Of Note

The Church and Health Care

When we think of the Church and health care, we usually go immediately to ethical issues. However, underlying all the ethical questions – and our responses to them – are deeply held theological convictions. The Sept. issue of *Theological Studies* contains two articles that address the subject of ecclesiology and how the church understands itself. Neil Ormerod's article, "A (Non-Communio) Trinitarian Eccelsiology: Grounded in Grace, Lived in Faith, Hope, and Charity," examines ways beyond communio ecclesiology for relating the Trinity to the life of the church. He says the recent development of Lonergan's four-point hypothesis offers a more profound account of the church as an "icon" of the Trinity. This approach, grounded in Trinitarian theology, provides interesting opportunities for relating the church to other religious traditions.

In the other article, "The Roman Curia at and after Vatican II: Legal-Rational or Theological Reform?" Massimo Faggioli discusses the role of Vatican II and its ecclesiology for the reform of church structures. Francis's pontificate seems to be, on many levels, a return to the intent of Vatican II. The challenge is to choose the inspiring criterion that should inform the reform. A reformed ecclesiology should inform the reform of curial structures and it should also inform how the Church interrelates with other churches and faiths. These are both excellent theological background for the ways in which historical changes in the church affect its ministries. *Theological Studies,* Sept. 2015

Noncommunicable Diseases Account for Two-thirds of Global Deaths

The Sept. 2015 issue of *Health Affairs* focuses on the threat that noncommunicable diseases present to global health. This is notable, since Ebola, TB and other communicable diseases have commanded a great deal of attention in recent months. "Noncommunicable diseases are the leading health concerns of the modern era, accounting for two-thirds of global deaths, half of all disability, and rapidly growing costs." The issue contains nine articles that address various aspects of noncommunicable disease including mortality documentation, effects of country wealth, mental disorders, improving care systems, universal health coverage, community health workers, extending statin prescription, and the access-to-medicine movement. Three of these have special pertinence for the U.S. context:

- "Understanding the Relationship between Noncommunicable Diseases, Unhealthy Lifestyles, and Country Wealth" By Thomas J. Bollyky and Colleagues
- "Integrating Mental Health in Care for Noncommunicable Disease: An Imperative for Person-Centered Care" by

Vikram Patel and Somnath Chatterji

- "Increased Use of Prescription Drugs Reduces Medical Costs in Medicaid Populations" M. Christopher Roebuck and Colleagues

Panel Discusses Initial Consumer Reactions to Population Health

On June 11, 2015, Health Forum of the American Hospital Association convened a panel of seven health care executives and industry experts to discuss the juncture of population health and consumerism. The Sept. 2015 issue of *Hospitals and Health Networks* published excerpts of their conversation. The panel included five health care CEOs and the directors of Citigroup Global Markets and Boston Consulting Group. The article reports three key findings. These findings include becoming more consumer friendly, starting with changing terminology to reflect consumer sentiment. Another finding suggests that hospitals and health systems focus on providing preventive care and wellness to certain populations instead of trying to provide everything to everyone. Lastly, the panel noted that consumers take many factors into consideration when choosing a health care provider. Patients are willing to go out-of-network to receive higher quality care, shorter wait times and greater convenience. *Hospitals and Health Networks,* Sept. 2015

Should We Incentivize Mammography Screenings?

In a recent article in JAMA, "The Ethics of Incentivizing Mammography Screening?" (Volume 314, Number 10 Sept. 8, 2015) author Harald Schmidt suggests that incentives for completion of mammograms are an ethically disconcerting distraction in a complex decision-making process. When it comes to breast screening, the right way forward is for all payers to offer incentives for using optimized evidence-based decision aids – irrespective of the ultimate decision in favor or against screening. Doing so promotes autonomy by minimizing regret that may result both from having and not having undergone screening. Incentivized active choice can furthermore assist with reducing disparities between income and educational groups. Policy makers implementing the IOM's recommendation by making mammography completion rates a priority measure should complement this initiative with measuring the informedness of decision making. A focus on completion rates alone is ethically misguided given that the balancing of potential benefits and harms is highly preference sensitive. Harald Schmidt, "The Ethics of Incentivizing Mammography Screening?" (Volume 314, Number 10 Sept. 8, 2015) JAMA

Is the Value Assessment of Intensive Care Changing?

