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FEATURE ARTICLE

Is Fossil Fuel Investment a Sin?

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The Catholic Health Association holds that Catholic health care "continues Jesus' mission of love and healing in the world today." We believe that in the face of climate change, this mission calls the health care ministry to divest from fossil fuel corporations and reinvest in companies and industries that promote the common good, of which the climate, as Pope Francis emphasizes, is an essential part (23). In this essay, we call on Catholic health care systems and institutions to lead the way among all health care systems and institutions by seriously considering financial divestment from fossil fuels.

I. Global Warming

In 1859, Irish physicist John Tyndall showed that greenhouse gases like carbon dioxide in the Earth's atmosphere trap heat in a process later termed the "greenhouse effect." Since Tyndall's discovery, human activities – especially fossil fuel combustion – have increased the amount of greenhouse gases in the atmosphere beyond any levels in human history. Between 1850 and 2007, the United States produced nearly thirty percent of the world's carbon pollution.[1] As a result, average global temperatures have increased by nearly one degree Celsius. This global warming is already producing geophysical consequences like glacial melt, drought and altered disease vector habitats.

Since humans are impacted by the natural environment, climate change already causes thousands of deaths and illnesses each year. According to the World Health

Organization, "Climatic changes are already estimated to cause over 150,000 deaths annually" and between 2030 and 2050 climate change related health hazards are "expected to cause approximately 250,000 additional deaths per year" due to heat exposure and extreme weather, diarrhea, malaria and other vector-borne diseases, and under-nutrition because of famine.[2] In 2009, the Lancet/UCL Commission for Global Health, a collaboration between *The Lancet* medical journal and University College London, reported that the threat to human health from climate change is so great that it could reverse the last five decades of development and public health progress worldwide. As with much ecological degradation, the poor are disproportionately harmed by climate change despite contributing least to the problem.

Globally, the fossil fuels that drive anthropogenic climate change create immense additional health risks via the pollution of particulates. Every year, air pollution contributes to the death of 7 million lives. Pollution imposes very high costs, including over 200,000 premature deaths per year in the U.S., and is linked to neuro-cognitive disabilities in children as well as asthma.[3] The impacts are particularly harsh on the poor, as polluting industries and toxic sites are often concentrated in poor and minority neighborhoods.

Scientists widely recommend that global warming should be capped at two degrees Celsius above pre-industrial temperatures to avoid triggering so-called "tipping points" beyond which feedback loops make warming essentially irreversible. Additionally, the Paris Agreement urges limiting global warming to no more than one and a half degrees Celsius above pre-industrial levels. However, for this to happen, one of the things that nations – especially the U.S. – must do is reduce reliance upon fossil fuels. As one writer conservatively concluded after considering several estimates and figures, "So while it is good to understand what factors will determine our carbon budget, it is much more important to call on politicians and investors alike to get a grip on this issue and face up to the simple and incontestable reality: there's far more fossil fuel than we can burn, and the more of it that we take out of the ground, the greater the risk of an irreversible climate catastrophe."[4]

The world's known coal, oil and gas reserves are owned by publicly traded corporations that sow scientific disinformation about climate change and lobby against polices to limit greenhouse gas pollution.[5] According to market logic, these companies will burn these reserves – and lead to a possible 10 degree Celsius rise globally – unless massive reversals in public opinion and legal repercussions emerge.[6]

II. *Laudato Si'* and Catholic Responses

In his 2015 encyclical *Laudato Si'*, Pope Francis affirmed the inescapably social dimension of climate change, writing, "We are faced not with two separate crises, one environmental and the other social, but rather with one complex crisis which is both social and environmental."[7] Additionally, he refers to "the symptoms of sickness evident in the soil, in the water, in the air and in all forms of life," thereby linking the disease of the planet and the disease of people who are sick due to human-induced climate change and environmental degradation.

Consistent with Saint Pope John Paul II and Pope Emeritus Benedict XVI, Francis then calls on all Catholics and Catholic institutions to "protect our common home," the earth. In particular, Francis stresses "that technology based on the use of highly polluting fossil fuels – especially coal, but also oil and, to a lesser degree, gas – needs to be progressively replaced without delay" (165). Additionally, he underscores the "urgent need to develop policies so that, in the next few years, the emission of carbon dioxide and other highly polluting gases can be drastically reduced, for example, substituting for fossil fuels and developing sources of renewable energy" (26).

In response to the pope's encyclical, many Catholic parishes and schools are taking "practical steps on behalf of the environment."[8] In 2016, the Catholic Climate Covenant (of which the Catholic Health Association and the U.S. Conference of Catholic Bishops are members) developed and launched the Catholic Energies program to help Catholic dioceses and institutions increase energy efficiency and renewable energy consumption. Dan Last, chief operating officer for Catholic Energies, notes that Catholic parishes, schools, campuses, hospitals, and nursing homes operate approximately 70,000 buildings, most of which use energy inefficiently, wasting around $1 billion per year. Dan Misleh, the executive director of Catholic Climate Covenant, adds that Catholic Energies is "providing the opportunity at the parish and school levels, and perhaps at universities and hospitals, to do something" about their energy choices in response to climate change.[9] Since health care facilities are among the most energy-intensive buildings in the United States, Catholic Health Association members can substantially benefit from Catholic Energies.[10]

III. Divestment from Fossil Fuel Corporations

In addition to addressing their own energy consumption, many Catholic institutions are also reconsidering their investments in fossil fuel (i.e., coal, oil, gas) companies. Indeed, a growing number of organizations – including Catholic institutions – have chosen to divest from these corporations and reinvest these assets in climatically responsible places.

In the Catholic tradition, social action requires "The Two Feet of Love in Action."[11] The first, charity, includes local efforts to address immediate concerns. The second, justice, addresses the root causes of social issues by reforming systems, structures and policies. With respect to climate change, fossil fuel divestment and re-investment elsewhere are acts of justice. Pension funds and institutional investors represent a significant source of needed capital for renewable energy industries. The divestment and re-investment of these funds is thus a positive, non-trivial structural reform that provides capital for renewable energies that lack the tax breaks and subsidies available to fossil fuels. Additionally, divestment – especially by faith-based institutions – seeks to so morally stigmatize fossil fuel corporations that lawmakers finally reject their financial contributions which systematically maintain the agenda to burn all known carbon reserves. At a minimum, many Catholic institutions are divesting to maintain structural fidelity to their missions and avoid investing in companies and systems that undermine the church's core social teachings.

Catholic Health Care and Divestment

Health care organizations are highly respected institutions with a clear mission to support human life and well-being. There is a logical mission inconsistency between advocating for and serving individual and population health while at the same time funding corporate initiatives that undermine health. Mission integrity calls for investments in clean, healthy energy that do not subsidize pollution deaths and climate impact deaths. Catholic hospitals and health care systems must thus consider divestment as an expression of their mission and values and as a health care imperative.

In 1981, the United States Conference of Catholic Bishops identified personalized patient care, medical-moral issues, the prophetic role, and rights and responsibilities of employers and employees as "four areas that Catholic health care facilities can demonstrate their fidelity to the Catholic traditions."[12] Divestment from fossil fuels fits with each of these categories.

First, Catholic health care facilities are committed to offering personalized patient care. In a globalized era, patient care must include preventative health care measures.[13] Public health initiatives have long recognized that the environment affects health. Divestment from fossil fuels will reduce carbon impact and mitigate the severity and frequency of health care visits for climate change-related health hazards.

Second, divestment must be seen as a medical-moral issue. Catholic health care facilities that divest from fossil fuels will help mitigate climate change – and concomitant health hazards – as well as stand against environmental racism.[14] The poor and vulnerable rarely have adequate access to health care and thus are most drastically impacted by pollution. The United States Bishops' Resolution on Health Care Reform acknowledged that "reform of the health care system which is truly fundamental and enduring must be rooted in values which reflect the…claims of the poor."[15] If the health care industry invests in dirty energy that produces carbon emissions, it fails in its commitment to care for those most affected by climate change-related health hazards.

Third, the prophetic role of the church is an underemphasized, but vitally important, aspect of Catholic health care. Catholic health care facilities have been leaders in many significant issues around human dignity, beginning of life and end-of- life care, and social responsibility.[16] Numerous Catholic hospitals and health care facilities have already committed to sustainability and this ought to be lauded. But a prophetic role goes beyond current social wisdom that recognizes climate change as a moral issue. The prophetic role in health care includes denouncing structures of injustice. Divestment will lead towards sustainable health care and ethical investments.

Fourth, Catholic health care facilities have a responsibility to provide a healthy working environment for employees. Health care workers suffer mentally from distress and may experience compassion fatigue from their vocation.[17] This will be compounded as the lines between fossil fuel use and avoidable climate change health hazards are drawn. Clinicians and allied health professionals also suffer physically from environmental toxins and other occupational hazards that rely on fossil fuels for their manufacturing and production.[18] Employees are entitled to a healthy, safe environment. Divestment is one step toward this goal.

To question the prudence and moral consistency of health care providers' investment in unhealthy energy is not to suggest that such investment is a so-called "intrinsic evil." The health impacts of fossil fuels are instead best understood as originally unintentional byproducts of the industrial economy's current, though rapidly shifting, dependence on fossil fuels. Nor does recognition of the health impacts deny energy's essential function to support human dignity, economic development, and the provision of health care, and real dependence upon fossil fuels by the poor in many areas of the world.

To the first point, it is precisely the complex structural nature of fossil fuel economy that requires an intentional effort to disinvest from polluting energy and re-invest in clean energy. To the second point, Vatican teaching on energy states that advanced nations, which have already benefited from industrialization, have the moral responsibility of developing new clean energy technologies *specifically* so that developing nations continue to use, but also move away from, the energy sources that are currently most accessible (including fossil fuels). This development occurs precisely through investments in research, development, commercialization, and deployment.

V. Divestment as Too Risky and Merely Symbolic

Catholics have a Eucharistic, incarnational spirituality expressed in the integrity of our institutions. Ultimately investment choices, like other business choices, should be shaped by faith, and that faith responsibility complements fiduciary responsibility. Responsibility is directed toward financial resources and what these resources are used for: in this case, health and well-being. Still, we must consider common objections that divestment is too economically imprudent and merely symbolic.

Investments always entail risk, and investors may always question the level of risk involved in any investment decision. Indeed, fiduciary responsibility compels institutional investors to assess the impact upon returns. Yet, important caveats attend this legitimate concern for returns and prudent stewardship of funds. First, the market is inherently unpredictable and no guarantees of uninterrupted growth pertain to any investment choice. All who felt the impacts of the 2008 market correction can attest to this. Second, new risks are inherent in remaining invested in fossil fuels. Global society is shifting decisively to low-carbon. Even without the formal commitment to the Clean Power Plan or the Paris Accord, many analysts predict that the United States is on track to meet the goals of the Clean Power Plan, simply due to the acceleration of market forces and the deployment of clean energy systems. The reserves of fossil fuel companies face the prospect of becoming legally unburnable due to future global accords becoming "stranded assets," forcing depreciation of those assets. As a result, new definitions of fiduciary responsibility are challenging the conventional wisdom of remaining heavily invested in fossil fuels.[19]

From the perspective of Catholic moral theology, it has never been morally legitimate to seek maximum financial return on investments. This is clear from the United States Bishops' *Guidelines on Socially Responsible Investing*. This Catholic commitment to investing in socially responsible ways that protects human well-being and God's creation is not new. What is new today is the imperative to interpret these guidelines in the context of climate change and its impacts upon human health and well-being. Given growing scientific evidence about the impacts of fossil fuels, the risk of continued extraction and combustion of fossil fuels is rapidly outpacing financial and other benefits.

