The Witness

Volume 79 • Number 6 • June 1996

Hospitals: quality, access and spirit

Is it ever okay to lie?

YOUR APRIL ISSUE WAS VERY TIMELY for us in Christian Peacemaker Teams. On several occasions in the last year persons in Hebron (Palestine) and Haiti have asked what to do when local persons living under military rule (oppression) have asked us to withhold information or to lie so that they will not get into trouble. A taxi driver who had taken us to a location where we cut down a fence that settlers had put around someone's land asked us to tell soldiers, if stopped, that he had been driving us around Hebron instead.

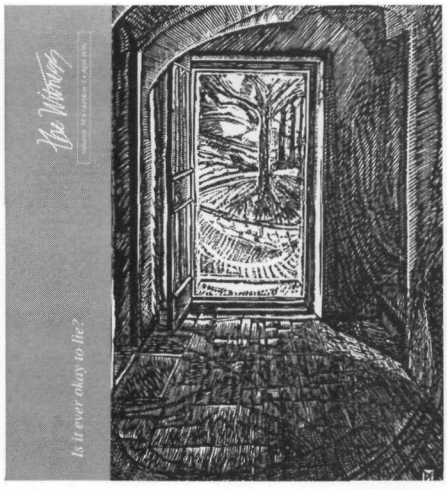
In Israel, when we go through airport security, we must figure out evasive answers in order to protect our Palestinian co-workers. We speak of being tourists going to the holy places and we are evasive about our final destination. Normally we give temporary neutral addresses in Jerusalem instead of our destination. It is widely understood that Israeli airport security has much more to do with collecting information on activist Palestinians and opposition Jews than on potential bombers.

Soldiers often ask "Why are you here?" to which we gladly reply that we are Christian Peacemakers. However if we are *en route* to another city we are careful of what we say at checkpoints.

Sometimes it is inappropriate to give any information at times of arrest. Instead of our names we may speak of Samson, the great and strong Old Testament character or another honored Biblical personality.

We believe that it is always best to tell the truth in the spirit of being "wise as serpents and gentle as doves." Our CPT workers generally do not come from institutionalized oppression and for many of us the withholding of truth is a disconcerting experience.

The work of nonviolence is the work of truth telling from the point of view of the bottom. Because our education and background taught us so little about life at the bottom, in oppression, we have to develop an



ethic in the trenches.

Thank you for helping us along the way.

Gene Stoltzfus
Christian Peacemaker Teams
Chicago, IL

TRUTH OR CONSEQUENCES — editorial was superb!

Michael Dwinell
Cape Elizabeth, ME

In the Church's Intere$t

THIS IS ONE HELL OF AN ISSUE. Sally Bucklee summarized my feelings about the magazine precisely when she said she was not interested in the subject matter some months, but always found herself inevitably sucked in by the quality of writing and thought. It's true. I haven't heard anybody intelligently dispute the morality of usury since I was in Sunday School with underpants which heralded the days of the week.

I loved Jeanie's interview with Chuck Matthei. You should be ashamed when you forget what a nifty job you have. You get to rub shoulders with human beings of authentic integrity... sometimes damn if I forget they EXIST!

Dierdre Luzwick
Cambridge, WI

Righter trial

I AM WRITING WITH REGARDS TO Julie Wortman's article on the Righter trial [4/96]. The only certifiable "heretics" in the whole affair would be the presenters themselves who seem to be insisting on a rarified version of Donatism.

Donatism was an aberration among some of the members of the early Church which held that priests had to be "sinless." The entire idea contradicts Christ's openness.

I quite appreciate that the presenters were actually reacting to the openness of the particular homosexual candidates. After all, as long as homosexuals acted ashamed by remaining silent most did not indicate a problem with the situation.

The anomaly, of course, is that what the Church has been doing is prizing dishonesty over honesty when it comes to sexuality. And especially so with regards to homosexuality.

It seems to me that Mr. Tennis of Delaware may have unwittingly half-elucidated the question when he tried to confine it to homosexual priests who "are living in committed relationships." I would suspect that the phrasing Mr. Tennis chose was an indication that he realized that to go beyond those in committed relationships would be unthinkable. The problem is that the Resolution ("practicing homosexual") upon which the trial is based does "go beyond" those of us in committed relationships.

What amuses me most comes at a point in the article where the "prosecutor" (a Mr. Blakingship) alludes that the case is about the "doctrine of marriage."

This does get to the core of the presenters' dilemma. They are searching for a doctrine upon which to hang their case and they simply shot from the hip. The "doctrinal question" is not ordination.

"Marriage" is the gay question! Ordination is the women's question just as baptism was the Blacks' question two centuries ago.

I suspect that the actual reason the presenters chose to attack at the point of ordination was that it would be easier to win an argument with people who are cowed into silence.

However, such a situation also reveals the fragility of the presenters' basic premise. If the traditionalists' concept of "Christian marriage" cannot stand the light which self-respecting homosexuals might subject it to, then it would seem to be a weak institution. Whatever the case, ordination would be apples

to marriage's oranges. Personally I feel quite comfortable suggesting that Christian marriage ends up looking like idolatry.

I came close to sympathy with Mr. Blakingship when he says that "you have to take each one of those situations and consider what the nature of the witness was and make a judgement — and that essentially is a diocesan problem and not a national canon." He couldn't have phrased Mr. Righter's case better.

I would quibble with Mr. Blakingship's reply as to whether the presiding bishop would have been considered a heretic for signing one of those intermittent Conscience Statements. Blakingship's "Perhaps the bishops should have done something about the dissenting opinions," comes across as an especially Episcopalian peculiarity when one recalls that it was the traditionalists who invented that device at the time of the votes on the new prayer book. If the traditionalists did not want the horses out of the barn, they should not have opened the gate.

John Kavanaugh
Detroit, MI

BISHOP RIGHTER AND I have been fellow servants of Christ in the House of Bishops since he entered the House 24 years ago. This trial and all the publicity calling him a "heretic" because of his ordination of Barry Stopfel as deacon moves me to say, "I would rather be a Righter than a Wronger!"

Ned Cole
Syracuse, NY

Come Spirit Come

I HAVE ALWAYS LOVED *THE WITNESS,* so you can imagine how thrilled I was to receive one [6/95] that brought back alive the sweet memories of our visit to South Africa [for the Conference on Afro-Anglicanism].

I quite appreciate your friendship and care; that you even thought of making a reference to my humble contribution on Faith Commitment and Christian Attitude to Life in the Community in *The Witness* editorial!

We are truly grateful for your interest in our church. Uganda is both rich and poor at the same time. Our country has resources and potential to grow out of rampant poverty. The people have energy and capacity to progress, but since Idi Amin's reign of terror, Ugandans have lived under pressure and struggle for survival. The church has to be a role model. The challenge is that church people have no special schools for their children, market place or work — they share in common struggle with the rest, but watchfully.

Grace N. Ndyabahika
Kampala, Uganda

Correction

The Witness mistakenly reported that Dan Berrigan was involved in the 1971 Harrisburg trial.

Witness praise

IT IS SATURDAY and not having time all winter, I chose today to clean out my large linen closet which contains nary a pillow case nor a dinner napkin. It is stacked with copies of *The Catholic Worker, Peace Work, National Catholic Review,* etc. Now, about two hours ago, while I was going through a stack of *C.W.s,* I came across a most marvelous magazine! A copy of *The Witness*, Political Prisoners [1-2/95]. The morning is gone. I have read every line in this issue and after mailing this, I shall re-read every line again.

Where this came from I have no idea or how long it has been buried in the pile. I do know that I must subscribe immediately.

Bill McYarry
Albany, NY

THE CONFERENCE ON THE Legacy of Stringfellow was a *great* day and a half. Thank you for the role *The Witness* played in helping to bring it about. It was a great complement to my studies at Sewanee! Tom Warne and I distributed 50 copies of *The Witness* when we returned from the Conference and already some of the articles have cropped up in class conversation. I look forward to seeing Bill and Jeanie Wylie-Kellermann again. They have helped open a new world of inquiry, theology, faithfulness and tension to me through their work at *The Witness* and on William Stringfellow.

Thomas R. Cook
Sewanee, TN

Classifieds

Integrity National Convention

Integrity, Inc., the national lesbian and gay ministry of the Episcopal Church, will hold its national convention in New York City on June 27-29, 1996. The convention will feature well-known speakers who will address such topics as lesbian/feminist spirituality, multiculturalism, liberation theology, evangelism, gay parenting and relationships. There also will be workshops on HIV/AIDS and bereavement. A concluding banquet with entertainment will cap the event.
For registration and further convention information, call (212)989-8173.

Vocations

Contemplating religious life? Members of the Brotherhood and the Companion Sisterhood of Saint Gregory are Episcopalians, clergy and lay, married and single. To explore a contemporary Rule of Life, contact: The Director of Vocations, Brotherhood of St. Gregory, Saint Bartholomew's Church, 82 Prospect Street, White Plains NY 10606-3499.

Marketing Director

The Other Side, a Christian magazine onpeace and justice issues, is seeking a full-time marketing director to strategize outreach to new and current subscribers, conceptualize and produce creative marketing materials, and analyze results. Experience in marketing and/or magazine publishing desirable. Excellent benefits. Applications being accepted immediately. Contact Hiring Team, The Other Side, 300 W. Apsley Street, Philadelphia, PA 19144 (215-849-2178).

Classifieds

Witness classifieds cost 75 cents a word or $30 an inch, whichever is less. Payments must accompany submissions. Deadline is the 15th of the month, two months prior to publication. For instance, items received January 15 will run in March. When ads mark anniversaries of deaths, ordinations, or acts of conscience, photos — even at half column-width — can be included.

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Managing Editor	Julie A. Wortman
Assistant Editor	Marianne Arbogast
Circulation Coordinator	Marietta Jaeger
Magazine Production	Maria Catalfio
Book Review Editor	Bill Wylie-Kellermann
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Cover: Laundry worker, Bellevue Hospital in N.Y.C. by George Cohen/Impact Visuals.
Backcover: Grace Cottage Hospital in Vermont photographed by Joan Seidel of Scarborough, Maine.

Learning to sit with pain

by Jeanie Wylie-Kellermann

A woman in a hospital in considerable pain told us she felt there were two kinds of people who came into her room. She said she noticed one kind of person could hardly sit down next to her, and when they did, 'they couldn't sit still at all. They would fluff my hair or put lipstick on me, or thumb through magazines. They would go to the window and open it if it was closed or close it if it was open. But they couldn't stay long with my pain.' She said they had no room in their hearts for her pain because they had no room for their own. 'But,' she said, 'there were others who could just come in and sit down with me. And if my pain was so intense or I was too fidgety and couldn't stand to be touched, they would just sit quietly next to me. They didn't need to take my pain away and they didn't make me feel that I needed to be different when I was in pain. They had room for my pain because they had room for their own.'

—Stephen Levine,
Healing into Life and Death

I'd like to be someone who can sit comfortably in a hospital room facing death and its lesser invasions with down home equanimity.

In truth, I am really ambivalent about hospitals. After avoiding them most of my life, I visited the emergency room twice during 1995 holding a sobbing five-year-old whose pain ran through me like fire.

The hospital officials who gauged her injuries — a broken arm once, then a lacerated wrist — put her in line for care. As I sang to my daughter Lucy, I prayed. I felt utterly dependent upon and grateful to the doctors and attendants who mended her wounds, told her she was brave and handed her an artificially flavored and colored popsicle when it was over.

Of course, like most others, I've also felt uneasy in hospitals, worrying about the degree to which I surrender to the opinions of doctors because medicine is so unfamiliar to me. Or feeling rude when I question their judgment. Like an animal caught in a trap, I vacillate internally between yielding and rebelling, unsure whether either or both will release me.

Lucy's aftercare for her broken arm involved repeated visits to the hospital's clinic. Twice they decided to put on a new cast, although it was arguable that she had healed. They said her anxiety concerned them. It meant little to them when I explained that her attitude was partly formed by how afraid she was of the buzz-saw they used to remove the cast. (When I had mentioned Lucy's fear to the nurse, she had held it against her own hand saying, "See it won't cut you, at worst if you hold it in one spot it will burn you." In Lucy's eyes I saw horror — loud *and* burning.)

Six weeks later, it seemed like a huge act of resistance to decide on our own that her cast should be removed. Lucy sat in her older sister's lap while her Dad read to her and I gently soaked her cast in warm water and unwrapped it.

Now, when she does cartwheels and climbs signposts, I give thanks.

In both hospital encounters, we, of course, had to withstand the bureaucracy — we got fed into computers, identified by number, evaluated by our insurance and our care was coded there. It's in this anonymous process, presumably, that people's medical treatments can get denied or confused, that a spirit of negligence can take hold.

WomenWise, a women's health collective publication, reports that, "In 1991 a Harvard University study estimated that 86,000 people a year die in U.S. hospitals from negligence. The government's Center for Disease Control and Prevention recently estimated that 80,000 people die from nosocomial (hospital-caused) infections each year. Studies suggest that at least half of these are preventable."

And, of course, there are economic questions — who has access to hospitals? How is it paid for? What kind of care does it entitle one to? And how does the movement of dollars nationwide influence the hospitals' approach to care?

Finally, each of these tensions flow into an amalgam of powers and principalities that can induce ill health and perpetuate it. Hospitals are temples of sorts, rife with idols, initiation rites and the deepest of prayers.

I hope this issue may lead toward developing some equanimity in the face of these forces. The issue doesn't attempt to offer a definitive evaluation of the state of health care in the U.S., nor about health insurance policy debates, nor about the professionalization and commercialization of medicine, nor does it address the vitality of alternative health care.