In their recent article in JAMA, (Volume 314, Number 10 Sept. 8, 2015) "Assessing the Value of Intensive Care," authors Ian J. Barbash, MD and Jeremy M. Kahn, MD, MS suggest that ICU admission may benefit lower risk patients. The abstract of the article says: Spending on hospital admissions involving intensive care accounts for nearly half of all hospital costs, making ICU admissions an important focus for reducing overall expenditures. In this issue of JAMA, Valley and colleagues demonstrate a tangible benefit of ICU admission for a cohort of low-risk patients. The study found that admission to an ICU for patients with pneumonia whose need for ICU admission was borderline or discretionary was associated with a 5.7% absolute reduction in 30-day mortality, 14.8% for ICU admission vs 20.5% for general ward admission, compared with admission solely to a hospital ward. Additionally, there was no statistically significant differences in total costs or total Medicare payments between groups, suggesting that ICU admission can save lives for lower-risk patients, and can do so at similar costs. Although the study has many limitations, it provides important empirical evidence that ICU admission can benefit low-risk patients. The exact mechanism of this benefit is unknown. Further research is warranted into discovering the reasons ICU care seemed to help patients with borderline criteria for ICU admission, and how to extend this benefit to patients outside the ICU, either through enhanced inter-professional care, improved monitoring, or treatment protocols to guide clinical decision making. Ian J. Barbash, MD and Jeremy M. Kahn, MD, MS, "Assessing the Value of Intensive Care," (Volume 314, Number 10 Sept. 8, 2015) JAMA

Can Advertisers Adequately Convey Risk in Direct-to-Consumer Advertising?

In their recent NEJM article (Volume 373, Issue 12 Sept. 17, 2015), "The Vernacular of Risk – Rethinking Direct-to-Consumer Advertising of Pharmaceuticals" authors Jeremy A. Greene, M.D., Ph.D., and Elizabeth S. Watkins, Ph.D. examine the usefulness of information present in ubiquitous pharmaceutical ads. The abstract says, "Earlier this year, the FDA sought public comments on new guidance for pharmaceutical marketers on communicating risks to consumers in print advertisements. The FDA proposes that drug marketers use a new "consumer brief summary" focused "on the most important risk information … in a way more likely to be understood by consumers." Drug marketers are being asked to use popular idiom to communicate with people with a wide range of literacy levels; to use larger fonts and more readable formats; and to use visual elements such as white space, logos, and color scheme to highlight the most relevant risks. Public comments on the proposal have focused on the challenges of

implementation. The medical terminology, dense verbiage and tiny fonts of these inserts have made them inscrutable to the average consumer and virtually useless as information sources. For all its capacity to encourage over diagnosis and over medication, direct-to-consumer advertising's (DTCA) virtue is that it treats consumers as people who deserve to know something about the compounds they take into their bodies. After 30 years of DTCA, it's not clear that advertising is the best medium for communicating risk information, but marketers should at least be required to try to communicate risk information as effectively as they do their promotional message." Jeremy A. Greene, M.D., Ph.D., and Elizabeth S. Watkins, Ph.D., "The Vernacular of Risk – Rethinking Direct-to-Consumer Advertising of Pharmaceuticals" (Volume 373, Issue 12 Sept. 17, 2015), NEJM

Gov. Brown Signs California Right-to-Die Measure

California has become the fifth state to allow terminally ill patients to use doctor-prescribed drugs to end their lives. The debate sprang from the actions of 29 year-old California native, Brittany Maynard who moved to Oregon last year to end her life. Ms. Maynard's story achieved national coverage and in a video recorded days before her final act, she "told lawmakers that the terminally ill should not have to 'leave their home and community for peace of mind, to escape suffering and to plan for a gentle death.'"

The debate in California divided the legislature who often "drew on personal experience to explain their decisions…" Gov. Brown, a lifelong Catholic and former Jesuit seminarian, said "he consulted a Catholic bishop, two of his own doctors and friends." Gov. Brown remarks, "In the end, I was left to reflect on what I would want in the face of my own death. I do not know what I would do if I were dying in prolonged and excruciating pain. I am certain, however, that it would be a comfort to be able to consider the options afforded by the bill." Juliet William, *Associated Press,* Sept. 9, 2015.

How Assisted Suicide Will Work in California

Patrick McGreevy, in the *LA Times* reports on the details of the measure allowing for physician-assisted suicide. McGreevy remarks that the law is modeled after the bill passed in Oregon. It "would require two physicians to confirm a patient's prognosis of six months or less to live, as well as the patient's mental competence to make healthcare decisions."

