

Health Care Ethics USA

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CRISPR: What Potential? What Peril? Who Decides?

Rev. Kevin T. FitzGerald, SJ, Ph.D., Ph.D.

David Lauler Chair

Georgetown University Medical Center, Bioethics

Washington, D.C.

ktf3@georgetown.edu

Editor's Note: We acknowledge UC Berkeley, Mint research and "How Genes Are Edited Using CRISPR" by Nikita Mehta on the website, <http://www.livemint.com/Politics/kb7XfbE2hT9Sxg74Wola3J/How-genes-are-edited-using-CRISPRCas9.html> for the use of the CRISPR graphic that appears in this article.

The human genome contains around 6.2 billion nucleotides, usually referred to using the letters A, C, G and T. By contrast, the Bible has only about 3.5 million letters in it. Imagine how difficult it was to edit the entire Bible before the age of computers and word processing. Now imagine editing a book almost one thousand times larger and one can get the sense of the enormity of the challenge of reading and correcting the human genome.

Today, however, we can easily download a copy of the Bible, search for specific words or phrases, cut and paste any part, or rewrite what we want. Applying this kind of editing technology to the human genome is what is behind the current excitement about

the scientific breakthrough called CRISPR—which stands for Clustered Regularly Interspaced Short Palindromic Repeat. This name comes from the genetic structure that was discovered in many bacteria and archaea which allows these organisms to build up a collection of genetic sequences acquired from the viruses that attack them. These stored sequences are then used as a kind of immunity defense when the organism is attacked again by the same viruses. This defense works by matching up the stored sequences with the attacking virus's genetic sequence which signals the Cas9 protein (CRISPR-associated protein 9), or similar proteins, to chop up the invading viral genome. This combination of adaptable, yet relatively

precise, target sequence recognition and ability to cut DNA is what was so exciting to genetic researchers. [see figure on page 6]

While researchers have been using much more limited genetic editing technologies since the 1970s (e.g., restriction endonucleases), they have constantly worked to develop technologies that would allow them to target accurately any DNA segment in the human genome (or even multiple targets), edit it as desired (add, delete, substitute any number of nucleotides), and do all this at a relatively reasonable cost. The CRISPR-Cas9 breakthrough represents the first opportunity to achieve this kind of genome editing in bacteria, plants, animals and humans.

While CRISPR technology has these significant benefits, it also has some troubling limitations. Especially in its potential application to humans, there is concern regarding off-target effects, i.e., the constant challenge for genetic therapies of genetic changes that are made at sites in the DNA that are not being targeted that may disrupt normal cell functioning.

In response to this challenge, research is being done to reduce off-target effects through improved design of the guide

RNAs used for targeting, and to develop Cas9 variants or find alternative proteins to cut the DNA. In addition, the delivery of the components of the CRISPR-Cas9 system into cells can be difficult due to their relatively large size. Research has already generated several alternatives to the Cas9 protein that include smaller and more accurate DNA cutting systems, and even an enzyme, C2C2, that cuts RNA instead of DNA.

Still, CRISPR remains the most affordable and versatile genome editing technique widely available. That is why the CRISPR/Cas9 system has been the target of huge investment, wide publicity, and an ongoing major patent fight between the Broad Institute of MIT and Harvard and the University of California at Berkeley. Though this patent case has slowed somewhat the use and development of this exciting new technology, application of CRISPR-Cas9 has already moved into the realm of clinical trials.¹

China has initiated the first clinical trial using the CRISPR-Cas9 system. CRISPR is being used to knockout the PD-1 gene from patients' T cells to stimulate the patients' immune systems to more

aggressively attack their metastatic non-small cell lung cancer.² T cells are a type of white blood cell that scans for cellular abnormalities or infections. In addition, three more clinical trials are lined up in China to begin recruiting patients that will employ CRISPR to knock out PD-1 in the T cells of patients with bladder, prostate and renal cancers.

In the U.S., the University of Pennsylvania is poised to lead a clinical trial that will similarly target T cells from patients with several types of cancers. The 18 patients chosen will have their T cells removed and three CRISPR interventions done on them to facilitate T cells targeting the tumor and to prevent the tumor from disabling the T cells. After being checked for accurate CRISPR editing, the T cells will be infused back into the patients. This trial is being designed primarily to demonstrate safety rather than effectiveness, and it will take place in Pennsylvania as well as in California and Texas.³ Now that the door is open, it is safe to say that many more clinical trials targeting a wide array of genetic diseases will soon be proposed—if the current trials do not disclose some unexpected harm to patients from the CRISPR treatment.

The clinical trials I have described above all fall within the category of gene therapies that target somatic cells from one patient at a time. This type of genetic intervention has had broad support among researchers, ethicists and health policy makers for about 30 years. This broad support falls apart when genetic interventions that would potentially be passed from one generation to the next are considered. Such germline genome editing raises concerns regarding both the safety of such interventions (i.e., mistakes that would be passed on to future generations) and the normality or sanctity of human nature (i.e., germline genetic changes that would change who we are as human beings). The discussion of germline genome editing in plants, animals, and especially humans, is complex and contentious, and, hence, cannot be reviewed in this brief article.⁴ These developments raise serious issues of safety and the appropriateness of changing the genomes of living organisms, especially humans. I will cite two uses of CRISPR that I find particularly troublesome.

- 1) Human Germline Engineering. If one desires to use CRISPR to alter *all* the cells of a human being, including sperm and eggs, then one

might argue that logistically the best time to do that would be the embryo stage of development, as there are relatively few cells wherein one would have to change the DNA to affect the entire human being. This may have been the reasoning behind the research done on non-viable human embryos by researchers in China who published an article in 2015, describing their attempts to use CRISPR to modify the genes that cause beta-thalassemia.⁵ Since it was rather surprising to many that such an experiment had been both approved and published, it set off worldwide ethical debate. There were responses both in scientific journals and international meetings that the potential impacts of CRISPR and other genome-editing technologies were of such magnitude that extensive public engagement would need to take place before applications such as human germline interventions could occur. Despite these appeals for broad public engagement, additional human embryo research projects have since been approved in the UK, Sweden, and again in China. Though these

projects either involve nonviable embryos, or a promise not to implant the altered embryos in a woman's uterus, they clearly are oriented towards human embryo genome editing for reproductive purposes. Hence, regardless of one's position on the moral status of human embryos, or human germline engineering, this research has gone forward without the kind of global public dialogue that was proclaimed to be necessary.

2) Do-It-Yourself CRISPR editing.

The other use of CRISPR that requires public review is the Do It Yourself CRISPR movement. For \$150, anyone can purchase a home CRISPR kit from a company called The Open Discovery Institute (The ODIN) in Calif. The company has already sold thousands of kits, mostly to people who are curious about science and CRISPR, enabling them to experiment at home. The company's founder and CEO, Josiah Zayner, and other like-minded "biohackers," believe science should be available to everyone. But is this

true for CRISPR? After all, considering the potential CRISPR has for harm as well as benefit, should it be so available to the public? It is already too late for CRISPR, but the public will need to weigh in on how to balance public safety (regulation) vs public access (innovation).⁶

CRISPR-Cas9 has made genome editing available to all. It has dramatically raised the stakes of the ethical issues going forward—especially the need for robust public engagement.

What role should we, and our institutions, play regarding this rapidly developing biotechnology?

