emphatically, “Well, if the patient still has decisional capacity then **why** are we letting the daughter make decisions?” This type of responses should become second nature to everyone on the health care team.

The capability of triggering these reviews via an electronic medical record will be a reality at St. John’s Mercy Medical Center in the next twelve months. However, my preference is that the electronic trigger will be a complement to the weekly case review meetings to preserve the team building and interdisciplinary nature of these meetings.

**Continued challenges**

While these results have been promising, we continue to have challenges. We have not yet determined a way to measure the success of this process. Additionally, the team continues to be challenged by time constraints in getting representatives from ethics, patient relations and palliative care to the table each week. It has also continued to be a quandary as to when to have the ethicist directly involved with patients and families. Depending on the circumstances and dispositions of the patients and their family members, the introduction of the “director of ethics” can elicit counterproductive responses. Perhaps these challenges can be part of the dialogue this article prompts.

**NOTES**


Cleaning Up Our ‘Environmental Footprints’
Catholic Organizations Are Taking Responsibility for Environmental Protection

By Jayne E. Mardock
Ms. Mardock is an environmental health specialist with a master’s degree from Harvard Divinity School, Cambridge, MA. She provided direction to the National Religious Partnership for the Environment projects, including the Catholic Coalition for Children and a Safe Environment, of which CHA is a part.

Catholic health care is a ministry to the community: healing the sick, serving the vulnerable, and leading by example. It follows in the footsteps of Jesus, who not only healed the sick but challenged and transformed the social norms of society. Through its strength as more than 2,000 Catholic health care sponsors, systems, facilities, and related organizations, the ministry has the power and responsibility to transform the health care industry to make it more environmentally responsible and safe.

Concern for environmental issues grows out of Catholic social teaching to promote and defend human dignity at every stage of life, as well as a special commitment to care for vulnerable persons. Environmental hazards are particularly harmful to developing children—both before and after birth—and to poor, frail, and sick persons.

Hospitals are significant sources of pollution in communities because of the waste generated through modern health care delivery. Hospitals for a Healthy Environment estimates that the nation’s hospitals produce 7,000 tons of waste per day. According to the U.S. Environmental Protection Agency (EPA), medical waste incinerators are the third largest source of the dioxin and the fourth largest source of the mercury released into the environment. Health care’s environmental footprint has health consequences not just for patients, but also for staffs and the communities they serve.

Health professionals are committed to the ancient healer’s motto: “First, do no harm.” Catholics have a rich tradition of social teaching that calls on each person to care for the sick and vulnerable, the unborn, and all of creation. The commitment to serve the community and be a good neighbor requires Catholic health care facilities to take steps to reduce the environmental burden of health care delivery. But there are also financial reasons to be environmentally responsible. Waste is lost money; but those losses can be minimized through the deliberate reduction of waste. Hospitals and other care facilities are finding ways to reduce, reuse, and recycle waste, thereby saving thousands of dollars. They can leverage significant buying power to transform materials procurement so that the products used are more consistent with environmental goals, as well as cost competitive. By acting strategically, the Catholic health ministry can lead by example to help make health care delivery less wasteful and polluting.

Catholic Teaching and Environmental Concerns
Catholic health care organizations are rooted by their commitment to fulfill Jesus’ ministry of healing, caring for the poor and upholding the dignity of each person. The U.S. Conference of Catholic Bishops stated in its 1981 pastoral letter, Health and Health Care, that the long Catholic tradition in health care results from the fact that “the Church considers health care to be a basic human right, which flows from the sanctity of human life.” The tradition stresses that there is a special obligation to care for the poor and vulnerable as well. Those most vulnerable to environmental degradation are the young, the old, the sick, and the poor. As Catholic health facilities reduce waste and pollution, they leave a better environmental legacy to our children.

The ministry also has a special obligation to care for all creation and to be a good steward of the earth. In their pastoral letter of 1992, Renewing the Earth: An Invitation to Reflection and Action on Environment in Light of Catholic Social Teaching, the bishops wrote: “At its core, the environmental crisis is a moral challenge. It calls on us to examine how we use and share the goods of the earth. . . . The whole human
race suffers as the result of environmental blight, and genera-
tions unborn will bear the cost for our failure to act today.”

The bishops made a clear connection between the costs of
pollution and those most vulnerable to it, saying, “It is the
poor and the powerless who most directly bear the burden
of current environmental carelessness. Their lands and
neighborhoods are more likely to be polluted or host toxic
waste dumps, their water to be undrinkable, their children
to be harmed.”

As health care facilities work to protect the sanctity of all
life, they must reduce the chemicals in the environment that
disrupt learning, development, and reproduction. The
womb is the first environment, and it is often polluted by
the chemicals and metals that find their way into the body
through food, air, water, and our surroundings. The Centers
for Disease Control and Prevention estimate that 1 in 10
American women have within them levels of mercury high
enough to affect an unborn child’s ability to learn and con-
centrate.1 Breast milk contains hundreds of chemicals-chem-
icals that taint the best food a woman can give her child.
Lead, which is stored in the bones, is mobilized during preg-
nancy so that a child is born with much of its mother’s
lead.2 As the amount of chemicals that pollute our bodies is
reduced, the sanctity of all life is preserved.

Over the past decade, the Catholic health ministry has
become increasingly concerned about the larger environ-
mental implications of health care delivery and, as a result,
have made a commitment to reduce its burden. It has:

■ Joined with other organizations, including Health Care
Without Harm (HCWH) and Hospitals for a Healthy
Environment (H2E), to increase our understanding of the
problems involved and ways we might address them.
■ Asked group purchasing organizations (GPOs) to use
their leverage to provide environmentally preferable pur-
chasing (EPP) plans that deliver alternative, less damaging
products for use in health care facilities.
■ Engaged its member organizations to find ways to reduce
waste and pollution while saving money and being better
environmental stewards.
■ Joined other national Catholic organizations in the
Catholic Coalition for Children and a Safe Environment
to “practice what we preach” in health care delivery as a
means of protecting children and the environment.

The reader can learn more about the available resources
from the Resource section at the end of the newsletter. But,
first, more should be said about health care’s contribution to
environmental degradation and what the ministry can do
about it.

How Health Care Can Harm

Health care organizations can cause environmental damage
in several ways, including the generation of nonmedical
waste, waste incineration, and widespread use of polyvinyl
chloride (PVC) plastics.

Nonmedical Waste Health care uses a great deal of paper
and plastic disposable products in routine care and adminis-
tration. HCWH estimates that 53 percent of hospital solid
waste is paper and cardboard, 17 percent is food and organic
matter, 15 percent is plastic, and 15 percent is metals or
other waste.4 Health care is always looking for ways to
reduce costs, and facilities are beginning to see that by
reducing waste, they are saving thousands of dollars.

The leaders of St. Elizabeth Health Partners, Covington, KY,
estimate that the facility has saved $98,000 through recy-
cling programs and donates about two tons of unused, pre-
pared food to area food banks.5 St. Peter’s Health Care
Services, Albany, NY, has saved $300,000 by using a third-
party vendor to reprocess selected medical devices, such as
certain catheters, compression devices, scalpels, wands, and
scissors, and by buying back reprocessed equipment at a
reduced price.

A waste audit can help facilities identify problems and devise
ways to reduce waste. Health care organizations can make it
easy for staff to recycle and segregate trash throughout their
facilities. Marian Medical Center, Santa Maria, CA, solicits
employee suggestions for improving its ecological program and
rewards those employees who submit ideas. The facility has
also cut its energy costs by 13 percent, saving $60,000 so far.

Medical Waste Incineration
For decades, hospitals turned to incineration to address their
waste problems. However, medical waste incineration remains
a significant source of harmful mercury and dioxin air emis-
sions, in addition to toxic ash residue, which can contaminate
water sources if not disposed of properly. A host of other toxic
chemicals and metals can be found in medical waste as well.
Dioxin  Dioxin is a class of chemicals created by the burning of chlorinated waste, and it is one of the most potent pollutants known to humans. The incineration of plastics is the primary source of health care dioxin emissions. Although dioxin is ingested by most people when they eat meat, fish, and dairy products, it passes to unborn children in utero and to infants through breast feeding. Dioxin exposure has been linked to disrupted sexual development, birth defects and damage to the immune system, IQ deficits, and developmental delays.

St. Elizabeth Health Partners has reduced costs by $17,000 by switching from waste incineration to sterilization and shredding, thereby reducing medical waste volumes by 80 percent.

Mercury  Mercury is a potent neurotoxin, especially for the unborn, infants, and children. Medical waste contains as much as 50 times more mercury than ordinary waste, according to the EPA. Mercury is found in various thermometers, blood pressure cuffs, esophageal dilators, measurement devices in medical laboratories, fluorescent lighting, and batteries. In addition, thermometers used in the home account for 10 percent of the mercury in the municipal waste stream. In 2001 the U.S. Food and Drug Administration released advisories urging pregnant and nursing women to avoid eating shark, swordfish, tilefish, and king mackerel because they had been found to contain enough mercury to damage unborn babies and young children.

A number of Catholic health care organizations—including Pittsburgh Mercy Health System; St. Joseph Mercy Health System, Ann Arbor, Mi; Dominican Hospital, Santa Cruz, CA; and St. Joseph’s Hospital, Atlanta—are involved in mercury-reduction efforts, including community thermometer exchanges. Through its participation in H2E, CHA and many of its members have committed themselves to beginning to eliminate mercury whenever possible.