The issue simply attempts to serve as a traveller's guide through a foreign yet familiar temple in which birth can be facilitated, death abated or endured. A place where pain is a constant. While there, it is worth noting who is there too, the patients and staff, the advocates and the ones who pray. Perhaps in their company we can learn to sit still with other people's pain, because we have made room for our own. TW

Jeanie Wylie-Kellermann is editor/publisher of *The Witness*.

editor's note

In the waiting room

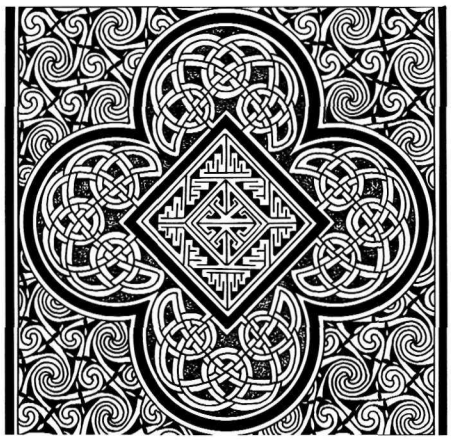
by Mary Alice Bird

Late February 16, 1993, we received one of those phone calls all parents dread. Two thousand miles away, our youngest daughter and her two-month-old son had been hit by a car. Sarah suffered a concussion, but Mason was undergoing his second brain surgery and it was doubtful he would live through the night. By early morning we were on a plane, but it wasn't until we reached Austin, Texas, late that day that we learned Mason was still alive.

All the way to Texas, we silently prayed, but I confess those prayers were ambiguous. We knew if Mason lived, he would be severely brain damaged. In our confusion, we didn't know whether to pray for his life or his death. As a mother, anguishing for my own child, my heart said to pray for life. A powerful image from Ingmar Bergman's *Cries and Whispers* kept coming back to me — the bastard sister unclothing herself to lie in bed and cradle her dying sister, while the two legitimate sisters stand by paralyzed by fear.

When we arrived at the hospital, Mason was hanging onto life. He had been baptized during the night, while Sarah was still unconscious. Knowing this brought both reassurance and despair. Sarah's room, the surrounding hall, and the waiting room were filled with people. I lay beside my daughter but I did not bare my soul or touch hers.

We were all praying, but to ourselves, until God sent an "angel," a co-worker of Mason's father. This man kept pacing the hall. He asked several times if we were praying and we would all say "Yes." Finally he blurted out, "Are you praying *together*?" It was the simplest and most profound of questions. For without communion, how could we hope to experience the healing power of the Holy Spirit?



Celtic never-ending pattern.

This friend's simple question turned despair towards healing, not just for us and Mason, but I believe for several other families who joined the circle of prayer that evolved over the next three weeks while Mason remained in intensive care. For when we answered, "No," he brought us into a circle, joined our hands and helped us to express our fears and pains and ask for help.

Despair was always in that room. But for me, and I believe for all those who joined the prayer circle, grace was also present.

That circle grew. Initially, it was the few people who were at the hospital that day. Then, as the word spread, others would arrange their work schedule to join us for noon prayers. Gradually the circle encompassed other parents who shared the intimacy of the intensive unit waiting room, the place we all retreated to when we needed respite from the intensity of sitting with children hovering between life and death, attached to respirators, heart machines, etc.

Despair was always in that room. But for me, and I believe for all those who joined the prayer circle, grace was also present.

For example, I know that night after night as I sat with Mason, I was surrounded by a holy circle of calm but that just outside that circle, I could palpably feel the demons of death lurking — and I watched as that circle allowed an almost catatonic father of a severely abused child to begin to share his pain and love.

As one who grew up on liturgical prayer, that circle freed me from theology and rhetoric and allowed me to pray from my most basic need — to ask that Mason live, to ask that God keep me from despair. Mason did live, and in our family we call him the "miracle boy," but the miracle is not his physical but his spiritual life.

When Sarah was still recuperating, a parent of a severely brain-damaged child visited her. He shared that his child had profoundly made him realize that life is not about "cognition" but "spirit." I have meditated on that simple statement often.

In a world where we strain to identify our individual talents, often deluding ourselves that we do so for the greater glory of God, Mason is a reminder that Christ is everywhere, in all life. He is a reminder that Christ didn't die for a cause or a theology, but so that we might have life abundantly.

In the midst of the suffering and death of this world, if we choose the circle of prayer, then indeed communion in love can still the demons and bring that peace which passeth all understanding. TW

Mary Alice Bird is a former Episcopal Church Publishing Company board member living in Spruce Head, ME.

New Witness *Poetry Editor:*

Leslie Winfield Williams

Leslie Winfield Williams is a writer and teacher in West Texas. She earned a Ph.D. in literature at the University of Houston in 1994, and has studied theology and church history at the Episcopal Seminary of the Southwest in Austin, Tex. In 1993, her poetry won *Radix* magazine's national contest, judged by Luci Shaw, Madeleine L'Engle, Walt Hearn, and Jean Janzen. Her work has been accepted by and published in a wide variety of periodicals, including *The Christian Century*, *St. Luke's Journal of Theology*, *Presbyterian Record, RiverSedge*, and the *Trinity Review.* Her book, *Night Wrestling*, is forthcoming from Word Publishing early in 1997.

Her husband, Stockton Williams, is rector of Holy Trinity Episcopal Church in Midland, Tex., and they have two children, Jase, 9, and Caroline, 6.

Elevator

by William G. Feeler

She rides straight up the wind
From the plane of the walking dead
To the plane of the fully living —
Sixth floor, south wing, nothing by mouth.
Here her sister sleeps in her tent
Seeing with the new eyes of near-dying,
Even in sleep. Last supper — no host,
No blood — drips into her arm soundlessly
As she sleeps ever deeper in the word of love.

As she steps into eternity's anteroom,
Crowded with guests patiently checking
Schedules, living each breath till departure,
She spies her sister at the end of the hall,
Bed nestled into the corner, one foot pushed
Through the bars of the bed, toes turning blue
From loss of communication. She sees
The eyes of recognition, the faint smile
Through the gurgle of the yellow tube.

Though the air smells of mucous, here is life
Lived in the face of death. Breaths span
Ever greater arches of time till the bridge
Evaporates into mist. untwinned
After seventy years and nine months,
She wonders how to return to the land
Of the entwining dead. *untwinned.*

Competing for paying patients

by Michael Betzold

The walls are tumbling down in America's citadels of medicine. Not long ago, most hospitals were bulwarks against change. Now, spurred by intense economic competition, hospitals are reaching out, gobbling up or bailing out. They're even calling patients "customers" and paying close attention to what they say.

Business, not ethics, increasingly defines what hospitals are about. Yet, as business demands cost cutting, hospitals are finding involvement is usually cheaper than arrogance.

Consolidation, shorter hospital stays and more outpatient clinics save money. Outreach is cheaper than using emergency rooms for primary care. Prevention is less costly than disease intervention. And paying attention to patients, improving quality of services and involving employees makes good business sense.

For the poor, the picture is mixed. More people are uninsured. Nearly one in five Americans under age 65 lack health insurance. Poor people tend to use hospital emergency rooms for primary care services and to delay treatment until conditions are acute, two things that add considerably to health care costs.

Many large public hospitals are closing. More hospitals are becoming for-profit and some close their doors to the uninsured. But many hospitals, especially urban non-profits, are incurring greater uncompensated costs. Hospitals absorbed $28 billion nationally in unpaid fees in 1994, according to the American Hospital Association.

Michael Betzold is a striking *Detroit Free Press* reporter.

To justify their tax status, non-profit hospitals must demonstrate they are doing work that benefits the community they serve. Uncompensated care is part of that. And even for-profit hospitals like the image of being community helpers.

"When for-profits were below a 10 percent market share, they were not significant, and they could act irresponsibly," said Gary Gunderson, director of operations of the Interfaith Health Program at the Carter Center in Atlanta. "As they grow, they get on the political screen and they have to accept some social consequences for their size."

Now, more than 70 percent of hospitals have long-term plans for improving the health of their communities. Not all are effective, and some are more for show than for substance. The most successful are those which abandon traditional concepts of dispensing medicine to address real needs in areas they serve.

Business, not ethics, increasingly defines what hospitals are about. Yet, hospitals are finding involvement is usually cheaper than arrogance.

"We don't figure out what the community needs, we ask the people in the community," says Brenita Crawford, chief operating officer of Mercy Hospital in Detroit. "We once treated symptoms; now we are repairing causes."

Knowing many women need prenatal care, Mercy pays a dollar for each woman referred from beauty parlors.

Recently, the hospital turned a former topless bar into a renal dialysis outpatient clinic.

A few hospitals even tithe. At Memorial Hospital of South Bend, in Ind., 10 percent of the hospital's net revenue is used to award grants to outreach projects that address unmet needs among a medically underserved population.

Managed care has spurred a quest to cut down on the expensive use of emergency rooms for primary care.

"We are seeing a lot of HMO-type plans being adopted by states to cover the poor," said David Berg, marketing director for Catholic Healthcare West, a northern California health system. It's part of cost-containment measures to reduce hospital visits. "The nice thing about managed-care coverage for people who are poor is that there is more emphasis on prevention."

Managed care also means shorter hospital stays and more satellite clinics for outpatient procedures. Outpatient visits have doubled since 1984. Clinics are cheaper and more efficient and part of a growing emphasis on preventive and primary care.

Rapidly, hospitals are losing old identities and merging into huge health networks. These networks compete to enroll independent physicians, especially in outlying parts of urban areas. Even hospitals that remain independent are launching joint ventures to provide hospice programs, home health care, psychiatric and rehabilitation services.

A record 735 hospitals were involved in mergers in 1995. The deals included a $5.6 billion acquisition of Healthtrust, a 115-hospital chain, by Columbia-HCA Healthcare Corp., a for-profit giant based in Nashville. By year's end Columbia owned 335 hospitals with $17 billion in assets. Religious hospitals were also consolidating, with a deal pending to unite

Sisters of Charity Health Care Systems, Catholic Health Care Corp., and Franciscan Health System.

Some fear hospitals will become insensitive empires, but others believe patients can benefit from mergers. Consolidation reduces overhead costs through economies of scale so that staff doesn't have to be cut. "Just because it's big doesn't necessarily mean that it is out of touch with the needs of the poor," Berg says. His health system is involved with the Bakersfield basketball league, housing programs, job training and education.

"We've learned that of the basics of life, health care is not usually the highest priority."

In a more competitive marketplace, religious hospitals are forced to reexamine their role. In some places, such as New Orleans, managed-care networks have gobbled up so much of the market that religious hospitals have been squeezed out. In other areas, religious hospitals have survived by becoming more like their secular competitors.

"Religiously affiliated hospitals often have very nice flowery mission statements, but there is virtually no difference in the quality of care among patient populations," said Mel Hall, head of Press Gainey, the nation's largest patient surveying firm.

The demise of many religious hospitals has sparked concern over who will care for indigent patients. But Gunderson of the Carter Center believes that in markets where religious hospitals are "trapped by having to compete, it would be wise to sell out" and put the proceeds into an endowment for community-based services.

"Owners of religious hospitals may find that once they are freed from the constraints of running a hospital, they can focus on seeking the maximum health of the community and the poor," Gunderson says.

Many religious organizations are paying more attention to the leading causes of premature death: violence, especially involving guns, traffic accidents and family abuse, and substance abuse. "Few of these behaviors can be engaged by hospitals or medical professionals," Gunderson points out.

George Cohen/ImpactVisuals

Pediatric nurse's aide at Bellevue Hospital, N.Y.C.

"Parish nurse" programs often are aimed at behavioral health risks. More than 6,000 parish nurses nationwide work in disease screening, smoking, weight loss, well-baby care and immunization. Hospitals and congregations often share the costs.

In some communities, including low-income areas of Atlanta, volunteers from congregations have become "health promoters" trained in basic disease screening and referral techniques.

To survive, religious hospitals must confront the needs not of sectarian congregations, but of the areas they serve. "It gets to the heart of what our mission is about," said Kathy Garbarino, a spokeswoman for Detroit's Mercy Hospital. "Scripture didn't define who you served, it defined how you served."

For any hospital to survive, it must treat patients more like human beings. Since the late 1980s, hospitals have been required to measure patient satisfaction for accreditation. In addition, managed care has flattened cost differences between hospitals and helped spur an emphasis on meeting customer needs.

"Hospitals can no longer differentiate themselves by cost, so they distinguish themselves by quality of care. Said Hall of Press Gainey. "You can gain competitive advantage by being able to demonstrate quality of care."

Satisfied patients are more likely to comply with instructions and to take responsibility for their own care. They also are more likely to recommend their caregiver to others, so hospital officials now pay close attention to patient surveys. Some hospitals are tying bonuses and merit raises for nurses, physician assistants and department managers to scores they get on satisfaction surveys. Soon even the pay of physicians could be affected by patient feedback.

In response to surveys, some hospitals have changed meal delivery to keep hot foods hot and cold foods colder. Others have adopted standards on how quickly nurses must respond to call buttons. At Holy Cross Hospital in Chicago, employees get to take more responsibility for patient care.

It's still unclear what kind of hospitals will emerge if what patients say, rather than their ability to pay, becomes a driving force. But hospitals can't afford to keep doing business the old way. TW

Touching into the beast: unionizing hospitals

by Camille Colatosti

"Right now, the health care industry is going through massive restructuring," says David Rodich, director of the local union organizing department of the Service Employees Industrial Union, the largest union of hospital workers in the country, representing over 300,000 health care employees. "A lot of corporations have moved into the health care field, displacing non-profit hospitals. Hospitals want to cut costs at any cost. They reduce staffing and overload workers. They assign nurses additional patients. They move patients out as quickly as possible. On the west coast, in some hospitals, women are having babies and checking out the same day."

