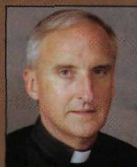


# REGAINING MINORITIES' TRUST



A Clinic Project in a Philadelphia Neighborhood May Serve as a Paradigm for Catholic Hospitals



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Recent studies have shown that racial and ethnic disparities persist in U.S. health care. Indeed, it has become clear that the American health care system, which in many ways is the envy of the world, is not only flawed due to basic injustices; it may be the cause of both injury and death in members of racial and ethnic minorities.

In 2002, as directed by Congress, the Institute of Medicine (IOM) reviewed more than 100 studies indicating a wide range of disparities in the nation's health care system. This study found that racial and ethnic minorities in the United States receive lower-quality health care than whites, even when their insurance and income levels are the same as whites'.<sup>1</sup>

Another study, this one conducted by Allen Gifford, MD, and his colleagues, found that although African Americans and members of other ethnic minorities make up a growing percentage of Americans infected with the human immunodeficiency virus (HIV) that causes acquired immunodeficiency syndrome (AIDS), they are seriously underrepresented in clinical trials studying new treatments for the disease.<sup>2</sup> Gifford's report, a comprehensive analysis of studies involving treatments for HIV, noted that African Americans and Hispanics were roughly half as likely as whites to participate in HIV treatment trials and about half as likely to receive experimental medicines. This trend was occurring at a time when HIV was spreading among African Americans at a higher rate than among whites.

A third study, directed by Gieselle Corbie-Smith, MD, MSc, and two colleagues, found that African Americans were far less trusting of the medical establishment, and of medical researchers in particular, than were whites. Among African Americans, 79 percent said that people of their background were likely to be used as guinea pigs without having given their consent; 52 percent of the whites surveyed expressed a similar belief. The study also found that 63 percent of African Americans believe that physicians often prescribed medication as a way of experimenting on people without their consent; 38 percent of whites agreed.<sup>3</sup>

These studies only confirm what many in the minority community have known for years—that racism, whether explicit or subtle, is alive and well in the medical profession. It is also clear that subtle or unconscious forms of racism are just as harmful as openly expressed hatred and bigotry, because they affect the medical care that minorities receive. The IOM study found that most

health care providers are well-intentioned, but it cited "indirect evidence" that physicians' decisions were influenced by perceptions of race.<sup>4</sup>

This is a problem that should concern all in the health care field, but it should especially concern workers in Catholic health care because it is directly related to the *Ethical and Religious Directives for Catholic Health Care Services*, especially directives 2, 3, and 23.<sup>5</sup> Unless measures are taken to address this form of racism and to establish a new sense of trust between the medical establishment and racial and ethnic minorities, these injustices will continue to deepen and expand, and more lives will be placed in jeopardy. What is needed is a comprehensive, multilevel, culturally relevant strategy that contains interventions that target individuals, communities, and the nation as a whole. Creating this strategy will entail understanding the causes of racism and injustice in the medical profession, identifying practical interventions to address this racism and injustice, and forming partnerships that will work toward a new sense of trust.

Medical disparities in the U.S. health care system are a complex, multifaceted mixture of quality and access problems intertwined with historic injury. What is critical is that policy makers define the problem correctly so that solutions address their intended goal—health security for all regardless of race, ethnicity, or socioeconomic characteristics.<sup>6</sup>

In this article, we hope to do three things:

- Examine the medical facts about hypertension, diabetes, and obesity and discuss the reasons why these are major medical problems for the African-American community
- Describe the ethical reasons why Catholic hospitals must work to overcome medical disparities in minority communities
- Discuss a clinic project in Philadelphia that we hope will become a paradigm for tackling racial and ethnic disparities in U.S. health care

### THE MEDICAL BACKGROUND

Over the past four decades, advances in medical technology and a better understanding of the disease process have greatly improved health care in the United States. These advances have contributed to better management of the disease process, which has, in turn, improved morbidity and mortality rates and increased life expectancy. Unfortunately, this improvement is seen predominantly among *white* Americans. Other groups, especially inner-city African-American and Hispanic populations, lag behind.<sup>7</sup> U.S. health

care, often considered the best in the world, has its own flaws, one of which is leaving millions of people with inadequate health care services.