PVC Plastics and DEHP  PVC is pervasive in health care delivery. It is found in intravenous feeding and blood bags, plastic tubing, bedpans, patient ID bracelets, plastic wrap, vinyl-coated notebook binders, flooring, and even wallpaper. PVC has a higher chlorine content than any other plastic and therefore creates much more dioxin when manufactured and burned in an incinerator. Compounding the problem is DEHP-Di(2-ethylhexyl) phthalate—a chemical added to PVC to make it supple. However, DEPH does not bind to PVC and can leach out when it comes in contact with liquids, lipids, or heat. For this reason, it is a poor choice for medical devices and equipment. DEHP is especially dangerous for male babies and can cause sexual reproductive problems in them. At a minimum, hospitals should try to eliminate all PVC and DEHP products from maternity, pediatric, and neonatal ICU departments. Bags, tubes, and gloves account for 98 percent of the disposable PVC care products used in health care. Office supplies and food preparation are the other areas of concern. Cost-competitive alternatives exist for most of these products. Consorta, a GPO used by many Catholic health care facilities, has developed an extensive EPP program that provides products that reduce or eliminate toxic waste. The program also labels PVC products, thereby helping facilities track PVC use and possibilities for reduction. Some facilities, in their efforts to reduce PVC use, are looking at building materials such as flooring and wallpaper.

Reducing Health Care’s Environmental Footprint
Catholic and other health care organizations are doing a number of things to eliminate or at least limit damage to the environment.

Plastic Reduction  To better manage their use of plastics, such organizations are:
■ Conducting audits to identify products containing PVC and DEHP and determine appropriate alternatives.
■ Targeting disposable PVC items first, especially those used in neonatal intensive care units, maternity, and pediatric departments. They are also phasing out PVC office supplies.
■ Seeking plastic products that are easily recyclable (no. 1 and no. 2 plastics) or are made with recycled plastics.
■ Taking advantage of products that can be returned to the manufacturer, such as printer cartridges.
■ Purchasing PVC-free office furnishings and construction materials when renovating or building new wings or buildings.
■ Specifying that durable medical products must be PVC-free.

Paper Reduction  To better manage their use of paper, they are:
■ Supporting aggressive waste minimization and recycling efforts throughout the facility.
■ Using both sides of paper, when possible.
■ Avoiding paper products that cannot be recycled, when alternatives exist.
Separating paper and other nonmedical waste from medical waste during disposal.

**Mercury Elimination** To reduce the use of mercury, they are:
- Conducting facility-wide mercury audits.
- Accessing the H2E listserv, which offers information and strategies for the reduction or elimination of mercury in medical facilities.
- Taking H2E’s “Making Medicine Mercury-Free Pledge,” thereby joining hundreds of other medical facilities that are equally committed to reducing and eventually eliminating medical uses of mercury.
- Implementing a mercury-free purchasing policy, encouraging materials managers to learn about alternatives, and asking the GPO to provide an EPP plan involving mercury.
- Holding community-wide mercury thermometer exchanges and providing mercury-free thermometers to parents of newborns and other patients.
- Sponsoring a local battery roundup, collecting batteries from employees and their families for proper disposal.

**Purchasing with the Entire Life-Cycle in Mind** Health care organizations are also:
- Seeking paper products that have higher recycled content and are “chlorine free,” thereby helping to reduce dioxin emissions at paper mills.
- Looking for products that are easier to recycle or return to the manufacturer.
- Buying PVC- and DEHP-free products, when alternatives exist.

**Working with Other Organizations**
The Catholic health ministry, through participation in several national efforts aimed at reducing the harm from the health care industry, has become increasingly committed to environmental stewardship. Through their involvement in HCWH and H2E, Catholic facilities have access to a wide range of materials and expertise that will help them become more sensitive to environmental problems.

**Group Purchasing Organizations**
A GPO can be another important ally for facilities seeking to become more environmentally responsible. In October 2002 four large GPOs-Premier, Inc.; Novation; Broadlane; and Consorta-committed themselves to providing clients with EPP plan options. Most EPP plans provide products that replace those containing mercury and PVC plastic, reduce wasteful packaging, and support increased recycled content and “recyclability.” Over the years, CHA and many of its members have worked closely with Consorta, which operates in more than half of all Catholic hospitals, to become an industry leader in providing environmentally responsible product lines.

In the past decade, the Catholic Church has become a prophetic voice for environmental stewardship. This has grown out of the church’s longstanding commitment to protect the sanctity of life, especially the lives of the most vulnerable. In his 1989 address, “And God Saw That It Was Good,” Pope John Paul II said, “Faced with the widespread destruction of the environment, people everywhere are coming to understand that we cannot continue to use the goods of the earth as we have in the past. . . . The ecological crisis is a moral issue.”

Committed Catholics and health care professionals have a moral responsibility to do everything possible to minimize wastefulness and pollution. Significant strides have been made, and the Catholic health ministry is poised to be a leader in today’s health care environmental transformation.

**NOTES**
6. U.S. Environmental Protection Agency, *Background Information on Mercury Sources and Regulations*, available at www.epa.gov/grtlakes/bnsdocs/mercsrce/merc_srcr.html#Table%202B (Table 2B).
At Catholic Healthcare West (CHW), we recognize the interdependence between human health and the environment we live in. Global warming and the pollution of our air, water and soil are pervasive problems in our world. What we do today to preserve our planet will impact our patients’ health and well-being now and in the future for their children and grandchildren.

Creating a Healthy Environment
Our mission is to be part of the solution, advocating for practices that protect our environment. After all, ecology comes from the Greek word “oikos,” meaning home. The planet is our home and as members of the Earth community, we must revere its gifts — energy, water, material and land — using them efficiently and avoiding waste.

For more than a decade, CHW has woven environmental programs and processes into the work we do every day. From big to small, our efforts have impacted our organization and our planet in a positive way.

As leaders in helping to change the healthcare industry’s impact on the environment, we continue to share our best practices and we encourage others to join us in this important work.

Designing Efficient Buildings
CHW seeks to create a healing environment while minimizing the environmental impact of all our building projects. From the aesthetic to the practical, our construction teams pay attention to indoor air quality, light, noise, temperature and humidity. Our contractors collaborate with us to use materials, technologies and processes that limit the negative impact on the environment whenever possible.

We’re also improving energy efficiency and reducing greenhouse gases created by our existing facilities. Since 2001, we’ve identified and implemented specific projects aimed at reducing energy and water consumption. We estimate that our efforts in these facilities will reduce electric consumption by 64M kWh (16%) and natural gas consumption by 119K MMBtu (7%).

Marian Medical Center in Santa Maria, Calif., for example, has installed a state-of-the-art system of transforming methane gas waste from the local landfill into “green” energy in a process called cogeneration. Not only will this process fuel and power the hospital, it will significantly reduce methane emissions into the environment. The system also offsets the use of other resources, such as coal, natural gas and oil, while saving the hospital $225,000-$345,000 annually in energy costs.

Conserving Water
We require all our facilities to keep track of water usage. Our data indicates that an average facility uses 25-35 million gallons of water each year.

We’ve reduced water consumption in a variety of ways. Old heating and cooling equipment and steam traps have been retrofitted to become more efficient. At some facilities, we use drip irrigation in our landscaping and plants that require less water to thrive.

We’ve implemented water saving technology in our X-ray film developing process. This program is expected to save more than 140 million gallons of water annually, about 90 percent of the water currently used for X-ray production. We’ve also introduced digital X-ray technology in many of our facilities, meaning that film and chemical processing is eliminated. We’ve reduced the costs associated with chemical maintenance, hazardous material handling and dark-
rooms and the water savings are more than 100,000 gallons per processor each year.

We continue to promote water conservation efforts and train our staff to be more energy efficient in their daily work.

**Reducing Our Waste**

Looking for a plastic container? A used computer? Furniture? Saint Francis Memorial Hospital in San Francisco is one of six CHW hospitals that operates reusable stores, offering used hospital items for employees and community members. Items no longer needed by the hospital are offered free in an effort to save them from a landfill.

Hospital waste is a serious problem. Hospitals nationwide generate some 6,600 tons of waste daily, according to Hospitals for a Healthy Environment (H2E). About 85 percent is non-hazardous solid waste - paper, plastic, food, cardboard, metal and glass. That gives hospitals plenty of recycling opportunities.

We reduce our overall waste through a variety of programs. Some items can be recycled. Other items are sterilized and reused. In fiscal year 2006, CHW diverted 88 tons of medical waste by reprocessing items and conserving resources, without putting our patients or employees at risk.

Overall, we’ve reduced the amount of waste by 23 percent since 2000 and have maintained our current usage levels for three years. We consider this a practical goal for waste reduction given the current hospital environment, but continue to look for ways to improve.

Reusable stores are just one of the many programs we’ve developed to reuse and recycle common hospital items. Here are descriptions of other efforts:

**Blue Wrap**

Each year CHW purchases about 200,000 pounds of blue wrap, a polypropylene material used frequently in hospital operations. We’re working with the California Integrated Waste Management Board to develop a blue wrap recycling program statewide. If this recycling program is a success, it could potentially reduce landfill waste by millions of pounds.

**Construction Debris**

CHW constantly renovates existing facilities and builds new ones. We work with our contractors to ensure that much of our waste is recycled. We recycle steel studs, aluminum, copper and cardboard. Old concrete is crushed and used as backfill. And we are using recycled building materials when possible.

**Electronic Waste**

In 2006, we established a program to manage electronic waste, primarily computers. We’ve protected our data to comply with federal, state and local regulations. And we’re working with our vendors to safely dispose of electronic equipment, thus reducing the amount of electronic equipment in foreign landfills.