The change in hospital management is motivated partly by shifts in health insurance to manged care programs. The payer is in charge, not the patient and not the doctor. Both public and private insurers limit the amount of money a hospital can receive for care.

Insurance companies no longer reimburse hospitals for each service they provide. Instead, hospitals are paid a set fee per patient.

The result is increased pressure to reduce costs by cutting workers. A *Modern Healthcare Magazine* survey found that 36 percent of hospital executives intend to reduce their total staffs in 1996. At the same time, there is an effort to replace licensed workers with lower paid staff. Particularly hard hit are nurses. According to a 1994 American Nurses Association survey, more than 66 percent of hospitals across the country had laid off nurses or were going to. At the same time, 45 percent of hospitals said that they were increasing their use of unlicensed assistant personnel. Not unexpectedly, staffing affects quality of care.

Helen Cyrulik, organizing director for the 3,400-member Buffalo-based organization Nurses United, affiliated with the Communications Workers of America (CWA) Local 1168, notes the changes she has seen in nursing during her 14-year career.

"Years ago, in the early 1980s, patients came to the hospital the night before an operation. Nurses would visit patients, telling them what they would experience the next day. We would answer questions for them and their families. Now both patients and nurses feel like we're on an assembly line: getting everything done as quickly as possible and seeing as many people as possible.

> *"Now nurses feel like we're on an assembly line: getting everything done as quickly as possible I don't have time to allay patients' fears."*
>
> *— Helen Cyrulik*

"I spend my time running around, getting patients ready. I don't have time to allay their fears. Then they go home after the procedure. I don't really talk to them."

Richard Sanders, a consultant for unions, explains that while the hospital industry says it cares about patients, it really doesn't. "The interest is in cost efficiency. Private, for-profit hospitals are increasing and bringing ideas into private non-profit hospitals and public hospitals. The differences between profit and non-profit hospitals have been narrowing for years — but may be obliterated now."

Sanders, who led a union organizing drive at the largest hospital in Rhode Island in 1993, argues that the hospital industry is essentially unregulated. "Hospitals now face far fewer regulations at the state level than ever before. In fact, the people who are deciding on how to restructure are the people doing the restructuring."

As hospitals deregulate, competition increases. Smaller, non-profit hospitals are being absorbed into larger, often for-profit hospitals and hospital systems. There are fewer and larger hospital owners than ever before. The large owners demand bulk discounts from suppliers; they win large contracts with health insurance companies and overwhelm the competition. Columbia Healthcare Corporation and HCA Hospitall Corporation of America, for example, is the nation's largest for-profit hospital chain. In 1988, Columbia/HCA owned 22 hospitals. By 1994, it owned 195 hospitals. It expects to own more than 400 hospitals by 1999. Sometimes Columbia buys hospitals simply to eliminate competition. The company has spent about $100 million acquiring facilities that it promptly closed.

Effect on workers

Restructuring has left the nation's 3.8 million hospital workers insecure. Nurses fear elimination. Janitorial, dietary and laundry workers worry that their jobs will be contracted out to an independent firm.

Camille Colatosti teaches English at the Detroit College of Business.

"Workers have been offered no role in figuring out restructuring," says Rodich. "Hospital administrators make changes and workers have to go along or lose their jobs. Many workers now see that organizing into unions is really their only way to win a seat at the table."

While the percentage of hospital workers who are unionized is very small — only 15 percent of nurses are organized, for example — Rodich believes that the pace of organizing is picking up. "Workers are coming to us because they view collective bargaining as the only real vehicle they have to get a stake."

The SEIU recently won collective bargaining status at St. Bernard's Hospital in Chicago. Over 300 employers voted to join the union. "This is the first privately owned hospital that has been organized in the Chicago market in a number of years," says Rodich, "and it suggests that new organizing will develop. We had lost an election there a number of years ago, but fear of not being protected by collective bargaining outweighed fear of the employer."

Helen Cyrulik of Nurses United agrees. "Many employees have been afraid that if they join a union, or think about joining a union, the employer will retaliate against them. But fear of losing their jobs is replacing fear of employers."

In March 1996, Nurses United won their first organizing victory in two years. Nurses, technicians, social workers and dieticians at Renal Care of Buffalo, Inc., a dialysis center, voted to join the union.

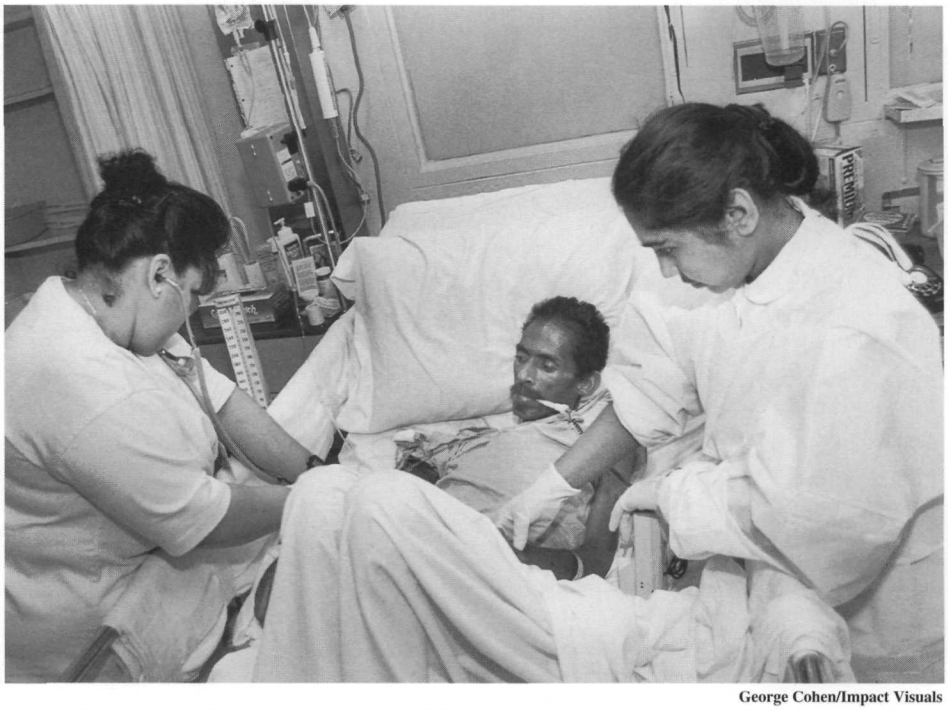
Changes in National Labor Relations Board regulations regarding health care workers have benefitted unions. In 1989, the NLRB determined that unions may divide hospital workers into eight different employee units: registered nurses; physicians; other professionals; technical employees; skilled maintenance employees; business office and clerical employees; guards; and other nonprofessional employees.

Hospital administrators opposed this ruling, fearing that it would make it easier than ever for unions to win elections. For the smaller and more homogenous a unit, the greater a union's chances of success. But there are few victories. The intense resistance to unions on the part of employers still makes organizing difficult. Rodich believes that "the employers we face today are some of the wealthiest and greediest in America. They have massive resources to fight us."

Linda Lash, coordinator of the Organizing Technical Office and Professional Department of the United Auto Workers, agrees. "The hospitals have a tremendous amount of money and will spend whatever it takes to beat the union. The National Labor Relations Act is weak. Companies hire anti-union consultants. In the 30s, we called them company goons. They busted people's heads and shot them. Now they play psychological games. Goons make it clear to hospitals that it is okay to break the law, to lay people off, fire them, if they support the union. While these tactics are illegal, even if the board issues charges against the hospital, all the company has to do is post a notice. There is no fine. Companies can break the law again and again."

So what motivates hospital workers to risk their employer's anger and join a union? Unionized health care workers earn 10 to 15 percent more than non-union workers. But far more important than winning wages is workers' desire to have a say over their employment. Unions reduce management's ability to make unilateral changes in wages, hours and working conditions.

Hospital workers are concerned about the same things that all employees worry about: "how decisions get made," says union consultant Richard Sanders. While he agrees with Lash and Rodich that employers have been vicious in their anti-union campaigns, he also believes that unions have not always focused on what



George Cohen/Impact Visuals

Medical surgical technician and nurse's aide care for tuberculosis patient.

matters most to workers. He explains, "Hospital workers aren't necessarily convinced that a unionized hospital means having a say — being an equal partner — in staffing, training, information."

Sanders led a successful campaign to organize the more than 3,000 workers at Rhode Island Hospital in Providence, in 1993.

"This was an important victory because Rhode Island Hospital is the largest in the state and will shape how the hospital industry looks there. It was also important," Sanders adds, "because there have been few victories of this size in the last 10 years. Finally, it showed that we have the ability to develop a strategic vision and plan to counter management's vision and plan.

"We won by building a large representative organizing committee. We identified early on the leaders in every area and department, people who had earned the trust and respect of their co-workers, people who work hard, who have good ideas, who are committed to their jobs. We tapped into workers' desire for change and personal and professional leadership. We trained them in union organizing but they organized their co-workers and developed the vision about their profession. They led the campaign. They are the leaders now."

Sanders is hopeful that unions will begin organizing on a much larger scale than they have before. In October 1995, the American Federation of Labor — Congress of Industrial Organizations (AFL-CIO), the country's largest labor federation, faced its first contested election in its 40-year history, and voted in new officers. New AFL-CIO President John Sweeney, formerly president of the SEIU, promises to rebuild the strength of American unions by investing $20 million in organizing. The federation is establishing joint strategic campaigns to organize a particular region of the country.

Organizers foresee greater cooperation than ever before among the many different unions that organize health care workers. The largest of these are the Service Employees International Union, Local 1199, and the American Nurses Association. Other unions representing health care workers include the United Auto Workers, the Communications Workers of America, the International Brotherhood of Teamsters, and the United Food and Commercial Workers Union. The SEIU and the Hotel Employees and Restaurant Employees Union (HERE), for example, are working together to organize the health care industry, and the casino and hotel industries, in Las Vegas.

As Sanders says, "Only by organizing workers in a whole region, will we be able to deal with corporate restructuring. This is true in the hospital industry and really in every industry. Union building is not about tapping into anger and frustration. It's about building a democratic, powerful partnership between all the people in a community." TW

Death penalty anniversary

The U.S. Supreme Court reinstated the death penalty 20 years ago (Gregg vs. Georgia, 7/2/76). To mark this occasion, the Abolitionist Action Committee is inviting concerned citizens to join them for their annual four-day fast and vigil in front of the U. S. Supreme Court building in Washington D.C. A program will be held from 10 p.m., until midnight on Friday, June 28. A dawn til dusk vigil and protest will follow on June 29. On Tuesday, July 2, the anniversary date of reinstatement, there will be a 24-hour presence from midnight to midnight. Fasting is not necessary for participation. Marietta Jaeger, anti-death penalty activist and circulation coordinator at *The Witness* will be there. For more information, please call her at 313-841-0544 or Rick at 214-768-3284 days.

New Party victory

The Eighth Circuit Court of Appeals has ruled that multiparty fusion voting is not unconstitutional. Once legal, fusion has been banned in 40 states. Fusion, or cross-endorsement, allows candidates to run simultaneously on several ballot lines, encouraging small parties to pool their efforts. For example, if fusion were legal in California, Ralph Nader could run as the candidate of the Green Party as well as for the Peace and Freedom Party, the Natural Law party and even Ross Perot's party, if they wanted Nader as their candidate. [See *The Witness* issue on the New Party, 11/95.]

Third force, May/June, 1996

Detroit newspaper strike: NLRB probes *The Witness*

More than 250 people have been arrested outside the offices of the *Detroit News* and the *Detroit Free Press* while protesting Gannett and Knight Ridder's ten-month failure to negotiate a contract for their unionized workers.

Four city council members, five Wayne County Commissioners, a state legislator and candidate for the U.S. Senate have been arrested during Readers United's protests, as well as lawyers, nurses, union local presidents, youth advocates, bishops, nuns and Baptist pastors.

In April, the National Labor Relations Board (NLRB) made inquiry into *The Witness* magazine and Readers United in an effort to determine whether either was "an agent of the striking unions." Bishop Stewart Wood and six others went with Jeanie Wylie-Kellermann to the NLRB to express their outrage at the implications.

short takes

Advocating patients' rights

Patients' rights advocate Ellen Greenlaw, a woman in recovery from a severe auto accident three years ago, offers a variety of suggestions to people who may be facing hospital care.

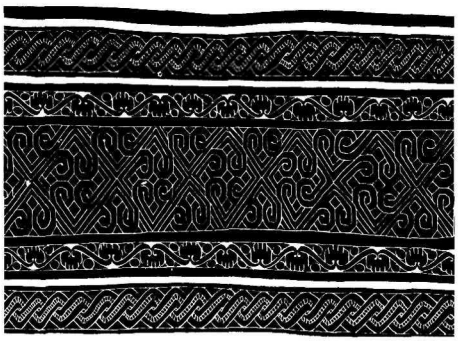
Have the attitude, "This is my body. I'll make the choices," whenever feasible. Ask questions. Make a list of what you want to discuss. You are in charge. Put out what you want. It may help to brainstorm questions and concerns with someone you trust. Don't assume that when you enter a hospital that you will be taken care of. You or your advocate may need to assert your basic needs, let alone preferences.

Medical staff duties tend to be fragmented, each covering a limited aspect of your needs. Educate yourself. Discover who does what and put together a package of providers to cover what you feel you need. Don't have unrealistic expectations regarding a particular individual's knowledge or skills. Shop around, whenever possible, for the best person to orchestrate your needs. For example, a diagnosis, or a type of surgery. Ask people whose judgment you trust for recommendations.

If you don't like the hospital staff assigned to you, ask for different people. Sometimes, however, a nurse can be a good advocate for what you want. After a serious accident, or diagnosis of major illness, you may want a therapist for emotional assistance. You can ask to see the hospital's social worker, and regardless of your religious affiliation, sometimes a clergy person can be helpful.