¹ Dermot Martin, “Who Owns CRISPR?” <http://www.labnews.co.uk/features/owns-crispr-17-01-2017/>

² NCT02793856 “PD-1 Knockout Engineered T Cells for Metastatic Non-small Cell Lung Cancer in Sichuan, China,” www.clinicaltrials.gov

³ “First CRISPR Clinical Trial Gets Green Light from U.S. Panel,” Sara Reardon, *Nature*, 22 June 2016, doi:10.1038/nature.2016.20137

⁴ For a general review of the ethics of genetic interventions see,

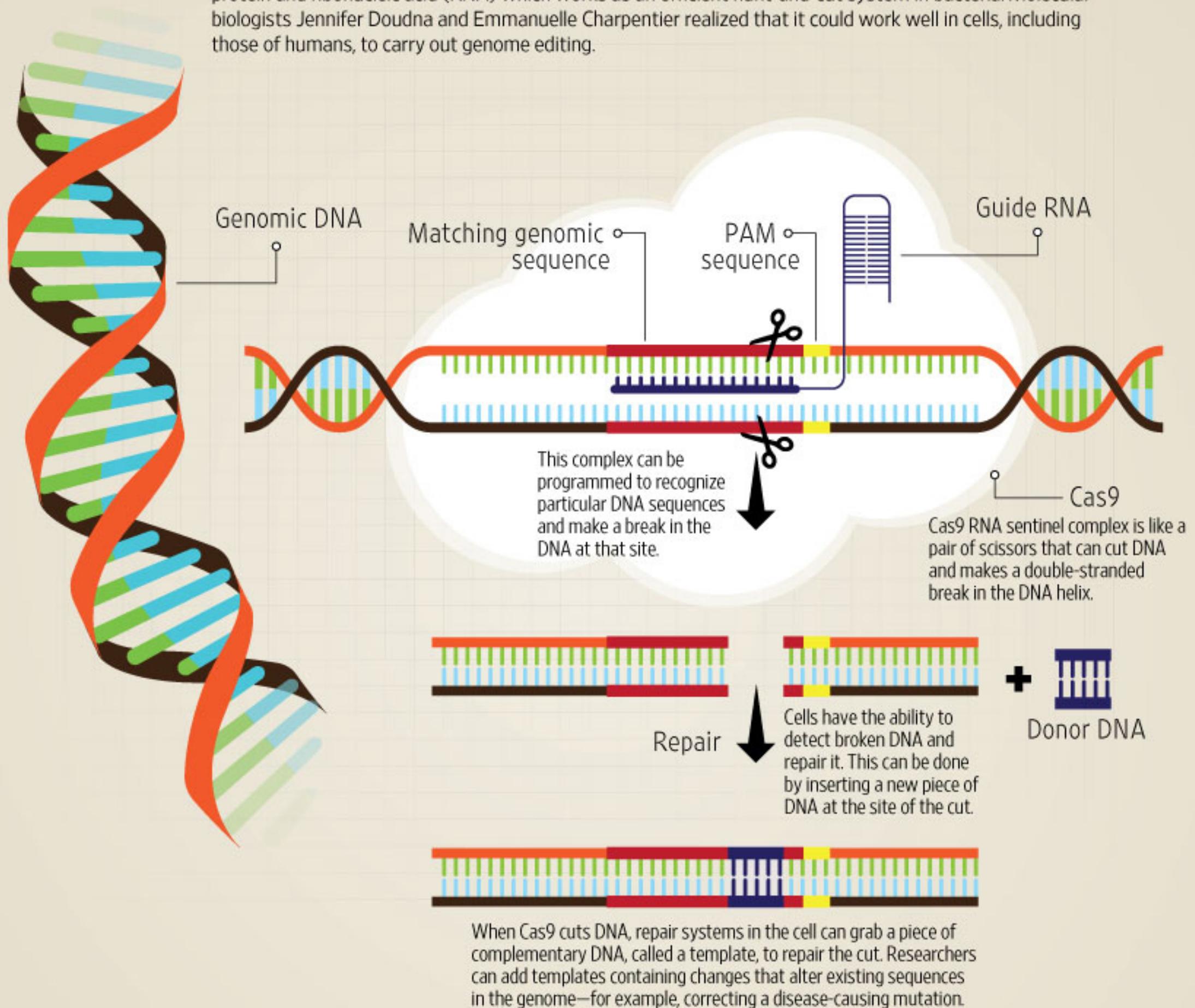
<https://www.chausa.org/publications/health-progress/article/september-october-1999/ethical-issues-in-genetics>. For a more indepth analysis of the role of religion and philosophy in assessing human genome editing see, Kevin FitzGerald, S.J., “The Need for a Dynamic and Integrative Vision of the Human for the Ethics of Genetics,” in *Genetics, Theology, and Ethics*, ed. Lisa Cahill, The Crossroad Publishing Co., 2005.

⁵ “CRISPR/Cas9-mediated Gene Editing in Human Triprenuclear Zygotes,” Liang et al, *Protein & Cell*, May 2015, Volume 6, Issue 5, pp 363–372.

⁶ “CRISPR for the Masses,” Rachael Moeller Gorman, <http://www.biotechniques.com/news/CRISPR-for-the-Masses/biotechniques-365397.html?autnID=344253#.WIEs1IWcE2w>

HOW CRISPR WORKS

CRISPR-Cas9, abbreviated from clustered regularly-interspaced short palindromic repeats, is a hybrid of protein and ribonucleic acid (RNA) which works as an efficient hunt-and-cut system in bacteria. Molecular biologists Jennifer Doudna and Emmanuelle Charpentier realized that it could work well in cells, including those of humans, to carry out genome editing.



● When viruses infect a cell, they inject their DNA. In bacterium, the CRISPR system allows that DNA to be plucked out of the virus and inserted in little bits

into the chromosome of the bacterium.

● These integrated bits of viral DNA get inserted at a site in the bacteria.

● CRISPR allows cells to record over time the viruses that they have been exposed to, so that cells are protected from those viruses.

Caring for Patients with a History of Illicit Intravenous Drug Use: Ethical Obligations from Bedside to Boardroom

Nicholas J. Kockler, Ph.D.

Regional Director

Providence Center for Health Care Ethics

nicholas.kockler@providence.org

A few years ago, Infection Control in one of our ministries asked for an ethicist's perspective of whether it was ethically permissible to unilaterally remove a peripherally-inserted central catheter (PICC) from a person who tampered with it and who had a history of illicit intravenous drug use. The tampering concern was precipitated by regulations on reimbursement that suggested if a hospital's central-line associated blood stream infection (CLABSI) rates reached a certain point, there would be a financial penalty.¹ Immediately, the question transcended clinical ethics and entered into the organizational realm, which necessitated careful consideration of the mission and core values of our Catholic health system. This initial conversation with Infection Control morphed into a more than a year-long project, involving several different departments across our ministries.

Key questions were: How should one think of the ethical obligations toward such a patient? What informs those parameters? The narrative of this project involved a complex pattern of socialization, criminalization, medicalization, moralization, and other ways of thinking about persons who use drugs, their health, and the obligations to care for them.² In the end, the ethical analysis revealed that it would be permissible to remove a PICC from a patient *if* there was demonstrable evidence s/he tampered with the device *and* caregivers exhausted all available efforts to solicit the patient's willing engagement and support the patient's ability to engage in the care plan.

Situations

A typical clinical scenario involves a young adult patient who presents with a life-threatening infection (e.g., osteomyelitis or endocarditis) that requires days to weeks of antibiotic therapy

delivered intravenously. These patients often have altered mental statuses when they present to the hospital and the PICC lines are started either as an emergency intervention or with the permission of a surrogate. As the patient regains alertness, he or she typically becomes more conversant and engaged.