**Nourishing Our Bodies**

When it comes to hospital fare, patients and employees at Dominican Hospital in Santa Cruz eat right. The hospital serves fresh, organic fruits and vegetables supplied by the local Agriculture and Land-Based Training Association (ALBA), an organization that helps small, novice farmers prosper.

Organic food offers healthier choices than those found in most vending machines. Our purchases of organic food from local growers also support economies in the communities we serve.

As Americans struggle to control diabetes and obesity brought on by unhealthy food choices and a lack of exercise, CHW aspires to create a healthier food system.

We define healthy food not only by its nutritional quality, but also by where it comes from. We look for food systems to be economically viable and environmentally sustainable.

CHW has signed the Health Care Without Harm healthy food pledge to continue to achieve environmentally-friendly food service and supplies. We’ve also developed our own vision to promote healthy food and discourage waste, while working with producers and processors who uphold the dignity of farmers and workers in their communities.
Eliminating Hazardous Chemicals

From premature babies to the elderly, hospitalized patients often receive life-sustaining fluids and medication through IV bags. Historically, IV bags have been made of polyvinyl chloride (PVC), a plastic used in many medical devices.

We have been working to reduce our use of this material for several important reasons. The cancer-causing agent dioxin can be formed during the manufacture of PVC or during the burning of PVC products. The chemical DEHP, used to soften the PVC plastic, also has been linked to birth defects and other illnesses.

By fiscal year 2006, we phased out most PVC/DEHP IV products, using IV bags produced by B. Braun Medical, Inc., which do not contain those chemicals. This is just one example of how CHW has worked with manufacturers to create products that are safer for patients and healthier for the environment.

We've also removed all significant amounts of the poisonous heavy metal mercury from our facilities and instituted purchasing policies to ensure no new mercury is introduced.

Tracking Greenhouse Gases

Greenhouse gases trap heat in the atmosphere and contribute to global warming. Some occur naturally, but others are generated solely through what we do as humans. Tracking greenhouse gases gives us information on activities that contribute to climate change.

CHW is committed to reducing greenhouse gas emissions. We're participating in the California Climate Action Registry, a voluntary program that helps companies calculate and certify greenhouse gas emissions. We're currently tracking carbon dioxide from a variety of sources, including our cars and trucks, diesel generators, direct heating, cooling and electricity use.

Through these measurements, we plan to identify the sources of our emissions and how we might work to reduce the greenhouse gases we create.

Advocating for Change

CHW’s mission is to advocate for change, both within our industry and globally, that improves the quality of life. We continually ask ourselves and others how we can balance both moral and strategic issues in how we do business.

Part of the solution is to question the status quo. Much of our progress has first involved facing the challenges of steering our own organization to providing services in a safer, healthier way.

We've taken our best practices and worked in partnership with others to impact public policy on the state and national levels.

Our advocacy helped create the California Climate Action Registry, a non-profit voluntary registry that tracks greenhouse gas emissions. CHW was the first healthcare organization in California to participate in the Registry.

CHW has also successfully advocated for the passage of several bills in California that protect both the environment and consumers. In particular, we advocated for the Safe Cosmetics bill, which strengthens consumer protections regarding chemicals in cosmetics, and for the passage of a bill requiring that child care products and toys designed for children under the age of three be free of toxic chemicals called phthalates. And because there are large gaps in understanding the effects of environmental contaminants on human health, CHW was proud to support the passage of the Biomonitoring bill, which established a formal mechanism for measuring toxic chemicals in people.

We continue to help advance the debate with local, national and international partners on the development of a comprehensive chemical policy.

We've put a lot of effort into our push for change, but we acknowledge our work has just begun. We believe it's everyone's duty — as individuals and as members of organizations — to promote optimal health while caring for our planet.

Recognizing Our Environmental Efforts

CHW is a recognized leader nationwide in environmental performance. In 2007, Hospitals for a Healthy Environment (H2E) awarded CHW, for the sixth year in a row, the Champions of Change Award, honoring our environmental leadership in the hospital industry.
CHW in 2006 received more than 19 additional awards for a wide range of environmental programs, setting the industry standard, and many of our hospitals have individually been honored for their environmental efforts.

In 2007, H2E honored CHW hospitals in California with the following:

**Partners in Change Award** — to Mercy Medical Center in Redding, Sequoia Hospital in Redwood City and St. Bernardine Medical Center in San Bernardino for mercury elimination, waste reduction and pollution prevention programs.

**Making Medicine Mercury Free Award** — to Mercy General Hospital in Sacramento and St. Bernardine Medical Center in San Bernardino for meeting the challenge of becoming a mercury-free facility.

**H2E Environmental Leadership Circle** — Dominican Hospital in Santa Cruz and St. Joseph’s Medical Center in Stockton were inducted into this prestigious circle for their ongoing efforts to create environmentally-responsible healthcare programs.

**Restoring Our Planet**

At CHW, our environmental program is a key part of our healthcare ministry. As we provide our patients with excellent care and our employees with a healthy and safe working environment, so too do we strive to treat our planet.

The work to be good stewards of the resources entrusted to us and to collaborate and partner with others to share our best practices is ongoing and urgent. We’ll continue to explore processes that help us protect our resources, make us more efficient and cost effective, and improve the health of our patients and our planet.

For more information about CHW’s environmental commitment, please contact Sister Mary Ellen Leciejewski (maryellen.leciejewski@chw.edu).

To learn more about Catholic Healthcare West visit us at www.chwhealth.org/ecology.
Catholic Healthcare West’s Policy & Procedure

Environmental Policy and Statement of Principle

I. PURPOSE

To articulate Catholic Healthcare West’s commitment to respect and protect Earth and its endorsement of the CERES Principles for environmental protection and conservation.

CERES, the Coalition for Environmentally Responsible Economies, is a non-profit organization comprised of leading social investors, environmental groups and public entities. CERES promotes environmentally responsible economic activity for a just, healthy and sustainable future throughout the world. The CERES Principles provide a model corporate code of environmental conduct. Companies that endorse the CERES Principles pledge to monitor and improve their environmental practices. These companies conduct an internal environmental audit and complete an annual public report according to a standard format.

II. POLICY

Catholic Healthcare West manages its operations in a manner demonstrably protective of human health and the environment. CHW seeks new and better ways to meet its environmental goals through conservation, reduction, reuse and recycling programs. CHW is committed to improving environmental management in its hospitals and to partnering with others in its community to safeguard the environment.

III. PRINCIPLES

These principles, known as the CERES Principles, guide CHW’s internal practices and its healthier communities initiatives. Adherence to these principles will ensure consistent, measurable progress in CHW’s efforts to respect and protect Earth for all peoples and future generations.

A. In an effort to minimize environmental damage to the air, water, earth or persons, we will:

- Use environmentally responsible products as much as possible, and

- Reduce and make continual progress toward eliminating the use of any substance that causes environmental damage or health or safety hazards.

B. We will make sustainable use of renewable natural resources. We will conserve non-renewable natural resources through efficient use and careful planning.

C. We will reduce and, where possible, eliminate waste through product and packaging source reduction, re-use and recycling. All waste will be handled and disposed of through safe and responsible methods.

D. We will conserve energy and improve the energy efficiency of our operations. We will make every effort to use and promote environmentally safe and sustainable energy sources.

E. We will strive to maximize the health and safety of our employees through maintaining the health of the environment in which they work. We will maintain safe technologies, facilities and operating procedures and effective emergency preparedness programs.

F. We will promptly and responsibly correct conditions we might cause that endanger health, safety or the environment. To the extent feasible, we will redress injuries we might cause to persons or damage we have caused to the environment.

G. We will inform in a timely manner those persons who are adversely affected by conditions we cause and of the measures and safeguards we have implemented to guard health, safety and the environment. We will regularly seek advice and counsel through dialogue with persons in communities near our facilities.

H. We will make collaborative education and training programs available within our communities so that everyone has an opportunity to participate in implementing these principles.

I. We will develop processes for self-evaluation of our environmental practices and prepare an annual report on our progress in implementing this environmental policy.

Disclaimer: These Principles establish an environmental ethic with criteria by which environmental...
performance can be assessed. In endorsing these principles, CHW pledges to go voluntarily beyond the requirements of the law. The terms may and might are not meant to encompass every imaginable consequence, no matter how remote. Rather, these Principles obligate CHW to behave as prudent persons who are not governed by conflicting interests and who possess a strong commitment to environmental excellence and to human health and safety. These Principles are not intended to create new legal liabilities, expand existing rights or obligations, waive legal defenses, or otherwise affect the legal position of CHW.

IV. PROCEDURES
A. ENVIRONMENTAL ACTION COMMITTEE — An Environmental Action Committee, appointed by each hospital’s President, is responsible for:

1. Establishing annual goals for improved environmental performance,
2. Monitoring progress toward those goals,
3. Submitting quarterly and annual reports to the hospital community board and the CHW board of directors,
4. Overseeing implementation of the environmental policy,
5. Educating employees on environmental issues, and
6. Seeking opportunities to partner with others in the community in support of ecological projects and advocacy initiatives.

The Environmental Action Committee (EAC) may be an independent committee or a subcommittee of the Health and Environment of Care/Safety Committee. Optimally, the EAC includes representation from:

- Patient Services
- Mission Services
- Community Benefit
- Risk
- Purchasing
- Engineering
- Maintenance
- Housekeeping
- Dietary
- Pharmacy
- Infection control
- Laboratory
- Safety and security
- Administration

Employees who show a particular interest or desire to assist

The EAC meets regularly, keeps minutes of its meetings and reports to the Community Advisory Board on key environmental issues.

