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a matter of spirit

This issue: Healthcare

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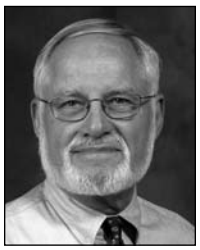


John W. Glaser has worked in healthcare ethics for 35 years. Together with Sr. Nancy O'Connor, he founded the Center for Healthcare Reform, St. Joseph Health System, in Orange, CA.

Healthcare Reform: Public Conscience Work

John W. Glaser

U.S. Healthcare as Chronic Social Sin

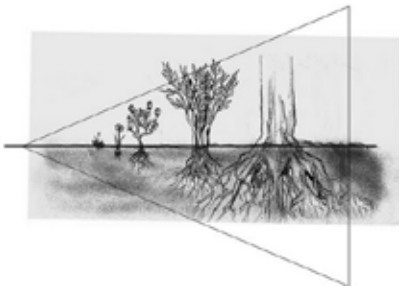
I believe that U.S. healthcare is an instance of *chronic social sin*—like child labor was in 1850—an inherited moral pathology, deeply anchored in society and individuals, needing radical, systemic transformation, but so colossal that it intimidates rather than animates energy for reform. It helps to review a few salient points:

- U.S. healthcare is a huge industry—the world's sixth largest economy—equal to the combined GDP of Italy and Spain. But it represents poor stewardship, not generosity. We allocate these vast resources absent accountable leadership or explicit principles, without clearly articulated goals or metrics.
- According to World Health Organization (WHO) rankings, we are first in spending but 37th in health outcomes and 55th in fairness. Low-wage employees working two jobs without health benefits are taxed at each job to provide Medicare benefits for the parents of George Clooney or Donald Trump.
- Our rampant health inflation creates more uninsured persons and fewer services for those who are insured. We shrink our essentials, such as mental health, dental health, and long-term care, while we spend prodigally at the frontiers of rescue medicine.
- We squander 4-5 times as much on administration as we spend on prevention. While we have a highly organized, national system for tending to every failing U.S. kidney, we leave the inevitable Tsunami of suffering and illness caused by the quake of obesity to thousands of scattered, voluntary efforts.

U.S. healthcare is an instance of chronic social sin—an inherited moral pathology so colossal that it intimidates rather than animates energy for reform.

Past reform efforts have failed because we have underestimated the magnitude and complexity of the social injustice we face. In this article I offer some tools of Catholic moral theology to help our diagnosis and strategy for reforming U.S. healthcare.

Continuum of Social Sin



Catholic moral theology has long recognized the distinction between personal sin and social sin. Social sin refers to systems and structures of society that cause harm without proportionate justification. Implicit in this concept is the notion of the *continuum of social sin.*

Understanding social sin as a continuum forces us to think about its magnitude, complexity, density, the interdependence of its elements, its anchored-ness in culture and society. This awareness makes it clear that strategies and methods apt to remedy injustices toward the simpler end of the continuum will be ineffective when they confront more deeply-rooted issues higher up on the continuum.

The figure above illustrates key aspects of this continuum. As we move from left to right, the systemic injustice grows in size, complexity, density, and intransigence. A sweatshop in L.A. is an instance of social sin with a place on this continuum. The sociopolitical situation in Baghdad is also social sin, but how different a place it deserves on this continuum. This framework emphasizes the need to tailor our tactics, strategies, expectations, and timeframes to fit the varieties of social sin.

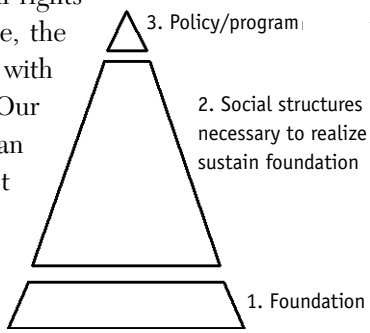
Chronic Social Sin

I suggest that we use the term "chronic social sin" for pathologies falling on the right half of the continuum. Such culturally-saturating injustice has these characteristics:

- It is inherited—the *weltanschauung* we are born into.
- It has no identifiable villain, but countless parties who perpetuate its vitality.
- No single social entity is responsible or empowered for its reform.
- It is enmeshed with the major institutions of society: law, politics, education, business, etc.
- Proposed solutions tend to be infected by the very injustice they intend to remedy.

Moral Transformation Before Policy Change

Two justice advocates remind us that traditional political advocacy is not the answer to such social sin. Jeffrey Sachs notes: "Great social transformations—the end of slavery, the women's and civil rights movements, the end of colonial rule, the birth of environmentalism—all began with public awareness and engagement. Our political leaders followed rather than led." 150 years earlier, abolitionist Garrison noted that politicians were merely weather vanes indicating popular sentiment. "There is no need to trouble ourselves about the vanes; let us raise the winds."