Greenlaw emphasizes that you don't have to allow resident doctors, other than your own, to examine you or interact with you. If you have doubts or don't understand your treatment, ask more questions. Make the decision to treat when you're ready. Request tests that indicate allergic reactions to dyes or chemicals used in diagnostic procedures before the process has begun.

Find out exactly what is to be gained from a procedure, including side effects, pain, clarification of your condition, and treatment recommendations. Ask beforehand about all possible reactions to any diagnostic medical procedures. Inquire



about alternative methods and painkillers. Ask what it means if you decline any procedures, so that you can carefully consider the benefits as well as the drawbacks, which will help you make an informed decision.

Sometimes the staff may not want to explain diagnostic tests or treatment procedures. Insist that they, or someone else, does. In our litigious society the medical community is very cognizant of lawsuits. This can be used as a tool. Unsurprisingly, the threat of a lawsuit may make your nurses or doctors take notice. Remember, it is legally considered assault if you receive a procedure or drug against your will. If you decide not to receive treatment, simply request that the practitioner write, "patient refuses procedure" on your chart, transferring the responsibility from the hospital to yourself.

It's helpful to get hospital permission to have your alternative health practitioner see you. More than likely, the hospital will not want this person to come in. However, you may be able to obtain permission if you sign a liability release form for the hospital discharging them from any legal responsibility regarding your alternative health worker's recommendations.

Ellen Greenlaw's general advice, for emergency care, is to let practitioners do their job. You will only be in an emergency room because you are in a life-threatening situation. If able, contact someone you want to be your advocate. Insist that this person stay with you whenever possible.

Carry identification on your person listing who to call in an emergency. Your instructions can include one or more people for your personal needs as well as medical support or advocate. It's wise to shop in advance of a catastrophe for a healthcare worker, skilled at interacting with doctors/practitioners, who knows your needs and preferences. Inform that advocate whom you want contacted as resource people, support, companions and visitors. The latter is especially important for people in same-sex relationships. Many hospitals will allow only "family members" (heterosexist definition) to visit patients, especially if they are in critical condition. You may arrange for someone to have medical power of attorney to make decisions for you, or be consulted by medical decision-makers if you are unconscious or mentally unable to communicate. Just as you cannot wait to die before writing a will, you shouldn't wait for serious illness to consider protection in advance of a medical disaster.

—Becca Harber is an herbal educator in Willseyville, N.Y. This article is adapted from WomenWise, *a quarterly publication of The Concord Feminist Health Center, 38 S. Main St., Concord, N.H. 03301; (603) 225-2739.*

'An acolyte in hell': working in the ER

by Maria West

When I walk into the emergency department at the start of my shift, it is like stepping onto the stage of a sacred drama, already in progress, where suffering gets too many lines and redemption is an understudy. There are bright lights, a cacophony of sound effects and choreography for rolling stretchers. I never know how the plot may turn out — so I approach my job with a Zen flexibility and engaged detachment.

But this particular day, I was stunned mute and motionless as the nurse, going off-duty and turning over to me the care of my first patient, described how the paramedics, who usually transport their patients with cheerful equanimity, were weeping when they brought Angela in.

Angela was found wedged between her car and an automatic teller machine in a neighborhood riddled with gang violence, with one gunshot wound to the side of her face. She was transported rapidly by ambulance from the bank to the emergency department's resuscitation room. There, the trauma team worked on her aggressively: inserting a breathing tube through her mouth to her lungs and attaching the tube to a mechanical respirator; placing an IV line into a large vein in each of her arms; collecting blood specimens; taking X-rays and CAT scans of her head and face. But all the test results only confirm what the paramedics saw when they lifted her eyelids and waved a penlight back and forth in front of her eyes: the damage was lethal and irreversible. The neurology team was paged to begin the process of declaring Angela brain-dead.

After her first nurse completes her report to me, Angela is brought to the critical care area of the Emergency department, next door to the resuscitation room, and it is here that I assume her care. Because the initial attempt to save her life was so intense, she lies on a stretcher undressed and smeared with blood. The sheet that covers her up to her shoulders is littered with empty paper and plastic wrappers, tongue depressors and alcohol swabs. I take her vital signs and check the placement and function of every line, tube and wire connecting Angela to life support. I make a few notes in her chart. Then I run some warm water into a basin to bathe her.

A man rushes through the door, screaming for Angela. He stands, then kneels beside her stretcher, moaning. Only the beeping of the heart monitor answers. The man stands and faces the nurses, aides and security guards now gathered in the room. I try to think of how to say that Angela is mortally wounded. The man speaks first.

"She's not going to make it."

I want to apologize to the man for not having been able to clean and dress her before he arrived. The man, who identifies himself as Angela's husband, takes the basin of water from my hands, asks for some towels and begins to wipe her bruised, swollen face. The pink, sudsy water smells of antiseptic soap. It deepens in color as he sponges her hair. I hand him basins of clean water and piles of fresh towels, and continue to check her pulse and blood pressure, adjust her IVs and trouble-shoot the life-support machinery. Together we remove the torn clothing from beneath her, and place her in a blue and white print hospital gown, carefully threading the IV bags and tubing attached to her arms through the sleeves. We tie the gown at the back of the neck and secure the plastic coil that connects her breathing tube to the respirator. We change the linen under and over her, and place an absorbent pad under her head. As we work, I explain how each piece of equipment is taking over the work of her injured brain: airway control, breathing, circulation. Then he starts to tell me about her.

She was pregnant. She was planning for her young son's birthday party. She struggled financially but had a strong web of family members, people who would now have to decide whether to withdraw life support and whether to donate her organs. People who would have to live with the knowledge that Angela's assailants were children no older than her own.

The poor, including guests of the soup kitchens and shelters whom I have known, can best help me develop into the kind of nurse I want to become.

My experience with Angela and her family is distinct for me because during that long vigil, I felt suffocated by the horror of another random and meaningless murder. My role was of an acolyte in hell, sponging Angela's face clean of the blood and offering her family small sacramentals

Maria West is an emergency room nurse and freelance writer in Detroit. Photographer **Rebecca Cook** is on strike from the Detroit Newspapers.

— coffee, the telephone, Kleenex, privacy.

Sometimes I am amazed to find myself working in the ER, yet for five years it has been where I belong. I never pretended to be a nurse when I was a child and I wasn't a candy-striper in high school. I did work for four summers as a nurses's aide at a place with the unhappy name of the Washington Home for Incurables. But not even then did I imagine I would become a nurse.

The truth is that the person who led me into nursing school was a young man who has worn the same faded jeans, plaid shirt, toothless grin and sunglasses every time I have seen him for 15 years. Ron lives on a small disability check. He is a regular guest/volunteer at the Catholic Worker soup kitchen and a patient at Cabrini Clinic, a small, parish-based free medical clinic where I helped out, first as a clerical assistant to the manager, then as the manager. I was the keeper of the keys, the coffee and schedule maker for the volunteer doctor and nurses. I delivered blood specimens to a volunteer medical lab and sorted tons of donated drug samples. But to Ron, I was a woman in a medical facility and that made me a nurse.

One summer evening, Ron appeared at my home and asked me to examine his foot. He said he had stepped on a nail, which had penetrated his worn tennis shoe and punctured the sole of his foot. He knelt on one knee on the porch and began to unlace his shoe, over my protests.

"You need to see a doctor and get a tetanus booster," I advised.

"I want a nurse," he replied.

"I am not a nurse."

Ron put his bare foot up, for emphasis.

"But you are my nurse," he insisted.

It occurred to me then that what I really wanted, was to take care of people like Ron — complex, likable people, with really lousy health habits and a haphazard approach to health care.

A year later I was in nursing school.

It would be untrue to say that I breezed through my nursing studies. But I enjoyed the clinical rotations. I intentionally chose placements at hospitals in the urban core of Detroit, places that typically serve the poor. I dreaded dissecting human cadavers and typing papers, but neither proved a major problem.

After a brief stint of medical-surgical nursing, I went to work in the emergency department of one of the hospitals in the city's medical center and have spent the last five years as an emergency-trauma nurse. The choice was a deliberate one. This is the setting where most of the poor, including guests of the soup kitchens and shelters whom I have known, get their health care. I believe that they, who led me into nursing, can best help me develop into the kind of nurse I want to become. I have not yet been disappointed. Hardly a work week goes by that there isn't a reunion. As one man from the soupline stated, "Whoever thought that when I saw you again it would be in this horizontal environment?"

And where else could one touch as many of the wounds that prostrate the wounded and healer both: gang wars, handgun violence, car jackings, domestic abuse, AIDS. In the emergency department these are not headlines, but faces, arranged in rows like flowerbeds.

Nursing is both high tech and high touch. The irony is that my hands sometimes hurt on the way to easing someone's pain. Inflicting pain by drawing blood or giving an injection is one of the unavoidable and difficult parts of the job I do.

Maria West at work in a Detroit emergency room. Rebecca Cook

What I say is as important as what I do and I never say, "This won't hurt a bit," especially if I'm holding a sharp object.

I try to make words instruments of healing, by addressing and referring to a patient by given name, not symptom or diagnosis. By giving the patient my name and by giving the patient the names for things in the alien world of medicine.

The hospital where I work is typical of urban trauma centers: unpredictable, almost overwhelming. It is like life-sized, high-stakes speed chess. Every move you make for a patient, whether it's a medication, a test or a procedure, has the potential for good or the risk of harm, so that I am always thinking several moves ahead,

Overusing the ER

by Julie Wortman

Today's cost-conscious hospital administrators repeatedly point out that if more low-income people focussed on preventing or mitigating health care problems before they develop — by routinely visiting a facility where they can get pelvic exams, blood pressure readings, AIDS/HIV tests, mammograms, cholesterol readings and advice on how to practice safe sex — the financial drain on hospital resources, especially in terms of emergency-room care, would be significantly decreased.

As it is, for a huge percentage of under-insured people, an emergency-room visit is often the only sort of health care treatment they seek.

According to Cassandra Jackson, Michigan Public Health Institute's (MPHI) program director for public health practice, people who fall into this category don't make use of public health facilities because of what she calls "institutional barriers."

"We've found that for this population the primary barrier to accessing health care is the complexity of their lives," Jackson said, referring to a recently completed MPHI-sponsored study that focussed on the non-financial barriers to securing health care faced by low- or no-income people at 14 different public health agencies in both urban and rural areas. "Low-income people have so many needs that are difficult to get met that health care gets pushed to the bottom of the list. For them to pursue preventative health care, the health care facility must be geared to the realities of their lives."

But most institutions that provide public health care, Jackson said, see the client, not the institution, as the problem.

"Some clinics have the attitude, 'How *dare* these people not keep their appointments?' or 'How *dare* these people not come back for follow-up?' But the clinic itself might be open only during the day or might be open only one night a week or might be located in an inaccessible part of town." Prospective clients with poor reading and writing skills often feel overwhelmed by the number of forms they must complete when they come for an appointment, Jackson said.

"And for women the child care issue is very important, especially for women over 20. They'll neglect their own health care if necessary. If you can't bring your five kids to the clinic because there is no child care, you won't come."

Jackson said people will also avoid using a facility if they feel they are not understood or respected — or accorded a degree of privacy.

"One Planned Parenthood clinic in the study is located in a depressed area of town where low-income clients can get to it easily," Jackson pointed out. "That's a positive thing, but you walk in the door and you are immediately faced with bullet-proof glass barriers between you and the receptionist. You have to shout your business. Who wants to shout out that you're there for an AIDS test?"

Jackson also told the story of a Detroit woman suffering from hypertension who would not take her medication. "Her doctor didn't want to hear why. But the medication made frequent potty stops necessary and she had to take the bus — using two transfers — to get to work. In Detroit most doctors drive to work. They have no idea what commuting by bus can be like."

One of the problems the MPHI researchers encountered in rural Euro-American communities stemmed from a relatively high incidence of incest.

"The people exhibited a real aversion to any discussion of sex," Jackson said. This, combined with the community's strong anti-government bias, has kept a lot of people from seeking health services.

"The young girls are the big victims," Jackson said. "They don't know how to protect themselves."

The MPHI study also surfaced many problems associated with health care services directed at non-European ethnic groups.

"We found that Native Americans were basically invisible in the health care system," Jackson said. "Providers did not see native peoples as having a distinct culture and history" that influenced their health practices. Likewise, Arab Muslim women were inclined to avoid health clinics that were not staffed by women.

Jackson hopes the MPHI study will help government-funded health providers rethink some of their approaches to health care aimed at historically under-served populations. But she worries that preventative education and health promotion activities will be lost as agencies focus on cost containment.

"Health care is becoming more institutionally-based rather than community-based," she said. "This is a trend away from what people are saying they need. Institutions that want to be community-oriented still don't understand how to access the population in need."

Julie Wortman is managing editor of *The Witness.*

with a mental flowchart.

If I give an ordered dose of morphine into a patient's IV it could relieve his pain. It could make him nauseated. It could interfere with normal breathing patterns. For each possibility there is an appropriate response which has its own set of potential risks and benefits and sets the whole process in motion again. I give the morphine very slowly, watching his face, listening to his moans, counting his respirations, feeling the grip of his hand in mine and waiting for him to let me know what to do next.

It's unclear to me how long I'll continue to work in the ER. So far, it has been the most challenging and satisfying work I can imagine. But the American health care system is in the process of a rapid, radical overhaul. Providing uncompensated primary care in the ER to poor people like Ron is less feasible in an era of price controls and managed care. Fewer hospitals are willing to do it. County hospitals are closing. Suburban uninsured patients report being put in taxicabs by their local hospitals and instructed to seek care in the city. Providing the highest level of trauma care to critically injured patients like Angela is expensive and under close scrutiny by insurance companies and legislators. Where patients like Ron and Angela will get their care after the smoke of health care reform clears is uncertain. The role of a registered nurse is also changing, away from direct patient care and towards the management of patient care by others.