B. ENVIRONMENTAL LEADERSHIP — CHW and its hospitals will work to become environmental leaders among health care providers. We will establish and maintain environmental programs that will be viewed as state-of-the-art within the health care industry and the healthier communities movement.

C. LEGAL COMPLIANCE — Each hospital will comply with all applicable environmental laws. Upon discovery of any issue of non-compliance, the facility shall act immediately to remedy the situation and notify the CHW Legal Department.

D. RISK CONTROL — Each hospital will actively avoid unacceptable risks to the environment and will minimize risk to the System from previous, existing and potential environmental conditions.

E. WASTE MINIMIZATION — Each hospital will pursue systematically opportunities to minimize the quantity and degree of waste that results from its activities. Each hospital will initiate processes to achieve applicable percentages and timelines for reducing solid waste generation.

F. ENERGY USE MINIMIZATION — Each hospital will monitor and evaluate its energy usage and will implement goals and procedures for increased energy efficiency.

G. ENVIRONMENTAL COORDINATORS AND MANAGERS — The Environmental Action Committee, Product Review Committee, and Environment of Care/Safety Committee shall seek input and provide direction, guidance, and resource recommendations to the hospital president for approval which are designed to assure successful
implementation of hospital and system goals and objectives in environmental health.

The director/manager and supervisors of each department will assure successful implementation of hospital/system goals and objectives in support of a healthy environment as well as compliance with laws directly associated with his/her particular functions and services.

H. TRAINING AND AUDIT — Each hospital will participate in environmental training, awareness, and audit programs.

I. BENCHMARKING/SHARING OF BEST PRACTICES — Opportunities for systemwide sharing of best practices will be provided on a regular basis.

J. ENVIRONMENTAL REPORT — As part of the commitment to this Policy, each hospital will submit quarterly and annual environmental reports to its Community Board of Directors and to the CHW Board of Directors. Hospital reports will be compiled in a systemwide report that will be available to the public.
Since March, 2004, when Pope John Paul II delivered a speech on the use of feeding tubes with patients in a persistent vegetative state, several State Catholic Conferences have revised their advance directive materials. Among them are Colorado, Kansas, Maryland, and Rhode Island. It is interesting to note how each defines ordinary and extraordinary means and how each deals with the issue of artificial nutrition and hydration (ANH). A full review is not possible here. The intent is only to point to what may be an “ethical current.” A more complete analysis would be needed to verify whether what seems to be a direction is or is not the case.

The Colorado bishops (August 2007), for example, when discussing ANH, do not distinguish between patients in PVS and other patients. They begin by affirming the strong presumption in favor of providing ANH to all patients and then ask when they may be withheld or withdrawn. The answer: “As long as the person is able to absorb medically assisted food and water they continue to be beneficial in sustaining life. If the person is unable to absorb them, their administration may be discontinued. When inevitable death is imminent, one may cease the administration of food and water if the administration of them provides the person with no comfort and ceasing their administration will not be the cause of death.” Earlier in the document, the Colorado bishops defined “ordinary” means as those that “have a medically reasonable hope of sustaining life,” and “extraordinary” means as those that “have no medically reasonable hope of sustaining life.”

The Rhode Island bishops, in a more recently released advance directive document (February 2008), say this about ANH with regard to all patients: “Food and fluids should always be provided until it is found that the organs can no longer assimilate them, a sign of the onset of natural death. Here, the body’s refusal to sustain nourishment is instructive of life’s ending, and the removal of nutrition and hydration is an act of allowing nature to take its course rather than of withholding food and drink in order to cause death.” They describe ordinary and extraordinary means somewhat differently than the Colorado bishops. Ordinary “care” is said to be “standard, routine treatment that preserves life and health and that promotes comfort and dignity to the patient.” Extraordinary “care,” on the other hand, is discussed in this way: “Treatments that are not necessary to sustain life but that might offer some benefit to a patient are morally optional and accepted or foregone depending on the circumstances. Here, the benefits are compared to the burdens of a treatment. ... When the burdens or risks are found to be well out of proportion to the proposed advantages of a treatment, it may be found reasonable to forego it.”

In the Kansas Catholic Conference advance directive form itself, released in January 2006, the bishops state this regarding ANH: “I believe that food (nutrition) and fluids (hydration) are not medical treatments, not medical procedures, but ordinary means of preserving life. Therefore, I direct my health care provider(s) to provide me with food and fluids orally, intravenously, by tube, or by other means to the full extent necessary both to preserve my life and to assure me the optimal health possible. Furthermore, if at such time I am unable to eat and drink on my own (i.e. in a natural manner) food and fluids must be provided to me in an assisted manner (i.e. by tubes or a similar manner) unless: (a) my death is imminent (i.e. likely to happen without delay); or (b) I am unable to assimilate food or fluids; or (c) food or fluids endanger my condition.” This advance directive form also states that “health care decisions be made which are consistent with my general desire for the use of medical treatment that would preserve my life.”

In their advance directive materials (published in 2007), the Maryland bishops define ordinary and extraordinary means as what is “useful” and “useless.” “A medical treatment is ‘useless’ to a particular patient if it cannot bring about the effect for which it is designed. Such an intervention is both ineffective and medically inappropriate.” They continue: “A medical means
or treatment should not be deemed useless, however, because it fails to achieve some goal beyond what should be expected. For example, a feeding tube is used to provide nutrients to a patient no longer capable of eating; the tube is useful when it delivers these nutrients to the patient who, in turn, absorbs them. It is useless if the patient becomes incapable of absorbing the nutrients the tube delivers. Moreover, a feeding tube should not be described as useless if the nutrients it provides are unable to cure an underlying pathology; the feeding tube should not be expected to restore the patient to consciousness or to remove any other debility not related to the need for nutrients.”

They continue: “A seriously ill patient is not necessarily obliged to employ every possible medical means, even those which promise some benefit. In many cases, there is no obligation for patients to accept interventions which impose serious risks, excessive pain, grave inconvenience, prohibitive cost, or some other extreme burden. While the most basic principles of Christian morality oblige us to preserve human life, nonetheless, individuals need not undertake excessively burdensome efforts to preserve their lives. Whether a treatment is necessary or useful to a particular patient is a medical question requiring the expertise of health care professionals. Whether a particular treatment is excessively burdensome to an individual patient is a moral question requiring the advice of a priest or someone else well trained in sound moral theology.”

While a more extensive analysis of these (and other) advance directive materials is necessary, they do seem to reflect a different interpretation of the ordinary (proportionate)/extraordinary (disproportionate) means tradition as expressed in Directives 56 and 57, as well as the statement of Pius XII (1956) and the Declaration on Euthanasia (1980). With regard to ANH, the documents do not limit their discussion to patients in a persistent vegetative state, and they seem to say (and require) more than what is said in Directive 58, namely, “a presumption in favor of providing nutrition and hydration to all patients....” Are these different understandings idiosyncratic or do they reflect something else, perhaps an “ethical current.”

—RH
SSM Says Goodbye To Bottled Water
Starting June 1, 2008, SSM Health Care stopped offering bottled water at its 20 facilities in Missouri, Illinois, Wisconsin and Oklahoma due to the environmental impact of making, transporting and disposing of the plastic bottles. SSM won’t provide bottled water for meetings or sell it in cafeterias or vending machines. Patients and guests will get water in cafeterias using recycled cups. Employees are being encouraged to use reusable bottles or cups for their own use. (St. Louis Business Journal, May 28, 2008)

Green Sister Advocates for Sister Mother Earth
“Environmental Tips from the Green Franciscan Sister,” a column in a Marian Medical Center publication in Santa Maria, CA, is one way Sr. Janet Corcoran spreads the word about the importance of saving water. “Sister Mother Earth” needs help,” Sr. Janet told the National Catholic Reporter Jan. 11, 2008. “It’s a matter of getting people to think more consciously about what they’re doing.”

The Franciscan Federation’s website provides a link to the “Think Outside the Bottle” campaign, urging people to pledge to choose public tap water over bottled water and “support the efforts of local officials who prioritize strong public water systems over bottled water profits.” The campaign is part of Corporate Accountability International which says that demand for bottled water in the first world threatens water supplies in other parts of the world. According to CAI, 17 billion barrels of oil (enough to fuel more than one million American cars for one year) were used to make plastic bottles for water. Most of the bottles end up in landfills or as litter. (California Catholic Daily, June 12, 2008)

Underinsured Face Big Gaps in Coverage
The number of Americans who have health insurance but cannot afford adequate medical care continues to climb. About 25 million Americans — or approximately one of every five adults younger than 65 with health insurance — lack sufficient coverage to protect against financial hardship if they end up in the emergency room or become seriously ill, according to a study released in June by the Commonwealth Fund. “We’re moving in a direction where you can be insured all year and still face medical bankruptcy,” said Cathy Schoen, the study’s lead author and a senior vice president for research and evaluation at the Commonwealth Fund, a private foundation in New York specializing in health research.