Public Conscience Work

Public conscience work is about "raising the winds." I believe public conscience work has been at the heart of the social movements of our history—abolition, universal education, women's suffrage, civil rights. I believe it also needs to be at the heart of U.S. healthcare reform.

Public conscience work is the movement of a major proportion of the general public to a broadly-shared consensus, from unrealistic expectations to responsible choices, and from a wish for someone else to change things to a growing sense of shared moral responsibility for change.

Foundation of Public Conscience Work: A Consensual Vision

There is a model to guide the long-term, arduous task of public conscience work needed for healthcare reform. The figure above sketches its major components.

1. The *foundation* is a vision of the desired reality and its essential elements. Such a vision statement for a just healthcare system might include the following key elements:

- Is accessible to all
- Is health-promoting and preventive
- Is transparent and accountable in its unavoidable rationing
- Is managed by a system proportionate to its size and complexity
- Allocates resources based on evidence
- Provides care across a balanced continuum—prevention, acute, chronic, mental, dental, etc.
- Controls disruptive inflation
- Is financed progressively (according to ability)
- Engages the public in evaluation & improvement

2. The *middle of the pyramid* explores the *kinds and degree of social structures needed to realize and sustain this vision*. For example: is commercial insurance equal to, better than, or worse than social insurance for realizing and sustaining our foundational vision? Working through the substance of these and similar issues, and the reasons behind them, is the challenge of this middle of the pyramid.

3. When these layers of value and systemic complexity have been worked through by the public, we will have the foundation we need to create and sustain *policy/programs* of a just healthcare system.

Help Your Communities Formulate Their Vision

What we Christians can and should do is help ourselves and our neighbors start at the foundation of public conscience work—to develop an explicit, succinct vision of the healthcare system we want to bequeath to our grandchildren. Too many efforts of reform start at the top of the pyramid, offering a programmatic solution without having first done the hard work of parts 1 and 2. Social morality invites us to start at the bottom. This leaves much work to be done, but provides the foundation for proceeding respectfully, systematically, and effectively. It begins to build a strategy that better matches the magnitude of the chronic social sin that is U.S. healthcare. ~

If you are interested in participating in public conscience work, the Sr. Nancy O'Connor Center for Healthcare Reform has some tools and processes to aid your efforts. Contact: Jack.Glaser@stjoe.org or Michael.Culliton@stjoe.org.

A Market Model of Healthcare: The Wrong Prescription

Leonard J. Weber

Leonard J. Weber, Ph.D., is an Ethics Consultant to healthcare organizations and the author of *Profits Before People? Ethical Standards and the Marketing of Prescription Drugs*.

When New York Times economics columnist David Leonhardt made his selection of best economics book of 2007, he picked an analysis of U.S. healthcare by Shannon Brownlee: *Overtreated: Why Too Much Medicine Is Making Us Sicker and Poorer*.[1] This, he said, is "the best description I have yet read of a huge economic problem that we know how to solve—but is so often misunderstood."[2]

The U.S. healthcare system is clearly the most expensive in the world—and clearly not the best. The cost of healthcare in the U.S. continues to increase rapidly, from $1.4 trillion in 2000 to $2.1 trillion in 2006; it is now 16% of GDP. The cost of U.S. healthcare far exceeds that of other industrialized countries, but almost all of these countries rank higher on measurements of comparative health, such as life expectancy. The number of uninsured in the U.S. was 47 million in 2006, up from 38.7 in 2000, numbers unheard of elsewhere.

From a practical justice perspective, the biggest problem is cost. Expanded coverage can only be achieved, at least in a sustainable manner, by controlling healthcare costs. As Ezekial Emanuel points out in a recent article on "The Cost-Coverage Trade-off," there is a strong relationship over time between healthcare costs and healthcare coverage: the rate of uninsured increases as the costs increase.[3]

The economics of the system result in unnecessary and unnecessarily expensive healthcare. This, in Brownlee's words, results in harmful health consequences, making us "sicker," and a waste of financial resources, making us "poorer." The high cost, in turn, is a major barrier to coverage for all.

Supply-Driven Demand

Market-based initiatives are touted by some as a way of making healthcare delivery more efficient and, especially, as a way to control cost. The evidence, however, suggests that the failure to control cost is directly related to the ways in which the market model already dominates so much of healthcare.

The market model is driven by the pursuit of increased consumption. "Blockbuster drugs" are not those that are most effective at treating a medical condition at the lowest cost, but those with the highest sales. Market-driven means marketing-driven. As Brownlee recounts, when Lunesta was approved by the FDA in May of 05, Sepracor, the manufacturer, was ready to go with a multi-million dollar ad campaign. "A month and a half after Lunesta's debut, doctors were writing sixty thousand new prescriptions a week for the drug, and drug industry analysts were proclaiming the dawning of a new day for the sleeping pill market."[4] This is the market model of healthcare at work.