Markets are shifting towards renewable energy as a business investment at a rapid rate.[20] Shareholder engagement is advocating for reporting and transparency. But there is a timeless matter of stating the truth. It is not ethical to formally intend the exploitation and combustion of fossil fuels, and to invest resources in the exploration and expansion of fossil fuel infrastructure when we are aware of the long-term consequences. It is not moral to invest in that knowing what we know now. The past decades of industrial advancement are not realities for which we should feel guilty, but they are not investments to which we can continue to be committed.

Others may argue that Socially Responsible Investing (SRI) can empower shareholders to advocate for change from within companies. However, since fossil fuel corporations fundamentally seek to maximize carbon reserve extraction and combustion, SRI is unlikely to affect enough internal corporate change to avoid climate catastrophe. To defer questions of ethical investing to the strategy of shareholder engagement is inadequate.

Divestment is indeed symbolic from the perspective of Catholic theology, but it is an effective symbol: a visible sign of invisible realities, the visible reality of using funds to build a healthy and sustainable economy. A sacramental realization of love of neighbor in directing funds to clean investments is no less symbolic than providing funds to buy bread for the hungry, which is the actual reality of love of neighbor. "In a real theology of the symbol, based on the fundamental truths of Christianity, a symbol is not something separate from the symbolized…. which indicates the object but does not contain it. On the contrary, the symbol is the reality, constituted by the thing symbolized as an inner moment of itself, which reveals and proclaims the thing symbolized, and is itself full of the thing symbolized, being its concrete form of existence."[21] The symbolism of divestment is thus deeply important from a Catholic perspective.

VI. Conclusion

Catholic health care ministry is committed to the protection of human life and the promotion of human dignity, especially of the poor and vulnerable. Since climate change appears to be at least in part due to choices by large fossil fuel corporations, Catholic health care institutions have a moral obligation to divest from the fossil fuel industry and reinvest in companies whose core business models do not sicken, injure and kill vulnerable persons and communities.

Divestment is a real possibility for Catholic institutions. In 2014, the

University of Dayton, a Catholic university, announced its divestment of its $670 million investment pool from fossil fuels, invoking Catholic social and ethical teaching on the environment as the basis for the decision. Health care systems such as San Francisco-based Dignity Health (formerly Catholic Health Care West) and St. Louis-based SSM Health, are doing likewise. To mark the 2017 Feast of St. Francis, four Catholic institutions similarly announced their intent to divest from fossil fuels.[22]

Climate change health hazards from fossil fuel-related greenhouse gas pollution highlight the social and environmental issues facing Catholic health care that divestment can, in part, remedy. Health care simply cannot continue to sacrifice the health of all people by supporting the fossil fuel marketplace. Catholic health care must find a way to continue the mission of healing without harming the earth or the people who inhabit it.

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FEATURE ARTICLE

Assisted Suicide, Euthanasia or Better End-of-Life Care?

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Introduction

Physician-assisted suicide (PAS) has been in the news a lot lately, as many states have either entertained or passed legislation allowing what has been termed "aid in dying".[1] At its heart, PAS is not just a legal issue nor a political issue. It is not even fundamentally a religious issue. It is a human issue. As such, it transcends political, legal and religious boundaries. Factors that lead to requests for aid in dying such as loss of a sense of control, loss of a sense of meaning and purpose, fear of being a burden on others, and uncontrolled physical pain or other severe bodily symptoms, lie at the heart of human dignity. Health care which addresses these fundamental concerns is an obligation we owe and wish to render to our most vulnerable patients. Proper care for the dying is not the same as assisting them in suicide.

Discussion

Physician-assisted suicide is inherently unethical. This is so crucial since "Physicians are members of a profession with ethical responsibilities; they are moral agents, not merely providers of service"[2]. It violates codes of ethics and fundamental principles of bioethics as well as the *Ethical and Religious Directives for Catholic Health Care Services.*[3] A central tenet of the Hippocratic Oath states, "I will not give a lethal drug to anyone if I am asked."[4] The American Medical Association Code of Ethics states:

> Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to

> control, and would pose serious societal risks. Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Multidisciplinary interventions should be sought including specialty consultation, hospice care, pastoral support, family counseling, and other modalities. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication.[5]

The American Nurses' Association Statement on Physician-Assisted Suicide states:

> The American Nurses Association (ANA) prohibits nurses' participation in assisted suicide and euthanasia because these acts are in direct violation of the *Code of Ethics for Nurses with Interpretive Statements*, the ethical traditions and goals of the profession, and its covenant with society. Nurses have an obligation to provide humane, comprehensive, and compassionate care that respects the rights of patients and upholds the standards of the profession in the presence of chronic, debilitating illness and at end-of-life.[6]

More recently, the American College of Physicians (the enormous national organization of internal medicine specialists) issued an updated statement against physician-assisted suicide.[7]

The Argument in Favor of Physician-Assisted Suicide: The Slippery Slope in Practice

Proponents of physician-assisted suicide often cite the experience of the Death with Dignity Act (DWDA) in Oregon, and many assert that the bill has improved overall care for the dying in that state. They cite a greater willingness on the part of physicians to discuss end-of-life issues with patients and to effectively pursue pain management. Yet discussions regarding goals of care and end-of-life issues and commitment to appropriate palliative care do not flow from the existence or legalization of physician-assisted suicide, but rather from the deep-seated desire of health care providers to enter into the experience of dying patients and to accompany them on this journey. Safeguards meant to prevent abuse are sometimes not observed. For example, in 2013 the state of Oregon reported that only "two of the 71 DWDA patients who died during 2013 were referred for formal psychiatric or psychological evaluation."[8] The rate of formal psychiatric consultation for DWDA patients in Oregon fell from 11 percent in the first decade of enactment—itself an abysmally low level—to 3 percent in the second decade.[9] Thus, overall only 5.9 percent of all patients who received life-ending medication were referred for psychiatric evaluation even though most practitioners are aware that "despite its prevalence among patients with serious illness, clinical depression is often unrecognized"[10] and even though assessments of decision-making capacity, possible depression, and emotional stability are key elements of the Act.

Another issue is the role of the physician in prescribing and administering fatal medications. If it is true that in some cases, doctors prescribe but are not present at the time of administration, this seems to us to be a possible dereliction of duty. This is especially true if complications develop that the family or other caregiver cannot handle. There are also questions about whether other caregivers should be present at administration of the drug. While normally a medical professional would oversee administration of medication, presence of a Catholic nurse or a nurse supplied by a Catholic organization could easily be construed as moral complicity.

The risks of abuse and misapplication of physician-assisted suicide are real, and bear consideration. The Netherlands began with legalized active voluntary euthanasia and physician-assisted suicide. Like most current assisted-suicide legislation in individual American states, there was no mandated reporting of aid-in-dying by physicians. The Dutch government relied on physicians to self-report their use of aid-in-dying. The *Remmelink Report*[11] cites instances of physicians who participated in assisted-suicide and active voluntary euthanasia, which are legal in that country; but also reports instances in which they participated in non-voluntary euthanasia, (i.e., the patient did not request euthanasia but was euthanized), and even of involuntary euthanasia whereby the patient expressly rejected euthanasia but was euthanized anyway. A disproportionate number of the involuntarily euthanized were elderly, poor, disabled and mentally ill: the most vulnerable in society.

Those who support what they deem “compassionate aid in dying” legislation often adduce testimony from physicians and patients about personal experiences with terminal illness. These are often heart-wrenching stories of anguish, pain, other suffering, and loss. Our first response to these patients is, of course, one of empathy and utmost compassion. The main problem with legalized physician-assisted suicide is its potential to undermine or replace proper care for the dying. Studies indicate that, contrary to one’s intuition, physical pain is not the most significant factor in requests for physician-assisted suicide. It currently ranks fifth on the list of factors. Indeed, the National Cancer Institute states:

> While unrelieved physical suffering may have been widespread in the past, modern medicine now has more knowledge and skills to relieve suffering than ever before. Today, specialists in palliative care believe that if all patients had access to careful assessment and optimal symptom control and supportive care, the suffering of most patients with life-threatening illnesses could be reduced sufficiently to eliminate their desire for hastened death. Even when the desire persists, avenues other than physician-assisted suicide or euthanasia are available to remedy suffering and still avoid prolonging life against the patient’s wishes.[12]

In fact, one study states that “pain alone was a motivator in 3 percent of requests [for physician-assisted suicide].”[13] Patients cite loss of control, loss of a sense of meaning and purpose, and the fear of being a burden on others as the most significant factors in requests for assisted suicide. These experiences are very real, and need to be addressed with compassion and a multidisciplinary approach to caring for the dying. We don't address these patient concerns by deliberately ending a life. Rather, we address them by caring for the person in crisis even when we cannot overcome or extirpate these profound and grave difficulties. This conclusion mirrors the prescient comments made by Dame Cicely Saunders, the founder of the modern hospice movement, in a review from 37 years ago that emphasized repeatedly evaluating intractable symptoms and seeking creative approaches to alleviate suffering when conventional means fail or are exhausted.[14]

A Holistic Approach to End-of-Life Care as an Alternative to Physician-Assisted Suicide

In order to most compassionately and effectively respond to the needs of the terminally ill and their families, we must address those factors that lead to requests for aid-in-dying. We can address the fear of loss of control by encouraging patients and their families to discuss goals of care and wishes for treatment early in the trajectory of illness.[15] Hospitals, medical schools and residency programs need to provide better training for physicians, nurse practitioners and physician assistants so that they know how to initiate discussion of end-of-life care and concerns with patients and their families. It is absolutely indispensable that open discussions occur *before* chronic or terminal illness is present. Nor can conversations about advance directives be outsourced: clinical social workers, nurses, palliative care practitioners are all superb facilitators for such discussions. However, without representation of the attending of record and other team members who possess primary responsibility for the patient and carry an immediacy, credibility and authority that can only derive therefrom, such discussions too often prove vague and unsatisfactory.

Advance directives in the form of a living will or appointment of a health care representative can be a useful tool in this discussion, but they do not supplant this discussion.[16] An advance directive is an outcome of meaningful conversation, but not the only reason for the conversation. Advance directives give the gift of understanding and increased peace of mind to loved ones and patients. They also extend autonomy beyond what most physician-assisted suicide bills would do, since the scope of these bills is customarily limited to terminally ill patients who still have decision-making capacity. Advance directives allow for autonomy to be established during competency and then to continue to guide care even after patients lose capacity. One does not have to be terminally ill to benefit from a health care proxy or other representative who advocates for and helps carry out one's wishes. Up to 85 percent of patients who have an advance directive, report feeling increased control and with it a better sense of being cared for by both their physician and family.[17]

Over treatment or inappropriate care is another major problem. Advance directives allow patients to refuse unwanted medical interventions such as artificial nutrition and hydration, mechanical ventilation, endotracheal intubation or CPR if they are no longer beneficial, and/or overly burdensome. The right to reject such extraordinary care is supported by Catholic medical ethics and the *Ethical and Religious Directives for Catholic Health Care Services*. It was confirmed in the Supreme Court's ruling in the *Cruzan* decision, and upheld in the two assisted-suicide cases, *Washington vs. Glucksberg* and *Vacco vs. Quill*.[18] These cases also affirmed that physician-assisted suicide is not a fundamental constitutional right, and that withholding or withdrawing extraordinary medical care is fundamentally different from physician-assisted suicide. Current legislation in Connecticut regarding the pilot program for MOLST is expected to enhance patient autonomy, assuming that the ethical principles of beneficence, nonmaleficence and justice remain in action.