The relentless rise in the cost of medical care, combined with a growing number of insurance plans that require patients to pay a higher portion of the medical bills, has led to a 60 percent increase in the number of underinsured adults from 2003 to 2007, according to the study. The Commonwealth Fund first calculated the number of underinsured in 2003 when it estimated that 16 million Americans lacked sufficient coverage. As the nation debates how best to improve its health care system, including how to insure the increasing number of Americans without coverage, policy makers also need to discuss the quality of available coverage, said Karen Davis, president of the Commonwealth Fund. “Lack of insurance is only part of the problem, as even the insured have serious gaps in coverage,” she said. The fund’s estimate is based on a survey conducted last year of adults under 65 years old who had insurance throughout the year. Persons were considered underinsured if out-of-pocket medical expenses were ten percent of their income, or five percent if they were low-income adults or had insurance deductibles that exceeded five percent of income. (New York Times, June 10, 2008)
Cost Concerns Drive Even the Insured To Forgo Treatment

Growing numbers of Americans, many with health insurance, are delaying or forgoing medical treatment because of cost concerns, according to a report from the Center for Studying Health System Change. About 20 percent of the respondents to a 2007 survey of 18,000 people said they had postponed or gone without needed medical treatment at some point in the year, up from 14 percent in a 2003 survey. Of those who said they scrimped, 69 percent cited cost as a reason. “As health care costs increase, more of these costs are shifting to people and families,” often as large deductibles or other requirements that patients pay a significant share of their care out of their own pockets, said Peter Cunningham, lead author of the report from the Center for Studying Health System Change. Cunningham said the weakening economy may have been a contributing factor to patients’ behavior last year but that they also may simply have “reached a tipping point” in terms of being able to afford care amid a steady rise in medical costs. The center is a nonpartisan policy research group in Washington that receives funding from the Robert Wood Johnson Foundation, the Kaiser Family Foundation and the federal government among others. (Wall Street Journal, June 26, 2008)

Millions Miss Out On Existing Coverage Simply From Lack of Knowledge

Providing education, information and resources can help people who lack health insurance find out about available options and help hospitals deal with the rising ranks of the uninsured. In April 2008, the Foundation for Health Coverage Education in San Mateo, CA collaborated with hospitals in utilizing the Internet to provide information and an online application system for government-sponsored programs that are available to the uninsured. The organization’s website, www.coverageforall.org contains an easy, five question quiz so people can determine their eligibility. (Philip Lebherz, Opinion section, Modern Healthcare, June 16, 2008)

End-of-Life Patients Need Big Picture

Patients with advanced cancer often don’t know how long they have to live or how chemotherapy will affect their lives, according to a study in June in the Journal of the American Medical Association. Only 37 percent of doctors told patients how long they had to live, even when patients asked for the information the study said. Sometimes, patients don’t understand what their doctors say or perhaps hear what they want to hear. Patients may also ask for aggressive, painful therapies that have no hope of help. More than 20 percent of Medicare patients who have advanced cancer start a new chemotherapy regimen two weeks before they die, said study co-author Sarah Harrington, assistant professor at Virginia Commonwealth University School of Medina in Richmond. These patients may miss the opportunity to mend relationships, seek spiritual counseling or create important documents such as advance directives. “In the last few weeks or months of a patient’s life, a lot of good work can be done,” said Harrington, a specialist in palliative care. Patients frequently learn more about their prognosis from other patients in the waiting room than from their doctors, authors say. (USA Today, June 11, 2008)

Doctors Miss Cultural Needs, Study Says

As researchers ponder growing evidence that blacks have worse outcomes than whites in the treatment of chronic disease, they often theorize that members of minorities suffer disproportionately from poor access to quality care. A new study
of diabetes patients has found stark racial disparities among even patients treated by the same doctor. The study attributed the differences less to overt racism than to a systemic failure to tailor treatments to patients’ cultural norms.

“It isn’t that providers are doing different things for different patients,” said Dr. Thomas D. Sequist, lead author of the study and assistant professor of health care policy at Harvard Medical School. “It’s that we’re doing the same thing for every patient and not accounting for individual needs. Our one-size-fits-all approach may leave minority patients with needs that aren’t being met.” As an example, counseling black or Latino patients with diabetes to lower carbohydrate intake by cutting rice from their diets may not be a realistic strategy if rice is a family staple. “We may be listing fruits and vegetables that are part of one person’s culture but not another,” Dr. Sequist said. “We’re not giving them information they can use.

Published in The Archives of Internal Medicine, the study said that socioeconomic factors like income or insurance status explained 13-38 percent of the racial differences. But, much larger racial disparities - from 66-75 percent - were in patients treated by the same doctor. Adjusting for clinical differences among patients did not change the findings. (New York Times, June 10, 2008)

**Editor’s Note:** Students from the Center for Health Law Studies and Student Writers Association at Saint Louis University School of Law contributed the following items to this column. Kelly Dineen, assistant dean for academic affairs and instructor of health law, supervised the contributions of health law students Shane Levesque (JD/PhD anticipated ’10) and Phillip Terrell (JD/MHA anticipated ’11).

**Fed Chief, others chime in on health care crisis at symposium**

Ben Bernanke, chairman of the Federal Reserve, in a daylong symposium of the Senate Finance Committee told Congress that “health spending would ‘rise relentlessly’ unless lawmakers overhauled the system.” Both Democratic and Republican party representatives predicted the symposium would ultimately lay the groundwork for upcoming health care legislation in the next year. Senator Max Baucus (D-Montana) felt that some sort of “federal health board” might be one part of the solution, especially with regard to technical policy decisions such as setting proper reimbursement rates for procedures. In the alternative, Bernanke suggested establishing a commission like the Federal Reserve Board to set health policy. Ultimately, both Democrats and Republicans alike agreed that Americans should be insured, but that they should also have a choice in what form that insurance may be, with private health plans competing in a market against government programs. Large American employers are also poised to begin demanding real changes in the health care system. Intel Chairman Craig R. Barrett said firms like Intel are frustrated with the general inefficiency of the health care system: “[Almost every other industry] has automated itself and now pays less for better quality.” (New York Times, June 17, 2008)

**Major health care centers reap the benefits of implementing policies of disclosure**

Prompt notification of medical errors to patients, rather than their concealment, has led to dramatic decreases in malpractice litigation and associated costs according to the Universities of Michigan and Illinois, which have spearheaded a growing national initiative that may lead to a needed fundamental change in the doctor-patient relationship. Traditionally, according to medical malpractice lawyers, most patients become angry plaintiffs in the event of an error due to its being hidden from them and the ensuing fear of its repetition. However, given the ever-rising costs of malpractice insurance and consumer insistence upon action against medical errors, a few institutions, including those above and others like Johns Hopkins, Harvard, and Stanford, are attempting to counter lawsuits before patients resort to them. Timely disclosure of medical errors accompanied by sincere apologies and fair compensation may work to restore the integrity of relationships between doctors and patients, with success coming by this approach in numerous documented cases (most involve quick settlement by the health care provider in monetary form or gratis treatment to resolve the error). Both the American Medical Association and the American Hospital Association have adopted similar standards encouraging disclosure, with 34 states enacting laws protecting doctors’ apologies by blocking their admissibility in courts. (New York Times, May 18, 2008)
Gap in medical recordkeeping methods may soon be addressed by government-sponsored initiative

While 51 percent of larger practices with 50 or more doctors have adopted newer electronic medical record systems, a recent survey published in the New England Journal of Medicine found that fewer than 9 percent of doctors in small practices (which represent nearly half of the country’s doctors in sum) have emigrated to computerized records. Slow adoption by small practices is largely due to economic factors, as Dr. Paul Feldan, one member of a three-doctor practice in New Jersey echoed, “The idea of electronic records is terrific. But if we don’t see patients, we don’t get paid.” For his office, Dr. Feldan calculated an average expense of $15,000 to $20,000 per doctor, not including the costs of making the transition in the form of temporarily reduced patient loads and training and support time. The other issue surrounding the technology transition is whom exactly doctors’ expenditures in making the change will benefit. Private and government insurers will save money in the form of less paper handling and fewer unnecessary tests through their direct connection to office records, and patients stand to benefit as well in the form of fewer prescription mistakes and improved delivery of preventative care. To partly resolve this inequity in funding, the government announced the week of June 12 plans to spend $150 million in incentives for to doctors to digitize paper records, helping up to 1200 small practices. (New York Times, June 19, 2008)

Private genetic testing firms fall under stiff state regulatory scrutiny

One of the fastest growing new sectors of the biotechnology industry is a group of companies whose services purport to offer clients directly administered genetic testing for use in health and lifestyle planning. However, both California and New York State Departments of Public Health have recently cracked down on the firms’ solicitation of citizens in those states. Among the firms, whose offerings range in price from $1,000 to $350,000 and some of which also include diet advice and genetic tests for single conditions such as baldness or Alzheimer’s disease, the general posture toward the state governments’ efforts to require such firms’ licensure is one of non-necessity. “We think your genetic information is a fundamental part of you,” said Anne Wojcicki, founder of 23andMe, a California-based company with financing aid from Google (whose co-founder happens to be Ms. Wojcicki’s husband). “This doesn’t say you have a disease. It says you carry a genetic predisposition for the disease and should talk with a health care professional,” said Mari Baker, the chief executive of Navigenics, also based in California. Nonetheless, state offices of laboratory policy and planning in California and New York take issue with how casually genetic testing firms tend to characterize their services. California’s latest action in the form of 13 cease-and-desist letters to various firms was spurred by consumer complaints about the cost and accuracy of the tests. Kathy Hudson, director of the Genetics and Public Policy Center at Johns Hopkins University, felt it was “not surprising that the states are stepping in [...] to protect consumers, because there has been a total absence of federal leadership.” (New York Times, June 26, 2008)