It is not necessary to use examples from for-profit industry to exemplify the extent to which the market model has influenced all of healthcare. Despite the frequently used rhetoric, healthcare is increasingly perceived and managed as though it were just another business or commercial venture. Many hospitals, including nonprofits, are engaged in efforts to increase revenue by attracting paying patients for income-producing services, and reducing services that are losing money. They advertise aggressively, and strategically place updated bed-occupancy data in the hospital management wing. The attention is on revenue.

The fundamental misunderstanding of the economics of U.S. healthcare is to assume that the system functions according to standard economic doctrine and predictions. It does not. The number and types of services provided are not dependent upon the demand or the need; the "consumption" of services is not even highly dependent upon cost. What routinely happens in healthcare, in fact, is that the demand expands to consume the supply of resources. The drive to increase revenue means increasing supply—often with unnecessary cost and poor health results.

Over the years, the work of Jack Wennberg and his colleagues at Dartmouth has demonstrated the extensive differences in treatment that are used for the same

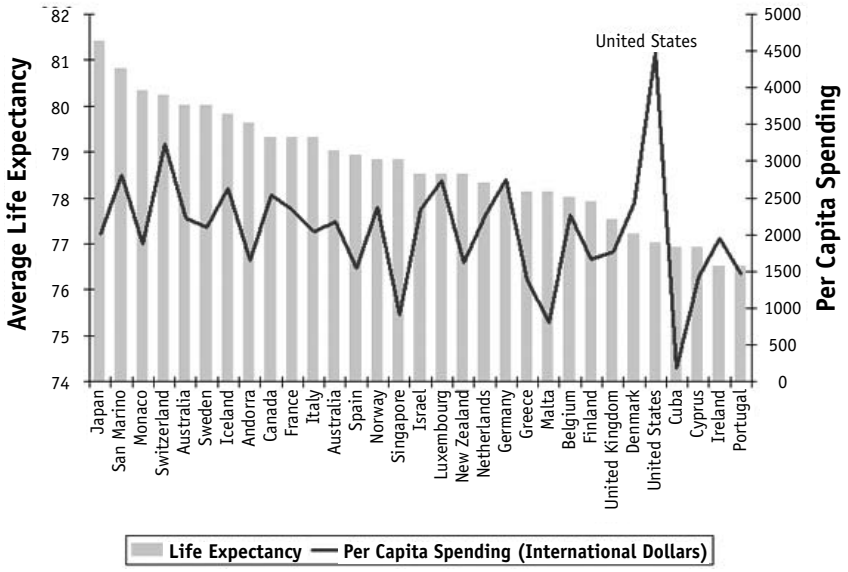
The cost of U.S. healthcare far exceeds that of other industrialized countries, but almost all of these countries rank higher on measurements of comparative health.

conditions in different locations. Part of the explanation is the supply-driven-demand nature of healthcare. For example, more catheterization labs regularly lead to more catheterizations and to more bypass surgery, though not necessarily to better outcomes.

The financial incentives are often perverse. When hospitals attempt to provide better care at less expense, they often lose financially. As many have long recognized, the payment system reimburses much more for invasive procedures and much less for the care that manages or prevents chronic diseases.

In December, 2007, the Commonwealth Fund released a report outlining options for achieving savings and value in healthcare.[5] Some of the biggest projected savings, according to this report, could come through the establishment of an effective center for evaluating which treatments work best for which patients.

The Cost of a Long Life



http://ucatlas.ucsc.edu/spend.php

Certainly good comparative information on clinical effects and cost effectiveness is needed in order to achieve desired outcomes in less costly ways. Much of this data already exists, but it is not what is driving the system. The financial incentives do not promote the implementation of high-quality and cost-effective healthcare for all. The solution is not just to have good clinical and good cost-effectiveness data. It is also to understand and to change the economics of the system.

Changing the System

Efforts to develop a more just system need to focus on cost and challenge the appeal to market methods as the solution. The market model teaches individuals to be focused on the financial cost to themselves and their families. "Consumer-driven healthcare" plans, for example, are designed to encourage individuals to think very carefully about what their medical treatment will cost them out-of-pocket.

Those who do not equate the common good with everyone's pursuit of self-interest also need to be concerned about what their medical treatments cost, but not just what they cost to them personally. When an elderly patient asked what the recommended physical therapy would cost, he was told that Medicare would cover it. He said, "That's not what I asked." He is right; the question is not just what it costs me, but what it costs us.