The Importance of Palliative Care

Meticulous pain and physical symptom management[19] are necessary but not sufficient: Proper care for the dying also requires psychological, emotional, spiritual and social support. Palliative care is designed to provide such a holistic approach for both patient and family. However, palliative care is poorly understood and significantly under-utilized in North America. When fully matured in a health care system, palliative care forms an intrinsic part of the continuum of care from earliest treatment, and is routinely provided alongside curative treatment as well as later in the course of disease. Palliation and cure, contrary to the pervasive stereotype, are not mutually exclusive. The Palliative Care Advisory Committee convened in Connecticut – which ranks in the bottom 2 percent in the United States regarding the timeliness of hospice referral - is optimistic about change and feasibility. However, a lot of work remains to be done. While hospice is not identical to palliative care, the two services are aligned, and parallel image problems beset both. Referrals to hospice are supposed to occur when a patient has six months or less to live as judged by a physician. On average in Connecticut, patients are referred to hospice with less than *two weeks* to live.[20] This does not allow for adequate time to address the physical, emotional, spiritual and psychological needs of patient and family. We can and must do better.

Every hospital and nursing home needs an active, vigorous multidisciplinary palliative care/end of life committee, with active rather than nominal physician leadership and participation. Meaningful training in advance directive conversations needs to be mandated for maintenance of clinical privileges—the antithesis of a checkbox that a question was asked about whether an advance directive exists: the extant tick-box is a sham of pseudo-compliance. The failure to obtain palliative care consultation in a patient who is terminal and has uncontrolled symptoms must be treated as medical error, with sanctions and re-education. Funding must be secured, now and going forward, to support palliative care teams, since collectable billings do not match the high cost of providing this human-resource-intensive service (though avoidance of futile expenditures ultimately makes the service financially sound as well as morally indispensable).

Conclusions

Physician-assisted suicide sends a message to the dying, however much we wish it wouldn't, that they are expendable and disposable. It allows health care providers and even family to avoid the strenuous work of acting with utmost creativity and responsibility in caring for the dying. Too often we have seen that patients who can no longer be cured are then, intentionally or otherwise, more or less completely ignored. The end of curing is never, in the practice of any merciful human being, the end of caring. We tend to avoid what we cannot fix, but if we push through to accompany the dying on their journey, we can encounter many blessings on the journey, and help them to do the same. It is a gift and a responsibility.

Fundamentally, providing "compassionate aid in dying" means helping the terminally ill to see that they are cherished in their personhood, however frail, however diminished, and that they are not disposable. The dying have so much to teach the rest of us about the preciousness and joy of ordinary daily life, if we only choose to listen and learn from them. We promote compassionate care for the most vulnerable among us when we affirm their existence, listen to and acknowledge their fears skillfully; when we tirelessly and creatively manage their symptom burden including pain, and thus help them alleviate their spiritual and existential suffering. Assisting them with suicide does not belong on this list of comfort and aid to the most vulnerable.

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[3] *Ethical and Religious Directives for Catholic Health Care Services*. Washington, D.C.: United States Conference of Catholic Bishops, 2001. See in particular Directive 60.

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[6] "American Nurses Association Position Statement on Assisted Suicide," *Trends Health Care Law Ethics* 10, no1-2 (1995): 125-127.

[7] Snyder, Sulmasy and P. S. Mueller. "Ethics, Professionalism and Human Rights Committee of the American College of Physicians. Ethics and the legalization of physician-assisted suicide: an American College of Physicians position paper." *Annals of Internal Medicine* 167 (2017), 576-578 and with it three thoughtful commentaries: Katrina Hedberg and Craig New. "Oregon's Death With Dignity Act: 20 Years of Experience to Inform the Debate." *Annals of internal medicine* 167, no. 8 (2017): 579-583.; William G. Kussmaul. "The Slippery Slope of Legalization of Physician-Assisted Suicide," *Annals of Internal Medicine* 167, no. 8 (2017): 595-596.; Timothy E. Quill, Robert M. Arnold, and Stuart J. Youngner. "Physician-Assisted Suicide: Finding a Path Forward in a Changing Legal Environment." *Annals of Internal Medicine*167, no. 8 (2017): 597-598.

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[14] Dame Cicely Saunders. "The hospice: its meaning to patients and their physicians." *Hospital Practice* 16, no. 6 (1981): 93-108.

[15] See for example, Rachelle E. Bernacki and Susan D. Block. "Communication about serious illness care goals: a review and synthesis of best practices." *JAMA Internal Medicine* 174, no. 12 (2014): 1994-2003.and Kirsty Boyd and Scott A. Murray. "Why is talking about dying such a challenge?" (2014): g3699.

[16] The Conversation Project (www.theconversationproject.org) was founded by a group of organizations specifically to encourage the conversation. Their website provides a wide range of resources for families, patients and clergy designed to get these conversations started. They note that while the vast majority of us say we want to have such a conversation, only about a quarter of us actually do.

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The Future Shape of Ethics: Are We Prepared for What's Coming?

Editor's Note:

Almost every discussion of health care ethics I have been involved in eventually gets around to the changing or evolving nature of the discipline. Not everyone agrees on what ethics will look like in ten or twenty years, but everyone agrees that it is going to change. Electronic medical records, virtual care, system mergers, the rapidly evolving role of the mission leader, changing patterns in reimbursement and emerging issues (e.g., genomics and transgender medicine) will force us to examine what ethics includes, as well as specific practices. Health Care Ethics USA invited two ethicists, Alan Sanders from Trinity Health and Becket Gremmels from CHRISTUS Health, to reflect on what they see as the future of the ethics function. Alan explores Trinity's "expanding vision" of ethics; Becket highlights several factors that are changing the way ethics committees work.
We invite other systems to share their observations about what Catholic health care will require of ethicists in the future.
C.B.

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When Catholic Health East and legacy-Trinity consolidated in 2013, the sponsors developed a mission and vision for the new Trinity Health. As a result, our mission today is to be a compassionate and transforming healing presence within our communities, and our vision is to be the most trusted health partner for life. This mission and vision are based on Trinity Health's founding story of the Good Samaritan. Prophetically, this story was modified in the 1990s by the late theologian and ethicist Jack Glaser to reflect changes occurring in the U.S. health care marketplace system in the era of managed care, changes that many say are similar to changes occurring today.

Glaser's modification of the story is simple, but it reflects the much more complex ethical questions that confront health care systems in our rapidly changing and challenging times.[1] In the modified version, rather than encountering one wounded traveler on the side of the road, the Samaritan encounters a number of wounded and realizes there are likely many more beyond his immediate sight. With his limited resources, he now faces a population of people needing help, prompting difficult ethical questions related to resource allocation, among others. This reminds the reader of the challenges health care systems face today, at a time when we are called upon to address population health and adjust to value-based payment models – models that reward health systems for measurable outcomes in improving health in place of the older fee-for-service model.

In response to this new environment, mission and ethics at Trinity Health has adopted a three-realms-of-ethics model to serve as an ethical framework for our organization. The realms are clinical ethics, organizational ethics, and social ethics. These three realms are not new to Catholic health care, especially in the context of the Catholic moral tradition, but they have not previously served as an overarching ethical framework for those who work in ethics in Catholic health care organizations.[2]

Ask anyone in Catholic health care what the word "ethics" suggests to them, and you will likely get answers ranging from choices related to clinical treatments (typically what is prohibited by the ERDs), to matters of compliance and law, to whether the organization is governed by principles of justice in the way it treats its colleagues. Generally speaking, most people do not think beyond the organization itself, to how ethics might impact the health of the population at large. Therefore, we have begun to educate and form all colleagues in mission and ethics around this expanded ethical framework, represented in the draft ethics icon below.

The draft icon depicts the three realms of ethics as concentric circles with Trinity Health's vision to become the most trusted partner at its center. The words "discernment" and "reflection" run throughout all three realms, and are rooted in Trinity Health's mission, vision, and values. The goal is that these three realms of ethics are seen as responsibilities for the entire ministry and its colleagues, not just the work of mission and ethics or other specific departments or, least of all, exclusively the work of ethics committees. However, each realm does have particular responsibilities that are evolving and emerging.

Clinical ethics is the realm with which most people are familiar. It is the realm of clinical ethics consultation or facilitation (e.g., end-of-life and beginning-of-life), and a host of policies and educational services guided by the ERDs. Over the years, the role of clinical ethics committees has evolved away from providing clinical ethics consults to supporting a trained team of individuals to facilitate and document those conversations. Consistent across many Catholic systems, clinical ethics committees continue to provide a retrospective review of cases, quality improvement of the ethics consult process, policy development, and education.

> The realm of organizational ethics has gained increasing attention over the years through the work of theologians and ethicists in Catholic health care.[3] Organizational ethics includes mission discernment, the name for Trinity Health's values-based decision-making model; assessment of partnerships, especially with other-than-Catholic partners; and close working relationships with human resources and other departments in the organization to help ensure that the ministry's decisions, practices, and policies promote and align with the Catholic moral tradition. However, members of clinical ethics committees are not equipped to address most matters of organizational ethics because their training tends to be focused exclusively in clinical bioethics, and representation on the committees often does not include those involved in organizational ethics decisions.[4]

Least defined in Catholic health care is the realm of social ethics, although this realm has a long-standing history in the Catholic moral tradition through the principles of social justice and the common good. In the draft ethics icon and related ethical models, the realm of social ethics surrounds clinical ethics and organizational ethics because the social realm is the largest and has more influence on them than they are able to have on it.[5] At its broadest reach, social ethics is the entire society and its culture.

Here, however, a distinction needs to be made regarding the voice or witness of the global Catholic Church in society, and the role of Catholic health care, a distinction that has been addressed by both Pope Benedict XVI and Pope Francis. Pope Benedict XVI offers some principles for social ethics related to Catholic health care in his encyclical *Deus Caritas Est* (*God is Love*), particularly where he states that the Church's charitable activity (including that of health care organizations) should not become just another form of social assistance. Further, he cautions that it must be independent of parties and ideologies, and should not be used as a means of engaging in proselytism. Rather, the Church's charitable activity is to be accomplished and distinguished by dedicating itself to others with heartfelt concern, enabling others to experience the richness of their human dignity.[6]

Pope Francis further emphasizes these obligations by comparing the Church to a field hospital that seeks and heals society's wounded.[7] He makes a similar point in his apostolic exhortation *Evangelii Gaudium* (*Joy of the Gospel*), where he says the Church's pastoral ministry cannot be obsessed with the transmission of a disjointed multitude of doctrines to be imposed insistently, but rather, should strive to bring out and develop facets of the inexhaustible riches of the Gospel that meet the needs of those who are suffering in the moment.[8]

While the voice and witness of the Catholic Church and Catholic health care are distinct, they are not mutually exclusive when viewed in the light of value-based payments and the need to address the multiple needs of communities under the umbrella of population health. The goal of population health is not to just treat illness, but also to encourage wellness and reward health systems for achieving that goal. "Wellness" is a very broad category, one that juggles both scientific and political agendas, and includes the physical, mental, social, and spiritual aspects of human beings. As examples, the clinical classification of gender dysphoria, and the related, but often conflated, social issues of gender identity, as well as genomics, are small drops in a sea of changes in front of us challenging conceptions of human health and the role of medicine.