In particular, three disease processes that afflict racial and ethnic communities tend to receive inadequate attention from the health care system.

### HYPERTENSION

Hypertension is a major cause of morbidity and mortality in people all around the world. However, the incidence of high blood pressure is significantly higher among black people than among other ethnic groups. Among black people, the illness is more predominant in the African-American population than in the African population.

The incidence of hypertension in U.S. black children is increasing, especially in urban families with low socioeconomic status. Factors other than socioeconomic status—age, body weight, and the mother's educational level and smoking habits—also play a role in the development of hypertension in black children.<sup>8</sup> It has been shown that, in black newborns, a heavier birth weight is associated with hypertension later in life. In addition, many black children have low insulin sensitivity, which has been seen as an independent risk factor for high blood pressure.<sup>9</sup>

Hypertension involves many factors, including electrolytes in the blood, blood flow to the kidneys, the functional capacity of the kidneys, and hormonal activities such as adrenal hormones and thyroid hormones. But some researchers suggest that the pathophysiology of hypertension programmed during the fetal period is race-specific and may have a genetic component. These scientists postulate that the exploration of racial disparities in the developmental origin of health and disease is a critical step toward understanding the fetal programming of chronic diseases and, eventually, developing interventions against them.<sup>10</sup>

Some of the factors contributing to the development of high blood pressure—age and race, for example—cannot be modified. Others—socioeconomic status and level of education, for example—are considered modifiable. People who are poor and have little education often lack knowledge concerning a healthy lifestyle. A healthy lifestyle not only helps postpone the onset of hypertension; it also helps reduce the amount of medication needed to control it, once onset has occurred. Well-structured education programs designed to improve knowledge about a healthy lifestyle have a significant effect on the primary prevention of chronic diseases.

## DIABETES

Diabetes mellitus is a chronic disease estimated to affect some 21 million Americans. About 15 million Americans are currently diagnosed as having diabetes, and another 6 million are estimated to have it.<sup>11</sup> About 177,000 people at age 20 or below have diabetes. Of these, approximately one in every 400 to 600 children and adolescents has type I diabetes. Among Americans 20 years of age or older, about 14 percent of Hispanics, 13 percent of blacks, 13 percent of Native Americans, and 9 percent of whites have the disease. About 1.5 million new cases of diabetes were diagnosed in 2005.<sup>12</sup> Approximately 41 million Americans are considered as prediabetic, with a high risk to develop diabetes in later life. Diabetes as a cause of death is underreported; even so, it is the sixth leading cause of death in the United States.<sup>13</sup>

Diabetes is caused by problems with insulin production by the pancreas. Type I diabetes, which results from reduced production of insulin, is typically seen in children and adolescents. Type I diabetics are generally thin and show no genetic predisposition to the disease. Type II diabetics, on the other hand, tend to show a genetic predisposition and to be overweight. Type II diabetes, which is caused by reduced sensitivity to insulin by the body's cells, typically occurs in people over 20. However, in recent decades, a high incidence of Type II diabetes has been seen in black and Hispanic children.

The disease's morbidity and mortality rates are due mainly to its complications. Diabetes affects all body systems. About 65 percent of deaths among diabetics result from heart disease or stroke, the risk of stroke being two to four times higher for diabetics than for other people. Diabetes and hypertension go hand in hand. Approximately 73 percent of adults with diabetes also have high blood pressure.

In the United States, diabetes is the leading cause of blindness in adults, with some 24,000 new cases documented each year. Diabetes also accounts for 44 percent of new cases of kidney failure; every year, some 44,000 people require dialysis because of the disease. Most diabetics develop nerve damage, resulting in poor sensation and pain in the hands and feet, and some develop dysmotility of the digestive system. Most nontraumatic amputations are due to diabetes. Nearly a third of people with diabetes have severe gum disease, and most of them lose their teeth. Poorly controlled diabetes during pregnancy can result in excessively large babies and peripartum

complications. In addition, severe infections like pneumonia and influenza are common in people with diabetes.