A level of skepticism about whether the benefits justify the costs—and questioning whether there may be a less costly way of achieving reasonable benefits—is precisely what is needed to challenge a system characterized by overtreatment, excessive costs, and perverse financial incentives.

The level of interest in healthcare reform this Presidential election year is an indication that a new opportunity exists to address our national failure in healthcare. Effective advocacy for healthcare justice means demanding universal coverage and, at the same time, demanding effective cost control. Most importantly, it requires challenging the doctrine that problems of cost, access, and quality can be "fixed" by managing healthcare as though it were a commercial enterprise.

The ethical foundations of healthcare are clear and strong. They can be unabashedly appealed to as the basis for reform. The Code of Ethics of the American College of Healthcare Executives puts it this way:

"The fundamental objectives of the healthcare management profession are to maintain or enhance the overall quality of life, dignity and well-being of every individual needing healthcare service and to create a more equitable, accessible, effective and efficient healthcare system."[6] ~

1 Bloomsbury, 2007

2 *The New York Times*, December 19, 2007

3 *JAMA*, February 27, 2008

4 Brownlee, Shannon, *Overtreated: Why Too Much Medicine Is Making Us Sicker and Poorer*, (Bloomsbury, 2007), p. 187.

5 Commonwealth Fund, "Bending the Curve," December, 2007

6 American College of Healthcare Executives, Preamble, Code of Ethics

Integrative Medicine

Astrid Pujari

Astrid Pujari, M.D., is an internist and credentialled medical herbalist who practices integrative medicine at the Pujari Center in Seattle, WA.

I am a real advocate of integrative medicine. I love the vision, and I believe it's the way medicine should be practiced. The only problem occurs when nobody knows exactly what I am talking about.

"Integrate what, exactly?" is a question I frequently hear. Integrative medicine combines the holistic and conventional medical worldviews. Conventional medicine is what many people in the United States think of when they think about going to the doctor. People sometimes call this approach "Western medicine" or "allopathic medicine." Research scientists like to describe holistic medicine as "everything else"—including ancient modalities such as Ayurveda from India and traditional Chinese medicine, as well as more recent approaches, such as homeopathy, Reiki, naturopathy and chiropractic care. Nutrition and herbal medicine are cornerstones of almost all these modalities.

With such a large mix of natural options, it may seem impossible to compare the conventional medical approach to the holistic approach. However, several interesting themes emerge when we take a higher level view of holistic medicine in comparison with allopathic medicine.

The Disease Model

Some people say that conventional medicine is based on something called the disease model. Simply put, the idea is that conventional medicine spends most of its time trying to diagnose people with diseases. Doctors do this using all sorts of fancy tests—ranging from blood work to CT scans—to help locate problems. And if one is found, the goal is to treat it. The treatments, especially prescription medications, often seem to work by counteracting the body's natural responses. For instance, for heartburn, doctors might give an acid blocker.

The disease model...can also give the impression that being healthy simply means, "I don't have a disease." It doesn't entirely make sense to define health by what it's not.

The downside is that when you go looking for problems, you usually find them. And not everyone agrees that the best way to treat a problem is by blocking the body's natural response. It can also give the impression that being healthy simply means, "I don't have a disease." It doesn't entirely make sense to define health by what it's not.

I have met people who argue that holistic medicine doesn't do this sort of thing. But I disagree. It depends on what type of holistic medicine you are talking about. Many holistic providers use the disease model. For example, let's take the case of the person with heartburn above. More often than not, people go to a holistic provider and get a "natural substitution" for the acid blocker in the form of a supplement or an herb. In that case, holistic medicine is still following the disease model, but using a different remedy for the problem.

Ironically, natural medicine tests usually have a *lower* threshold for finding problems. Conventional medical diagnostic tests are generally designed to diagnose overt pathology. They tend to use stringent cut-offs, with the goal of finding severe problems, such as diabetes or heart failure. That makes sense, because conventional medical treatments definitely have risks. Having rigid test criteria is one way to try to avoid giving prescriptions to people who don't need them.

The problem is that there are lots of people who fall into a grey zone between "normal" and "overt pathology." These people may not qualify as unhealthy by conventional medical tests, but they still don't feel well.

Natural medicine tries to address this issue using "functional" tests, which help to diagnose people in this "in between zone." Because the goal is to detect more subtle imbalances, these tests often have looser criteria for what is considered abnormal—and ironically, more people can end up diagnosed as "sick." That being said, natural medicine tends to use more gentle remedies, like nutrition, vitamins and herbs. The goal is to support the body's own healing processes, rather than counteracting them. The fact remains, though, that there is a risk for over-diagnosis.