Often times, these patients use tobacco products along with intravenous (IV) drugs. This reveals a critical tension in caring for this patient population: smoking while receiving care.³ In Oregon, our hospital campuses are non-smoking facilities. This means that patients who decline nicotine replacement therapy and insist on continuing to smoke have to leave the premises. Does this mean a discharge [against medical advice]? A temporary leave (aka, a “hall pass”)?

Clinicians raise concerns about this patient population because of their history of using IV drugs and the presence of the port (PICC) on their person that gives them direct access to their bloodstream. Situate these concerns in the hospital setting where there is concern about diminished reimbursement for what is already likely to be a long hospitalization, and the moral distress can be palpable. Clinicians worry that patients may use their PICCs to inject illicit drugs or other substances (we have observed

fecal matter, applesauce, and other substances). Sometimes the worry is more about the infection risk than about the use of drugs *per se* though the worries are often concomitant and inseparable.

While patients who do not have history of IV drug use may be discharged home or to a skilled nursing facility, concerns for patient safety for this patient population often result in patients remaining hospitalized in the acute care setting.⁴ Consideration of a second-line antibiotic may reflect sub-standard treatment.⁵ Surgeons may also dispute the number of times a heart valve may be replaced.⁶ Moreover, too few skilled nursing facilities in our major metropolitan area accept patients who are both medically complex and have a history of substance use. Prolonged hospitalization seems to further complicate patient care. Leaving the nursing unit for a ‘smoke break’ constitutes a highly risky venture, may be logistically challenging, and reflects continuation of behavior that undermines both the patient’s health as well as caregivers’ efforts.

Background

Space does not permit a thorough exploration of the context and care provided for these patients.⁷ Suffice it to say that any ethical analysis should reflect three levels of discourse: the interpersonal level (caregivers and patients);

institutional level (hospitals/systems, caregivers, and patients); and social level (health care industry, law enforcement, and the community).

For purposes of this essay, I describe the ways an ethics consultation service may address these cases. The framework I use here is based on ethnographic research that suggests caregivers do not necessarily request ethics consultation when there is a clear and concise ethical dilemma, but rather when there is a disruption in patient care (or an anticipated disruption).⁸ In this way, one may describe *ethically significant* disruptions without needing caregivers to identify the particular issues involved.⁹ The nature of ethics consultation in these cases may relate to any one or more of the following disruptions:

- **Ambiguity around patient preferences:** e.g., whether the patient wants to enter into recovery for substance use, or whether the patient wants help to survive the infection;
- **Patient does not demonstrate interest in medical recommendations:** e.g., whether the patient agrees with or desires to engage in provider recommendations (patients who do not demonstrate such an interest are often labeled as “noncompliant” or “nonadherent”);
- **Patient needs are unaccommodated:** e.g., whether the patient had / has access to

housing, financial security, social support, or other outpatient services;

- **Ambiguity of institutional policies:** e.g., confusion over whether or how to implement (or enforce) non-smoking, discharge process, visitor restrictions, or search of patient belongings policies; and
- **Ambiguity over scope of service:** e.g., whether to remove a PICC and discharge the patient.

A useful lens through which to see the ethical issues is that of the three components of **therapeutic relationships** among caregivers and patients: the *bond* [of the clinical encounter], the shared *goals* [of care], and the *care* [or interventions offered and accepted].¹⁰

- **BOND:** The *bond* between caregiver and patient in the clinical encounter corresponds to these ethical issues:
 - Caregivers may attribute the medical condition, burdens, or woes of a patient in an *ad hominem* explanatory model;¹¹
 - The first issue relates to a second: that **the patient is solely culpable for his or her limited or lack of engagement** in care;
 - **Mutual trust** may be in short supply, and while a lot of literature has emphasized how much providers need to trust patients, it is asked much less whether and how patients can trust providers;¹²

- **Mutual respect** may also be limited, this is often reflected in chart lore and caregiver labeling of patients;
- **Clinical empathy** could be a remedy to many of the issues above, its lack may be the source of them, too;¹³
- **Moral distress** or the emotional distress accompanying a perceived threat to one's integrity occurs for a variety of reasons internal and external to one's exercise of conscience;¹⁴ and
- Caregivers risk **patient abandonment** if they "give up" too readily or discharge the patient from service before arranging for or offering alternatives for the patient.
 - **GOALS:** The *goals* of caregiver and patient may not always align, and there may or may not be overlap between what each party is willing to negotiate. The issues include:
 - Caregivers may believe that such patients cannot be helped in any way, this is **therapeutic nihilism**;
 - Caregivers may think about **harm reduction** and yet may still remain steadfastly attached to their own goals for the patient; and
- Patients and caregivers may simply have **disparate, divergent, and/or irreconcilable goals**. Sometimes the goals and the differences between them may not be explicit.
- **CARE:** The *care* or interventions provided also may involve a degree of negotiation between what caregivers feel is professionally or personally acceptable and what patients are willing or able to accept and tolerate. The issues include:
 - Interprofessional tension may arise when there is variation, for example, from hospitalist to hospitalist in their **willingness to tolerate ongoing substance use** (be it tobacco or heroin) as well as tension between caregivers who may require absolute abstinence as a condition of continuing care whereas others may not;

- Like negotiating goals of care described above, patients and caregivers may have **differing ideas about and willingness to accept and offer interventions as part of a negotiated care plan**. An example is a patient's unwillingness to use or attempt to use nicotine replacement therapy for the duration of hospitalization; and
- Lastly, caregivers may feel or actually become **complicit in the wrongdoing** (e.g., use of illegal or diverted controlled substances).

Ethical and Theological Analysis

Although space does not permit a comprehensive treatment of all the ethical issues, I will describe key principles that have guided our discernment at all levels of our organization.

Respect for Human Dignity. As articulated in the *Ethical and Religious*

Directives for Catholic Health Care Services (ERDs), Christian love is the animating principle behind Catholic health care.¹⁵ That is, the caregiving by health care professionals ought to honor the inherent worth of each person irrespective of behavior patterns or social status. We therefore aspire to distinguish the behavior of using drugs from the person in need and avoid the attribution error. Following the Centers for Disease Control and Prevention (CDC), we talk about “persons who use drugs” not “IV drug abusers.”

Grounded in this love, mutual respect forms a pillar of the professional-patient relationship. In caring for persons who use drugs, we seek healing and care of the whole person. Quoted in the *Charter for Health Care Workers*, St. John Paul II says, “It is important ‘that there be an attempt to get to know the individual and to understand his inner world; to bring him to the discovery or rediscovery of his dignity as a person, to help him to reawaken and develop, as an active subject, those personal resources, which the use of drugs has suppressed, through a confident reactivation of the

mechanisms of the will, directed to secure and noble ideals.”¹⁶

Hospitality and the Principle of

Toleration.¹⁷ Next, it is also important to recognize the relationship between the moral evaluation of substance use itself and the caring and contexts of caring to ongoing drug use. St. John Paul II indicated that drug use is always illicit because it “implies an unjustified and irrational refusal to think, will and act as free persons.”¹⁸ Different commentators have offered various interpretations; some have gone as far as to characterize IV drug use as “intrinsically evil.”¹⁹ For purposes of this article, I will take at face value the moral wrongs of illicit drug use; however, I submit that a thorough analysis of the morality of these actions is warranted.

In light of seeing illicit drug use as ethically problematic, the question remains: What are professional caregivers to do? What *can* a health care provider *actually* do to help patients who may not [yet] want to stop using drugs?