I may return to school to become a nurse practitioner so that I can help staff a street clinic since that seems to me to be the direction health care for low-income folks is going. I listen to the winds of change in health care feeling much as I do when I hear the rise and fall of an ambulance siren: tense and confident. The outcome isn't clear, but I will wait, watch and follow.

Community supports own hospital

Bucking the trend, a small community in Vermont has established and supported its own hospital, raising money through bake sales to ensure personalized care.

Grace Cottage is Vermont's only hospital with its own 24-hour ambulance service, which is staffed completely by volunteers.

"I believe that community support is so strong because we provide for the community whether we can afford to or not," says Director of Operations Effie Chamberlin, who has worked at the hospital for 34 years.

"We're very efficient, and we're very parsimonious with our resources," says Robert Backus, a physician who has been at Grace Cottage full-time since 1980. Unlike the physicians at most hospitals, Backus and the other three family practitioners at Grace Cottage often take their own X-rays and EKGs, run their own lab work, and drive the ambulance without any extra charge to the patient or community. They also donate their on-call hours in the emergency room.

Community volunteers act as hospital receptionists and couriers. Walter Meyer, who formerly drove the ambulance, parks cars at a flea market in nearby Newfane on Sundays during the summer. In place of a parking fee, he accepts donations to Grace Cottage, raising $1,000 per day. Local farms frequently donate tomatoes, cabbage, lettuce, and other produce to the old-fashioned hospital kitchen.

To keep operating expenses down, CEO Al LaRochelle continually fights state and federal regulations which, he says, are usually designed for larger institutions. Recently, he won the battle over an expensive ventilation hood that the state claimed was necessary to vent fumes from chemicals used in chemotherapy and cytology preparation. Neither of these procedures is performed at Grace Cottage. LaRochelle lost the battle, however, over a $40,000 elevator to access the new administrative offices.

Diversification has been a key ingredient in the success of Grace Cottage, which boasts the lowest cost per patient stay of any Vermont hospital. The new Wolff building, constructed with money from Campaign '90, has freed up space for profitable, outpatient services such as orthopedics, urology, chiropractics, and podiatry, which help to compensate for operating losses due to inadequate reimbursement. These particular services were chosen because of the community's response to Leigh's mailed survey.

Many people worry that renovations will destroy some of the hospital's charm. As it stands now, Grace Cottage still features a wallpapered lobby that evokes the comfort of a living room. The hallways have sloping floors and stenciled walls. Country curtains, made by volunteers, adorn the windows in patients' rooms. A sunporch looks out on a green lawn bordered by begonias.

"Structurally, I think there's going to have to be some changes in order to comply and meet all the needs and regulations, but I don't believe it's going to lose its personal aspect," Effie Chamberlin says. "That's not only what attracts people here for care, it's what attracts our family practice physicians."

— Kathleen Koman is a freelance writer who lives in Winchester, Mass. This article is adapted from a longer piece in HOPE. To subscribe, send $24.95 to PO Box, Brooklin, ME 04616; 800-513-0869.

Grace and the frog

by Robert Hirschfield

"The frog is cooking," Grace tells me. She says so matter-of-factly, and I nod and say nothing. The frog is the reason I'm at work so early, the reason Grace is sitting on her stoop across from the Projects waiting for me.

"The car will be here in a half hour to pick us up," I tell her.

"The car?" Grace's empty brown jaws orbit furiously around her cigarette. She is trying to take in what this means. A car once glided up to her and a policeman got out with his gun drawn. Grace was sharpening a steak knife on the curb. The super from her building rushed out and breathlessly vouched for her. The policeman uncorked a staticky lecture about menacing behaviour and holstered his gun.

"The car to Beth Israel," I say, "to see the frog specialist."

"Oh," she says, "the frog specialist."

Grace has been to Beth Israel before. The biopsy doctor stuck three long needles into her, and Grace was told she had cancer. She decided the place was evil. For a time, she would not even tolerate the mention of his name. But finally, owing to the endless sweet nagging of her case manager, she agreed to return one last time to Beth Israel to have her decaying breast poked and contemplated.

"I don't want them carving me up," she says. "That's crazy."

This expedition is to seek an alternative to carving. Grace has the idea that only in Nova Scotia is there a cure for her cancer. She cannot say why. But Nova Scotia is her heart's mythical healing land beyond the surgeon's knife.

Dierdre Luzwick

The 66-year-old woman lives in a 45-unit SRO near the East River in Manhattan run by a not-for-profit agency that houses the mentally ill. She lurches through the halls in baggy sweatshirts, arthritic, wrapped in the protective bubble of her own space.

Prior to this SRO, Grace lived in an apartment in the Bronx from which crack users banished her. Occasionally, she will reveal snippets of her history. She tells of the death of her mother in her infancy in Florida, of having five babies yanked from her by midwives, of being driven from her sister's home because she smoked, of being hounded by the government which smuggled Spencer the Frog inside her breast.

The car comes, and Grace rubs her back against the upholstery and smiles broadly. Luxury!

In a few minutes we're at Beth Israel. The new oncology clinic dazzles inappropriately. It is tiny. Even at this early hour, there is much gnashing together of elbows. Grace sits with her knees, elbows and face all flying in the direction of the door.

She begins looking for a cigarette. I say, "Not here." Nicotine is her angel.

I once asked her, "Grace, is there anything you love more than cigarettes?"

She said, "Egg nog."

Her name is called, and Dr. S, a young Jewish doctor with tiny, benign eyes waves her enthusiastically into his office. I take him aside for a hasty consultation. The word cancer is not to be mentioned, or Grace will bolt. The operative word is frog. Dr. S is agreeable. He tells Grace to sit down on the ominous diagnostic table not unlike a diving board.

He begins reading distractedly from her chart: "Arthritis, schizophrenia, high blood pressure ..." He could be reciting the items he's packed for a trip.

"Now let's see what kind of a frog this is," Dr. S says.

The broad spotted mass has eaten into her left nipple and spread beyond it. The doctor probes and measures it. Grace stares hard at the white wall. She'd like to disappear into it. She is unnerved by the sober travelling of the doctor's fingers.

"Do you mind if I smoke?" she asks at one point in the procedure.

Robert Hirschfield lives in New York City. Artist **Dierdre Luzwick** lives in Cambridge, Wis.

"Not at all," Dr. S replies. "Just wait till I am gone, so I won't lose my job."

Sometimes, in the afternoon, Grace will camp beneath the medicine cabinet in the case managers' office, and wait to be served her Haldol and Cogentin along with her cup of Great Bear water. If she is in the mood, she will tell one of her long tales that no one can understand because she has no teeth, and because the words tend to skip haphazardly on the fractured loom of her memory. When she is finished, she may punctuate her tale with a high-stepping cackle that stops the chattering of the office computers and makes heads turn. Grace's cackle sounds like it comes from the depth of the earth, only streamered with joy.

Her humor can also be sly. One afternoon, a case manager was lost in feverish political discourse. Grace wordlessly turned to him and offered him her medication.

Dr. M, Dr. S's superior, joins us, and Grace presents her breast for re-examination like a school girl obediently opening a book for a teacher.

"Any pain?" Dr. M asks.

"Sometimes I feel he's gonna eat the veins, the heart and all."

Coached like his partner to avoid the C word, Dr. M rolls his eyes portentously, as if all this talk of Grace's frog is going to land him in a straitjacket.

"Grace," he says finally, "we may be able to help you shrink the frog. We can shine lights in the frog's eyes to make it smaller. It will hurt the frog, but it won't hurt you."

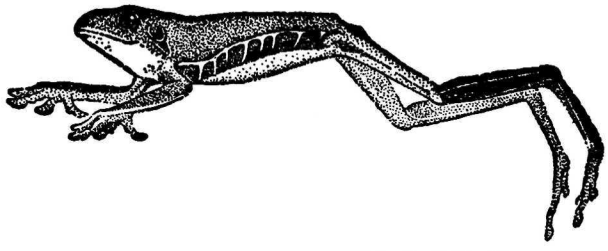
Grace is pleased. She is clearly terrified of these men and the power of their words, and is willing to accept as positive any verdict short of outright annihilation.

We are told to go across the street to Radiology and see Dr. K. Grace will not go until she's smoked two cigarettes.

Climbing down the two flights of stairs to Radiology, Grace remembers something.

"Next month, I got to go back for a scalp treatment." Her hair is snow white and quite woolly. "They get me sitting up there cooking, burning like fire."

In Radiology, dim as a crypt, Grace takes a seat next to a dark-haired young woman holding a briefcase. She sighs



Vivian Day/Rubber Stamps of America

ever so slightly when her name is called. She folds her *New York Times* with slow white hands, as though she'd like to drag the crease beyond this moment and this place.

"I'm just a frame," Grace mutters. It's a word I've never heard from her before.

"What's inside the frame?" I ask.

"Bones?"

"Nothing else?"

"That's all."

I think surely there must be a spirit burrowing through her like an inspired mole. I ask her what she thinks. She just laughs. She brings up Jesus who she says hangs out in the little Spanish restaurant where she goes for her coffee.

"Sometimes he speaks to me," she states simply, "and sometimes he don't."

A nurse comes and takes Grace to a cubicle where she navigates for her the slit and loops of her gown.

Finally, Dr. K appears with his round, friendly belly. He and another doctor immediately interest themselves in the frog's diameter.

The two men disappear for consultation. We are left alone amidst the white walls, jars, screens and sudden silence. Grace disappears inside herself. I am reminded of an endangered forest creature seeking the shelter of familiar shadows.

Dr. K returns with information about what radiation would entail.

"It's a five week course, five days a week. You would have to lay still during the treatments."

Grace listens hard. The slight easing of the bones in her face indicates she is receptive. She says nothing. She is not asked to say anything.

Dr. K motions me into the next room. He is having second thoughts. Grace's cancerous mass is too massive. Radiation won't do. He recommends surgery.

But what about Dr. M? I stammer. He probed the same mass, endorsed radiation. Dr. K won't respond. He is like a priest who refuses to be lured into schismatic debate. He writes down the phone number of the head surgeon at the surgery clinic.

"Grace does not want surgery," I say.

"She is not mentally competent," he answers. He is a busy man. He wastes no time playing his trump card.

"Grace," the doctor says finally, "we may be able to help you shrink the frog. We can shine lights in the frog's eyes to make it smaller. It will hurt the frog, but it won't hurt you."

I take Grace and we go. She suspects something is wrong. I don't tell her. I don't know how to tell her. She is kind, and doesn't ask me to tell her.

She is hungry. I buy us each a banana from a street vendor.

Grace steps out of the wind to light another cigarette. She takes a long drag. This new moment is without frogs. TW

The powers in hospital ministry

by Bill Wylie-Kellermann

Who shall separate us from the love of Christ? Shall tribulation, or distress, or persecution, or famine or nakedness, or sword? As it is written: 'For thy sake we are being killed all the day long; we are led as sheep to be slaughtered.' No, in all these things we are more than conquerors through the one who loved us. For I am sure that neither death, nor life, nor angels, nor principalities, nor things present, nor things to come, nor powers, nor height, nor depth, nor anything else in all creation can separate us from the love of God in Christ Jesus our Lord.

— Romans 8:35-39

How many times have pastors read this passage at a hospital bedside where the extremities of pain and fear and death hover. Here is compressed a confession of faith which serves in those moments as the preeminent word of pastoral care. Yet it's only in recent years that I've been struck over and over, how this practice actually names the principalities and powers (not to mention their main methods of operation) in a personal and presumably private word of comfort.

The implications are great for pastoral theology. The standard formula of pastoral care is altered. Instead of a schema in which the relationship of the pastor (or the pastoral community) to the person is featured as nurturing an uninterrupted relationship with God, we get a picture in which additional forces, visible and invisible are at work. Any pastoral work which is oblivious to these forces, is at best hampered in the work of nurturing whole personhood, and at worst may end up serving systems, structures and spirits that intervene designing to separate us from the love of God.

For example, in the hospital room, it is astonishing how many illnesses are actually attributable to the powers. Cancers and birth defects, allergies and immune deficiencies which are the assault of toxins loosed upon our bodies and earth. Addictions fostered in cold calculation by the powers of commercial greed. Corporate stress rupturing hearts. The hurry-up indifference to hazards of the workplace. All the grinding and chronic ailments of poverty. The epidemic of gunshot wounds pouring in the emergency room door which can be traced back to the shipping docks of the domestic armaments industry. Hell, the economics of the insurance industry and government policy turning certain people away, gradually or finally, at those hospital doors. And this is just to name a few. Tribulation, distress, persecution, famine and sword — we are led like lambs to be slaughtered.

Florence Nightingale is reported to have quipped, "I may not know what a hospital is for, but I'm pretty sure it isn't the spread of disease."

The pastoral effort is modified if an illness may be understood not merely as the tragedy of happenstance, but as the assault of the principalities. Hospitals are probably the buildings in which the most prayer is uttered per square foot. But is it prayer that takes into account the work of the powers, creating a space for freedom and seeking to break their binding grip? Intercessions in this pastoral theology take on a new focus and fuse necessarily with advocacy or resistance. This is to say we are not mere passive victims in relation to the principalities. In so many instances — violence, stress, or addiction — we are complicit in our own bondage. We co-operate in our own crippling ailments. Pastoral ministry, witness the healing work of Jesus in the gospels, involves nurturing or affirming this renewed freedom in the victims: Take up your bed and walk.