The Wellness Model

People sometimes contrast

the disease model of health with a concept called the "wellness model." Wellness defines health as a positive, rather than as the absence of disease. Often people describe it as a sense of spiritual, mental, emotional and physical well being. It assumes that health is our natural state, and that the body already knows how to heal. Our major task is to support the body to do what it already knows how to do.

Wellness sounds good in theory, but it can be hard to put into practice. Most people focus on the last part, physical wellness. Things like proper diet, vitamins and regular screening exams appeal to people because they are concrete. So that is what they, and their providers, emphasize.

But that leaves out three quarters of the definition of wellness —the spiritual, mental and emotional. The fact is that most people assume that a sense of peace, or joy, is an automatic function of being alive. What they don't realize is that cultivating these inner qualities takes as much work, or more, as being in good shape physically. Conventional medicine does little to help with these assumptions, since the only time that most doctors think of recommending counseling is when there is a "problem" to be treated, such as depression or anxiety. This approach assumes that the only time we need to be thinking about our spirituality, or our emotional health, is when there is a crisis. But we all know that an ounce of prevention is worth a pound of cure.

Integrative Medicine: The Whole Person

Integrative medicine assumes that no single paradigm will meet the needs of all people—or even one person. In order to begin to appreciate the whole person, you have to be willing to adopt different points of view. You can achieve this in many ways. One very effective way is to train a single person in multiple paradigms. This allows them to switch view points as needed in real time, rather than having to wait and discuss it with another provider. Another option is to have an open system—in which several different kinds of providers all talk to each other and work in synergy to assist someone in healing.

Integrative medicine assumes that no single paradigm will meet the needs of all people—or even one person.

So what does integrative medicine look like, from a practical point of view? Well, let's take another look at that person with heartburn. An integrative provider would start by listening to their symptoms and how severe they are. They would then try to understand that person's values and priorities. The provider would then present different avenues, from various modalities, that may be helpful. These could range from diet changes to natural supplements, herbs, homeopathy, or acupuncture. They might also include prescription medication or surgery, as well as a discussion of emotional, spiritual or mental issues that could be contributing.

After that, the provider would help them weigh the pros and cons of all the different options, in the context of that person's values. This is an important, and often overlooked, benefit of integrative medicine. Too often, people go to see their holistic provider and hear one opinion, and then go to their "regular doctor" and hear something else. In fact, they may even get different opinions from different holistic providers. As a result, the person is left trying to integrate conflicting information without any medical training, or help—and without anyone who really understands what their priorities are. This can lead to confusion, frustration, and discouragement.

In terms of what people can do to advocate for change, I would start by looking at your own life. Start by taking an active role in your own preventative health—not only on a physical level, but on a spiritual, mental and emotional one as well. Seek out providers who can help you to do this if needed. Because when you change your own life, you change that of everyone around you. ~

Living Well All the Way to Death

Gretchen Gundrum

Gretchen Gundrum is a psychologist and spiritual director in Seattle.

We rented a hospital bed and put it by the living room window so Mom could see the flowers, birds, squirrels, clouds, and sunshine. It was also easier to receive visitors that way, especially kids, grandkids, and the parishioners who came daily to bring her Communion.

She refused to take pain medication up until the final weeks. This was not just from an "offering it up" spirituality. She was also practical: the opiates dulled her senses and made her sleep more. She didn't want to miss out on anything until she absolutely had to. "It's not so bad yet that I can't handle it," she'd say of the cancer's pain.

One morning after the hospice nurse had left and bedside ministrations were completed, she asked, "What do you think happens when we die?" Profound question. It deserved an honest, thoughtful answer.

"I don't know, Mom. No one's ever come back from the dead to tell us what it's like." She laughed a little.

"But I no longer believe that heaven is a place where we go. I think it's like Einstein's theory of relativity—everything is either matter or energy. I think we change states, and live in a new consciousness. And I hope to see God."

She nodded. We were both quiet for awhile.

Then I added, "Everything in nature tells us resurrection follows death. Flowers bloom, go to seed, and come up again. I think death may be another birth. When we were in the warmth and dark of the womb we didn't want to come out into the light and noise. We didn't want to leave the safety and familiarity of that space. Most of us entered the world kicking and screaming. Death may be like that."

"I'm scared," she said.

"I am too," I answered.

Living well—morally and ethically—until death has always been a focus of spiritually oriented people. While modern science and technology provide us with expanded means to prolong life, death will come eventually. To live well until we die means we must also take time to consider what kinds of decisions we want others to make when we are not able to do so. Our Catholic tradition helps us to enter into the process of dying with care. In *Living and Dying Well*, Rev. Lawrence Reilly writes:

"We do not have a moral obligation to take extraordinary means to preserve our health or our lives. Extraordinary means are those that place a grave burden on a dying person or on the dying person's family. Sometimes, treatments that are medically ordinary become morally extraordinary.