Circuit court says hospitals may lawfully charge uninsured patients higher rates

In a decision appealing from a prior grant of summary judgment, the U.S. Court of Appeals for the Third Circuit affirmed on June 24 a lower court’s finding that a class action lawsuitfiled against multiple New Jersey health systems had no court-attainable remedy. (DiCarlo v. St. Mary Hospital, 3d Cir., No 06-3579) Alleging breach of contract, breach of the covenant of good faith and fair dealing, unjust enrichment, breach of fiduciary duty, and violation of the New Jersey Consumer Fraud Act, plaintiff DiCarlo claimed that the hospitals’ practice of charging uninsured patients higher rates than the discounted ones it charged Medicare, Medicaid, and privately insured beneficiaries was wrongful and discriminatory. Earlier in 2006, the district court held that hospitals do not breach their agreements to provide services at reasonable rates or breach the duty of good faith and fair dealing by charging uninsured patients more than those paid by managed care organizations or government programs. “What Plaintiff is asking the Court to do here is, put simply, to solve the problems of the American health care system, problems that the political branches of both the federal and state governments and the efforts of the private sector have, thus far, been unable to resolve,” said the district court opinion written by Judge Dickinson R. Debevoise. (BNA Health Law Report, July 3, 2008)
Report finds access to medical care dropping for uninsured and insured

Issued June 26 by the Center for Studying Health System Change, the report entitled *Falling Behind: Americans’ Access to Medical Care Deteriorates, 2003-2007* finds that in recent years insured people experienced faster growth in unmet medical needs (a 62 percent increase) compared with uninsured people (a 33 percent increase). This trend worked to narrow the access gap between the insured and uninsured population. “We can no longer say health care is a problem of the uninsured. This is proof that we have a system that is unraveling,” said Rick Kellerman, chairman of the board, American Academy of Family Physicians. By the report, which surveyed about 18,000 people, in 2007, one in five Americans (or about 59 million people) reported not receiving or delaying needed medical care, up from one in seven in 2003. Rising health care costs, health insurance-related problems, and health system-related problems appear to be the major contributors to the declining access to care, the report indicated. Kellerman also referenced another disturbing trend: the primary care doctor shortage, which will only exacerbate problems alongside growing out-of-pocket expenses and bureaucratic difficulties encountered by consumers and their own insurer. (BNA Health Care Policy Report, June 30, 2008)

First phase of New Jersey universal health care plan passes legislature

If signed by Governor Jon Corzine, the measure approved by both houses of the New Jersey Assembly would implement the first phase of a comprehensive reform of New Jersey’s health care system that has universal coverage as its ultimate goal. Currently, some 1.25 million New Jersey residents are uninsured, with 250,000 children among them. “Rather than encouraging bad health practices by forcing the uninsured to seek emergency room care, we would be allowing people to get regular check-ups and receive care for medical problems before they become serious health concerns,” said Joseph Vitale, chair of the Senate Health, Human Services and Senior Citizens Committee. Taking effect one year after the bill’s enactment, provisions in it would require all children 18 and younger to have health insurance through an employer-sponsored or individual health benefits plan, Medicaid, or the NJ FamilyCare Program. FamilyCare uses state and federal funds to provide free or low-cost health insurance to low-income families; this most recent legislation would expand eligibility criteria to include parents with income up to 200 percent of the federal poverty level. New Jersey estimates 13,700 parents and 8,200 more children would enroll for coverage in fiscal year 2009 if the bill is enacted, at a total cost of $8.8 million. By 2011, 12,100 more children are projected to enroll, with 40,200 adults, increasing costs by $43.6 million. (BNA Health Care Policy Report, June 30, 2008)

Cities struggling with rising indigent, uninsured health care costs urge federal action

According to a report issued June 23 by Families USA, a lack of federal action on universal health care is causing cities to pay more in health care costs themselves. A majority of the cities surveyed indicated that they faced problems of increased demand for services at community health clinics, increased demand for mental health and substance abuse services, family support services, and crowding in hospitals and emergency rooms. Some cities have had to face as well hospital and major trauma center closures, making provision of services for the uninsured even more difficult. All thirteen cities surveyed agreed that raising eligibility levels for Medicaid and the State Children’s Health Insurance Program would ease the burden that uninsured individuals place on cities. Some, such as San Francisco, have begun their own preventative health care initiatives. By paying a minimal enrollment fee not to exceed 5 percent of family income for those with income below 500 percent of the federal poverty level, those normally uninsured receive preventive and primary care through a network of cooperating public hospitals, health clinics, and some private providers. Ron Pollack, executive director of Families USA, said in a news release that he recommends cities such as San Francisco for their efforts, but that cities alone “cannot solve the fundamental problems in America’s health care system. This is ultimately a national problem, and leadership and action must come from Washington.” (BNA Health Care Policy Report, June 30, 2008)
Study finds doctors referring patients more to physician-owned facilities, leading to increased utilization overall

A new study published by the Robert Wood Johnson Foundation determined that referrals to physician-owned hospitals, surgery centers, and imaging facilities have increased considerably in the past decade. Higher utilization of such doctor-owned facilities has particularly correlated with imaging services. Moreover, the quality of care to be found at physician-owned surgery centers and hospitals is comparable to care provided at general acute-care hospitals, which are still maintaining profit margins despite the increased referral of cases to physician-owned facilities. “General hospitals appear to have adapted by entering into joint ventures with physicians, by employing physicians who might otherwise compete with the hospital, and by expanding their own focus on profitable services lines,” researchers Sarah Goodell and Lawrence P. Casalino said in the study. Alongside this trend is an increased number of surgeries being performed outside traditional hospital settings; the researchers found that surgeries are being performed more often in physician offices and ambulatory surgery centers, most of which doctors own. (BNA Health Care Fraud Report, July 2, 2008)

‘Neglected infections of poverty’ highlight impact of lack of health care on minorities, those living in poverty

Published June 25 in the journal PLoS Neglected Tropical Diseases, a new analysis points out that diseases similar to those encountered in Africa, Asia, and Latin America are also occurring in high frequency among the poorest people in the United States, especially women and children. Caused by chronic and debilitating parasitic, bacterial, and congenital infections, these “neglected infections of poverty” are understudied and not well known even by physicians and public health experts. Being of such an insidious nature, those afflicted by such diseases often find themselves in an inescapable circle of poverty due to their effects on child development, pregnancy outcome, and productive capacity. Dr. Peter J. Hotez, author of the analysis and faculty member at the George Washington University department of Tropical Medicine, emphasizes that the enigmatic and hidden nature of these diseases “points to the urgent need to increase surveillance for these infections; use cost-effective existing drug control and treatment efforts; implement newborn screenings; and develop new drugs, diagnostics, and vaccines for these infections.” (ScienceDaily, June 25, 2008)

Costs rise for patients with alcohol and drug abuse disorders

A study in the June issue of the Journal of Substance Abuse Treatment documents that 14 percent of patients admitted to the hospital have alcohol and/or drug abuse and addiction disorders. The coincidence of such disorders with other medical problems (99 percent had other problems in addition to substance abuse addictions) has led to a sharp increase in hospitalization and associated care costs, with hospital care for patients with substance abuse disorders increasing in cost overall by 134 percent between 1994 and 2002. Patient disorders varied by insurance status, with those on Medicare or Medicaid being more likely to have drug addictions, while privately insured patients more often had only alcohol abuse disorders. In either case, patients with alcohol abuse disorders accounted for the highest proportion of costs. “Understanding alcohol and drug abuse and addiction disorders’ broad impact has implications for delivering better health care, decreased [alcohol and drug-related] illnesses and mortality, and reducing health care costs,” said researchers in the study. (ScienceDaily, June 26, 2008)

Bush signs genetic nondiscrimination act into law

On May 21, President Bush signed into law the Genetic Information Non-discrimination Act (GINA), the first civil rights legislation of the new millennium. GINA will provide protections against discrimination based on an individual’s genetic information in health insurance coverage and employment settings. “Since all of us are predisposed to at least a few genetic-based disorders, we are all potential victims of genetic discrimination,” said House Representative Louise Slaughter of New York, “Americans can finally take advantage of the tremendous potential of genetic research without the fear that their own genetic information will be used against them.” The health insurance protections offered by GINA are set to go into effect 12 months from its May enactment, while employment protections will be in place in 18
months. Specifically, GINA protections extend to discrimination by health insurers or employers by prohibiting group health insurance plans and insurers offering group and individual plans from basing eligibility determinations or adjusting premiums or contributions on the basis of a person’s genetic data. Insurers of Medigap policies are likewise prohibited from adjusting pricing or conditioning eligibility on the basis of genetic information. Finally, employers are prohibited from firing, refusing to hire, or otherwise discriminating with respect to compensation, terms, or other privileges of employment. None of the affected groups may request, require, or purchase genetic information, and are also prohibited from disclosing personal genetic information. (ScienceDaily, May 26, 2008)

California passes law requiring doctors to inform terminally ill patients of end-of-life care options
The California State Assembly passed a bill in May that requires doctors to inform patients with terminal illnesses of all legal end-of-life care options available, if the patients request that information. The bill, which is currently under consideration by the state Senate, would result in the first law of its kind within the U.S. It would mandate that physicians tell those patients with less than a year to live not only about the availability of hospice and palliative care, but also other alternatives used to accelerate the dying process, including palliative sedation and the refusal of nourishment. Those physicians who are unwilling or unable to comply with the law because of their personal religious or ethical beliefs would be required to refer the patient to another physician. Those who oppose the bill voice concerns regarding the state’s increased involvement in the physician-patient relationship, and caution that the law might be an unwise intrusion. At the time of its report on the bill, the American Medical Association had no specific position on the appropriateness of the mandate, but it does maintain a policy that disapproves of euthanasia and physician-assisted suicide. (American Medical News, July 14, 2008)