The total annual cost (direct and indirect) of managing diabetes in this country is about \$132 billion. The direct medical cost is about \$92 billion, and the annual health care cost per person with diabetes is \$13,243, versus \$2,560 for nondiabetics.<sup>14</sup> The nation has seen an alarming increase in the burden of diabetes and its complications. Key factors in preventing the complications and improving quality of life are early detection, improved delivery of care for better glucose control, a better understanding of the disease, and the ability to learn to live with it. Regular eye examinations and foot care, better control of blood sugar and blood pressure, daily exercise, an optimum diet, and a healthy life style are important in reducing diabetic morbidity and mortality.

## OBESITY

The last decade has witnessed a 75 percent increase in obesity among Americans. Obesity has increased in both sexes, in every state, across all ages, and in all socioeconomic classes. Among men, the occurrence of obesity increased significantly between 1999-2000, when it was seen in 28 percent of the male population, and 2003-2004, when it was seen in 31 percent. (Obesity was seen in 33 percent of women in both periods.) In 2003-2004, extreme obesity (body mass index > 40) was found in 3 percent of men and 7 percent of women.<sup>15</sup>

Obesity in both men and women tends to increase with age, until about 69. However, in the past decade, there has been a sharp increase in obesity among adolescents and young adults, especially those who are black or Hispanic.<sup>16</sup> Like the other chronic diseases described above, obesity is also more prevalent among African Americans and Hispanics than among whites. Black and Hispanic women are more likely to be overweight than black and Hispanic men. Among all racial and ethnic groups, women of lower socioeconomic status are 50 percent more likely to be obese than women in higher income groups. Obese people are more likely to have less education than nonobese people.

Obesity results from many complex factors, including genetics, behavior, environment, culture, and socioeconomic status. It generally occurs when calories consumed exceed energy expended. It is a fact that food rich in fat is abundant in First World countries. In addition, machines in the First World have taken over most manual jobs, and people have become more sedentary, so their expendi-



ture of energy has decreased. Other factors—including maternal diabetes, maternal smoking, the tendency to replace breast-feeding with bottle-feeding, early adiposity rebound (the loss in children of “baby fat”), some medications, and some viral infections—also contribute to First World obesity.<sup>17</sup> Genetics also plays a role in the development of obesity. Researchers have noted that fat cells secrete a hormone called leptin, which controls food intake and affects other metabolic functions that regulate energy balance.<sup>18</sup> Overweight people have been noted to have high blood leptin concentrations as well as leptin resistance.

The consequence of obesity is not just waistline enlargement but also serious illness and early death for tens of thousands of Americans. Obesity is today considered the nation’s second leading cause of preventable deaths, claiming about 300,000 lives a year.<sup>19</sup> Chronic diseases like hypertension, diabetes, high cholesterol, stroke, many cancers, sleep apnea, asthma, arthritis, impotence, and depression are more prevalent in obese people than in nonobese people. (Modest weight loss in obese individuals reduces the risk of these comorbid conditions). In 2000, the total cost for obesity was

\$117 billion. (Most of the medical costs associated with obesity deal with the comorbid conditions.)<sup>20</sup>

Education is the single most important intervention in dealing with these illnesses and their complications. A good first step would be educating both parents and children about the American Diabetes Association’s revised nutrition guidelines for diabetes prevention, which stress weight control and exercise.<sup>21</sup>

### ETHICAL ANALYSIS

The evidence is quite compelling that minorities suffer racial and ethnic disparities in health care. David Satcher, MD, a former U.S. surgeon general, argues that this evidence correlates with persistent health disparities seen in statistics concerning illness and death. Satcher contends that although disparities in care result from complex interactions among genetic variations, environmental factors, and specific health behaviors, there is also reason to believe that race and ethnicity play a major role.<sup>22</sup>

Disparities in care certainly constitute a medical problem, but they are—for all Americans—an ethical problem as well. Allowing race and ethnicity to play any role in the provision of health care goes against the basic principles of ethics. The ethical principles of respect for persons, beneficence/nonmaleficence, and justice argue that immediate action be taken to address these concerns and eliminate any form of racism in the medical profession, whether explicit or unconscious. Such action will not only save lives; it will also do much to rebuild a sense of trust between the African-American community and the medical establishment.