A bridging analogy from the therapeutic community to this kind of pastoral theology may be found in the emergence of family systems theory. An addict, say, once treated in isolation as having an individual physical or psychological problem, has, by virtue of understanding co-dependency, come to be seen often holding a place in a dysfunctional family system. In such cases treatment apart from naming the pattern and addressing the whole family system is all but futile. In fact, as Anne Wilson Schaef has pointed out, the system is much larger than the family. The patterns and mechanisms of addiction are endemic to our culture — they are replicated and writ large in what she terms the Addictive System, a synonym for the cultural bondage in which so many of our illnesses occur.

All this means that pastoral work, in the hospital as elsewhere, relies heavily on discernment. As William Stringfellow aptly put it in *An Ethic for Christians and Other Aliens in a Strange Land:*

"This gift enables the people of God to distinguish and recognize, identify and expose, report and rebuke the power of

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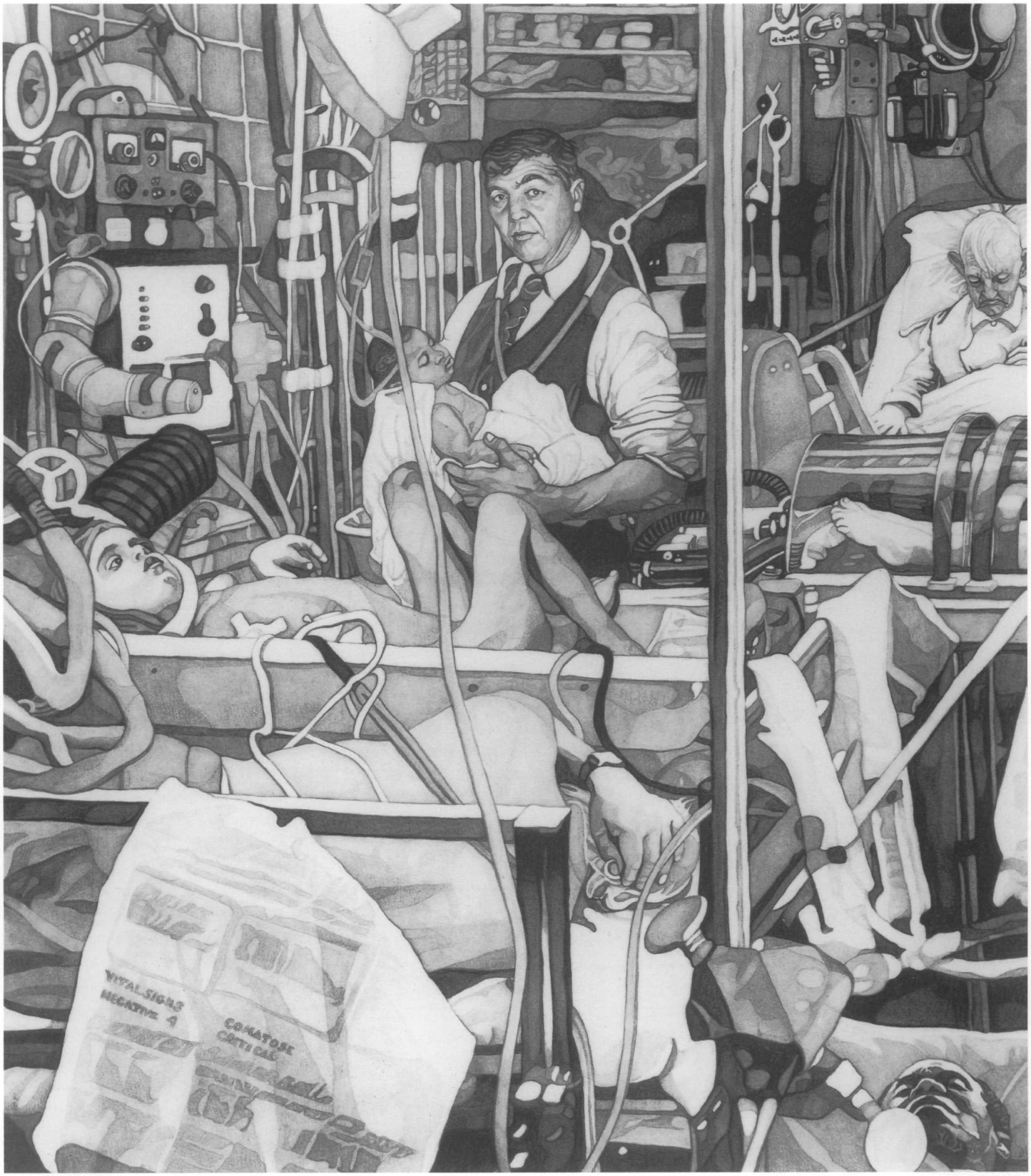
Bill Wylie-Kellermann teaches at the Whitaker School of Theology in Detroit. This article is adapted from a talk he's given to several Clinical Pastoral Education seminars. Artist **Dierdre Luzwick** lives in Cambridge, Wis.



Life supports

Dierdre Luzwick

death incarnate in ... institutions or other creatures. ... The discernment of spirits refers to the talent to recognize the Word of God in this world in principalities and persons despite the distortion of fallenness. ... This is the gift which exposes and rebukes idolatry. This is the gift which confounds and undoes blasphemy. Similar to the discernment of signs, the discernment of spirits is inherently political while in practice it has specifically to do with pastoral care, with healing, with the nurture of human life and with the fulfillment of all life."

It is no coincidence that Stringfellow, who may be credited with reviving the current interest in the principalities, hammered out his theology of the powers partly from a hospital bed. He had been prompted to explore this biblical understanding first by the people of the ghetto with whom he lived and worked. The way they spoke of the police, the mafia, the social work bureaucracy, or absentee landlords as predatory beasts eating them alive pushed him toward the biblical texts. "In the wisdom of the people of the East Harlem neighborhood, such principalities are identified as demonic powers because of the relentless and ruthless dehumanization which they cause." But subsequently in the grip of dire illness, in his own experience of pain and even of commercialized medicine, he recognized the same forces at work. He described his experience of the 1960s in *The Christian Century* in this way:

"The decade locates me, at its outset, deeply in the midst of work as a white lawyer in Harlem, but it closes in fragile survival of prolonged, obstinate, desperate illness. It begins in social crisis, it ends in personal crisis. For me, these are equally profound *because* the aggression of death is the moral reality pervasive in both and, moveover, the grace to confront and transcend death is the same in each crisis. Indeed, I do not think the two episodes, which roughly mark personally the boundaries of the last decade, are essentially distinguishable."

The story of that illness is recounted in the second, and least known, volume of Stringfellow's autobiographical trilogy, called *A Second Birthday*. This book, if only for the theology of pain it articulates, ought to be a standard text in courses on pastoral ministry. It ought to be prominent, next to flowers and greeting cards, in hospital gift shops. When it names the powers, it includes the principalities of commercialized medicine. It names and exposes the hospital itself.

This is a key point for pastors, but even more for chaplains and for that matter any Christian working in the hospital system. In Stringfellow's thought the hospital must be regarded as a creature standing before the judgement of God with a life and integrity of its own, a living creature called to praise God and serve human life, but one whose vocation is distorted and confused in the fall.

This question of vocation is no small matter. It goes to the roots of creaturely identity. A hospital is called specifically to praise God and serve human life by ... what? Offering hospitality in an environment, spiritual and physical, of healing? Serving patients by nurturing their health and wholeness? It is equally important to comprehend the degree to which that vocation has been confused and forgotten in the fall.

Florence Nightingale is reported to have quipped, "I may not know what a hospital is for, but I'm pretty sure it isn't the spread of disease." The vocation of a hospital is distorted, often to demonic proportion, in a variety of ways. Certainly by the market mentality which puts profits before patients, seeing them virtually as servants of the hospital rather than vice versa. By the idolatrous inflation to which medicine, as a purveyor of life and death, is inherently subject. By turning the person from the subject to the object of care. By the rapid multiplication of

Working for change

People of faith who want to influence the current budget debate should let their congressional representatives know they oppose drastic cuts to Medicaid and Medicare,according to InterHealth, a Washington, D.C.-based "values-driven group that brings people together to share ideas and improve community health."

They should add that any anticipated savings achieved by cutting these entitlements should be used to maintain and expand services within the health and social service delivery systems to benefit the affected populations.

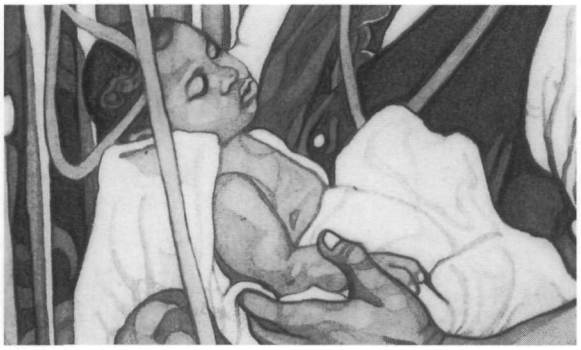
More than 30 million very low-income Americans depend on Medicaid to pay for their hospital care. Low-income elderly people depend on Medicare. But cutting Medicaid and Medicare has become a key element of current efforts to reduce the federal budget deficit.

Although some reforms to both programs may be warranted, InterHealth concedes, drastic cuts to either could be catastrophic because another 40 million Americans who do not qualify for Medicaid, but who cannot afford or qualify for medical insurance, are already looking to hospitals for charity care.

"It seems important for people to let their senators and representatives know that they don't want the budget balanced on the backs of those who have the least," said InterHealth staffer Brent Ewig. — *J.A.W.*

technology and technique in the practice of medicine. By the competitive anxiety concerning institutional survival which supplants any and every other purpose.

Anyone working in a hospital setting will be asked to serve these distorted purposes, which Stringfellow saw in league with death itself. Who, for example, does the chaplain serve? Is his purpose to be alert to ethical issues, intervening mainly to prevent the hospital from being sued? Or does she intercede and advocate on behalf of the patient? Does she smooth things pastorally in large part for the efficient running of the operation? Or does he risk rebuking and challenging the hospital in the name of health? In short, does the chaplain look for ways to renew the hospital's true vocation, calling it back to itself, to its identity in the Word of God?



Does the chaplain look for ways to renew the hospital's true vocation, calling it back to itself, to its identity in the Word of God?

It is when I have raised these questions in Clinical Pastoral Education seminars, that I've gotten the biggest rise. Students already understand the ways in which they are actively constrained in their ministry by the spirits of the hospital which hover over their work, requiring their allegiance and hemming them in.

How these questions are answered is often predicated on who pays the chaplain. To whom is she accountable — to the church or to a medical bureaucracy? It's the difference between the jail chaplain who has the keys or one who waits the wait of prisoners in order to see those whom she serves. It's the seductive dilemma of the military chaplain whose career is measured by the stripes on his sleeve.

Frankly, people exercising "the grace to confront and transcend death," as Stringfellow put it, may find themselves in trouble. The gospels are adamant to the point of redundancy that real healing may get one into political straits. Think of those Sabbath healings which so gall the scribes and pharisees.

Recall how perturbed and provoked the authorities become should Jesus, God forbid, forgive sin to effect a healing. There is that long story of the man born blind, dragged before a grand jury of sorts and interrogated about the details of his recovery — eventually to be cast headlong out of the synagogue. And in John's gospel it is the raising of Lazarus which is the last straw in the arrest and execution of Jesus.

I believe this is so because one power or another is invisibly involved in each of these situations, be it the law (purity code and debt code) or the turf and dominion of certain rulers, not to mention the power of death itself. I believe the love of Christ is at work in each of these healings, subverting the domination of principalities which manufacture, profit by, or sustain illness. In our ministries, we simply witness that nothing in all of creation can separate us from that love. TW

Back Issues

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The Lutheran-Episcopal concordat:

No reason to panic, but you might want to fasten your seatbelt

by Julie A. Wortman

The church press has been devoting a lot of attention lately to the fact that in 1997 Episcopalians and Lutherans belonging to the 5.2 million-member Evangelical Lutheran Church in America (ELCA) will vote on whether to be in "full communion" with each other by signing a "concordat of agreement" that would permit the "full interchangeability" of Lutheran and Episcopal clergy.

It's a formal arrangement that has been 27 years in the making, but let's face it, you are moving in rare circles if you have found very many church friends or colleagues who understand it. Almost no one I know can get through more than a few sentences of analysis — most of it quite enthusiastic, with commentators pronouncing it "revolutionary," "prophetic" and a "*kairos* in ecumenism" — before finding themselves befuddled.

The mind-numbing dryness of much of the discourse understandably leads most to believe that the concordat is largely an academic matter that will not have much impact on their daily lives. A few, in fact, hope rather desperately that this is the case, because the thought of any sort of deep, sustained contact with the other denomination brings on a panicky concern about identity.

The good news for such uneasy souls, according to Walter Bouman, a professor at Trinity Lutheran Seminary in Columbus, Ohio, who has made the Episcopal-Lutheran concordat a speciality, is that if by "identity" they mean matters of worship and spirituality, they can relax.

"The concordat is not calling for Episcopal and Lutheran congregations to merge," says Bouman. "Both confess the same Christian faith, but they do it in the context of their own traditions," traditions shaped by differences in historic and cultural origins. ELCA Lutherans are of German and Scandinavian descent, whereas Episcopalians tap into an English colonial heritage.

Future clergy of both denominations will be trained to understand both traditions, Bouman says, which should make them acceptable leaders of worship in the limited circumstances where they are invited to do so.

But outside of worship settings, prudent church members on both sides might well want to fasten their seat belts because it could be a bumpy ride.

For one thing, the concordat should mean the beginning of the end of inter-denominational competition for members.