What is clearly in the realm of social ethics for Catholic health care are issues of social justice (e.g., human trafficking), socially-responsible investing, the work of foundations, advocacy, and current work in population and public health aimed at promoting healthy behaviors. Catholic health care organizations are already struggling with questions about social priorities amid competing interests and limited resources. Other pressing concerns include balancing obligations to further the common good of communities, while respecting both the autonomy of individuals who live within them and the individual discretion of providers, as well as providing models for encouraging healthy lifestyles such as diet and exercise.[9]

All of this is to say that in mission and ethics at Trinity Health we know that the work of ethics is expanding, and we are just beginning to outline what all of this means practically. First, Trinity Health is drafting what it considers “essential work in ethics” for mission leaders and ethicists in these three realms, guided by Catholic social principles and the *Ethical and Religious Directives for Catholic Health Care Services*. Second, we are forming a system-wide ethics council and regional ethics councils to drive this work, including outlining responsibilities of mission leaders and ethicists in assessing the effectiveness of the activities. Third, we will continue training and process improvement for our clinical ethics facilitation teams, including quality improvement in ethics consult documentation and tracking. And finally, all of this work must be applied across the continuum of care as well as integrated with Leading Catholic Identity (LCI) and Promoting Catholic identity (PCI), Trinity Health's formation and assessment programs respectively.

We in mission and ethics at Trinity Health know we have a lot of work ahead of us and, like many other Catholic health care systems, will be relying on the expertise and reflection of Catholic theologians and ethicists to help us navigate these swirling waters. The point is that we can no longer fixate on matters of clinical bioethics but have an obligation to create systems and structures that also support organizational ethics and social ethics. While clinical ethics remains vital to patient care and safety, an exclusive focus on questions concerning clinical treatments will cause ethicists and those serving in ethics structures, such as ethics committees, to miss this bigger picture. The three realms are not mutually exclusive, and when each realm is given its due attention and expertise, we provide a more robust ethical framework for addressing the increasing complexity of ethical challenges that confront us.

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[2] Frank Morrissey, "Implications of Canon Law for Catholic Health Care Leaders and Organizations," (presentation at the Catholic Health Association (CHA) Sponsor Formation Program for Catholic Health Care, Itasca, IL, March 6, 2016).

[3] Philip Boyle et al., *Organizational Ethics in Health Care: Principles, Cases, and Practical Solutions* (San Francisco, California: Jossey-Bass, 2001). See also Editors, "Shedding Light on Organizational Ethics: Five Ethicists Help Define and Contextualize an Elusive Topic," *Health Progress*, 87, no. 6 (Nov.-Dec.2006): 28-33.

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[6] Benedict VXI, *Deus Caritas Est* [Encyclical On Christian Love], Vatican Website, December 25, 2005, Part II, 31-32, accessed January 8, 2018, http://w2.vatican.va/content/benedict-xvi/en/encyclicals/documents/hf_ben-xvi_enc_20051225_deus-caritas-est.html

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[9] Michael Rozier, "Structures of Virtue as a Framework for Public Health Ethics," *Public Health Ethics* 9, Issue 1, (April 2016): 37-45.

The Evolution of Ethics Committees at CHRISTUS Health

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Health care today is a rapidly changing environment. Not only are we being asked to do more with less, we are asked to have it finished yesterday even though we were only told about it today. As soon as the goalposts are reached, they are moved farther downfield. Ethics committees are no exception as their work is in flux. Many are taking a hard look in the mirror and asking how we improve what we do and if how we do that work still meets the need we serve. In my work, I have seen this discussion focus on four main areas, and I expect that ethics committees will continue (or begin) to focus on them in the years to come.

First, data. Data has driven clinical decisions for decades but nowadays it drives organizational decisions as well. Without evidence to show that an action will likely have the desired impact, many leaders and administrators will not support an initiative. While some might lament this change (I have heard a few people say, "Jesus didn't have a scorecard"), the push for data-driven decisions is an attempt to be good stewards of our resources. Stewardship is not so much about saving money as it is about doing the most with what we have. Without evidence brought by data, how else can one evaluate competing choices that all have the potential to fulfill our mission? The same is true for the goals of an ethics committee.

For ethics committees, data primarily involves tracking clinical and organizational ethics consults. For example, elements like the patient's age, race, gender, insurance status, length-of-stay (LOS), diagnoses or diagnosis related groups (DRGs), discipline of consult requester, unit where the consult occurred, inpatient or outpatient, reason(s) for the consult as stated by the requester, reason(s) as discerned by the ethics consultant, etc. A few articles have reported data from ethics consults in Catholic hospitals, many more in secular hospitals[1] Many ethicists and ethics committees track data yet have not reported it in the literature. I encourage all my colleagues working in ethics to publish the data they track. Baseline comparisons are available for most other fields in health care, and establishing such for ethics would benefit all of us, especially those who have historically lacked resources.

By reviewing data on its consults, an ethics committee (or ethicist) can strategically target its education efforts or process improvement work in the Next Generation model.[2] For example, if there are six consults over two months on the same unit about family members wanting to override a patient's living will, it would behoove the ethics committee to provide a lunch and learn or other educational event on this topic to that unit. Without data, many of these learnings and consequent efforts would be hard to come by.

Second, value. Many ethics committees and ethicists are using this data to show the value of what they bring to the hospital, especially the value of clinical ethics consults.[3] Here, value means the benefit that an ethics consult brings to the organization. To be meaningful, the value of consults needs to be expressed quantifiably and in a way that the organization typically analyzes operational benefit. This typically involves metrics like LOS, 30-day readmissions, use of non-beneficial treatment at the end of life, voluntary turnover of front-line staff, patient satisfaction, employee satisfaction, contribution margin (also called realization rate), etc. If an organization uses other operational measures, an ethics committee should use those as well.

A sharp distinction must be drawn between the quality of an ethics consult and its value to the organization. This raises legitimate concerns that using such metrics could pigeonhole ethics committees into a cost-reduction mechanism. Improving such metrics should not be the goal of an ethics consult; we do not exist to reduce length of stay, but to help those making clinical decisions do so in an ethical manner. Moreover, value does not necessarily mean quality. A good ethics consult might involve a recommendation to extend length of stay. This may benefit the patient, but not the organization. Conversely, a bad ethics consult might involve a recommendation that increases employee satisfaction. For example, an ethics consultant might recommend prohibiting an angry family member from visiting the patient (which would make staff happier as they do not have to interact with an enraged person) yet not follow the proper process of due diligence or meeting with the family member alone to hear their side.

The fields of palliative care and hospice have both successfully shown their value based on the financial implications that come from their services while maintaining their direct purpose of focusing on patient comfort and reviewing the quality of services based on their metrics. The Center to Advance Palliative Care (CAPC) has such a database for palliative care consults. If palliative care and hospice have done this for decades, why not ethics? I believe that a primary reason why palliative care and hospice typically have more support and resources than ethics committees and ethicists is because we have not taken steps to quantify our value in a manner that is meaningful to hospital administrators. By refusing to provide resources to a project that cannot show its value, administrators are only being good stewards of the organization's resources. It is a delicate task to show this in a manner that does not relegate ethics committees to a cost-reduction tool, but we do not get a pass because we are doing good work. If we are to be taken seriously as a clinical service, then we must act like one.

Third, quality. Here, I do not mean clinical quality indicators but ethics quality, or the facets of an ethics committee that make it a good ethics committee. For years, the literature in Catholic bioethics has lamented the lack of clarity around quality but not much has changed.[4] In 2011, we received a valuable tool in *Striving for Excellence in Ethics* published by the Catholic Health Association.[5] It is a great resource for assessing the quality of a committee's structure and work. Unfortunately, it is not clear how widely it is used or how many ministries expect their ethics committees to adhere to its recommendations. More importantly, there has not been much critical feedback on the tool in the literature despite a request from CHA for such a field test and calls from others for such standards in Catholic health care.[6] If we want to improve the quality of the work of our committees as a field, we must take constructive criticism seriously and ask ourselves "*What does good ethics look like?"* Such a task is outside the scope of this article, but I will make one point here.

Striving for Excellence in Ethics sets good, reasonable standards for ethics committees (especially regarding their structure, function, education efforts, policy work, integration, etc.,) but the document is rather vague regarding specific quality elements for ethics consultation, especially the process of consultation itself. For example, it states that the ethics committee has guidelines for its ethics consultation service regarding the methodology for consultation, documentation, scope and authority of the service, evaluation, etc. Yet it does not describe in any detail what these should look like. In my experience, having worked with dozens of ethics committees, such details are vital to assessing the true quality of an ethics consultation service. In that regard, resources like ASBH's *Core Competencies for Ethics Consultation* or *Assessing Clinical Ethics Skills* (ACES) from Loyola, are more helpful insofar as they have specific, measurable, detailed expectations for the consultation process.[7] Tailoring these and similar tools to Catholic health care would go far in helping ethics committees and ethics consultation services review the quality of their work. Outside of the work of Kockler and Dirksen, there has not been much from Catholic health care on this topic.[8]

Fourth, standardization. As health systems continue to grow they are increasingly standardizing processes at the system level. What was once decided locally and performed differently in every region is often becoming the same throughout the whole health system to increase efficiency and quality. This is true for many fields, and ethics is no different. For example, in July 2017, CHRISTUS Health's Ethics Council (a system level group that consists of regional mission leaders and ethics committee chairs, and ethics leaders from the system office) finalized our internal Standards for Ethics Committees. It outlines expectations for our committees' functions, structure, scope, processes, etc. Other systems are doing similar work.[9] Such standardization helps fill in the (intentional) gaps in documents like *Striving for Excellence in Ethics* and helps ensure the quality of the work done on the ground. Others are attempting to standardize the field itself, across systems, in part through quality efforts like those described above.

Two challenges for any standardization effort are: (1) to strike a balance between system-wide standardization and appropriate local flexibility; and (2) to standardize in a manner that respects the principle of subsidiarity. To the first point, it makes little sense to standardize the method of requesting ethics consults (calling the operator, using a pager, calling personal cell phones, etc.) across a system the size of CHRISTUS Health, but it is quite reasonable to standardize the method of documenting ethics consults in the patient's chart across our multiple electronic medical record (EMR) platforms. Such appropriate standardization also facilitates the collection and comparison of data, which in turn helps an ethics committee prove its value. To the second point, our approach at CHRISTUS has been develop standardized processes within the Ethics Council. With this process, the regional leaders develop the expectations to which they themselves will be held.

As ethics committees in Catholic health care continue to evolve, discussions about that evolution often focus on data, value, quality, and standardization. Each area bleeds over into the other three, and pursuing each one aids pursuit of the others. I encourage anyone working in Catholic health care ethics to contribute to the literature on these topics. Tell your story or critique and improve the work of others. Without our collective efforts, the continuing journey of ethics committees in Catholic health care could founder on the shoals of the broader changes in health care occurring today.

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[2] Janis Rueping and Daniel O Dugan, "A Next-Generation Ethics Program in Progress: Lessons from Experience," *Hec Forum* 12, no. 1 (2000).

[3] Mark Repenshek, "Assessing ROI for Clinical Ethics Consultation Services," *Health Care Ethics USA* 25, no. 3 (2017).

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Teaching Old Docs New Tricks: Changes in Medicine Mean Changes in Medical Education

In 1910, Abraham Flexner issued the Flexner Report, a devastating analysis of the state of medical education at the time. Abraham Flexner was an educator, not a physician; but he had studied the educational models of John Dewey, and he had a keen eye for what we would today call outcomes assessment. He immersed himself in the study of medical education that included a whirlwind tour of medical schools in the United States and Canada.