### RESPECT FOR PERSONS

This principle incorporates two ethical convictions: First, every person should be treated as an autonomous agent; and, second, a person with diminished autonomy is entitled to protection. The principle of respect for persons thus divides into two separate moral requirements—the requirement to acknowledge autonomy and the requirement to protect those with diminished autonomy.<sup>23</sup> The physician-patient relationship is a covenant based on mutual trust. It is a fiduciary relationship based on honesty. Edmund Pellegrino, MD, and David Thomasma, PhD, both of whom have written extensively in this area, argue that technical competence is one obligation owed to the patient by the physician. “The act of the medical professional is inauthentic and a lie unless it fulfills the expectation of technical competence,” they write.<sup>24</sup> Patients should be able to expect their physicians to have the technical skills to assess and manage their medical conditions.

Unfortunately, racial and ethnic minorities often believe that their medical conditions are *not* being assessed and managed by physicians in the same way the conditions of white patients are assessed and managed. The IOM report made it clear that disparities between whites and minorities exist in a number of disease areas.<sup>25</sup> Eight times as many blacks have AIDS as do whites, and blacks are nearly twice as likely as whites to die from diabetes.<sup>26</sup> Corbie-Smith and her colleagues found that African Americans were "more likely to believe that their physicians would not explain research fully or would treat them as part of an experiment without their consent."<sup>27</sup> Minorities often do not trust physicians, believing that doctors sometimes use them as guinea pigs in experiments. They believe that they sometimes are not offered the same medical procedures that whites are offered, even though they have the same clinical symptoms. Indeed, they believe that the technical competence of some physicians is compromised by prejudice on the physicians' part. And research has shown that minorities' concerns have a basis in fact.<sup>28</sup>

These concerns directly relate to the issue of informed consent. Patients have the right to be informed about the advantages and disadvantages of any medical treatment, experimental or otherwise, and about any viable alternatives as well. Research has shown that, in many cases, racial and ethnic minorities cannot give informed consent because they have not been informed of all the options available to manage their illnesses. Violations of informed consent by medical professionals treating minority patients have been documented and, in some cases, widely publicized.

The essence of the principle of respect for persons is that a person should never be treated simply as a means to an end. When a caregiver fails to give his or her patient all relevant information concerning risks and benefits, or inform him or her of all possible treatment options, or purposely withholds treatment that is the "standard of care," then that caregiver is using patients as a means rather than an end. The medical profession is based on treating all people with dignity and respect. Until U.S. health care can show an improvement in the overall quality of care—and work to aggressively promote public health interventions in such diseases as hypertension, diabetes, and obesity—it will never gain the trust of the minority communities and close the ever-widening gap in quality of care.

All hospitals—and, because of the *Ethical and*

*Religious Directives for Catholic Health Care Services*, Catholic hospitals in particular—have a moral and ethical obligation to address the medical disparities existing in minority communities. If Catholic hospitals are committed to treating every person with dignity and respect, they must remove all barriers to equal treatment for all patients and put a renewed emphasis on patient dignity and empowerment.

### **BENEFICENCE/NONMALEFICENCE**

The principle of beneficence involves the obligation to prevent, remove, or minimize harm and risk to others and to promote and enhance their good. Beneficence includes nonmaleficence, which prohibits the infliction of harm, injury, or death upon others. In medical ethics, this principle has been closely associated with the maxim *primum non nocere* ("Above all, do no harm"). Allowing a person to endure pain and suffering that one could relieve violates the principle of beneficence, because, in behaving this way, one is failing to prevent harm and, therefore, not acting in the other person's best interest. In medicine, the duty to act in the patient's best interest must take preference over the physician's or researcher's self-interest.