After these determinations, the patient would have to "make two oral requests to a physicians for help in dying, at least 15 days apart, with witnesses to the requests." The patient would have to self-administer the medication.

However, the date for the enactment of the bill is uncertain. McGreevy reports that it will go "into effect 90 days after the adjournment of the special session on health care. That adjournment date has not been set but could be in January 2016 at the earliest and November 2016 at the latest." Patrick McGreevy, *LA Times,* Oct. 5, 2015.

Catholic Bishops Disappointed Assisted Suicide Measure Signed into Law

California bishops state that law "stands in direct contradiction to providing compassionate, quality care for those facing terminal illness. This bill does nothing to validate the lives of the vulnerable."

The California Catholic Conference will continue to work with Californians Against Assisted Suicide and its partners. The Conference states, "As Catholic bishops in California, we join hands with the disability rights groups, physicians, other health care professionals and advocates for the elderly in opposing physician-assisted suicide as the wrong way to advance the human dignity for those facing a terminal illness."

In the eyes of these prelates, the legislation will "adversely affect the poor, as those with resources will always have access to palliative care." This statement moved the Conference to make note of the excellent work the 48 Catholic hospitals in California have done to "provide excellent palliative care services…" As Californians Against Assisted Suicide remark, "this is a dark day for California and for the Brown legacy." *Catholic News Service,* Oct. 6, 2015.

Cardinal O'Malley of Boston Condemns California law as a tragedy

California's legalization of assisted suicide, which took place a few days ago when Jerry Brown, the Governor of California, signed the law, has been defined by U.S. Bishops as "a great tragedy for human life." In a letter, adding to the firm stance of local bishops, Cardinal Sean Patrick O'Malley, Archbishop of Boston and chairman of the committee on Pro-Life Activities of the U.S. Conference of Catholic Bishops, expressed his grief over this "deeply flawed action."

Cardinal O'Malley also said this legislation will create "confusion" because "seriously ill patients suffering from depression and suicidal feelings will receive lethal drugs instead of genuine care to help alleviate that suffering." *L'Osservatore Romano*, October 9, 2015.

Supreme Court Prepares to Take on Politically Charged Cases

This month begins this year's term for the United States Supreme Court and will be the start of John Roberts' second decade on the court. For this upcoming term the court will "decide major cases on politically charged issues, including the fate of public unions and affirmative action in higher education. It will most

probably hear its first major abortion case since 2007 and revisit the clash between religious liberty and contraception coverage."

This term's rulings will most likely be made public in June, 2016 when the heat of the presidential election is full strength. They will most likely come into play during the final presidential debates. "Constitutional law and politics are certainly not the same thing, but they are interrelated, never more so than in a presidential election year that will likely determine who gets to appoint the next justice or two or three," said Vikram D. Amar, dean of the University of Illinois College of Law.

Concerning the death penalty, the new term has "an unusually high number of capital cases presenting more focused issues, including a challenge to Florida's sentencing scheme, Hurst v. Florida, No. 14-7505, and a case on race discrimination in jury selection, Foster v. Chatman, No. 14-8349."

The last decision on abortion occurred eight years ago when the court upheld the federal Partial Birth Abortion Ban Act. "That seems about to change. The most likely candidate is a challenge to a Texas law that threatens to reduce the number of abortion clinics in the state to about 10, down from more than 40." An appeals court upheld the provision, but the Supreme Court in June blocked the ruling while it considered whether to hear the case. Adam Liptak, "Supreme Court Prepares to Take on Politically Charged Cases", *New York Times,* Oct. 4, 2015.

"Hard Cases Make Bad Law" says ACLU Senior Fellow

In an article in the *Washington Times* about the lawsuit recently filed by the ACLU against Genesys Hospital in Mich., ACLU Senior Fellow Robert Knight says that the ACLU is "ramping up its campaign to use the courts to force all Catholic hospitals to provide abortions and sterilizations."

Knight cites Michigan ACLU Staff Attorney Brook A. Tucker, who said "Catholic Bishops are not licensed medical professionals and have no place dictating how doctors practice medicine, especially when it violates federal law." Health care law expert and Samford University Professor Emeritus Leonard Nelson said that the ACLU "is trying to force Catholic hospitals to relax their rules. They would like Catholic hospitals not to have any particular religious orientation, especially when it comes to abortions.

Knight concluded his article by saying, "Hard cases make bad law, and the ACLU is very obviously going out of its way to destroy the unique, religious character of Catholic hospitals." Robert Knight, *The Washington Times,* Sunday, Oct. 11, 2015.