We have found guidance in the Principle of Toleration,²⁰ which articulates a

foundational rationale for a *harm reduction philosophy of care*. Harm reduction aims to minimize the risks and reduce the harmful effects of certain behaviors that undermine and threaten health and well-being. Such an approach is relevant in settings wherein the ideal, recommended care and hoped for outcomes are not likely to be feasible. Harm reduction is about *how* caregivers engage patients ‘while they wait’ for different circumstances or choices to manifest.

It is essential, however, to distinguish the ethical Principle of Toleration from an attitude of indifferent tolerance. As David Hollenbach notes, the behaviors of mere non-interference reflect tolerance: a ‘live and let live’ attitude.²¹ The principle, in contrast to the attitude, seeks new circumstances, new choices, and not mere non-interference. Thus, the proper correlative attitude is *hospitality*: the loving care, the welcoming invitation to change, and the endurance of wrongs (committed by others) that may be too burdensome or harmful to change (see below).²² I argue that individual health (in the long run) and the common good are best served

when we apply the principle through the healing arts animated by Christian love and an attitude of hospitality.

Social Justice and Meeting the Demands of Fidelity of Relationships.

In the biblical tradition, one may describe *justice* generally as “fidelity to the demands of a relationship.”²³ What does this mean in the clinical encounter between a professional caregiver and a person who uses drugs with a life-threatening infection? Arguably, the role of the ethicist in such circumstances is to navigate the dynamics of such relationships as ‘an ally for social justice’.²⁴ For example, this may mean making explicit such things as no one is obligated to do the impossible and thus there is no ethical obligation to provide non-beneficial treatment or disproportionately harmful treatment. It may also mean, as it did in our practice setting, that use of tools such as “behavior contracts” need to have an element of mutuality and reciprocity. It also means helping caregivers recognize that, after the team has exhausted all attempts to create a therapeutic relationship, the therapeutic relationship itself may not be sustainable – even in a

harm reduction mode – and that is beyond their control. It may also mean that if a patient wishes to make a choice that is not in his or her interests, imposing a care plan, detaining the patient in the hospital, or forcing treatment is ethically problematic.²⁵

It is important to note that in a mission-driven organization that identifies itself as providing excellent care *especially to the poor and vulnerable*, there is a certain ‘burden of Mission’ that may weigh on the conscience of caregivers and be a source of moral distress itself. This may sound heretical – and it should in a certain sense sound that way – but the role of an ethicist is often in the uncomfortable position of having to say ‘you have done enough.’ As evidence that such a reality is in fact within our heritage, we have found in our archives an episode wherein the Sisters of Providence demonstrated that they did all that they could for a person who suffered from substance use disorder and yet the Sisters could no longer sustain care for him and he had to be “dismissed.”²⁶

Recommendations

Caring for persons who use drugs and are suffering from a life-threatening infection *and* who continue to be at risk for recurrent bloodstream infections is enormously complicated; it is difficult to overstate the complexity. What are some practical take-aways in service to answering the relevant ethical questions? Our overall strategy has been to position caregivers proactively with a toolkit containing several different tactical approaches that may be used in real-time, or as appropriate, in any given case. The list below is a brief snapshot of this toolkit, which includes some conceptual tactics as well as concrete mechanisms:

- **Framing a Diagnostic Dilemma of Difficult Encounters with Patients:** To avoid labeling patients as “difficult,” ethicists encourage caregivers to think of the *encounter* as difficult and then treat the difficulty of the encounter as a diagnostic dilemma: Rule-out psychiatric or neurologic issues, psychosocial stressors, cultural, linguistic, or health literacy issues, logistical

challenges, and system-access issues.

- **Managing Moral Distress and Patient Engagement Guide:** Using the VitalSmarts™ *Influencer* framework, I developed a guide to help caregivers assess and manage moral distress; for example, one can use it as a guide to know when all has been exhausted.²⁷ (See table at the end of this article on pgs. 20-21.)
- **Screening Patients with a Decision-aid:** Nursing staff developed this guide to screen and assess patients for risk of bloodstream infections. One innovation here is that while it is not a policy *per se* it does utilize the same electronic policy database system and easily cross-links to relevant policies thus creating a clearinghouse of applicable policies, too. The other key innovation of this tool is that it seeks to minimize provider-to-provider variation in how care is given to these patients. While it remains to be seen whether there is in fact a demonstrable reduction in such

variation, we already have observed caregivers using a common language and recognition of a care pathway for these patients as well as a recognition of the full array of tools at their disposal.

- **Use of Physical Deterrents:**

There are many clinical tactics available to caregivers.

Recognizing the persons who use drugs may have diminished control over their wills given how profound physical dependency on the substance may be, caregivers can employ a variety of devices to help deter patients from tampering: for example, alcohol caps and stickers on PICC.²⁸

- **Temporalizing Goals and Care:**

It may be helpful for patients who show no desire to stop smoking to suggest as a ‘temporary measure’ nicotine replacement therapy. Perhaps some interpersonal tension may be relieved if patients are not pushed to stop smoking while they recover from an infection.

- **Motivational Assessment and Interviewing:** Ethicists

encourage caregivers to engage in both motivational assessment (i.e., readiness to stop drug use and enter recovery) and motivational interviewing (i.e., discovery of patient interests and patient-identified barriers to those interests).²⁹

- **Utilizing Empathic**

Communication: Empathic communication can not only benefit patients by revealing clinically significant barriers to care but may also aid in caregiver resilience and recognition of what she/he brings to the encounter.³⁰

- **Engaging in Care Conferences:**

It often appears helpful to conduct team conferences early in admission (and as frequent as needed) as well as early and proactive patient care conferences.³¹

- **Shared Expectations Letter and the Notice of Conditions for Continued Hospitalization:**

Ethicists developed two communication documents for attending providers to use during the prolonged hospitalization of

persons who use drugs at risk for bloodstream infections. The first is a letter communicating mutual and shared expectations; the second is a notification of the conditions of continuing hospitalization, including a reiteration of the consequences of not meeting those conditions. Indeed, these two documents replaced a single “care plan contract” document that was a one-time, make-it-or-break-it document. Both documents aspire to be patient-specific, mutual and reciprocal, and serve not as a “contract” but rather as a method of documenting communication and conversation between caregivers and patients.

¹ Elizabeth Hayes, “Medicare Penalizes Oregon Hospitals for Hospital-Acquired Infections,” *Portland Business Journal*, December 10, 2015, <http://www.bizjournals.com/portland/blog/health-care-inc/2015/12/medicare-penalizes-oregon-hospitals-for-hospital.html>, accessed December 2, 2016.

² For a fascinating expose on the relationships between criminalization, medicalization and moralization, see Peter

Conrad and Joseph W. Schneider, *Deviance and Medicalization: From Badness to Sickness* (Philadelphia, PA: Temple University Press, 1992).

³ See Annette S.H. Schultz, et al., “A Qualitative Investigation of Smoke-Free Policies on Hospital Property,” *Canadian Medical Association Journal*, December 13, 2011, 183 (18): E1334-E1344; and Annette S.H. Schultz, et al., “An Ethnographic Study of Tobacco Control in Hospital Settings,” *Tobacco Control*, 2006, 15:317-322.

⁴ See Carolyn Jewell, et al., “Residential Addiction Treatment for Injection Drug Users Requiring Intravenous Antibiotics: A Cost-Reduction Strategy,” *Journal of Addiction Medicine*, 2013, 7:271-276.