Physicians have, as moral agents, an ethical responsibility to treat their patients in a way that will maximize benefits and minimize harms. Failure to adequately assess and manage a patient's medical condition, for whatever reason, is not in the best interest of the patient. Research has confirmed disparities in health care among racial and ethnic groups. African Americans and American Indians have higher overall mortality rates than any other U.S. population group. These two groups have almost twice the infant mortality rate of whites.<sup>29</sup> The death rate from all cancers is 34 percent higher for blacks than for whites.<sup>30</sup> There are eight times as many blacks as whites with AIDS, and blacks are nearly twice as likely as whites to die from diabetes.<sup>31</sup> Hispanics and American Indians are approximately twice as likely as whites are to have diabetes.<sup>32</sup>

Although proof is lacking (and probably impossible to acquire), it seems logical to assume that racial and ethnic prejudice on the part of medical professionals are to some degree responsible for such disparities. Physicians have a moral responsibility to do what is good for their patients. Should a physician be impeded in the exercise of his or her reason and free will because of prejudice, then that physician has an ethical responsibility to either overcome that impedi-

ment or transfer the patient to another physician, one who will do what is demanded by the basic precepts of medicine—seek the patient's good. Hospitals also have a responsibility to their communities. If hypertension, diabetes, and obesity are major issues in the community a particular hospital serves, then hospital administrators and health care professionals have an ethical responsibility to formulate programs to deal with those medical issues.

Failure to recognize and overcome one's own prejudice is a failure not only of the test of beneficence; it may also be a failure of the test of non-maleficence.

**JUSTICE**

This principle recognizes that each person should be treated fairly and equitably and be given his or her due. The issue of medical disparities also involves distributive justice: the fair, equitable, and appropriate distribution of medical resources in society. At a time when reforming health care in this country has become a high priority, a failure to initiate measures that will steward medical resources for the long run violates the principle of distributive justice. The justice principle can be applied to the problem under discussion in two ways.

**Inequality in the Provision of Care** Inequality in the health care provided to Americans is a well-documented fact. For years, this inequality was attributed to socioeconomic causes, chiefly poverty. With the publication of the IOM report, however, it has become apparent that subtle racial and ethnic prejudice is also a reason why members of minorities sometimes receive inferior care, even when they are insured. Prejudice leads some physicians, medical researchers, and other health care professionals to treat members of minorities less seriously than white people.

Whether such bias is explicit or unconscious, it violates the principle of justice. Members of minority groups are not receiving the same standard of care that whites receive, even when they have the same symptoms. For example, a recent study of more than one million women suggests that inadequate breast cancer screening may be the chief reason that black women tend to be diagnosed with larger and more advanced tumors than those found in white women. Financial barriers, lack of access to facilities that perform mammography, and multiple personal and cultural reasons may explain the difference in screening results.<sup>33</sup> Similar gaps exist in infant mortality rates and in death rates from heart disease and cancer.<sup>34</sup>

The evidence indicates a disregard of the principle of justice.

**Inequality in the Allocation of Resources** The principle of justice also pertains to the fair and equitable allocation of resources. It has been documented that members of minorities are less likely than whites to be given appropriate cardiac medicines or undergo coronary bypass surgery. They are less likely to receive kidney dialysis, kidney transplants, or the best diagnostic tests and treatments for cancer. They are also less apt to receive the most sophisticated treatments for HIV and diabetes. As noted earlier, the total cost of diabetes in the United States (direct and indirect) was \$132 billion in 2002. If African Americans are twice as likely to die from diabetes than whites—in many cases because of a lack of adequate medical treatment—then the principle of distributive justice would dictate that programs should be implemented to screen, assess, and treat them and other minorities, not only for their benefit but also to benefit society as a whole.

We Americans espouse the belief that all men and women are created equal. Equality has also been a basic principle of the medical profession. If we truly believe in equality, we should insist that all men and women receive equal medical treatment and resources. Denying certain minorities such medical treatment, while providing to whites as a standard of care, is an unjust allocation of resources and violates a basic tenet of justice. Physicians and medical researchers have an ethical obligation to use available resources fairly and to distribute them equitably. To compromise the basic ethical foundations upon which medicine stands is destructive not just to minority patients but to society as a whole.

**"GUESTS AT THE TABLE"**

In his 1979 homily at Yankee Stadium, Pope John Paul II proclaimed that "the poor of the United States and of the world are your brothers and sisters in Christ. You must never be content to leave them just the crumbs from the feast. You must take of your substance and not just of your abundance in order to help them. And you must treat them like guests at your family table."<sup>35</sup> The challenge facing Catholic health care is to treat all patients like "guests at the family table," regardless of diagnosis or ability to pay. To balance mission and margin is to be creative stewards, giving from our "substance and not just our abundance." It is to meet people where they are, to listen with sensitivity, and to render competent and compassionate quality care.