"Both Episcopal and Lutheran churches do not have to be in the same place," Bouman says. If both churches confess the same faith, he says, insisting on the "Episcopalian" or "Lutheran" label is like insisting on a Ford or Mercury when all that is needed is a car.

In the 17th century, "denominationalism helped Christians stop murdering each other in the name of God," Bouman notes, but today it hampers cooperative activity that could have big implications for "the larger social picture."

It may also change the conversation.

"Broader membership means broader dialogue," Bouman states.

"One thing that will surely happen is that Episcopalian upper-class types will have to deal with middle-class Lutherans. Episcopalians will encounter a conservative group in Lutherans and Lutherans are already worried about signs of liberalism in the Episcopal Church."

Looking at the coffee table reading of the denominations, Bouman says, gives a strong clue as to what, in general terms, informs the likely fundamental conflicts the two denominations will face.

"Episcopalians tend to read the *New York Times* and *The New Yorker*," he says, while "Lutherans depend on their local newspapers, *Time* and, quite often, *Reader's Digest*."

Episcopalians are a more diverse group racially, Bouman says ("partly because Lutherans in this country never owned slaves"), and even in terms of class, but "the Episcopal Church has always been the unofficial church of the nation," partly because of its members' social influence.

"Being in full communion with the Lutherans could mute the 'justice' voice of Episcopalians because of Lutheran conservatism," Bouman admits, but in terms of public debate, the new alliance "will bring a very large constituency to bear on matters of social concern.

"Churches are being divided over the political and sociological issues being raised by electoral politics. They don't talk now because they fear competition. A broader commitment to each other reduces that fear. And arriving at a common mind may be a principle way to bring change. Unless our churches can *address* the culture wars, not avoid them, it will be a disaster."

In the meantime, the two denominations must still decide if the Christian unity that Paul extolled in Ephesians should be a priority. The debate will likely be dominated by questions of whether accepting Lutheran clergy who have not been ordained by bishops poses too grave a weakening of holy orders or whether accepting Episcopalians' treasured historic episcopate isn't an unacceptable concession to a hierarchial, insufficiently accountable, top-down institution.

But if the two churches can get past such concerns, Bouman believes, exciting times could be ahead for all.

Julie A. Wortman is managing editor of *The Witness*.

Vital Signs

Ordination: why cut back?

by Jennifer M. Phillips

Jennifer Phillips asks whether the church's quest for alternative models of ministry is leading us to devalue important aspects of the priestly vocation. While sharing her concern that "we not be driven into functionalism by our fear of the future or our perceived lack of resources," The Witness *staff believes that contemporary challenges to a traditional understanding of ordination are inspired by many valid concerns: the eclipse of the ministry of all the baptised, the needs of minority communities for culturally appropriate models, the problem of clergy burnout and the potential for clerical sexual abuse. Are proponents of alternative models throwing out the baby with the bathwater? We invite your response.*

Has the Church lost its theology of holy orders, or perhaps just lost its nerve? In dioceses across the country moratoriums on ordination are being declared, and candidates well advanced in the long process toward ordination have been dropped. There is widespread panic about dwindling financial resources which seems to be driving Commissions on Ministry, Standing Commissions, and bishops.

Models in which clergy are simply liturgical functionaries and consultants on itinerant circuits, or people ordained from and for a local mission without three-year seminary-level education, are gaining in popularity.

In my work on a Commission on Ministry, as a hospital chaplain and as a priest and rector in two dioceses and two provinces, I have heard many complaints about the oversupply of aspirants for holy orders. Almost no one is asking what God might be up to in the Church; just when resources seem so tight, many are being sent forward by their communities as worthy potential priests.

Screening bodies are rightly asking, in this age of individualism, how many aspirants are simply seeking to gratify their own needs to be useful, to have power and attention, or to feel closer to God through ordination. Along with seminaries, they may be doing less well at helping aspirants and parishes distinguish the call to ordination from the first, passionate questing for God which is the proper work of all the baptised.

It seems necessary to revisit our understanding of holy orders in tandem with our renewed attention to the ministry of all the baptised and to catechesis.

Priests are those who, first and foremost, are called to live lives woven in with those they serve, connecting people with the wider Church, both in place and in history. As sacramental ministers they help the people "daily lift life heavenward," and gladly point to the places where God is moving "usward" (to borrow Launcelot Andrewes' word). They are those who constantly come before God with the people on their hearts (Ramsey). They are those who are both deeply rooted in a particular community and also always passing through it.

In a nation with more people than ever who have never heard the Gospel, grown up in any sort of religiously observant home, or had any lived experience of community, are we right to be turning away priests because there are not traditional full-time jobs for them?

The parish priest at the Eucharist must be far more than a liturgical functionary. (S)he gathers the lives of the congregation on the corporal at the offertory along with the bread and wine of creation, and so must know those lives and pray her/his way through them. (S)he pastors not only the individuals in the congregation and its environs, but also the corporate Body. To do this (s)he combines knowledge of the people heard and observed at their prayer, in their homes and workplaces, in parish work, through their confessions and counseling sessions, and through knowing their parents and children and friends over time. Knowing the wealth of stories, pains, and celebrations, the parish priest is ideally situated to be able to preach to those persons in their lives and to gather their prayers for offering at the Lord's Table. The priest also is well-situated to mediate the concerns of the congregation to the structures of the Church at its councils, and to interpret the structures and councils to the people.

If, in a congregation, the various duties of the priest, rector, or vicar were to be divided up among a multitude of capable members, then who would put all the little facets of each person's and the Body's life together, so that they might be offered whole in the Eucharist? One of the most painful aspects of coming to the altar as a new parish priest is that sense of the poverty of not yet knowing and loving the people and having prayer emerge from those depths — of feeling one is stepping into an arranged marriage without having had time to fall in love and weather the first storms together.

The parish priest at the altar, in Anglican tradition, exercises a learned ministry and stands consciously among the cloud of witnesses as one able to tell their stories and transmit their passionate witness for God to the people now present. (S)he should know why every word and gesture of the Eucharist or other rite of the Book of Common Prayer is as it is, why we do one thing and not another, why the ancestors fought and sometimes died for

Jennifer Phillips is rector of Trinity Parish in St. Louis, Mo.

their meaning, and how to balance the expression of the congregation's unique voice and life with the reliable, stable current of the Church through the ages. In our time and place, this is an extraordinarily complex, controversial task. Three years *of full-time study is a short time to learn* the basics. Most priests go on studying lifelong if their ministries are alive and thriving. Nor is such education procured as effectively in solitary self-study as in a community of learners which includes other pastors who have integrated the wisdom of books, languages, and ideas into their own veteran pastoral practice in parishes and other institutions.

The parish priest's servant ministry centered in baptism and eucharist breaks open her/his life, solitude, and privacy. There is a degree of exposure that would be neither salutory nor tolerable for most members of a congregation which is part of the particular calling of a priest. This differentiates the work of the priest from that of a pastoral counselor, chief executive officer, social worker, educator, or consultant, and makes the lives of clergy families so taxing.

Yet an astonishing grace comes with this priestly silkworm-like work of being *visible, and of taking in and digesting* every atom of life — personal and corporate — and spinning out a thread of meaning which is offered back to the community to weave into their tapestry of life with God.

As we re-examine the theology of holy orders it seems essential that we not be driven into functionalism by our fear of the future or our perceived lack of resources. The discerning bodies of the Church need to be extremely clear in saying to those whom God and the communities are calling to ministry that there may not be salaries to go around, that the places priests are needed may not be where they would choose to serve, and that they will have to live by their wits and skills in the days to come; even that they need a second profession. But in a nation with more people than ever who have never heard the Gospel, grown up in any sort of religiously observant home, or had any lived experience of community, are we *right to be turning away priests because* there are not traditional full-time jobs for them?

Can it be that all these calls are simply mistaken? Or does God have in mind, of which we may know little at present, a future need of the world in raising up these aspirants? The Church should instead be saying to those so called:

"Go out and proclaim the Gospel and gather a church where there isn't one; draw in the people from the marketplaces and office towers and streetcorners and colleges and shelters. If you are willing to walk the way of the cross and connect yourself to its life, we will do our best to equip you and support you with prayer. Go make disciples of all people."

A balm in Gilead

by Marian (Meck) Groot

To Heal the Sin-Sick Soul: Toward a Spirituality of Anti-Racist Ministry, edited by Emmett Jarrett, Episcopal Urban Caucus, Boston, Mass., 1996; 80 pages; $12.00.

If you are looking for balm in Gilead, read *To Heal the Sin-Sick Soul.* A collection of six articles written by and/or for members of the Episcopal Urban Caucus on the subject of racism and the Episcopal Church's response to racism, this little book is a great gift of vision, prophecy, and love.

In the opening speech, "Developing a Spirituality for Anti-Racist Action," Kenneth Leech describes an anti-racist spirituality as one which is "both radical and traditional"; "both materialist and transcendent"; and prepared to face "into the very heart of the mystery of evil." He then lays out eight very practical implications of such a spirituality, including the need to network, "the centrality of conflict and struggle," the importance of self-scrutiny, and the need for quiet contemplation and reflection.

In each of the following contributions, we see such an anti-racist spirituality in motion. It is clear that each of the contributers has been struggling against the sin of racism for a long time. Each brings a clarity about structural and systemic racism as well as a strong understanding of the participation of the church in those systems. What particularly stands out is the recurring call to the leadership of the Episcopal Church to *actively* and *concretely* strategize to create "a church for all races, a church without racism," to do more than pay lip service to its deepest values, to put more "than their toes into the icy waters of economic and political analysis." The contributors look to the leadership of the church to initiate action because racism is about access to resources, the power to create and carry out policy, and the clout to define and shape a theology which undergirds either oppression or liberation.

In the second essay, Byron Rushing describes the shifting paradigm that refuses to work out of the belief that racism is in our nature. This is followed by Paul Abernathy's sermon in which he points up God's willingness to help as soon as we are prepared to act rather than our waiting for God to create a crisis of conscience in our lives. Pamela Chinnis outlines recent changes in the structures and policies of the Episcopal Church which have concrete implications for the church's anti-racist (or racist) practices. Emmett Jarrett urges whites to give up the delusion of whiteness and with it the comforts and privileges that whiteness offers. Finally, in an open letter, Ed Rodman calls on the leaders in the Episcopal Church to initiate dialogue that attempts in concrete ways to address the racial divide exemplified most recently in the polarized reactions to the Simpson verdict and the Million Man March.

This book is not for the faint of heart. But, as Pamela Chinnis shares in her speech, those who believe they are not supposed "to make waves" were not born to live.

Health benefits approved for same-sex partners by Canadian church

The governing council of the General Synod of the Anglican Church of Canada has rescinded a national prohibition against extending health care coverage to the partners of homosexual employees.

According to Jenny Mason, director of the national church's pension fund, the recommendation to change the policy on same-sex medical coverage was driven by recent decisions of the country's Human Rights Commission in which businesses have been directed to pay such benefits.

Still, some council members opposed the action because it would appear to condone homosexual relationships.

"The law ... requires that we provide health benefits to a partner whether they be gay, straight or common-law," said the bishop of Toronto, Terry Finlay, during the debate. "That is all the pension committee is asking us to recognize."

A remaining barrier to obtaining benefits for partners of same-sex church workers will be local dioceses who disapprove of partnered homosexuals. The national church will recommend that they provide coverage for partners, Mason said, but it is up to the diocese to decide if it is willing to do so.

—based on an *Anglican Journal* report

Bishop of Maine admits betrayal of trust, resigns

Edward C. Chalfant resigned as Bishop of Maine on May 6, following the revelation that he was involved in an extramarital affair with "an unmarried adult lay woman."

Initially, Chalfant had announced he would take a year's voluntary leave of absence during which he would seek therapy, holding out the possibility that he might return to his post. In making that announcement Chalfant said he deeply regretted the "betrayal of trust placed in me by the church, the diocese, and my family." Chalfant and his wife of 36 years, Marydee, have two grown children.

The bishop subsequently decided to resign, he said, because "the diocese has complicated work to do in order to proceed with its mission and ministry, " and he didn't want conjectures about his possible return to impede that work.

Maine's Standing Committee agreed that Chalfant should resign. In announcing the misconduct, the committee had stated that Chalfant's behavior had caused "grave damage to the bishop's relationship with the diocese."

A diocesan convention on May 17was held to begin the process of deciding on next steps for Maine's life as a diocese and search for new episcopal leadership.

— based on an Episcopal News Service report

Conservatives riled by Newark suicide resolution

Some conservative Episcopalians are charging that John Shelby Spong and the Episcopal Diocese of Newark were demonstrating arrogant disregard for the rest of the church in passing a resolution taking the untraditional position that suicide, including assisted suicide, "may be a moral choice for a Christian" under certain limited circumstances.

The action, taken at the diocese's annual convention in late January, was based on the recommendations of a diocesan task force which had conducted a year-long study of assisted suicide and the theological and ethical issues involved.

"I am appalled that a diocesan convention felt itself competent to address so cavalierly this issue with a resolution stating a public change in the church's moral theology," opined one outraged cathedral dean in the conservative periodical, *The Living Church*.

Another irate-sounding commentator, this time writing for Episcopalian's United's newspaper, *United Voice*, noted derisively that "Newark seems to have a task force for any given issue." In addition to the one reporting on assisted suicide, the convention heard this year from a task force on prayer book revision (see *TW*, May 1996) and another on "Christian Mission in an Interreligious World."

Spong, however, claims that his diocese has spoken only for itself. He also rejects the charge that taking on controversial topics is a "public relations campaign to enhance our controversial reputation.

"What we seek to do is to speak to the people of our diocese and through them to the whole Church and then to the world at large," he wrote after the convention.

"Our goal is primarily to raise consciousness, to create an awareness of new aspects of reality, to call these concerns into public debate and to legitimatize these issues for discussion."