Another important principle is: there must be a due proportion between the benefit I wish to achieve and the burden I bear to achieve it. That is, the "burden" of the treatment must not be greater than the expected benefit. "Burden" can include pain, loss of human dignity, financial cost, and submission to onerous treatments that do not offer cure or relief from suffering."[1]

Thinking about death or having conversations about it with those close to us is difficult. Even so, deciding on clear, written healthcare directives for the end of our lives will be a blessing for us, our loved ones, and healthcare professionals. No one can honor our wishes unless we express them. The transition from this life to the next is the greatest adventure we will face. Courage is taking action despite fear. *Carpe diem*! ~

1 *A Guide to Making Good Decisions for the End of Life*, Washington State Catholic Conference (www.thewscc.org).

If I knew for certain that I should die next week, I would still be able to sit at my desk all week and study with perfect equanimity, for I know now that life and death make a meaningful whole.

—Etty Hillesum,
An Interrupted Life
www.gratefulness.org

For Reflection:

1. Who would I like to gather with to share about end of life issues?

2. Consider using *A Matter of Spirit* and *A Guide to Making Good Decisions for the End of Life* to enter into a conversation about healthcare, wellness and death.

Andrew Marx is the Manager of Communications for Partners In Health.

Addressing Global Health Issues: Partners In Health

An interview with Andrew Marx of Partners In Health (PIH), a nonprofit organization based in Boston. They are active in the Caribbean, Latin America, Africa, Russia and the U.S. The mission of PIH is to provide a preferential option for the poor in healthcare. The publication and success of Tracy Kidder's book, Mountains Beyond Mountains, *brought new attention and resources to the work of PIH and global health issues.*

What are the goals of PIH?

To bring quality healthcare to the poorest communities in the world in a way that mobilizes community solidarity to overcome not just specific diseases, but also the conditions of poverty and social injustice in which disease takes root. Health and social justice are inextricably connected.

Our approach is to forge a genuine partnership—looking to the patients, health workers, and others in the communities where we work to take the leadership in identifying the main problems. These may not be purely "medical" problems. Often the community members start with, "We're hungry." Then it's our job to make sure people get enough to eat.

Food is, in a sense, the first vaccine—essential to prevent illness, and also at the top of the list for treating people once they're sick. There is a Haitian saying, "To give people medicine without food is like washing your hands and then drying them in the dirt."

How does PIH work?

The backbone of our approach are the *accompagnateurs* or community health workers, hired and trained by PIH to provide support and education. They visit patients with HIV or TB daily, bringing medicines and making sure they are taking their medicines properly. They are also looking at the conditions in which the patients live: Are they getting enough to eat? Is there a hole in the roof?

The *accompagnateurs* are a physical manifestation of community solidarity—bringing healthcare to people and bringing the community together as an effective, united voice to fight for social justice.

"To give people medicine without food is like washing your hands and then drying them in the dirt."

How has PIH made an impact?

Every year, ½ million women around the world die during pregnancy or childbirth. Many of these deaths can be avoided if Caesarian sections are available. PIH went into one of the poorest districts in Rwanda, where the maternal mortality rate was high. When we arrived, there was not a single doctor in a district of 400,000 people. The hospital had no electricity or running water. We totally refurbished the hospital, making it a priority to develop a functioning operating room. We worked with the Ministry of Health to staff the hospital with local doctors, surgeons, nurses and social workers. The lives of dozens of pregnant women have been saved.

Has PIH adapted new approaches to dealing with global health issues?

In Haiti, we pioneered a treatment for HIV at a time when others were saying it was "too expensive" to give HIV medications to poor countries, claiming that people had no clocks and would be incapable of taking their medicines properly. We felt this attitude was morally unacceptable. Our success rate has been remarkable, with rates of adherence of 95% or better. People are taking their medicines regularly, at the prescribed levels and the proper times, resulting in good health outcomes and in a reduced risk of drug-resistant HIV taking root.

What should the role of the U.S. be in addressing the global health crisis?

Health problems in poor countries are a consequence of centuries of global economic injustice —colonization, slavery, and the dismantling of public health programs in the 80's and 90's as a result of structural adjustment policies imposed by international financial institutions backed by our country. The U.S. has a major debt to pay.

What can the average citizen do?

Support and work in solidarity with people in the poorest countries. All of us can make donations, raise awareness, become involved with organizations that are doing this work. The long-term solution to global health problems hinges on the people in the U.S. and other wealthy countries learning enough history to recognize our responsibility to correct centuries of injustice. ~

Medical Waste

Eva Dale

In medical school, they teach "First, do no harm." As the interconnectedness of human health and the health of the environment becomes increasingly apparent, we need to shift how we apply this concept. Healthcare contributes to environmental degradation in many of the same ways as the rest of society. However, there are a few eco-polluting materials of particular concern that are specifically associated with healthcare:

• **Mercury** can often be found in thermometers, amalgam dental fillings, some over-the-counter medicines, and certain vaccines. Mercury can be toxic and bioaccumulates (higher concentrations can be found higher in the food chain).