International society proposes stem cell research guidelines
The International Society for Stem Cell Research is in the process of drafting a set of guidelines that it hopes will curb the risk posed by Web sites it says deal in stem cell “snake oil” treatments. The society, which will consult similar guidelines already drafted by various countries, said it hopes they will not only direct stem cell research in general, but will also educate the public on the state of stem cell technology so as to counteract the threat to patient safety posed by unethical and untested therapies. Although the guidelines have not yet been finalized, Reuters reports that they will denounce any therapies that have not undergone a clinical trial, and that they will make specific recommendations regarding peer review, informed consent, human test subject rights, and patient access. (Reuters, June 12, 2008)

Drug industry releases new policy banning some gifts to doctors
The Pharmaceutical Research and Manufacturers of America has issued a new set of voluntary guidelines governing the interactions of its member organizations with physicians, and these revisions will go into effect January 2009. This revised Code on Interactions with Health Care Professionals bans the distribution of gifts such as pens, mugs, and other small gifts to physicians by pharmaceutical companies, and will require the companies’ chief executives to signify in writing that their companies will comply with the new guidelines. The revised Code follows mounting concerns regarding the potential conflict of interest that may arise when physicians accept gifts from drug companies, a concern that has inspired some states to pass laws setting limits on the value of gifts to doctors. The revised Code does not, however, ban drug companies from delivering meals to medical offices, from inviting doctors to expensive restaurants for presentations, or from contracting physicians to act as consultants, or to speak on their behalf at medical conferences. (New York Times, July 10, 2008)

Rudeness and hostility by employees will jeopardize a hospital’s good standing with top accreditor
The Joint Commission announced that a new policy effective January 1, 2009 will require all accredited facilities to implement a code of conduct that guides employee behaviors in the workplace, and establishes “a formal process for managing unacceptable behavior.” Furthermore, the Joint Commission will include both rude language and hostility on its list of occurrences that may lead to “sentinel events,” a term

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used by the Joint Commission to describe incidents that could cause serious injury to, or the death of, a patient. To maintain good standing and accreditation, hospitals are required to report all such sentinel events to the Joint Commission, which then takes steps to prevent that kind of incident from occurring again. Other sentinel events include hospital-acquired infections and the accidental removal of a healthy limb. The Joint Commission, which has been charged by Congress with ensuring the safety of American hospitals, says this change is necessary, because verbal abuse and hostility can compromise patient safety. Should a hospital lose its good standing with the Joint Commission, it may risk losing its eligibility to receive Medicare payments, which may have the effect of threatening the facility’s financial stability. (Chicago Tribune, July 10, 2008)

Congress urged to pass law ensuring mental health parity

David Wellstone, the son of late Minnesota Sen. Paul Wellstone, has called on Congress to pass a bill requiring insurance policies that provide coverage for both physical and mental illnesses to do so in equal shares. The version of the bill passed in the House would require insurers to cover all mental illnesses, including addiction disorders, published in the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders; however, the Senate’s version did not have that provision. But while the House has agreed to drop that requirement in order to reach a compromise, the costs of the added coverage remain a point of contention. The Congressional Budget Office says that the bill would result in a $3.9 billion federal expense over 10 years. (Boston Globe, July 9, 2008)

Victims of African Pfizer drug trials rebuke settlement offer

The family members of children who were injured or killed following a test of the drug Trovan more than ten years ago in Nigeria has turned down a $10 million settlement offer by the company. The offer, which would be paid out to approximately 200 Nigerian families, would award $10,000 for each victim with “minor deformities,” and $100,000 for each victim with “major deformities” or who died as a result of the drug trials. However, Nigerian officials call the offer “demeaning,” considering that the company also offered to pay out $21 million to settle the parties’ legal expenses. The lawsuit, which seeks $2 billion from Pfizer, was filed after a Nigerian panel determined in an extensive report that the drug company violated international law when it tested Trovan, which was not approved, on children in the Infectious Diseases Hospital in Kano, Nigeria. Authorities have also filed eight criminal charges against the company, including criminal conspiracy and voluntarily causing grievous harm. Pfizer says there is no evidence linking Trovan to either deformity or death. (Washington Post, July 9, 2008)

Study finds that emergency rooms have become a “dUMPing ground” for the mentally ill

A recent survey reports that 79 percent of U.S. hospitals said they commonly “boarded” psychiatric patients in waiting rooms because of the unavailability of mental health services. One-third of the hospitals surveyed reported that psychiatric patients were left in waiting rooms for an average of at least eight hours, while 6 percent reported that waiting room stays could last for an average of 24 hours. While there were a variety of reasons cited for the waiting room stays, the most common was the lack of immediately available services. And, in many states, these sorts of wait times are can be routine. Hospital officials in Austin, Texas have complained that the county’s decision to limit the number of patients sent to a state psychiatric facility has resulted in more psychiatric patients stuck in emergency rooms. Similarly, Massachusetts has been criticized for a wait time for pediatric psychological services that can last for days. (AP, July 3, 2008)

Eighth Circuit rules that South Dakota doctors are required to tell patients before performing abortions that their fetuses are “unique living human beings”

In July, the U.S. Court of Appeals for the 8th Circuit struck down a preliminary injunction against a South Dakota law requiring doctors to tell pregnant patients that their fetuses are “unique living human beings” before performing abortions. Although enacted in 2005, the law was immediately challenged by Planned Parenthood, which won an injunction that prevented the state from enforcing it until the presiding U.S. District Court judge could determine its constitutionality. However, the decision by the U.S. Court of Appeals overruled that order, and sent the case back to the District Court for trial. Although
no date has yet been set, enforcement of the law went into effect almost immediately after the Court of Appeals decision was handed down. In addition to being required to tell patients seeking abortions that the procedure would "terminate the life" of the fetus, they are also required to inform patients that having abortions can make women suicidal and may cause other psychological harm. This requirement is only satisfied if doctors have the conversation with the patient no earlier than two hours prior to the procedure. The law works in tandem with a related statute, passed July 1, requiring doctors to ask their patients if they would like to see a sonogram of the fetus. (AP, July 18, 2008; Washington Post, July 20, 2008)

Consumer groups challenge university's patents on embryonic stem cells
Two consumer groups, the Foundation for Taxpayer and Consumer Rights and the Consumer Watchdog Foundation, appealed in July a decision by the U.S. Patent and Trade Office that the University of Wisconsin Alumni Research Foundation will continue to hold a patent on all embryonic stem cells in the United States. The groups criticize the agency for granting the patents, which are not recognized by any country outside the U.S., for so restricting U.S. scientists that their foreign counterparts are given a much greater advantage in their search for advances in stem cell research. The groups will argue against the agency's ruling on the grounds that the issuance of patents was not appropriate, given that, based on similar research conducted with other species, the development of human embryonic stem cells was "obvious." (San Diego Union-Tribune, July 21, 2008)

Study finds that kidneys obtained following cardiac death may decrease transplant disparities
Researchers at the Johns Hopkins Medical Institutions say that increasing the use of human kidneys obtained after cardiac death could have the effect of decreasing racial disparities in the allocation of these organs for transplantation. The study, which is to be published in October's American Journal of Nephrology, examined health outcomes for more than 100,000 adult patients who underwent kidney transplantation procedures from 1993 to 2006. The study found that black patients who underwent the procedure were more likely to experience increased survival rates when they received kidneys from black donors. The study also found that when black patients received kidneys from black donors following cardiac death, risk of kidney loss was reduced by 70 percent, and risk of death was reduced by 59 percent. Currently, black patients account for one-third of the Americans currently waiting for a donated kidney, but are 2.7 times less likely to receive a kidney than white patients, in part due to the fact that they are more likely to experience kidney failure following transplantation. The study found that, by using kidneys obtained following cardiac death, the nationwide supply of viable organs may be sufficiently increased, with the effect of bringing transplantation rates among black recipients increasingly in line with the rates of white recipients. (HealthDay, July 23, 2008)

Legislation broadening the Americans with Disabilities Act sweeps through House
In a landslide vote June 25, the U.S. House of Representatives approved a bill that would significantly expand the reach of the Americans with Disabilities Act by broadening the law's definition of "disability." The current law states that an individual has a disability for the purposes of the Act if he or she has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment. The determination of exactly which conditions qualify for recognition as a disability under the ADA has been the subject of considerable litigation throughout the course of the Act's existence, resulting in several decisions by the U.S. Supreme Court that significantly reduced the availability of relief under the ADA for claims of employment bias. The current bill, which reverses the Court's limiting decisions in Sutton v. United Air Lines and Toyota Mfg. v. Williams, states that disability "shall be construed broadly," and indicates that a major life activity will be considered "substantially limit[ed]" if it is "materially restrict[ed]" by a condition. It also states that even episodic limitation on major life activities is sufficient to qualify as a disability, so long as the condition, when active, results in a substantial limitation. The bill goes even further by providing a non-exclusive list of major life activities, which includes a specific provision for major bodily functions. (Law.com, July 21, 2008)
Health Care and Environmental Responsibility

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8. Pierce, Jessica and Andrew Jameton, The Ethics of Environmentally Responsible Health Care, Oxford University Press, 2004

ORGANIZATIONS

Health Care Without Harm (HCWH), which can be reached at 703-243-0056. HCWH is an international coalition of more than 473 organizations in more than 50 countries committed to reducing the environmental harm from health care, with particular emphasis on the phasing out of mercury, PVC, and incineration. The coalition offers extensive materials and information on its website (www.noharm.org), including “Going Green: A Resource Kit for Pollution Prevention in Health Care.”