Flexner said that medical schools at the time, many of which were proprietary, for-profit ventures, were marked by “low admissions standards, poor laboratory facilities, and minimal exposure to clinical material” and that that they were “producing a surplus of poorly trained physicians.” Even though his recommendations may have relied too heavily on the highly scientific German model of education which failed to link research with patient care,[1] his report was hugely influential. It resulted in the closure of almost a third of existing medical schools, radical reform of the rest, and the end of for-profit proprietary medical schools.

Today there is no single person who is changing the face of medical education, and we are not suffering from lack of quality or consistency in training. Still, we face challenges as daunting as those Flexner faced a century ago. These challenges will require changes as radical as those he proposed.

For example, we are still working to close the gap between science and patient care that plagued medicine after Flexner. Daniel Sulmasy has pointed out that there is still a tendency to see the patient as an object of scientific investigation and to neglect spirituality and the transcendent. He proposes a new kind of clinic that will remedy this problem. Patient care also suffers from poor communication between caregivers and patients. Doctors don’t always listen, and patients don’t always understand. The problem is exacerbated by the sheer number of care providers. Primary care physicians, advance practice and nurse practitioners, hospitalists, specialists and new disciplines like hospice and palliative care make the need for excellent communication and continuity of care even more urgent than they were in the past.

Another challenge is the shift from volume-based, pay-for-service system to a value-based system that stresses quality over quantity. Matt O’Connor has noted, “We care about the people and our goal is to keep them out of our clinics and hospitals – which means that we need to create the programs to do that.”[2]

Big data has provided the information that led to the transformation from a volume-based, individual approach to a value-based approach that is based on prevention, health and community need. In his well-known article “Hot Spotters,” Atul Gawande describes the case of Jeffrey Brenner, a family physician in Camden, New Jersey. After an encounter with a gunshot victim, Brenner started thinking about the link between hospital use and various social factors, including crime. He adopted the police department’s “Compstat” model, which used data to focus police resources on high-crime neighborhoods. He made his own crime maps and correlated them with reams of admissions data from three local hospitals.

“‘I’d just sit there and play with the data for hours,’ he says. The more he played the more he found. For instance, he ran the data on the locations where ambulances picked up patients with fall injuries, and discovered that a single building in central Camden sent more people to the hospital with serious falls—57 elderly in two years—than any other in the city, resulting in almost three million dollars in health-care bills. “It was just this amazing window into the health-care delivery system,” he says.

Brenner took what he learned from police reform and tried a Compstat approach to the city’s health-care performance—a Healthstat, so to speak. He made block-by-block maps of the city, color-coded them by the hospital costs of its residents, and looked for the hot spots. The two most expensive city blocks were in north Camden. One had a large nursing home called Abigail House and one had a low-income housing tower called Northgate II. Brenner found that between January 2002 and June 2008 some 900 people in the two buildings accounted for more than $200 million in health care bills. One patient had 324 admissions in five years. The most expensive patient cost insurers $3.5 million.”[3]

He eventually learned that just one percent of Camden’s population accounted for nearly a third of the city’s health care costs. That population was where the focus should be. This kind of discovery would not have been possible without the vast data Brenner had access to. As other studies have shown, the problem was not what the hospitals were doing wrong. Rather, poverty, crime, poor education and lack of social support were causing readmissions. His understanding of health care – focused on diversity and disparity and cause and *effect within communities* – is as dramatic as the change that took place in medicine after the discovery of bacteria or the mapping of the human genome. We have long understood the importance of disease vectors in public health, but this new population health model is far more nuanced. In the 1980s, a shift occurred from infectious to chronic health. As a result, public health has focused much more heavily on the social determinants and their environment – where people live, learn, work, pay and pray affect community health. This is where health care is not taking account of the vast knowledge of public health in addressing these community factors. It sees the community itself as a factor in causing disease and inhibiting health. This paradigm goes far beyond Flexner’s view of scientific observation of a patient.[4]

This new model has two important implications. First, we need to think of groups or cohorts of patients. Scott Wallace, an associate professor at Dell Medical School says physicians will have to think differently: “What does it mean to think about a segment of patients? How do you define and identify groups with shared needs?”[5]

This new perspective means that care providers no longer will have the luxury of looking at this patient only (as virtuous as that may be). Their vision must now be more circumspect, so that they see the-patient-in-his-or-her-socioeconomic-context rather than just an isolated specimen. This will require new professional habits or virtues,[6] broader vision and a different kind of diagnostic sensitivity.

Second, it requires a new public ethic, a new kind of virtue, that enables all of us to deal with illness as the social reality it is. As Michael Rozier points out in his excellent article, we must imagine “structures of virtue” that will compensate for the bad habits that lead to hypertension, diabetes, obesity, respiratory problems and other chronic illnesses.[7] These new virtue structures are analogous to structural or social sin (conditions or structures which foster injustice, prejudice and violence), except they will be oriented to moral goodness. They will provide organizational incentives that “nudge”[8] people and communities into a different view of themselves and the world around them, and lead them to make better choices as a result. It is not just about changing bad individual habits but creating environments that support healthy choices. For example, access to grocery stores, and places for children to play safely are key to healthy eating and physical activity.[9] Our responsibility as people of faith is to create environments that will help all people achieve better health outcomes and human flourishing.

This is an important insight because in the Catholic tradition, morality is based not just on obedience to laws (which comes as a surprise to many!), but rather on clear vision of the goal or purpose for which God has created us and an internal drive toward that goal.

St. Thomas Aquinas and others described this goal as happiness – the experience and joy that come from living life as God intended. This happiness is not superficial and transitory, but the deepest satisfaction of a life well lived. Virtues are not just individual acts of obedience, but the habitual skills or qualities of character that enable us to easily and happily choose things that contribute to happiness. Virtues are not just *knowing about* moral goodness or health, but *having* them as internal principles of life. These structures of virtue should eventually lead to a kind of civic virtue that moves from "me" to "us," and from disease intervention to disease prevention. They ask us to consider how our environments, policies, and law create opportunities to choose behaviors that promote health.

This paradigm shift is a challenge for ethicists who, as Rozier and others have noted, tend to see their work primarily in terms of individual patients and on discrete moral choices: "What is the answer to this case?" Sometimes this approach devolves even further into crisis management where ethicists are called as first responders to resolve the problem, but are not inclined to go upstream to see if the problem could have been averted in the first place. Many systems are aware of the need for change and are beginning to assess how their ethicists and ethics committees approach their work.[10]

Meeting these challenges in the United States will not be easy. Unlike other countries[11] that have a more social and egalitarian understanding of health and health care that is rooted in a notion of the common good, the prevailing ethos in the United States is highly individualistic and market-based. What is more, American individualism fosters a deep suspicion of institutions – starting with government but also extending to health care -- which will make it difficult to sell any idea of structures of virtue.[12] Many will consider such a concept to be one more example of inappropriate government involvement in private life. (Recall what happened when the Affordable Care Act tried to include a provision for paying physicians for consultations about end-of-life care. It was branded as a "death panel" and disappeared).

Population health, public virtue and public health itself are firmly rooted in Catholic notions of justice and the common good. Health is first an individual pursuit, yet it is also a community pursuit because our communities shape us and also provide the resources we need to stay healthy. Reversing long-held understandings of health as private and individual will not be easy, but doing so is an essential part of the transformative mission of Catholic health care.

C.E.B.

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[1] See Thomas P. Duffy, MD., "The Flexner Repot – 100 Years Later," *Yale Journal of Biology and Medicine* 84/3 (2011): 269-76. Duffy refers to this as the "hyper-rational system of German science [which] created an imbalance in the art and science of medicine."

[2] "MDs of the Future: Medical Schools Are Preparing Physicians to Enter a Value-Based World," *Hospitals and Health Networks* (September 2017)29-32, at 29. O'Connor is quoting Clay Johnston, M.D., the new dean of UT Dell Medical School. This effort is being led by established medical schools such as A.T. Still University School of Osteopathic Medicine in Arizona and New York University School of Medicine, but principles are being adopted by new medical schools across the country including the University of Nevada at Las Vegas.

[3] Atul Gawande, "The Hot Spotters: Can We Lower Medical Costs by Giving the Neediest Patients Better Care?" *The New Yorker* (January 24, 2011):

[4] For an example of public health in action, see the Harlem Children's Zone, https://hcz.org/about-us/history

[5] O'Connor, p. 30. See also Meredith Minkner, ed., Community Organizing and Community Building (Rutgers, 2011) Chapter 8, "Community Health Assessments or Healthy Community Assessments: Whose Community? Whose Health? Whose Assessment?"

[6] I thought I was very clever to draw this virtue analogy, but I discovered, happily, that many others have already thought of it. One of the best articles is by my colleague Michael Rozier, S.J. "Structures of Virtue as a Framework for Public Health Ethics" appeared in *Public Health Ethics*, Volume 9/1 (April 2016): 37–45. See also Tiffany Cloutier et al., "Living Virtues of Public Health"

and Henry Fineberg et al., “Seven Deadly Sins and Living Virtues of Public Health” *Academy Health*, February 15, 2012.

[7] The Robert Wood Johnson Foundation has a funding initiative called the Culture of Health. A summary of findings is available at htttps://www.rwjf.org/en/libraary/research/2016/10/defining-and-measuring-a-culture-of-health.

[8] Rozier refers to the “nudge” theories of Thaler and Kass; Malcolm Gladwell’s “tipping point” theory may also pertinent, in the sense that there is at point at which group opinion shifts toward a different kind of behavior.

[9] See Ellen Barnidge, PhD, MPH; Sandra Stenmark, MD; Hilary Seligman, MD, MAS, “Clinic-to-Community Models to Address Food Insecurity,” *JAMA Pediatrics*, (2017): 171(6): 507-508 doi:10:1001/jamapediatrics.2017.0067

[10] See two perspectives on this assessment Becket Gremmels of CHRISTUS and Alan Sanders of Trinity elsewhere in this issue.

[11] N Ikegami and J C Campbell, “Health care reform in Japan: the virtues of muddling through” *Health Affairs*, 18, no.3 (1999):56-75

[12] See Hugh Heclo, *On Thinking Institutionally*, especially chapter 1, “Our Modern Impasse,” for a description of the decline of confidence in our institutions (Boulder: Paradigm Publishers, 2008).

Tomorrow's Ethicists and Providers: Observations From the Field on Undergraduate Attitudes Toward Ethics

With the help of a group of young ethicists, CHA has been exploring the shortage of ethicists and the lack of awareness that prevent many students from exploring a career in health care ethics or mission leadership. As part of that inquiry, we thought it would be helpful to share some observations gleaned from teaching 60 undergraduates in the fall of 2017.

My 60 students included 51 freshmen, all learning to be health care providers. The course provides an overview of major ethical topics in the clinical world and is required for all students in a health-related degree program. It is probably the only time many of them will have a chance to discuss the ethical dimension of their future careers. For many, it was the first time they had questioned their own beliefs about ethics and morality. I understand that 60 people is not a substantial "n" in which to draw meaningful data. However, I do believe that we can gather some insight into the way this generation views morality and how they connect, or do not connect, ethics with a job in health care.