The report of Newark's task force on assisted suicide has been forwarded to the Episcopal Church's General Convention and to the New Jersey legislature "for their consideration."

— J.W.

Looking for 'some particular ministerial talents'

With the announcement that the high-profile James Parks Morton will be retiring as dean of the the Episcopal Cathedral of St. John the Divine, the search is on for a replacement. The list of qualifications is extensive, as a national mailing to all active Episcopal clergy recently stated. The right candidate will possess, in addition to "demonstrated skill in institutional leadership and financial development" and a love of New York City, the "ministerial talent" of being "comfortable with and able to minister with and to Jessy Norman, Carl Sagan, Vice President Gore, the waiter at the Amsterdam Café, the Duke of Richmond, politicians, priests, rabbis and homeless people." The new dean should also stand "fully and affirmatively within the Anglican and Episcopal Church tradition and is therefore open to the post-Christian religious reality of our city and world."

Got someone who fits the bill? Write the Search Committee for a Cathedral Dean c/o William McD. Tully, St. Bartholomew's Church, 109 East 50th St., New York, NY 10022.

'Hospice and spital': the roots of hospital care

[Ed. Note: We've taken the liberty of substituting excerpts of this excellent work for a traditional review.]

Ordered to Care: The dilemma of American nursing, 1850-1945, by Susan Reverby, Cambridge History of Medicine, 1987.

The nineteenth-century hospital, in its appearance and social role, bore little resemblance to its modern equivalent. It was a marginal institution primarily for society's most marginal people: the sick, poor, or displaced members of the lower working class. Most 19th century Americans lived and died never entering, and perhaps never seeing, such places, for the country had only 120 hospitals when the first official national survey was taken in 1873.

The historical terms to define a hospital, a "hospice," or home for the destitute or sick, and a "spital," or foul and loathsome place, had real significance for Americans at that time.

Within the hierarchy of paid labor, the hospital nurse was considered very near the bottom, caught in a degraded job in a fearsome institution. Unlike the professed nurse who became a household member only for the duration of a patient's illness, the hospital nurse was confined to the institution for both home and workplace. Many were partially recovered patients who were pressed into nursing duties. Before the 1870s, no nurses had any formal training or schooling for the work. Hospital nurses were considered the dregs of female society — mainly women who drank themselves into oblivion to endure their seemingly thankless and wretched labors of cleaning, feeding, and watching over the hospital's inmates. In the pejorative words of Florence Nightingale, hospital nurses were women "who were too old, too weak, too drunken, too dirty, too stolid, or too bad to do anything else."

Nineteenth-century medical etiology as well as social welfare structured the hospital's existence. Sharp lines between individuals and their environment, between moral behavior and illness, even between disease entities, had not yet been carefully drawn. For the majority of the hospital's patients, the regimen meted out discipline as well as beef tea and rest. Disease and dependence were intimately linked, and "moral treatment," "Christian nurturance," and exposure to proper discipline were all part of the curing and caring.

Although most institutions served primarily a lower-working-class and semi-chronically ill population, the distinctions between public and voluntary institutions emerged in the 18th century. The public institutions, for the most part, became hospitals by increments as urban almshouses had to provide space for the care of the sick among their indigent inmates. Voluntary hospitals were established by wealthy benefactors because of personal ties to physicians, a belief in moral stewardship, and a realization that some central location had to be found, outside the almshouse, for the "deserving and respectable poor" who were ill. Curability also distinguished the patients of the institutions. Chronically ill or consumptive patients, or those with venereal disease, were often barred from voluntaries.

Hospitals, whether voluntaries or public institutions, were primarily charity institutions supported by funds collected from church societies, donations and bequests, and governmental outlays, although patients were encouraged to pay if possible. In most voluntaries some space was reserved for those who could pay extra for their care. Many hospitals had one or two handsomely appointed rooms with damask drapes and heavy cherry furniture for such "pay patients." But the very existence of such rooms, and the differential treatment afforded these patients, only served as a counterpoint to the institutions' more functional charitable nature. Filth and neglect, rather than fancy drapes, characterized many of the wards in institutions, particularly the larger public hospitals. The woodcut of rats crawling over the comatose body of a young female Bellevue patient that appeared in *Harper's Weekly* in 1860 drew attention to the worst problems of hospitals. Dirt, vermin, and rampant cross-infection, known as "hospitalism," were common. Benevolence did not necessarily mean comfort or cleanliness.

Public institutions became hospitals by increments as urban almshouses had to provide space for the care of the sick among their indigent inmates.

The necessity for creating institutions for the centralized care of the dependent sick came in part from the religious doctrine of moral stewardship. The doctrine held that divisions between rich and poor were natural and inevitable but that the

Susan Reverby is director of Women's Studies at Wellesley College.

rich held their wealth in trust for the Lord. "The only sure way to reconcile labor to capital is to show the laborer by actual deeds that the rich man regards himself as the steward of the Master," Bostonians were reminded in a newspaper article on hospitals in 1879.

The attempt to enforce such class reconciliation was fostered by the link between moral and medical cures and the continual metaphorical reference to the hospital as a home. The effort to create strict order and discipline, in the name of home life, permeated the hospital as it did other 19th century social-welfare institutions. Rigid rules for behavior were established to regulate daily life; hours, visiting, and tobacco and liquor consumption were limited. Those who transgressed the regulations faced dietary restrictions and even punishment cells. The paternalism that pervaded the institutions sought to define the boundaries of the patients' daily lives as much as the high walls surrounding the institutions physically confined them.

Patients did not always accept such charity, or disciplining and incarceration, with deference and thankfulness. Most tried to avoid hospitalization. Others were willing to use the institutions. Women at the Boston Lying-In Hospital thought they could return whenever they wanted, leave their babies off while they went out looking for work, or use the hospital for lodging when nothing else could be found.

Trustees, usually male unless the hospital was built by women, controlled daily life in multiple ways. As required by moral stewardship and general business practices, their main responsibility was financial, although deficits were expected and served as indexes of the hospital's usefulness and service. In addition, the trustees were concerned with admissions, rates of pay, extensions of free care, and the screening out of incurable patients. Complaints by patients and staff were listened to by individual trustees who made frequent visits to the wards and clinics.

The hospital superintendent or steward was just below the trustees in authority. Usually male, he ordered supplies, hired and fired servants and nurses, and in general oversaw the running of the institution. If the hospital was large enough, there was also a matron (commonly the superintendent's wife) who organized the daily work of the nurses and servants and was responsible for supervising and for the cooking, washing, and cleaning of this enormous "household."

Sick Woman in Ward Overrun by Rats in Bellevue Hospital. Harper's Weekly, 1860

Most physicians never trained in, worked in, or brought their patients to be cared for in hospitals. A small elite, concerned with gaining more clinical experience or performing rare operations and treating unusual diseases, sought hospital positions. But even for hospital physicians, medical authority did not always translate into institutional power since the hospitals did not depend on the doctors for either their income or sense of purpose.

Hospitals had a very uncomplicated division of labor below the level of physicians. Nightwatchers, as their name implied, came into the larger institutions late in the evening to "watch" the patients until dawn. Head nurses, along with their assistants and orderlies, lived in the institutions and were responsible for whatever nursing care was given. Extra nurses were sometimes brought in daily from outside when needed. A number of laundresses, cooks, and kitchen helpers made up the rest of the work force.

Class and position linked the hospital's patients and workers together as much as it divided them from the trustees, matrons, and physicians. Patient, nurse, and servant were often one and the same person since ambulatory patients were expected to do much of the nursing care. In public institutions, the use of inmates from the near-by almshouse as nurses was common. The role of the public hospital, in particular, as a workhouse for the city's marginal population continued well into the 20th century. In 1913 a New York hospital survey noted:

"In the absence of other institutions where the periodic and semi-respectable drunks can live and work, they can, to the best advantage, both to themselves and to the City, be supported as workers in the City's hospitals."

[Reverby notes that the establishment of nursing schools toward the end of the 19th century transformed the quality of hospital care and caused hospitals to multiply. During the Depression, she adds, hospitals had become big business, and increasingly high-tech. Blue Cross emerged as a means of keeping hospitals solvent.] TW

book review

Witnesses, the quick and the dead

'Nothing official and not the everyday thing'

by Julie A. Wortman

The official purpose of one of the small rooms in the neo-natal intensive care unit of New York's Columbia Presbyterian Hospital is to provide temporary storage for frequently needed medical equipment. But by pushing the machines close to the walls and drawing a hospital curtain down the center Euthemia Kenton and two of her nurse colleagues on the night shift have managed to claim a portion of this crowded space for a need that arises when technology reaches its limits.

"It's a clean, quiet place where parents can have some privacy as they grieve the death of their baby," the soft-spoken Jamaican Anglican says of the simply furnished space. "We've put down a carpet, some rocking chairs and a table with a vase of flowers. We give the parents a chance to bathe their dead baby, to dress it in something clean. I tell them, 'Look at your baby, touch your baby.' We don't want parents to leave the hospital without having held their children. If their baby was born sick they had very few chances."

Some parents will spend an hour in this "grieving room," the 57-year-old neonatal ICU specialist says, others as long as two or three.

What Kenton and her colleagues do on these occasions "is nothing official and not the everyday thing," she says. With chaplains available in the hospital 24 hours a day, there is often no need. And in the 20 years that Kenton has worked at this upper Manhattan hospital, the number of prematurely born babies who manage to survive the respiratory problems, infections, hemorrhaging, anemias and other ailments to which very pre-term cardio-vascular and immune systems are vulnerable has increased dramatically — to better than 90 percent. Kenton's own grandaughter, Brittany, who just finished her first year of elementary school, is part of that positive statistic.

In this country you have to be in an intensive-care situation to get A-1 care.

Euthemia Kenton

"Younger nurses just take the technology for granted, but I can see the difference between now and how it was when I began in obstetrics — when we had nothing like this unit and the survival rate for many of these babies was poor."

Kenton emigrated to the U.S. in 1968, armed with degrees in nursing and midwifery she had earned in the West Indies. Her highly specialized knowledge in neonatal care has come through courses, seminars, trainings, professional gatherings and, most importantly, continuous hands-on experience. Up until a few years ago, when she decided she needed a break from administrative responsibilities, she was the neo-natal ICU unit's head nurse.

But although the nursing care Kenton and her colleagues provide, whether part of the unit's official or unofficial offerings, meets high standards of excellence, the satisfaction she takes in that fact has begun to sour.

"In this country you have to be in an intensive-care situation to get A-1 care," she says, but outside of such situations "people are being neglected."

Kenton cites a recent conversation with an RN who works in a hospital AIDS unit. "She was really upset. She talked about coming to work and finding patients lying in urine-soaked beds, their call-lights having gone unanswered for hours at a time. She said the other nurses didn't seem to care," a phenomenon that

Julie A. Wortman is managing editor of *The Witness.*

Kenton believes reflects a general situation of increasing demoralization among nursing professionals.

"Nurses are getting stressed out," she states bluntly.

Kenton speaks out of more than 10 years of experience as an official representative and officer of the union which represents the 1600 registered nurses who work at Columbia Presbyterian — a chapter of the New York State Nurses Association.

"I first got involved because of a restructuring in which my position was combined with another position. I ended up with with twice the responsibility and no increase in salary. It didn't seem fair."

With government cutbacks for Medicare and Medicaid, such "economizing" strategies have only increased, Kenton says.

"We've been negotiating a new contract for the past six months. The hospital would like to cut out everything it can to support big salaries at the top, some as much as $1 million when you count the perks." Kenton makes a base salary of $50,250.

In addition to reducing the length of time patients stay in the hospital, the hospital's administrators would like to "cluster" patients with different problems on the same floor in order to reduce the number of nurses needed, reduce continuing education funds for nurses by nearly 80 percent and eliminate the years of professional experience a nurse brings to the job as a factor in calculating his/her salary.

"Experience has been what has brought nurses' salaries up over the last 10 years," Kenton says with some frustration. "The hospital thinks that lower pay won't matter if there are fewer jobs, but experienced nurses won't work for nothing. A lot of people are taking early retirement to get out."

Those who can't retire and manage to keep their jobs face the continuing stress of too many patients and a diminishing sense of expertise.

"They work through their breaks because there is too much to do," says Kenton, "and the more they do that the closer they get to burnout. One nurse cannot cover all her patients and still have time to turn someone over, wash out a mouth, or rub a sore back."

To get that kind of care in today's big-city hospitals, Kenton advises, a patient needs to bring a loved one with them, "to be their hands and voice." Otherwise, the urine-soaked bedding which shocked Kenton's friend on her AIDS floor is an unpleasant, but not unfathomable, eventual likely result.

In fact, nurses who appear to be shirking their responsibilities or only going through the motions are sometimes themselves suffering from a deeply potent neglect, Kenton believes.

"I tell the younger nurses I work with that they have to remember that they are patient advocates, that the patient has rights," Kenton says. "But I also work hard to treat them with respect, letting them know they have a lot to bring to their work — a lot of knowledge, a lot to teach me and others."

Those she mentors in this fashion seem to appreciate the encouragement. "They seem surprised and pleased to think that an old experienced nurse like me could learn from them," Kenton says with amusement.

According people dignity in this way — or by offering them the sheltering privacy of a drawn curtain in an intensive-care-unit storage room — may not be the official, everyday thing a registered nurse is expected to do to reduce costs and maximize hospital efficiency, but it is a small, vital act of resistance to the dehumanizing effects of the balance-sheet forces which seem to have hospitals securely in their power. TW

"I believe that community support is so strong because we provide for the community whether we can afford to or not," Effie Chamberlain, director of operations, Grace Cottage Hospital in Vermont (Story on p. 17).

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