⁵ See Dominik Mertz, et al., “Appropriateness of Antibiotic Treatment in Intravenous Drug Users, A Retrospective Analysis,” *BMC Infectious Diseases*, 2008, 8:42, <http://www.biomedcentral.com/1471-2334/8/42>, accessed December 2, 2016.

⁶ J. Michael DiMaio, et al., “Ethical Obligation of Surgeons to Noncompliant Patients: Can a Surgeon Refuse to Operate on an Intravenous Drug-Abusing Patient With Recurrent Aortic Valve Prosthesis Infection?” *Annals of Thoracic Surgery*, 2009, 88:1-8; and Jay A. Jacobson, “The Effect of Patients’ Noncompliance on Their Surgeons’ Obligations,” *Surgical Clinics North America*, 2007, 87:937-948.

⁷ See Conrad and Schneider, 110-144.

⁸ Susan E. Kelly, et al., “Understanding the Practice of Ethics Consultation: Results of an Ethnographic Multi-Site Study,” *Journal of Clinical Ethics*, Summer 1997, 8 (2): 136-149.

⁹ This author elaborated on this framework at a paper presented at the annual conference of the American Society for Bioethics and Humanities in 2017 (Washington, DC) entitled, “Ethics and Humanities in the Work of Patient Safety and Quality Improvement: Partners or Problems?”

¹⁰ Michael K.S. Cheng, “New Approaches for Creating the Therapeutic Alliance: Solution-Focused Interviewing, Motivational Interviewing, and the Medication Interest Model,” *Psychiatric Clinics of North America*, 2007, 30:157-166. Cheng cites Bordin’s definition of the therapeutic alliances as consisting of these three components.

¹¹ Contrast this with the observations that trauma informed care and the exposure to toxic stress and adverse childhood events are major risk factors in substance use disorder.

¹² Joseph O. Merrill, et al., “Mutual Mistrust in the Medical Care of Drug Users: The Keys to the ‘Narc’ Cabinet,” *Journal of General Internal Medicine*, 2002, 17:327-333.

¹³ Jodi Halpern, “Empathy and Patient-Physician Conflicts,” *Journal of General Internal Medicine*, 2007, 22:696-700.

¹⁴ Elizabeth Gingell Epstein and Ann Baile Hamric, “Moral Distress, Moral Residue, and the Crescendo Effect,” *Journal of Clinical Ethics*, Winter 2009, 20 (4): 330-342.

¹⁵ United States Conference of Catholic Bishops (USCCB), *Ethical and Religious Directives for Catholic Health Care Services*, 5th edition (USCCB: Washington, DC, 2009).

¹⁶ Pontifical Council for Pastoral Assistance, *Charter for Health Care Workers*, available at <https://www.ewtn.com/library/CURIA/PCPAHEAL.HTM>, accessed December 2, 2016, #95.

¹⁷ I will set aside the discussion of needle exchanges and safe injection sites. In those cases, a thorough analysis of the moral action of using illicit drugs AND of the principle of material cooperation is warranted. Suffice it to say here, I suspect there is room in our tradition for such approaches. Though, this is not without controversy given the analysis provided by the National Catholic Bioethics Center (NCBC) in this Position Paper: Ethicists of the NCBC, “Cooperation with Moral Evil,” February 2013, http://www.ncbcenter.org/index.php/download_file/force/157/311/, accessed December 2, 2016. NB: The most relevant discussion

is on page 2, question 2, which suggests needle exchanges constitutes implicit formal cooperation with evil.

¹⁸ Pontifical Council for Pastoral Assistance, #94.

¹⁹ See this perspective from an Australian commentator: J.N. Santamaria, “Heroin Injecting Rooms and Catholic Health Care Services,” *Bioethics Research Notes*, September 1999, 11 (3):

<http://docplayer.net/11044087-Bioethics-research-notes-11-3-september-1999-heroin-injecting-rooms-and-catholic-health-care-services.html>, accessed

December 2, 2016.

²⁰ See Joseph J. Piccione, “‘Tolerance’ as a Moral Concept for Catholic Health Care Ministry in a Pluralist World,” *Healthcare Ethics USA*, Winter 2015, 12-22.

²¹ David Hollenbach, “The Common Good and Urban Poverty,” *America*, June 5, 1999. 8-11.

²² Margaret E. Mohrmann and Lois Shepherd, “Ready to Listen: Why Welcome Matters,” *Journal of Pain and Symptom Management*, March 2012, 43 (3): 646-650.

²³ John R. Donahue, “The Bible and Catholic Social Teaching,” in *Modern Catholic Social Teaching: Commentaries and Interpretations*, ed. Kenneth R. Himes (Georgetown University Press: Washington, DC, 2005), 14.

²⁴ I am indebted to Dr. Mark Kuczewski of the Neiswanger Institute at Loyola

University Chicago School of Medicine for the term and its relevance to the role of ethicists.

²⁵ John Tuohey and Jeffery T. Young, “Ethical Considerations in the Risk-Benefit Analysis for Patients with Diminished Capacity,” *Journal of Hospital Ethics*, Winter 2009, 1 (3): 20-23. The ethicists at the Providence Center for Health Care Ethics updated this framework and created a poster, which this author presented at the International Conference for Clinical Ethics Consultation in 2014 and is available online (<http://oregon.providence.org/~/media/Files/Providence%20OR%20PDF/patientvoicefullposter24x36.pdf>) and at the annual conference of ASBH in 2015 (as a paper).

²⁶ A colleague retrieved this brief story from the Archives of the Sisters of Providence; the story dates back to 1954.

²⁷ For more information on VitalSmarts™, visit <https://www.vitalsmarts.com/influencer/>.

²⁸ For example, Jennifer Ho, et al., “Safe and Successful Treatment of Intravenous Drug Users with a Peripherally Inserted Central Catheter in an Outpatient Parenteral Antibiotic Treatment Service,” *Journal of Antimicrobial Chemotherapy*, 2010, 65:2641-2644.

²⁹ Cheng 2007; and David J. Alfandre, “‘I’m Going Home’: Discharges Against Medical Advice,” *Mayo Clinic Proceedings*, March 2009, 84 (3): 255-260.

³⁰ Halpern 2007; and Frederick W. Platt and Vaughn F. Keller, “Empathic Communication: A Teachable and Learnable Skill,” *Journal of General Internal Medicine*, April 1994, 9:222-226.

³¹ Alfandre 2009.

Helping Persons Who Use Drugs Avoid Bloodstream Infections:

SOURCES OF INFLUENCE * 24-May-2016

| | MOTIVATION | | ABILITY | |
|-------------------|--|---|---|---|
| | Sign / Symptom | Strategy / Tactic | Sign / Symptom | Strategy / Tactic |
| INDIVIDUAL | Clinician <i>anger</i> towards or <i>blame</i> of the patient; Perceived volitional component to behaviors putting health at risk | -Avoid attribution errors; -Mindfulness, stress-reduction; -Assume good intentions of patient, verify | Prolonged / maladaptive coping; Addictive behaviors; Self-neglect | -Coaching / coping tools: self-discipline, delayed gratification, resiliency, distraction -Behavioral Health Consult; -Spiritual Care; -Chemical Dependency Consult; -Capacity assessment(s): decisional vs. executive functions (screening vs. tests) -Directive decision-making with assent/non-dissent of patient |
| | Emotional distress of the patient | Clinical empathy / Active listening | Emotional lability; Personality disorder [of the patient] | -Monitoring and identification of triggers -Team coordination -Behavioral Health Consult |
| | Resistance to / refusal of care, disengagement | Education; Explicit statement of shared goals | Interference with care, disruptive behaviors | -De-escalation techniques; -Team encounters (vs. 1:1); -Manage sources of agitation / agitation itself; -Pre-Code Gray / Code Gray |
| SOCIAL | Access to paraphernalia, illicit substances correlative to visitors | Visitation management: prohibition, restriction, scheduling | Suspicion of ongoing IVDU jeopardizing/ undermining antibiotic therapy | Search belongings, confiscation |
| | Maladaptive behaviors related to peer or other social pressure | Peer modeling / accountability / mentoring Coaching: empowerment [to dissent from peer pressure] Group therapy | Avoidance of patient Frustration expressed by patient Broken communication | Anticipatory scheduling / rounding |
| | Continued IVDU / smoking / EtOH; Recalcitrance to sobriety/recovery | Clinician expectations: Hospitality / Toleration vs. Abstinence (and of WHICH behaviors) | Social history is mere habit history | Take social history with socioecological model; assess for past or concurrent trauma |
| | Desires / demands to go to smoke | Recreational interests / activities: restriction or prohibition of "smoking" (i.e., the social venue of maladaptive/ risky behavior) vs. availability of other activities | Threats to leave / bargaining to engage in illicit / prohibited (by policy) recreational activities | Redirect / de-escalate (avoid AMA discharge) vs. Discharge/manage risks |
| | | | Socially isolated | Refer to resource desk / community resources |
| STRUCTURAL | Disruptive / maladaptive "personal economy" | Clarify / adjust incentives vs. disincentives: identify / explain natural and attributed consequences -Risk to safety -Risk to effectiveness (IV vs. oral abx) -Risk to feasibility -Risk for discharge | Demonstrated use of medical device for IVDU Access to dirty needles No smoking campus | Create barriers to maladaptive / disruptive behaviors: stickers Minimize risks of maladaptive behaviors Availability of clean needles and sterilizing tools Equitable or absolute 'no smoking' |
| | Broken communication; Pt at risk for premature discontinuation of hospitalization | Communication tools: shared expectations, notifications, contracts | Barriers to adaptive behaviors; environment not conducive | Augment adaptive behaviors: nicotine patches, visual cues, etc. |

| | | | | |
|--|-------------|---|--|---|
| | Malingering | Elimination / minimization of sources of secondary gain | Threatening to discontinue hospitalization prematurely; history of premature discharge (AMA) | Detainment (restraints) vs. discharge (AMA) with removal of devices |
| | | | Housing insecure Food insecure Legal issues | Refer to resource desk / community resources |

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The Critical Components and Ethical Nature of the Concept of Cultural Competence

Jordan Potter

Ph.D. Student

Center for Health Care Ethics

Duquesne University

Pittsburgh

Potterj1@duq.edu

In the United States more than five minority ethnic groups comprise a total of nearly 23 percent of the entire American population. This makes it imperative to have a multicultural perspective when it comes to dealing with policies, concepts, and institutions that affect more than one group. This is even more important due to the fact that religion, culture, and ethnicity can all affect one's ethical perspective on a matter.

In areas such as health and medicine, these differing ethical perspectives can have practical and tangible effects on the practice of health in a given population, so individuals must be prepared to understand and deal with differing cultural and ethical perspectives when working in the clinical setting. This type of multicultural perspective is known as cultural competence. Many differing models of

cultural competence have been proposed and developed for the clinical setting. Although there are many differing models of culturally-competent health care, this paper highlights how a review of recent literature suggests that there are three main, critical components that are necessary in virtually every viable model of culturally-competent health care: a commitment to pluralism, an awareness and commitment to cultural/ethnosensitivity, and the necessary skills to implement this sensitivity into the health care organization's practices. Further, this paper delineates why culturally-competent health care is an ethical obligation rather than merely an optional preference, and it argues that this ethical obligation is even stronger in Catholic health care due to its consistency with the overall mission and goals of the Catholic ministry of

health care, i.e., continuing Jesus' mission of healing and love ("Catholic Health Care in the United States" 2013).

History and Critical Components of Cultural Competence

Though the notion of cross-cultural medicine has been around for several decades, as a practical component for health care, the concept of cultural competence has only existed as a definable term for a little over 25 years. In the late 1980s, new research and statistical evidence emerged that demonstrated that minorities regularly received lesser health care than the majority population of white Americans, and it became apparent that cross-cultural medicine was not sufficient in its scope and methods. The discipline of cross-cultural medicine needed to expand its focus in three distinct ways: from a focus on only new immigrants to all minority groups; from a focus on only cultural differences to issues of prejudice/bias, stereotyping, and the social determinants of health; and from a focus on individual patient care to a larger focus on communities and the organizational approach to health care (Saha, Beach, and Cooper 2008).

Thus, in 1989 Cross et al. gave us the first standard definition and model of this newly

formed focus for cultural competence in their monograph, "Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children who are Severely Emotionally Disturbed."

This document was meant to create a philosophical and conceptual framework to more effectively serve all minorities and culturally diverse individuals, specifically children and adolescents. Cross et al. ultimately defined cultural competence as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations" (Cross et al. 1989). This definition has largely served as the baseline, standard definition of cultural competence throughout its existence (Stewart 2006).

However, numerous other conceptions of cultural competence have been derived from this original philosophical and conceptual framework, most giving their own definitions, such as Campinha-Bacote's definition that defines cultural competence as "a process for effectively working within the cultural context of an individual or community from a diverse cultural or ethnic background" (Campinha-Bacote 1994, 1-2). Culturally-competent health care even has

various different unique definitions, such as the following definition that includes differing interventions at the organizational, structural, and clinical levels:

“Cultural competence’ in health care entails: understanding the importance of social and cultural influences on patients’ health beliefs and behaviors; considering how these factors interact at multiple levels of the health care delivery system (e.g., at the level of structural processes of care or clinical decision-making); and, finally, devising interventions that take these issues into account to assure quality health care delivery to diverse patient populations. Given the evidence of sociocultural barriers to care and the levels of health care delivery in which they occur, a new framework for cultural competence would include organizational, structural, and clinical interventions...”
(Betancourt et al. 2003, 297).

In health care, then, cultural competence specifically “describes the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients’ social, cultural, and linguistic needs” (Betancourt, Green, and Carrillo 2002). Thus, cultural competence in health care can generally be described as a skill, process, and mindset that allows professionals in the dominant culture to effectively communicate and serve the health care needs of a variety of individuals that come from various different cultures and backgrounds.

In addition to the numerous differing conceptions and definitions of cultural competence, there are also numerous differing models for culturally-competent health care. However, virtually every model is based on three critical components that form the basis and foundation for every practical model. The first and most important essential component is the *desire* and *will* to ethically and effectively treat various different populations with vastly different backgrounds, beliefs, and values. As seen in America’s tumultuous past with race relations, this *desire* and *will* to be inclusive, tolerant, and accepting has not always been present. Thus, the first and most important component of cultural

competence is an acceptance of pluralism within the clinical setting. Pluralism can come in many forms, e.g., religious, cultural, moral, etc. With the presence of so many differing backgrounds and cultures in American society, it is unrealistic to expect a social consensus on ethical issues, especially those issues involving health (Charlesworth 2005). However, this does not necessarily mean that pluralism entails a relativistic outlook on all of these concepts either (Durante 2009). Rather, it is a process of dialogue that seeks to embrace and engage diversity and promote understanding across many lines of ideological differences (Eck 2006).