1) Autonomy Rules
When we discussed decision making, advance care planning, and physician-assisted suicide, students expressed a strong desire to defend autonomy. They saw the idea of choice as a right and felt that we should be able to choose to have or to deny any treatment, including physician-assisted suicide. PAS is seen as an option required on any end-of-life list. They have absorbed the libertarian arguments connected with the marketing of "death with dignity" and having control. Many unfortunately did not recognize the negative impact PAS could have on society or the way it limits autonomous choice. Their attitudes suggest that we (i.e., Catholic health care) need to do a much better job presenting our position on PAS.

2) More Advance Care Planning
With autonomy, students noticed the need for more discussion regarding care planning. I believe that this stems from the desire to defend a person's ability to make decisions for themselves. Most hinted at the hope that such discussions will make traumatic events easier by providing clarity for the surrogate decision maker. Paradoxically, however, they wanted advance directive documents to have more power. When choosing to undergo or withhold a treatment, they tended to think a written document should take precedence over a surrogate.

3) Relativism is Strong
This should not come as a surprise. Students identify ethics and morality as very personal. "I have my ethics. You have yours. We should respect that." Ethics is not grounded in principles, or in objective rules. This idea of relativism extends to the role of the physician and care team. Students want their physicians to be value neutral. They wanted the doctor to share medical knowledge and to provide the relevant treatment options, but they did not want the doctor to express personal preferences or offer opinions regarding the morality for any choice. This is the right of the patient. They saw that the role of the ethicist or ethics committee is not to establish boundaries or make recommendations, but merely to help to clarify values and negotiate a compromise.

4) Finally, Some Good News
   Most students were unaware of the ERDs, but were pleasantly surprised by them. Starting from a position of autonomy and personal choice, some students acknowledged their initial bias against the church "dictating treatment." However, after reading the document, they recognized the ways the church upholds human dignity and the many facets of a person's identity. Some students began to see an alternative to relativism, and said they respected Catholic health care in naming their values and beliefs. More importantly, they respect the institution for adhering to those statements. One named this as "authenticity."

My experience in the classroom may not be particularly encouraging, and it probably reflects societal attitudes. They are starting points, maybe even guideposts on our way to form future health providers. These observations provide a better understanding of our audience. As we consider who will replace us as ethicists, physicians and nurses, these observations provide Catholic ethicists with opportunities to engage with the upcoming leaders in health care. The students were very absorbed in the topic. Many even discussed joining in the health care ethics minor. Unfortunately, the current structure for educating future health leaders limits these conversations.

We at CHA and our members are in a position to provide opportunities for engagement with these students. You, our readers, may look at ways to bring local students into the conversation. Do you have an internship? Are you willing to host students for an afternoon or day? Could your ethics committee include positions for students? Do you network with local universities and medical education centers offering your expertise for talks, course design, and even instructing? By working with these students, we not only educate them, we give them the chance to further their own ethical training and reflection. We may even entice one or two to pursue formal ethics education. We all know the benefits that proper ethics education can have on health providers. So why not work together to tackle this very issue?

N.B.H.

OF NOTE

Jacob Harrison, Ph.D. student, Albert Gnaegi Center for Health Care Ethics, Saint Louis University, contributed the following items to this Of Note column.

The Opioid Crisis Is at Its Worst in Rural Areas. Can Telemedicine Help?

The White House's declaration of the opioid epidemic as a public health emergency on Oct. 26 is stimulating conversation on how to deliver opioid treatment to rural communities in America who are among the hardest hit by this epidemic. Jamey Lister, assistant professor of social work at Wayne State University, in a recent article for *The Conversation*, writes about the prospect of using telemedicine for opioid treatment.

Opioid treatment usually combines medication and behavioral therapy but there is growing concern about the numerous barriers to accessing opioid treatment in rural areas of America. Dr. Lister notes, "Many rural populations have a limited number of clinics that provide opioid treatment and behavioral therapy, as well as a shortage of providers who prescribe opioid treatment medications. People living in rural areas frequently travel long distances to their opioid treatment provider. Moreover, many may feel ashamed or stigmatized if they seek out opioid treatment in their local community." Telemedicine may play a crucial role in helping to overcome some of the barriers particular to rural areas. Jamey Lister, *The Conversation*, Nov. 9, 2017, https://theconversation.com/the-opioid-crisis-is-at-its-worst-in-rural-areas-can-telemedicine-help-86598

F.D.A. Speeds Review of Gene Therapies, Vowing to Target Rogue Clinics

The Food and Drug Administration (F.D.A.) issued new guidelines on Nov. 16 to speed the approval process of medical treatments involving human cells and tissues, including gene therapy. Included in these guidelines are measures to crack down on clinics that offer versions of these treatments that have not been approved by the F.D.A. and are potentially dangerous for patients.

The new guidelines are meant to expedite the review of some gene and cell therapies that demonstrate potential to treat unmet medical needs and serious illnesses. While these treatments will still be required to go through clinical trials the hope is that a faster process will more quickly put effective treatments on the market.

Currently only two gene therapy treatments - Kymriah from Novartis, and Yescarta made by Kite Pharma – have been approved by the F.D.A. with a cost in the hundreds of thousands of dollars. A third product designed to correct a gene defect that causes a blinding hereditary eye disease has been sent to the F.D.A. with a recommendation for approval by an advisory panel.

While the F.D.A. is trying to speed the approval process for treatments that show promising results, it is also vowing to crack down on stem-cell clinics that treat ailments through fat-derived stem cells that are injected back into the patient. These clinics claim to treat ailments such as arthritic knees, back pain, and heart disease but use largely unregulated and unapproved treatment methods. The F.D.A.'s goal is to "make clear to regenerative medicine developers that they will be held to the same standards as other drug and device makers." Sheila Kaplan and Denise Grady, *The New York Times*, Nov. 16, 2017, https://www.nytimes.com/2017/11/16/health/fda-gene-cell-therapy.html

Massachusetts Grabs Spotlight by Proposing New Twist On Medicaid Drug Coverage

A new proposal is being put forth to the U.S. Department of Health and Human Services by Massachusetts' Medicaid program that would give them "the power to negotiate discounts for the drugs it purchases and to exclude drugs with limited treatment value." The proposal is considered a step towards improving efficiency. With Medicaid spending on prescription drugs increasing nationally by 25 percent in 2014 and nearly 14 percent in 2015 other states are closely watching whether the Massachusetts Medicaid proposal is approved.

Currently, Medicaid covers most prescription drugs approved by the Food and Drug Administration. In turn, pharmaceutical manufacturers are required to discount the drugs for Medicaid according to a fixed percentage established through federal law. The problem, according to many states, is that the established percentage discount is no longer sufficient to defray the rising cost of drugs.

Luthra reports, "Massachusetts wants to go a different route, requesting a federal exemption known as a Section 1115 waiver, which is meant to let states test ways of improving Medicaid. It wants to pick which drugs it covers based on most beneficiaries' medical needs and which medicines demonstrate the highest rates of cost effectiveness."

Massachusetts argues that its Medicaid proposal provides the opportunity to better negotiate prices and therefore save public dollars while still providing patients with access to needed therapies because they guarantee coverage of "at least one medication per therapeutic class — that is, per specific medical need." The proposed plan also contains an appeals process for patients who need a medication not covered by Medicaid. But critics are concerned that the proposed plan will limit accessibility to medication for low-income people.

The proposal will be reviewed by the Centers for Medicare & Medicaid Services. There is no deadline for the decision but other states are paying close attention to whether this proposal is approved. Shefali Luthra, *Kaiser Health News*, Nov. 21, 2017, https://khn.org/news/massachusetts-grabs-spotlight-by-proposing-new-twist-on-medicaid-drug-coverage/

New 'Instructions' Could Let Dementia Patients Refuse Spoon-Feeding

End of Life Washington (EOLWA), a group that assists residents of the state of Washington with the state's 2009 Death with Dignity Act, recently created guidelines for dementia patients to refuse being spoon fed. The guidelines are titled, "Instructions for Oral Feeding and Drinking," and were recently posted on their website.

The document gives instructions for caregivers of Alzheimer's and other progressive dementia patients to withhold oral food or fluids under certain circumstances, namely, "the person appears indifferent to eating, or shows other signs of not wanting food — turning away, not willingly opening their mouth, spitting food out, coughing or choking."

"The new guidelines won't be binding — legally or ethically, experts say. Nearly two dozen states have laws that address assisted feeding, including many that prohibit withdrawing oral food and fluids from dying people." Proponents suggest the document is a step in the right direction with some proponents claiming the document doesn't go far enough. In contrast, critics are concerned that the document puts the vulnerable at risk for mistreatment with the possibility of starving the elderly or incapacitated. JoNel Aleccia, *Kaiser Health News*, Nov. 3, 2017, https://khn.org/news/new-instructions-could-let-dementia-patients-refuse-spoon-feeding/

First Digital Pill Approved to Worries About Biomedical 'Big Brother'

On Nov. 13 the Food and Drug Administration (F.D.A.) approved for the first time a digital pill - "a medication embedded with a sensor that can tell doctors whether, and when, patients take their medicine." The newly approved pill, called Abilify MyCite, is a digital version of the antipsychotic Abilify. Patients who agree to Abilify MyCite can sign consent forms that give their physicians and up to four other people (including family members) access to electronic data that shows the date and time the pills are taken. The patient can remove any person from having access to their data through a smartphone app.

The sensor in the digital pill, contains the safe ingredients (also found in food) of copper, magnesium, and silicon, which "generates an electrical signal when splashed by stomach fluid." A few minutes after ingestion the signal is picked up by a Band-Aid-like patch that is placed on the left rib cage (this patch must be replaced every seven days). The patch then transmits the date and time of pill ingestion via Bluetooth to a cellphone app. The app allows the patient to also record their mood and hours of rest. This data is then made available to those whom the patient has given permission to access the data. The pill is slated to be released sometime next year; a price has currently not been released.

Proponents point to the ability of digital medication to remind patients when they forget to take their medicine and the potential to reduce the estimated $100 billion annual cost attributed to nonadherence and noncompliance with medication. But whether the digital pill improves compliance remains to be seen.

Critics of the digital pill are concerned that instead of fostering trust the digital pill could lead to mistrust of physicians and medicine, especially with patients taking antipsychotics like Abilify. Furthermore, there is concern that digital pills will become coercive tools used by physicians, families, insurance companies, public health agencies, etc. Dr. Eric Topol, director of Scripps Translational Science Institute, said, “Insurers might eventually give patients incentives to use them [digital pills], like discounts on copayments.” Other companies are also developing digital medication technologies and some digital pill technologies that do not need clearance from the F.D.A are already in use or are currently being tested with patients who have heart problems, stroke, H.I.V, and diabetes. What remains to be seen is whether the majority of patients will freely consent to digital medication. Pam Belluck, *The New York Times*, Nov. 13, 2017, https://nyti.ms/2hAXsLz

New Gene-Therapy Treatments Will Carry Whopping Price Tags

In fall 2017, the Food and Drug Administration (F.D.A.) approved the first gene therapy treatment called Kymriah, which is used to treat rare forms of leukemia at a price tag of $475,000. There are currently 34 gene therapy treatments in the final stages of testing for F.D.A. approval and another 470 treatments in initial clinical trials. Most of these gene therapies target rare diseases that reach only a few patients and are designed to cure a patient with one procedure or injection. According to Gina Kolata, in an article in the New York Times, Sept. 11, 2017, the high cost is alarming medical researchers and economists. For example, Kolata reports that one drug in development to prevent blindness occurring from a rare genetic disease is projected to cost between $700,000 and $900,000 dollars.