Practice Greenhealth (H2E) formerly known as Hospitals for a Healthy Environment, which can be reached at 888-688-3332. H2E is a compact involving the EPA, American Hospital Association, HCWH, and the American Nurses Association. The partnership based on the compact offers extensive materials on waste reduction strategies and mercury elimination. The website is www.h2e-online.org.

Sustainable Hospitals Project, which can be reached at 978-934-3386. A project sponsored by the University of Massachusetts at Lowell, MA, the project has extensive product information relating to latex, mercury, needles, PVC, and other potential hazards. It also has a catalogue of alternative products and better practices resources. The website is www.sustainablehospitals.org.

Teleosis Institute is devoted to developing effective, sustainable health care provided by professionals who serve as environmental health stewards. The Institute seeks to provide education in the principles and practices of green healthcare, a forum for continued learning, discussion and collaboration on green healthcare practices and strategies for change, and tools for implementing green healthcare practices. They can be reached at 510-558-7285. Their website is www.teleosis.org.

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Book Review

Healthcare Guaranteed: A Simple, Secure Solution for America

By Ezekiel J. Emanuel, MD, Ph.D., with a foreword by Victor R. Fuchs, Ph.D., (New York: Public Affairs, 2008), 219 pages, $14.95

Here’s an interesting little book that just might change our world. Ezekiel Emanuel, an oncologist with an additional doctorate in political philosophy, and Victor Fuchs, a healthcare economist, have been collaborating since 2003 on crafting a new model for the financing and delivery of healthcare in the United States. Emanuel has persuasively and provocatively argued the case for their proposed model—what they call the Guaranteed Healthcare Access Plan—in Healthcare, Guaranteed.

This is a relatively short book of eight chapters and written for the non-specialist. Chapter One begins with a brief, if familiar, review of the current healthcare system’s woes. Chapter Two then outlines seven goals (elsewhere called “essential elements”) for healthcare reform. These goals function later in the book as criteria by which his and other reform proposals are evaluated. The goals are worth listing here as they reveal Emanuel’s thoughts (some might say biases) on what he believes a sustainable health system in a developed country such as ours should accomplish: guaranteed coverage for all citizens; effective cost controls; high-quality, coordinated care; choice; fair funding; reasonable dispute resolution mechanisms; and, interestingly, economic revitalization (by decoupling healthcare insurance and employment).

Chapter Three briefly reviews how we got into the current “dysfunctional mess,” and Chapter Four outlines Emanuel’s and Fuchs’ Guaranteed Healthcare Access Plan.

Under “Benefits and Coverage,” the plan would:
1) Guarantee coverage to each American household through a voucher system that would allow the individual or family to enroll in a health plan of their choice.
2) Define a generous set of standard benefits that would be modeled on those currently available to members of Congress. Patients could choose their own physicians and hospitals.
3) Offer freedom of choice with regard to health plans. Plans would be required to accept enrollees, without regard for preexisting conditions, and to guarantee renewal each year.
4) Permit the purchase of additional services with after-tax dollars.
5) Eliminate employer-based health insurance, along with the $200 billion tax exemption that accompanies it.
6) Phase out Medicare, Medicaid, and SCHIP. No one would be forced out of these programs, but they would not accept new enrollees, and current enrollees would have the option of joining the Guaranteed Healthcare Access Plan.

Under “Oversight and Administration,” the plan would:
7) Provide for oversight by a National Health Board and twelve Regional Health Boards, modeled on the Federal Reserve System. Funding for these boards will be independent of annual congressional appropriations and the boards would be insulated from lobbying efforts.
8) Direct each of the twelve Regional Health Boards to create a Center for Patient Safety and Dispute Resolution to receive and evaluate claims regarding patient injury, medical error, and physician concerns.
9) Monitor cost and quality control by creating an Institute for Technology and Outcomes Assessment.

Under “Financing,” the plan would:
10) Fund healthcare vouchers or “certificates” through a dedicated value-added tax (VAT), initially of 10 percent, on purchases of goods and services. Revenue from the tax could not be diverted to other purposes and no other tax revenues could be used to fund the plan. Congress alone would have the power to increase the VAT rate.*

Chapters Five, Six, and Seven consider the other leading reform proposals. Emanuel argues these other proposals fall short in addressing the seven goals he outlined earlier. None of them, he argues, is sustainable. One of the principal benefits of Emanuel’s model is that it is comprehensive. He claims that the other reform plans will not succeed primarily because they address only the financing side of healthcare. Unless a reform

* Emanuel, Healthcare, Guaranteed, pp. 83-84.
plan addresses both the financing and the delivery of healthcare, he argues, the steadily increasing costs of healthcare will always outstrip our ability to keep up with them. Thus, as we saw above, in addition to covering 100 percent of American citizens with the plan, he proposes an independent research institute to assess new technologies and to compare the cost and quality of competing treatments and treatment locations. Also, by allowing patient choice for health plans, physicians and hospitals, his plan introduces market incentives to encourage competition, more efficient organizations, and better coordinated care by health plans and providers. And, if patients want to buy additional benefits, they may do so, but only with their own, after-tax dollars.

Finally, in Chapter Eight, Emanuel the political philosopher considers what it might take to change the system we have currently to the one he is proposing. He does not discount the hurdles that must be overcome, but neither does he believe they are insurmountable. Nevertheless, *Healthcare, Guaranteed* deliberately refrains from providing the details a policy specialist might like to see and, at the same time, from engaging in extensive speculation about the political feasibility of the model. Rather, it straightforwardly describes the Guaranteed Healthcare Access Plan and then argues why it is more likely to succeed than other proposals. His aim is to have a viable proposal ready when the pressures for reform coalesce, as he believes they eventually must.

In the end, there are many questions we might like to press on Emanuel. He anticipates some of them in Chapters Five, Six, and Seven when critiquing the proposed reforms of others. Is not incremental reform a better way forward, especially in the light of the Clinton failure? Should we not give state mandates a chance to work before completely overhauling the entire system? And would not a single-payer system be more efficient in the long run? He does address these questions, if only briefly. But as I said above, he also is provocative. The Guaranteed Healthcare Access Plan is not overly complex and, in theory at least, is no more expensive than we are currently paying for much less than this plan promises. It addresses both the financing and the delivery side of healthcare, and it purports to bring together the best of government oversight and private competition. Emanuel has proposed a plan that might actually work, and it is worth giving his book serious attention.

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*The views and opinions expressed in this review are those of the reviewer and do not represent Providence Health & Services.*
Narrative Medicine advances the line of argument developed over the past twenty to thirty years regarding narrative ethics. This rich discussion has focused on the healing narratives of care givers and the illness narratives of patients. In terms of health care ethics this literature has highlighted the ethical task to be one of hermeneutics, the duty of the ethicist to discern the meaning and significance of events contained within the narratives of both care givers and patients. Narrative ethics has tended to focus on ethical responsibilities as the by-product of relationships between care givers and patients. The hermeneutical and relational foci of narrative ethics have been emphasized to distinguish this approach from the dominant approach to health care ethics in recent years, principlism.

Charon’s Narrative Medicine is an outgrowth of narrative ethics and the general characteristics of narrative ethics are woven deeply throughout her text. Her unique contribution is the manner in which she demonstrates that the traits associated with narrative ethics and literary theory should underlie medicine as a practice, a praxis in the sense articulated by Alasdair MacIntyre. “My hypothesis in this work,” writes Charon, “is that what medicine lacks today - in singularity, humility, accountability, empathy - can, in part, be provided through intensive narrative training. Literary studies and narrative theory, on the other hand, seek practical ways to transduce their conceptual knowledge into palpable influence in the world, and a connection with health care can do that.” (p. viii). Although her hypothesis stresses both the impact of literary studies on medicine and the contribution of medicine to literary studies, to the mind of this reader, the former is given much more emphasis throughout her text than the latter.

Rita Charon is a practicing physician with her own private practice who also shares some responsibility for the training of residents. Among the many interesting highlights of her text is the manner in which she distinguishes between the subjective, experiential narration of a patient at the time that he or she presents to the physician. On the other hand there is the objective, clinical, scientific narration contained in the physician’s chart of the patient. Although this is not a point developed by Charon, many ethics consultations could be construed as efforts to interpret and integrate the levels of meaning latent in these two narrative accounts of the same case.

What is truly innovative in Charon’s work is what she refers to as the “parallel chart.” The parallel chart is a brief one page narration of the resident’s or attending physician’s account of their experience, their emotions, feelings, anxieties, and moral distress that stem from caring for a patient. She provides numerous examples of parallel charts authored by her students that are poetic, deeply sensitive to the vulnerability of patients, and the moral and emotional distress frequently associated with the care of hospitalized patients. At a seminar each week, each student is asked to read his or her parallel chart and it is then discussed by the group. The purpose of these seminars is not to provide group therapy, they are neither support groups nor venting sessions. Rather the goals of these sessions “are to enable them (i.e. the residents) to recognize more fully what their patients endure and to examine explicitly their own journeys through medicine.” (p. 156) The practicum of the parallel chart, a narrative crafted by residents, becomes a vehicle through which the medical practices of these future physicians will hopefully be infused with singularity, humility, accountability and empathy.

Narrative Medicine is a very sophisticated text that reveals the author's knowledge of medicine, philosophy, literary theory and ethics. This book should be required reading for anyone engaged in medical or nursing education. Health care ethicists, of either a philosophical or theological bent, will find in Charon’s book an innovative and insightful approach to engaging patient care issues at a deeper, more sensitive, level.

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