Pluralism in the clinical setting then entails a perspective that seeks to understand and value individuals from differing backgrounds, cultures, and ethnicities as equal to oneself and worthy of respect and ethical and effective health care. Coincidentally, this is the final construct of Campinha-Bacote's model of culturally-competent clinical care, and she labels the construct as "cultural desire." She describes this acceptance of pluralism in the health care setting as:

“...the motivation of the health care provider **to want**

to, rather than have to, engage in the process of becoming culturally aware, culturally knowledgeable, culturally skillful, and familiar with cultural encounters... What is of grave importance is the health care provider's real motivation or desire to provide care that is culturally responsive. Cultural desire includes a genuine passion to be open and flexible with others, to accept differences and build on similarities, and to be willing to learn from others as cultural informants” (Campinha-Bacote 2002, 182-183).

This “cultural desire” and acceptance of pluralism in the health care setting is then the basic foundational component of any practical model of cultural competence in health care, because without this will and desire to change, there is no catalyst to change.

The second essential component of any practical model of cultural competence in health care is a commitment to

cultural/ethnosensitivity. This concept is defined as “having an awareness of a client’s cultural beliefs and practices... [that] enables the practitioner to respect and value the client’s perspectives and to be nonjudgmental and inoffensive when working with the client” (Huff, Kline, and Peterson 2015, 49). It further involves “the process of becoming more sensitive and respectful of cross-cultural differences” (Huff, Kline, and Peterson 2015, 13). Thus, this concept is both a commitment to being sensitive to potential cultural differences and having the requisite education and knowledge for that very cultural sensitivity, because without the education and knowledge of potential cultural differences, it would be virtually impossible to be culturally sensitive in any substantial way.

This component is widely present in practical models of cultural competence in health care. For instance, Mary Curry Narayan incorporates learning about patients’ cultural backgrounds and understanding how culture affects health care decision-making into the second and third steps of her six-step process towards cultural competence. She also associates this component with empathy, and argues that culturally-competent physicians are “sensitive to how it feels to be an outsider in

a different culture” and able to “walk in another’s moccasins” (Narayan 2001, 41-42). Additionally, Brach and Fraserirector’s cultural competency techniques include two techniques that employ the tactic of cultural education, experience, and sensitivity: the technique of cultural competency training programs and the technique of immersing oneself into other cultures for cultural experience, education, and sensitivity (Brach and Fraserirector 2000).

The final essential component of practical models of cultural competence in health care involves the practical skills and mechanisms necessary to implement this cultural sensitivity and education into the health care organization’s practices. Essentially, this is the skill and ability to combine the commitment to pluralism with the commitment to cultural/ethnosensitivity to effectively implement culturally-competent medical interventions and health plans. As with the second component, many authors already directly employ this ability and skill in their model’s framework. Perhaps the best illustration of this component, Berlin and Fowkes’ guidelines for health practitioners rely heavily on this skill in their steps of *recommend* and *negotiate*. These guidelines suggest that health professionals should *recommend* culturally appropriate health

plans and treatments to their patients, and the final determination should be a *negotiation* between the doctor and patient working to find the best health plan possible given the cultural context of the patient.

These guidelines best demonstrate this component, because they detail how to implement these commitments to pluralism and cultural/ethnosensitivity into ethical treatment decisions and health plans within the clinic (Berlin and Fowkes 1983).

Carrillo, Green, and Betancourt also devised a similar approach based on negotiating across cultures, which is basically another way of discussing this cultural skill of implementation, and both Narayan and Campinha-Bacote use the terminology of “assessments” to define this skill of devising and implementing culturally-competent health plans in their model’s steps and constructs, respectively (Carrillo, Green, and Betancourt 1999; Narayan 2001; Campinha-Bacote 2002).

The fact that these three critical components form the basis of virtually every practical model of cultural competence in health care is no surprise, because the original model from Cross et al. essentially created this foundation for these models. For example, Cross et al. states:

“Five essential elements contribute to a system's, institution's, or agency's ability to become more culturally competent. The culturally competent system would: 1) value diversity; 2) have the capacity for cultural self-assessment; 3) be conscious of the dynamics inherent when cultures interact; 4) have institutionalized cultural knowledge; and 5) have developed adaptations to diversity” (Cross et al. 1989).

Valuing diversity comes from an acceptance of pluralism. The development of cultural/ethnosensitivity allows individuals to have the capacity for cultural self-assessment, be conscious of the dynamics inherent when cultures interact, and have institutionalized cultural knowledge. Finally, the development of adaptations to diversity is a direct consequence of having the practical skills and mechanisms necessary to implement the commitments to pluralism and cultural/ethnosensitivity into clinical practice. Thus, these three components have formed the foundation of practical models of cultural competence from the very

beginning, and they are necessary components of any effective practical model of culturally- competent health care.

The Ethical Nature of Cultural Competency

It still might be asked – why is cultural competency needed in health care in the first place, and why is it a necessary component of Catholic health care? The answer to this question is twofold – poor health care outcomes and ethical obligations. And not coincidentally, cultural competency in health care primarily focuses on two distinct outcomes-based ethical areas of concern: language barriers and differing values, preferences, and interpretations of health and health care. For example, certain studies have found that hospital communication issues resulted in up to 65 percent of all sentinel events within the hospital (Keehan 2013). And communication only gets more difficult when language barriers exist between individuals. For example, certain subsets of American minorities, such as Mexican-Americans and other Hispanic-Americans from Central America, still have significant sections of their population who cannot speak fluent English. Further, studies show that communication with and material from the doctor is even more

difficult for patients to understand when English is not their first language. This impacts everything from the doctor’s communication directly with the patient to reading prescriptions and take-home directions from the doctor, and these issues significantly compromise health care quality even more for these patients with poor English fluency or patients whose primary language is not English (Collins et al. 2002).

On the other hand, differing values, preferences, and interpretations of health also can cause problems with the efficacy and quality of health care. For example, studies suggest that ethnicity contributes to decisions about the use of life support in end-of-life situations, and most minority American groups, specifically Korean-, Mexican-, and African-Americans, have a more positive view on life support at the end of life compared to the majority population of white, European-Americans. One Korean-American even stated that the health care team and family were obliged “to lengthen the life even one second or one minute longer.” And 78 percent of the Mexican-American participants agreed with the statement “life-sustaining machines should never be stopped even if the patients appear to be dying because there is always the chance of a miracle,” which is significant

compared to only 29 percent of European-Americans agreeing with this statement (Blackhall et al. 1999). Further, many non-Western cultures are not as individualistic as Western culture tends to be, and certain cultures interpret the concept of autonomy more in a familial sense than an individual sense. That is to say that these cultures generally expect the family unit, rather than individual patients themselves, to jointly deliberate and decide upon even routine medical decisions. This obviously has tremendous implications for clinical decision-making in our society's health care system that is so focused and reliant upon individual patient autonomy. (Fagan 2004). One Korean-American from the study stated the following regarding their own decision-making in keeping themselves on life support: "I would be the one who was dying, so it wouldn't be my decision to make" (Blackhall et al. 1999).

Thus, it's clear to see how these two areas establish cultural competency as a clinical ethics issue, because they can greatly impact the efficacy, delivery, and quality of health care in these populations, leading to poor health outcomes. If we assume that each individual, regardless of race, ethnicity, creed, or religion, is of equal value, worth, and dignity, which is an ethics thesis that is

virtually unanimously accepted in Western culture, then we must also assume that each person we treat is entitled to the same quality of treatment and standard of care. However, since it has been empirically proven that cultural and linguistic contextual factors do affect values and the conception, process, and quality outcomes of health care in culturally-diverse populations, it is absolutely unethical to not take these factors into consideration and be culturally competent in this way. In the Aristotelian sense, this would be "treating equals unequally" due to a non-moral property of race, ethnicity, or language, and it ultimately amounts to a type of professional negligence, especially if you practice medicine in a multicultural area.