• **PVC**, a widely used plastic, can be harmful to patients, the environment and public health. Dioxin, a known human carcinogen, can be formed during the PVC manufacturing process as well as during the incineration/ burning of PVC products. DEHP, a phthalate used to soften PVC plastic that can leach from PVC medical devices, is linked to reproductive birth defects and other illnesses.

• **Medical waste**—Hospitals generate more than two million tons of waste each year. A portion of this is biological, such as operating room waste, and needs special care. In the past, many hospitals combined all waste streams, including generic waste such as reception-area trash, and burned it in incinerators. Now we know that incineration is a source of highly toxic dioxin, mercury, lead and other air pollutants. And, there are more eco-friendly ways to treat the special needs of medical wastes, such as through the use of autoclaves.

• **Electronic waste**—Computers, lab analyzers, EKG monitors and other equipment used in hospitals every day contain many hazardous constituents—from lead in cathode ray tube (CRT) monitors to mercury in LCD displays. The hazardous substances found in electronics have been linked to human health effects, including cancer, birth defects, and hormone disruption.

• **Medicines**—Pharmaceuticals are found in waterways throughout the U.S. and, more recently, in very small quantities in the drinking water of several cities. There is a growing body of evidence showing that pharmaceuticals may cause harm to aquatic life. There is also concern regarding life-long exposure to small quantities and exposure to vulnerable populations, such as developing children and pregnant women.

Just about everybody uses medicines, either daily or on occasion. So we go a little deeper here and answer some basic questions about how to keep them out of the environment.

How do medicines get into the environment? When we take medicines, they pass through our bodies and through sewage and septic systems; when we put our unwanted medicines in the sink or toilet, they enter the water system. In both cases, wastewater treatment plants cannot remove all pharmaceuticals.

We need to reduce the amount of medicines wasted! There is no easy answer to the problem of medicines in the environment and we need to work on this issue from many angles. We can use help from physicians, nurses, pharmacists, and others working in healthcare to develop solutions.

What can we do with unwanted medicines? Unwanted Medicine Return! Although we were told in the past to flush our leftover drugs, we now know better. For now, in Washington State you can return medicines to participating pharmacies for secure disposal through the Medicine Return Pilot Program.[1]

If a return program is not available, please use the following instructions:

Keep the medication in its original container. Add a small amount of water and something like sawdust to discourage consumption. Tape the lid shut, place in a sealable bag and then in a non-transparent container. Discard in the garbage—not the recycling bin—away from children and pets.

To find out if there is a location near you, or for alternative disposal recommendations, visit www.medicinereturn.com or call 1-800-732-9253.

This pilot will be ending in November 2008. We need a long-term, sustainable solution for disposing of unwanted medicines through a manufacturer-funded medicine return program. To create such a program, a secure medicine return bill is being considered by the Washington State legislature. ~

Illustration by Shannon Leahy

1 Similar programs are needed in other cities. The San Francisco Bay area is the only other place in the West with any solution right now.

Eva Dale works at Washington Citizens for Resource Conservation on a project addressing pharmaceuticals in the environment. She has a background in both environmental toxicology and social justice organizing.

Justice Circles

The Justice Circles are flourishing!

Join them!

Even Start—Shelton, WA

Hospitality House—Burien, WA

Support them!

Advertise them!

Tepeyac Haven
Pasco, WA

Northwest Coalition for Responsible Investment: Shareholders Work for Healthcare Reform

What is one thing that every American is concerned about whether she/he is a presidential candidate, the CEO of a corporation, or an ordinary citizen? Yes, it's access to healthcare that is affordable. The failure of public policy to enact healthcare reform has motivated religious shareholders to undertake an ambitious five-to-seven year campaign to achieve universal access to quality affordable healthcare coverage in the U.S.

This year NWCRI and Interfaith Center on Corporate Responsibility members filed shareholder resolutions with nearly 40 pharmaceutical, technology, energy, retail, and manufacturing companies asking them to adopt principles supporting comprehensive healthcare reform principles.

- 23 companies, including Johnson & Johnson, General Electric, IBM, Target and Kohl's, are in dialogue with shareholders
- Resolutions are on the proxies of 10 companies
- Shareholders of Boeing, Ford and United Technologies have supported the resolution at the first year threshold of at least 3%

What Did You Say?

"One of the few publications I read cover to cover."

"I like your in-depth discussion of current issues."