Bluebird Bio, a company developing several gene therapies, recognizes that high treatment costs present many challenges. Elizabeth Pingpank, a spokeswoman for Bluebird Bio said, “We recognize that most payers in the U.S. are not currently set up to support one-time therapies that generate long-term transformative benefits.” In response, Bluebird Bio has put together a consortium with academics to develop novel ways for insurance companies to pay the high price treatments. Bluebird Bio is not the only one trying to address the future high cost of gene therapy, as many health care executives are rushing to develop new payment models. Gina Kolata, *The New York Times,* Sept. 11, 2017, https://nyti.ms/2xW5yRG

Message of the Holy Father to the President of the Pontifical Academy for Life on the occasion of the European Regional Meeting of the “World Medical Association” on “end-of-life” issues (Vatican, 16-17 November 2017), 11/16/2017

On November 16, Pope Francis sent a message to the president of the Pontifical Academy for Life, Archbishop Vincenzo Paglia, and to all participants attending the European Regional Meeting of the World Medical Association on “end-of-life” issues. Pope Francis reaffirmed the Catholic tradition on end-of-life care, writing, “To determine whether a clinically appropriate medical intervention is actually proportionate, the mechanical application of a general rule is not sufficient. There needs to be a careful discernment of the moral object, the attending circumstances, and the intentions of those involved.”

Pope Francis, citing the *Catechism of the Catholic Church*, stresses that the patient, if able, should have the primary role in evaluating and making decisions about treatments.

In the message Pope Francis calls attention to the growing gap in healthcare possibilities, noting that, "increasingly sophisticated and costly treatments are available to ever more limited and privileged segments of the population, and this raises questions about the sustainability of healthcare delivery and about what might be called a systemic tendency toward growing inequality in health care." He points out that this tendency is clearly visible at a Global level but inequalities also exist within wealthy countries.

Pope Francis also called caregivers to avoid the temptation to step back from patients when a cure is no longer possible. Instead he urged that "the supreme commandment of *responsible closeness*, must be kept uppermost in mind, as we see clearly from the Gospel story of the Good Samaritan (cf. *Lk* 10:25-37). It could be said that the categorical imperative is to never abandon the sick." He also pointed to the importance of palliative care in caring for the dying patient as it "opposes what makes death most terrifying and unwelcome—pain and loneliness." Pope Francis, *Message of the Holy Father to the President of the Pontifical Academy for Life on the occasion of the European Regional Meeting of the "World Medical Association" on "end of life" issues*, Nov. 16, 2017, http://press.vatican.va/content/salastampa/en/bollettino/pubblico/2017/11/16/171116d.html

Health Care & The Law

Students from the Saint Louis University School of Law Center for Health Law Studies contributed the following items to this column. Amy N. Sanders, associate director, supervised the contributions of Madhav Bhatt (J.D. anticipated 2019) and Aria Suek (J.D./M.P.H. expected 2020).

States Expand Medicaid Benefits Despite GOP Efforts to Cut Medicaid Funding

Medicaid is one of the largest state-federal insurance programs that covers at least seventy-five million people in the country. The congressional Republicans and President Trump have been attempting to cut major federal funding to Medicaid. Despite their efforts, 26 states expanded or enhanced benefits in 2017 and at least 17 states plan to do so in 2018. These increased benefits were largely for mental health and substance abuse treatment, but some states have also added telemedicine and dental care. Four states—Louisiana, Virginia, South Dakota and New York—added cancer screening benefits such as genetic testing for the BRCA breast cancer gene mutation. The number of states adding benefits in 2017 was highest in at least a decade. Medicaid continues to face uncertainty as the Trump administration weighs whether to allow states to require non-disabled, adult enrollees to work in order to qualify for benefits. At least six states have such a request pending, and a decision is expected before end of the year. Phil Galewitz, *Kaiser Health News*, Oct. 19, 2017, https://khn.org/news/despite-gop-efforts-to-corral-medicaid-spending-states-expand-benefits/

The Trump Administration Proposes Drastic Changes to the Way Doctors Are Paid

A consensus developed over the past several decades is that the United States' annual medical cost can be controlled by changing the payment method for doctors. Instead of fee-for-service payment, that is, paying doctors for every appointment or procedure, they should be paid for their quality of care. The Obama administration supported this consensus through Affordable Care Act (ACA) which mandates large experiments to test new methods of payment. Some in the health care field have supported moving away from fee-for-service payment, while many have criticized ACA mandates as overly prescriptive. The Trump administration is making several regulatory changes that drastically affect these initiatives. It has proposed to cancel or reduce Medicare initiatives that required doctors to accept lump sums fees for joint replacement and cardiac care, two of the biggest cost drivers of Medicare. The Department of Health and Human Services (HHS) has exempted doctors from a provision of a bipartisan law that created merit-based pay depending on quality of care. Also, the HHS now encourages smaller, voluntary programs instead and has proposed to enable doctors to determine their own prices by allowing them to contract directly with Medicare patients, a long-held Republican goal of so-called premium pricing. Abby Goodnough & Kate Zernike, *New York Times*, Nov. 12, 2017, https://www.nytimes.com/2017/11/12/health/doctor-pay-trump.html

Hospital Groups Sue to Stop Reduction of 340B Program Reimbursement Rates

Hospital groups, including the American Hospital Association, the Association of American Medical Colleges, and America's Essential Hospitals, sued HHS alleging that its rule released on Nov. 13, 2017, violated the Administrative Procedure Act and the Social Security Act. The rule lowers reimbursement rates offered by the 340B program from 106 percent of the average sales price of the drugs to 78.5 percent. The 340B program is a separate program from Medicare, and offers drug at low costs to public and not-for-profit hospitals and federally funded clinics serving large numbers of low-income patients. Under this program, hospitals purchase drugs at discounted rates, but are reimbursed by Medicare. The plaintiff organizations have also asked the court to grant a preliminary injunction against the rule. Matthew Loughran, *BNA*, Nov. 16, 2017, https://www.bloomberglaw.com/document/X7G4TPIC000000?bc=W1siU2VhcmNoIFJlc3VsdHMiLCIvc2VhcmNoL3Jlc3VsdHMvOTk0MjQ3MzJlMGQ2MGMyNDY1Y2ZmMDgzMmU3MTc3YzkiXV0--070db35a7dffcbf1b209298f3d059cbe5bc10652

N.Y. High Court: "Wrongful Birth" Claims Start at Birth

Most medical malpractice claims begin running on the date of the alleged negligence, but New York's highest court has carved out an exception to this rule. In this case, two couples claimed that they would not have had children through a fertility clinic had they known the egg donor was a carrier of a genetic defect. They alleged that Dr. Alan Copperman and Reproductive Medicine Associates of New York LLP failed to timely screen the egg donor for a genetic defect known as Fragile X or to notify the couples that they had not screened for this trait. The issue was whether New York's two-and-one-half-year statute of limitations for medical malpractice began running at the time the embryos were implanted or when the children were born. The majority held that wrongful birth claims begin at birth because it is impossible to determine whether the parents will incur extraordinary expenses for a child prior to birth, and from public policy standpoint, it gives parents a reasonable opportunity to bring suit. The dissenting judge argued that the majority has improperly carved out this exception. Y.Peter Kang, *Law360*, Dec. 14, 2017, https://www.law360.com/articles/994968/ny-high-court-says-wrongful-birth-claims-start-at-birth

The Regulatory Accountability Act of 2017 Imposes Substantial Requirements on Rule Making

The proposed Regulatory Accountability Act of 2017 would substantially revise the 1946 Administrative Procedure Act, a law that established rules for federal agency regulation, to impose onerous requirements on rule making. The proposed bill increases procedural requirements for rulemaking by expanding the extent to which businesses or other interested parties could intervene in the rulemaking process and imposes prohibitions on agencies from explaining how new regulations are beneficial. The bill promotes "formal rulemaking," an expensive and cumbersome procedure, where anyone could petition the agency to conduct a trial-like hearing for proposed major or high-impact rules, which include most health and safety regulations. While the proponents of the bill claim that it will minimize unnecessary regulatory burdens that harm the economy, it is likely that this Act will make rule-making time-consuming and costly, inhibit agencies from responding to emergencies and new scientific evidence, and deprive the public from formal guidance on rules. Jonathan J. Darrow, Erin C. Fuse Brown, and Aaron S. Kesselheim, *New England Journal of Medicine*, Dec. 20, 2017, http://www.nejm.org/doi/full/10.1056/NEJMp1711643#t=article

I.R.S. Says It Will Reject Tax Returns That Lack Health Insurance Disclosure

Beginning 2018, the Internal Revenue Service (I.R.S.) will reject tax returns filed electronically for those who do not complete the information required about health care coverage, regardless of whether the individual is exempt from the individual mandate or must pay the penalty. For those filing on paper, the I.R.S. could also suspend processing and delay refunds. This guidance strays from President Trump's first executive order, which instructed various agencies to scale back the regulatory reach of the federal health care law. The I.R.S.'s choice in strict implementation makes it clear that taxpayers cannot ignore the Affordable Care Act, stating all taxpayers are required to disclose coverage information. Nicole M. Elliott, a tax lawyer for Holland and Knight and a former I.R.S. official involved in putting the ACA into effect, said the I.R.S.'s levy of the penalty could still be lenient towards those did not sign up for insurance during the previous year, but suggests this requirement helps to ease the burden for those that have insurance or are exempt from the penalty. Gary Claxton, an executive with the Kaiser Family Foundation, suggested this was the best way to enforce the mandate. Reed Abelson, *New York Times,* Oct. 20, 2017, https://www.nytimes.com/2017/10/20/health/irs-obamacare-mandate.html?rref=collection%2Ftimestopic%2FHealth%20Care%20Reform

ACA Enrollment for 2018 Nearly Matches Last Year's, Despite Trump Administration Efforts to Undermine It

For the 2018 insurance year, in addition to cutting the enrollment period in half, the Trump administration reduced 90 percent of federal spending for advertising and other outreach activities that were utilized to help consumers sign up for health insurance. The enrollment navigator funding was also cut by two-fifths. These efforts were seen as undermining actions by the administration to reduce the number of enrollees for the upcoming year. However, by the end of the enrollment period, more than 8.8 million Americans in 39 states signed up for 2018 health plans through the federal HealthCare.gov website. These astonishing numbers come close to nearly 95 percent of those enrolled during a three-month period during the 2017 enrollment period. The final tally on those enrolled does not include those who signed up for plans individually or those affected by recent natural disasters. Robert Restuccia, the executive director of Community Catalyst, a large grassroots health-care advocacy group commented on the enrollment numbers suggesting they "make it clear that Americans demand and support the quality, affordable health insurance and consumer protects the ACA offers." Amy Goldstein, *The Washington Post,* Dec. 21, 2017, https://www.washingtonpost.com/news/to-your-health/wp/2017/12/21/aca-enrollment-for-2018-nearly-matches-last-years-despite-trump-administration-efforts-to-undermine-it/?utm_term=.66de036998b6

Requiem for the Individual Mandate

The individual health insurance mandate began as a conservative tool, transformed into a bipartisan effort, and was eventually branded as a Democratic policy for presidential platforms. As a central element of the Affordable Care Act, the mandate was intended to get healthier, less expensive individuals into the market, therefore lowering the average price of insurance. On Dec. 20, 2017, the individual mandate was eliminated in the newly passed tax bill. Some experts have suggested that the elimination will likely increase insurance prices and lower health coverage. The Congressional Budget Office has estimated that over the next 10 years as many as 13 million Americans could become uninsured and insurance premiums could rise by an additional 10 percent. However, it is unlikely to see the effect of the mandate elimination until 2019, when the tax penalties will no longer be collected for those uninsured. Other mandate enthusiasts have gone as far to suggest that the elimination of the mandate provision will lead to a death spiral of ever-escalating insurance premiums, eventually resulting in market collapses. In response, many Blue States have begun considering a state-level mandate to subsidize the effects of the mandate elimination. Margot Sanger-Katz, *New York Times,* Dec. 21, 2017, https://www.nytimes.com/2017/12/21/upshot/individual-health-insurance-mandate-end-impact.html?rref=collection%2Ftimestopic%2FHealth%20Care%20Reform

Students from the Saint Louis University School of Law Center for Health Law Studies contributed the following items to this column. Amy N. Sanders, associate director, supervised the contributions of Scott Vermeer (J.D. anticipated 2018) and David Bird (J.D. anticipated 2019) The content was developed for the Of Note section of the fall 2017 issue and was inadvertently omitted.