In his book *Meeting Jesus Again for the First Time*, Marcus Borg comments on the meaning of compassion: "The Hebrew word for compassion, whose singular form means womb, is often used of God in the Old

Testament. It is translated as 'merciful' in the characterization of God as 'gracious and merciful.'<sup>36</sup> Borg further remarks that "for Jesus, compassion was more than a quality of God and an individual virtue: it was a social paradigm, the core value for life in the community."<sup>37</sup> The impact of these observations cannot be overlooked. To claim that compassion is a "core value for life in community" has ramifications for those who claim the name "Mercy." This is not compassion of condescension or pity, but rather compassion of strength, integrity, and gentleness. This is a compassion that walks hand-in-hand with justice—a compassion that seeks out those on the margins of society.

Jon Sobrino, in *The Principle of Mercy*, remarks that in confronting the suffering of the world, "one will react with a compassion that seeks to eliminate such suffering. In contemporary terminology, compassion becomes liberation."<sup>38</sup> True to the Gospel message, Sobrino challenges us to face the suffering around us by acting in such a way as to help people live with freedom and dignity. Compassion then becomes the freeing movement of God in our world.

How does "compassion become liberation?" Who are the "guests at the family table?" How is compassion lived out in our world? How is it incarnated in health care?

Cardinal Joseph Bernardin, in addressing the Harvard Business School Club of Chicago on January 12, 1995, said, "We expect health care delivery to be a competent and a caring response to the broken human condition—to human vulnerability."<sup>39</sup> Cardinal Bernardin went on to add that "we endeavor to take care of the poor and the sick as much for our benefit as for theirs."<sup>40</sup> In the tradition of Catholic social teaching, the cardinal poignantly identifies for us the "guests at the table." The "guests" are the most vulnerable, the forgotten, those whose voices have been dimmed by hatred and prejudice. The guests at the family table are those who live in grinding poverty, overcome by violence and oppression of every kind. What follows is one hospital's attempt to accept the challenge.

## THE MERCY HOSPITAL PARADIGM

One possible solution is being undertaken by Mercy Hospital of Philadelphia, which serves the West Philadelphia community.

Mercy is sponsored by the Sisters of Mercy. It was founded in 1915, the first hospital in what eventually became Mercy Health System of Southeastern Pennsylvania. The mission of the Sisters of Mercy is to serve people who are poor, sick, and uneducated.

Mercy takes seriously its responsibility to the neighboring community. Mercy also takes seriously the mandate of the *Ethical and Religious Directives for Catholic Health Care Services*, that "a just health care system will be concerned both with promoting equity of care—to assure that the right of each person to basic health care is respected—and with promoting the good health of all in the community."<sup>41</sup>

Mercy's mission is to provide high-quality health care that is responsive to the community's evolving health care needs. Paying particular attention to persons who are poor and vulnerable is an integral part of the hospital's mission. Each year, Mercy evaluates its responsiveness to community needs. Several years ago, as part of the strategic planning process, the hospital's leaders identified the diagnosis and treatment of diabetes as integral to community care. Ninety-nine percent of Mercy's patients are African American (including a significant number of documented and undocumented African immigrants), a population that is especially vulnerable to diabetes and its comorbidities. One way of attempting to address the needs of our patients is through education and prevention.

The hospital's medical professionals have long been aware that a majority of African Americans

## One possible solution is being undertaken by Mercy Hospital of Philadelphia.

being seen in their hospital suffer from chronic conditions such as hypertension, diabetes, and obesity. The problem was that, because of inadequate health care, many patients were coming to the emergency department with advanced stages of these conditions. This finding is not unique. Studies have shown that "the major causes of death among African Americans are heart disease, cancer, stroke, accidents, and diabetes. Most of these are chronic diseases rather than acute illnesses, and all of these causes of death are at least arguably preventable."<sup>42</sup>

Mercy's leaders became concerned about the general responsibility of a Catholic institution to address disparities in health care—and about addressing the urgent needs of West Philadelphia patients. As a result, they designed a program to target hypertension, diabetes, and obesity in the African-American community, not only to improve the health of this minority community but also to rebuild a sense of trust between the community and

the local medical establishment.