"Latest issue was great—I'm using it with my faith sharing group."

"Include more theological reflection."

Thank you to those of you who filled out a Survey on *A Matter of Spirit*. We received good suggestions for future topics. We're still compiling the survey results.

It is not too late to mail in or complete the survey online. (www.ipjc.org/journal) **Your input always makes a difference to us!**

Needs and Wants

- ☒ Corporate support for the Women's Convocation: Program Booklet, coffee breaks, a speaker, young adult events and more. Do you have a company connection?
- ☒ Air miles for a Convocation Speaker
- ☒ New signage for our Intercommunity Peace and Justice Center
- ☒ Gift gas cards to support travel to Women's Justice Circles

www.WeeklySpiritualReflections.com

A new website and membership service to deepen your spirituality and enhance your prayer life, to awaken your spirit to the presence of God around us and within.

Faithful Citizenship

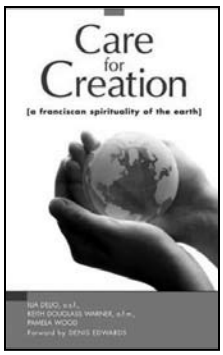
IPJC is scheduling regional workshops for the fall. Content will include:

- ✞ A Catholic Call to Political Responsibility
- ✞ Scripture
- ✞ Catholic Social Teaching
- ✞ Justice Issues
- ✞ Tools for Action

A New Book

Care for Creation: A Franciscan Spirituality of the Earth.

www.sampbooks.org



The Dawning of a New Story Gives Us Radical Hope!

We announce

NORTHWEST CATHOLIC WOMEN'S CONVOCATION IV

MAY 1-2, 2009

LOCATION: Meydenbauer Center, Bellevue, WA

Note: Washington State Convention & Trade Center was not available for several years

REGISTRATION: $110—Brochures available in November

You won't want to miss this opportunity to **gather with 2000 faith-filled women** and men for prayer, ritual, over 25 nationally-known speakers, workshops and transformation.

If you **did not** receive a letter in the mail and want to be sure and be on the list to receive a brochure, e-mail us at ipjc@ipjc.org or call 206.223.1138

Just Action

New Action Center @ www.ipjc.org


Click "Act"


Decide on Message


Click "Send"

This spring we rolled out our new Federal Legislative Advocacy tool on our website.

Take action on the issues that are important to you.

Currently have Action Alerts on Human Trafficking Legislation that is pending in the U.S. Senate.

National Housing Trust Fund and the Climate Security Act are pending in Congress at time of publication.

Principles for Healthcare Reform

The Catholic health ministry looks forward to a healthcare system that truly promotes the nation's well-being and respects the dignity of every person.

Catholic Health Association believes that healthcare in the U.S. should be:

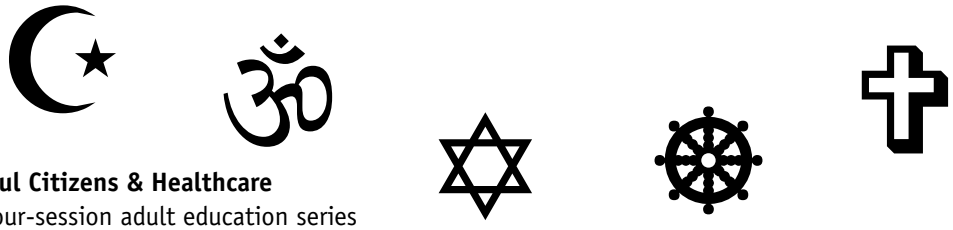
- Available and accessible to everyone, paying special attention to the poor and vulnerable
- Health & prevention oriented, with the goal of enhancing the health status of communities
- Sufficiently and fairly financed
- Transparent and consensus-driven in allocation of resources, and organized for cost-effective care and administration
- Patient centered and designed to address health needs at all stages of life, from conception to natural death
- Safe, effective and designed to deliver the greatest possible quality

—www.chausa.org

Affordable and accessible healthcare is an essential safeguard of human life, a fundamental human right, and an urgent national priority. We need to reform the nation's healthcare system, and this reform must be rooted in values that respect human dignity, protect human life, and meet the needs of the poor and uninsured. With tens of millions of Americans lacking basic health insurance, we support measures to ensure that decent healthcare is available to all as a moral imperative.

—U.S. Catholic Bishops, *Faithful Citizenship*, 2003

Resource



Vision & Voice: Faithful Citizens & Healthcare

- Is an innovative four-session adult education series
- Offers flexible designs for one to two hour meetings
- Includes a DVD of faith leaders reflecting on what the moral teachings of their tradition bring to work on healthcare
- Outlines action steps for individuals and communities of faith.

—www.visionandvoice.org

A Matter of Spirit
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