Trump Threatens Obamacare Chaos as He Cuts Off Insurer Subsidy

President Trump signed an Executive Order on Oct. 12 to immediately halt payments on cost-sharing reduction subsidies provided to health insurers participating in the Affordable Care Act's marketplace. These payments helped to reduce insurance costs for low-income enrollees. In 2017, around 58 percent of all marketplace enrollees received cost-sharing reductions, resulting in roughly $7 billion in reimbursements to marketplace insurers by the federal government. The White House based the order on the premise that Congress never actually appropriated the CSR payments. The administration's actions came after numerous unsuccessful attempts by Republicans in Congress to repeal the ACA. Trump's actions were unsurprising to most insurers, as many had adjusted and raised their premiums accordingly for 2018 amid the uncertainty over the future CSR payments. The Executive Order also contained language asking regulators to "craft rules that would allow small businesses to band together to buy insurance across state lines, let insurers sell short-term plans curtailed under Obamacare, and permit workers to use funds from tax-advantaged accounts to pay for their own coverage." The anticipated result of this order will create alternative forms of coverage that will likely be cheaper, but less comprehensive. However, the order was a considerable political risk by the Trump administration, as a Kaiser Family Foundation poll in August found that 78 percent of those surveyed wanted the administration to work with Congress to improve and make the current ACA work. Zachary Tracer, *BNA*, Oct. 13, 2017, https://www.bloomberglaw.com/document/XFCCNUH0000000?jcsearch=bna%25200000015f1548d3f9ad5fdd4d935f0000#jcite

California Legislature Turns Up Pressure on Big Pharma

A bill was that re-introduced to the California state assembly in early 2017 is nearing implementation and, if successful, would require the pharmaceutical industry to give notice anytime they plan to raise drug prices by at least 16 percent over the following two-year span. More than just giving notice, however, the new law would also require pharma companies to give justification for increases and note what percentage of the increase was caused by internal corporate spending. According to the bill's sponsor, support for this legislation came from numerous sociopolitical groups in many different industries and, although the bill failed to obtain enough votes in the state assembly when it was first introduced in 2016, it passed the 2017 vote with 15 votes more than required. Pharmaceutical advocates' argument that the bill will burden their research and development has largely fallen on deaf ears. California is not the first state to create these types of requirements but is the first that is large enough to make the pharmaceutical industry take notice. When smaller states tighten reporting structures, pharmaceutical companies can just pull out of the market, but when a state the size of California enacts such rules, market excision is not a viable option and companies are forced to comply or find viable legal counter attacks. Numerous other state legislatures are tracking these new regulations and if successful in California, will not be far behind in creating similar rules. April Demborsky, NPR, Oct. 4, 2017, http://www.npr.org/sections/health-shots/2017/10/04/551013546/california-bill-would-compel-drugmakers-to-justify-price-hikes

Insurance Expires for Nine Million Children

The Children's Health Insurance Program (CHIP) is a program which provides health insurance for low-income children and pregnant women. It was a product of the Clinton administration which was primarily funded by the federal government and which, during its two decades that it was in force, decreased the rate of uninsured individuals in the target population by nearly ten percent. To ensure that the program continued to operate CHIP needed congressional renewal no later than the end of Sept. 2017. However, due to the congressional focus on repealing and replacing the Affordable Care Act it was allowed to lapse. Although the federal government will recognize a roughly $16 billion savings by eliminating the program, those costs will now be put back on the shoulders of the at-risk population which the program was designed to support. The maximum payments which an insured mother or child could be billed under CHIP was capped at five percent of their annual family income. Without the program's protection and financial support these families are no longer shielded from ever-rising costs of modern medicine. Valerie Strauss, Washington Post, Oct. 1, 2017, https://www.washingtonpost.com/news/answer-sheet/wp/2017/10/01/9-million-kids-get-health-insurance-under-chip-congress-just-let-it-expire/?utm_term=.dc62637be5bc

Senate's Three Health Care Proposals: A Guide

There have been three major efforts to find a path forward since Republicans were unsuccessful at repealing and replacing the Affordable Care Act in July: the Graham-Cassidy Bill; insurance stabilization; and a single-payer plan. Sponsored by senators Lindsey Graham of South Carolina and Bill Cassidy of Louisiana, the Graham-Cassidy Bill would take money earmarked for Medicaid and insurance subsidies by the ACA and transform them into block grants for states. States would then be able use those grants to design their own health-care systems. On Sept. 26, Majority Leader Mitch McConnell announced that the bill would not be brought for a vote. Insurance stabilization is a rare bipartisan health-care push to repair and strengthen the individual insurance market. This plan would officially appropriate the funds necessary for payment of ACA subsidies that lower out-of-pocket costs for low-income consumers. This would allow stability in the market by eliminating the uncertainty factor regarding subsidy payments which should result in controlled premium increases. This plan faces significant opposition and it is unclear whether it will be voted on in the near future. Finally, the single-payer plan would create a national government-sponsored health care system. This plan would effectively supplant private insurance by extending Medicare-like health coverage to all Americans, except the medical benefits included would be the same as those provided under the ACA, eliminating the majority of out-of-pocket costs. This plan is also has an uphill battle as it is not universally supported among Republicans or Democrats. Michelle Hackman, *The Wall Street Journal*, Sept. 19, 2017, https://www.wsj.com/articles/senates-three-health-care-proposals-a-guide-1505813402

Senator Pushes for Hospital Inspections to Be Made Public

Sen. Chuck Grassley (R., Iowa), chairman of the Senate Judiciary Committee, is pushing for hospital inspection reports to be made available to the public. This issue came about amid complaints against the Joint Commission, a non-profit organization based in Oakbrook Terrace, Ill., which stated that one of the nation's largest hospital accreditation groups was not rigorously enforcing health and safety standards. An investigative report by the *Wall Street Journal* prompted Grassley's request as it found that the Joint Commission was not revoking or modifying the accreditation of hospitals when serious safely violations were found. The Joint Commission has previously held that confidentiality in the process encourages hospitals to be candid with the commission. It went on to say that making the reports public would lead to increased costs. However, this has drawn harsh criticism from consumer groups and physicians who worry that the serious problems being found are also being kept from the patients who use the facilities. CMS has said it has become increasingly concerned about accreditors' performance, specifically noting their inability to identify problems later found by government inspectors. In more than 30 instances, hospitals retained their full accreditation even though their violations were deemed by CMS so significant that they had caused, or were likely to cause, a risk of serious injury or death to patient. Accordingly, it issued a draft rule to make these accreditor inspections public; however, it withdrew the rule citing fears that the proposal was an attempt by CMS to circumvent the law. Stephanie Armour, *The Wall Street Journal,* Sept. 19, 2017, https://www.wsj.com/articles/senator-pushes-for-hospital-inspections-to-be-made-public-1505843279

The Affordable Care Act Remains as Polarizing as Ever

Two opposing factions in the Senate are trying to make changes in the Affordable Care Act. On the left is a group led by Sen. Bernie Sanders which proposes a single-payer plan which would expand Medicare's current coverage to eventually include all Americans. Sanders proposes paying for this expansion by, among other options, increasing taxes on wealthy Americans. On the other side are Sen. Lindsey Graham and Sen. Bill Cassidy who are lobbying for a dismantling of the ACA in favor of a financial formula which would re-allocate the ACA's funding into a federal block grant for each state. Republicans are still shaky in their support for such a drastic measure while most Democrats are focused on simply protecting the ACA and the coverages which it provides. While the ACA could use some refinement, the path toward revision is as murky as ever. Robert Pear, the *New York Times*, Sept. 13, 2017, https://www.nytimes.com/2017/09/13/us/politics/health-care-obamacare-single-payer-graham-cassidy.html

IRS Yanks Hospital Tax Exemption, Sends Strong Compliance Message

An unidentified hospital was notified last year that its non-profit tax-exempt status had been stripped due to a failure to comply with 501(r) requirements. This revocation was the first of its kind by the IRS. As a dual status hospital, it is a government-run hospital that also obtained tax-exempt status under section 501(c)(3). This particular hospital was cited for its failure to submit a Community Health Needs Assessment report or to adopt a plan which would address the health-care needs of the community discussed in said report. The hospital declined to contest the IRS' determination, as the hospital's administrators explained it was a "small rural facility" and "had neither the financial wherewithal nor the staffing to devote to the specific requirements of

Treasury Regulation § 1.501(r)-3." While the unnamed hospital was still able to fall back on its dual status as a partially government-run organization for exemption from federal taxation, this revocation should serve as a wake-up call for charitable hospitals, especially non-governmental hospitals, to comply with Section 501(r). It should also be noted, that the bar for revocation is very high, and if a hospital is making a good faith effort to comply with Section 501(r) requirements, it is unlikely that the IRS will make a case for revocation against them. However, a hospital's inability to comply completely and openly with the CHNA requirements could lead to an exceptionally more invasive audit of the hospital by the IRS. Matthew Loughran, *BNA*, Aug. 30, 2017, https://www.bna.com/irs-yanks-hospital-n73014463912/

Medicare to Narrow Scope of Health-Care Provider Audits

CMS announced that The Centers for Medicare & Medicaid Services' Targeted Probe and Educate Program will roll out nationally to all 12 Medicare administrative jurisdictions by the end of 2017. This program involves reviewing fewer claims per provider. It also adheres to the Trump administration's goal of reducing provider burdens and educates providers on proper claims billing. The audits were never intended to punish providers for improper payments, but rather to reduce the number of improper Medicare claims appeals. The program will target and focus on providers with higher claims error rates. These TPE audits are expected to be more persuasive in encouraging better billing habits because they will single out specific providers as potential problems instead of an entire industry sector billing for a particular code, forcing those providers to take the inquiry seriously. James Swann, *BNA,* Aug. 22, 2017, https://www.bna.com/medicare-narrow-scope-n73014463501/

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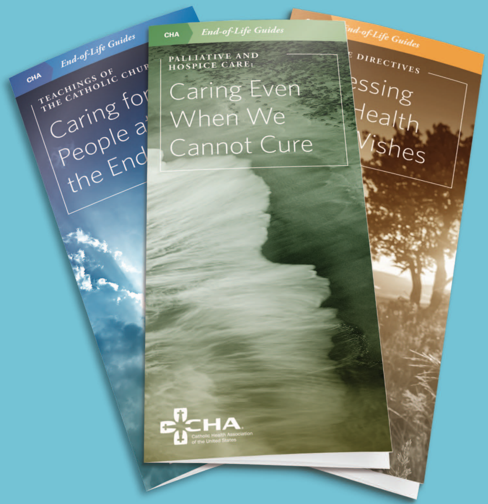

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