Although Mercy has a busy community outreach center across the street from the main hospital, its leaders felt they needed to broaden outreach to include the wider community. They considered establishing a separate, community-based clinic. Several possible sites were explored. Finally, Our Mother of Sorrows Parish, just 10 minutes from the hospital, was selected. Our Mother of Sorrows is located in an economically distressed part of the city. Its population is predominantly African American, although it also has a growing number of African immigrants. Additionally, the parish contains a significant number of homeless persons, many of whom have mental illness. By developing a clinic in this area, Mercy's leaders hope to reach out to traditionally underserved people whose mistrust of traditional health care has been described elsewhere in this article.

After meeting with the parish social minister and the pastor, Mercy's leaders decided that the best way to set up the clinic was to use what was already familiar to the targeted population. For example, the parish has a soup kitchen that operates two hours a day, five days a week. It was decided to begin the clinic with clients of the soup kitchen, people who are already familiar with the parish and its workers and who are accustomed to coming at a set time each day for a hot meal.

The plan was to staff the clinic on a rotating basis with internal medicine residents from Mercy. The residents would be supervised by members of the facility's hospitalist service. Students from Saint Joseph's University's Service Learning Program would serve as registration clerks and intake workers. Mercy's financial counselor would be available to help those who wished to apply for Medicaid, although there would be no fee for clinic services.

Mercy's leaders felt that since many of the potential clients were homeless and had mental illness, they were likely to be suspicious of people they did not know. The clinicians and St. Joseph's students would, therefore, begin "small"—they would go to the clinic one day a week to meet clients and begin to form relationships with them.

Seed money for the venture was to come from the C. Jules Rominger, MD, Foundation. Mercy began the foundation five years ago to honor the late physician, a radiation oncologist, who served at the hospital for more than 50 years. Each year, a lecture is held in Dr. Rominger's name and an award is given to an outstanding resident who exhibits humanitarian service. It seemed fitting that the initial funding for the clinic project should be provided by the Rominger Foundation.

In February, the clinic, called the Mercy Ambulatory Center, opened—temporarily—in the hospital; a move to the community is still planned. Its goals are simple—to provide screening, prevention, and education in a setting that is familiar and nonthreatening.

The challenges it faces are substantial:

- Earning the trust and confidence of patients
- Encouraging and supporting compliance
- Establishing a referral base for follow-up care

The Mercy Ambulatory Center is in keeping with Mercy's mission. Catherine McAuley, the foundress of the Sisters of Mercy, had the courage to address the needs of her time. Today, the Sisters of Mercy strive to address the needs of their time. The congregation's Fourth Vow of service to people who are poor, sick, and uneducated impels the sisters not only to relieve the suffering of those around them but also to help others reach their rightful place in society.

Such was Catherine's respect for the inherent dignity of each person that her counsel to her sisters was: "God knows that I would rather be cold and hungry than the poor should be deprived of any consolation in our power to afford."<sup>43</sup> The Sisters of Mercy, in their Institute Justice Ministry Purpose Statement, challenge themselves "to walk gently in solidarity with persons who are poor, oppressed, and marginalized, listening to their stories, encouraging their voices, and enabling their empowerment."<sup>44</sup>

Mercy's leaders hope that the Mercy Ambulatory Center will be one concrete way their facility can live out Catherine McAuley's dream in the 21st century. They hope not only to provide care to vulnerable members of racial and ethnic minorities, but also, by taking that care directly to minority people, to begin regaining their trust in the health care system.

Mercy's clinic project is still young; building trust among members of the West Philadelphia community will take time. Still, the leaders of Mercy Hospital of Philadelphia are convinced they are on the right track. They believe that if other Catholic hospitals will adopt Mercy's paradigm, they will go a long way toward fostering a new sense of trust between minority communities and the medical establishment. This new sense of trust would be based on treating all people with dignity and respect, which is the cornerstone of Catholic health care in the United States. ■

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