This ethical obligation is doubly important for Catholic health organizations, because it is inherently tied to the mission of Catholic health care. According to the Catholic Health Association of the United States (CHA), "Catholic health care is a ministry of the Catholic Church continuing Jesus' mission of love and healing in the world today" ("Catholic Health Care in the United States" 2013). CHA President and Chief Executive Officer Sister Carol Keehan, DC said, "The mission of Catholic health care is profound but simple: to treat with dignity

and compassion every person who is in our care” (Keehan 2013). Within the hospital context, though, treating each person with dignity and compassion is a complicated task due to the inherent differences within each patient’s sociocultural and linguistic context. Treating patients with dignity and compassion means to provide effective and empathetic health care to all within one’s care. However, one’s culture has a significant influence on one’s worldview and health care decision-making, which means a “one size fits all” approach is not appropriate for the utilization of health care in multicultural societies. Thus, an obligation to “treat with dignity and compassion every person who is in our care” requires a multifaceted approach that takes culture and language into context when caring for diverse multicultural populations.

But the connection is deeper than that. For example, Directive 3 of the *Ethical and Religious Directives for Catholic Health Care Services* states:

“In accord with its mission, Catholic health care should distinguish itself by service to and advocacy for those people whose social condition puts them at the margins of our society and makes them

particularly vulnerable to discrimination: the poor; the uninsured and the underinsured; children and the unborn; single parents; the elderly; those with incurable diseases and chemical dependencies; **racial minorities; immigrants and refugees**. In particular, the person with mental or physical disabilities, regardless of the cause or severity, must be treated as a unique person of incomparable worth, with the same right to life and to adequate health care as all other persons” (*Ethical and Religious Directives for Catholic Health Care Services*, Fifth Edition, USCCB 2009, 5).

Just as with Jesus’ mission, the marginalized and vulnerable of society are of utmost importance to Catholic health care, and the same is true of the culturally and ethnically diverse, who are significantly marginalized and vulnerable in many areas of health care, as these statistics (and many more) highlight. Just as serving society’s vulnerable

and marginalized populations is a central tenet of Christian philosophy, serving the health care needs of society's vulnerable and marginalized, including the culturally and ethnically diverse, is a central tenet of the mission and philosophy of Catholic health care. Thus, cultural competence and education are ethical obligations that are manifest throughout the very mission and goals of Catholic health care and its ministry of the continuation of Jesus' mission of love and healing for all. Jeff Thies states it best: "The very mission of Catholic healthcare draws us to emphasize the importance of culturally competent and linguistically appropriate care as we bring together people of diverse backgrounds and answer God's call" (Thies 2010, 11-12).

Conclusion

To conclude, Catholic health care has an ethical obligation to provide culturally competent care to all of its patients. Although there are many differing practical models of cultural competence in health care available today, they are all essentially expanded models of the basic three components that were analyzed within this paper. These commitments, skills, and abilities within these components are essential to any practical model of cultural

competence in health care, and they provide the basic framework for more expansive and elaborate models to be developed.

Essentially, these three components provide the logical sequence needed to address and overcome clinical ethics issues that are derived from cultural, ethnic, and linguistic differences in patients. If these components are not utilized, effective and ethical Catholic health care in a multicultural society may not be possible.

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Ethics and Politics

What should ethicists worry about in 2017?

The Affordable Care Act

The future of health care reform – and the progress we’ve made in access and coverage – is the biggest question. It is hard to know what Donald Trump really thinks about health care reform. In 2015 he referred to the Affordable Care Act, saying, “So it really does have to be changed...and, ideally, repealed and replaced...” Getting rid of it was a major theme of his campaign. But in 2015, he also said, “I want health care for everyone... You can't let the people in this country that are poor people, the people without the money, without the resources, go without health care. I just can't even imagine that you're sick and you can't even go to a doctor.” Later he said that he wanted to get rid of all of the ACA except pre-existing conditions and coverage for children until age 26. This would create a major problem for insurers who could not accept added risk without a broader premium pool.

Congress tried dozens of times to repeal Obamacare during the last four years, but their attempts were frustrated by presidential veto. This time, however, will be different. It is likely that the Affordable Care Act will be scuttled early in the 2017 Congressional term. *Replacing* the ACA will be a

much bigger challenge. “There is currently no consensus around alternative health policies to enact as the ACA is repealed,” says Linda Blumberg and colleagues of the Urban Institute.¹

Speaker of the House Paul Ryan and others have proposed various alternatives, but they are not comprehensive plans as much as an a la carte menu of various provisions, e.g., getting rid of the insurance mandate, offering private insurance across state lines, expanding the use of medical savings accounts, and replacing insurance premium subsidies with some kind of tax credit. Most of the proposals favor fee-for-service over bundled or episodic payments. Some propose “balance billing” which would allow physicians to bill patients for amounts over what Medicare and Medicaid pay. It is understandable why this would be helpful to physicians, but it would not be helpful to the poor, most of whom have trouble coming up with a co-pay.

Tom Price, Trump’s nominee for secretary of health and human services, is a long-time foe of the Affordable Care Act. In 2009 he sponsored an “Empowering Patients First Act” which proposed expanding medical savings accounts and tort reform, and allowing individuals to opt out of Medicare, Medicaid, TRICARE and Veterans’ benefits and purchase private insurance using tax credits.

Price also opposes many of the innovation elements of the ACA, especially “demonstration projects” that experiment with different methods of payment designed to increase quality and lower cost. He says bundled payment for joint replacements and restriction on payment for PSA tests in prostate cancer screening are attempts to commandeer clinical decision making. “Stop these mandatory demonstration projects,” he said bluntly.

These proposals all run counter to Catholic health care’s commitment to lower cost, greater access and higher quality. If the new Congress chips away at value-based purchasing and comparative effectiveness studies, there will be ethical problems of stewardship. Some of the proposals have the appeal of enhancing physician freedom and payment, but they would do so at the expense of progress we have made in population health and preventive medicine. They also tend to commodify health care in a way that we find objectionable because we do not see health care as a proprietary good that is distributed only according to market rules.

Other Ethical Issues

With regard to abortion, there is uncertainty about funding as well as legalization. The Hyde Amendment has prohibited federal funding for

abortions and the Weldon Amendment prohibits discrimination (in funding) against covered entities that refuse to provide abortions. The Democratic platform called for elimination of the Hyde Amendment, but Trump has said he would not allow federal funding for abortions, and that even though he thinks Planned Parenthood has been helpful to many women, he would not fund it because of the “abortion factor.” On Jan. 24, the House passed the No Taxpayer Funding for Abortion and Abortion Insurance Disclosure Act of 2017. The Act makes the Hyde Amendment permanent. A companion bill has been introduced in the Senate.

Trump has said he is pro-life and that he will appoint pro-life Supreme Court justices. He also said he would like to see *Roe vs. Wade* reversed and return authority on abortion to the states. However, given his vacillation on this and on other issues (including party affiliation) in the past, we will have to remain vigilant and see how his promises play out.

Many people voted for Trump because of his supposedly pro-life stance. However, even if he is sincere and even if he appoints Supreme Court justices who reverse *Roe v. Wade*, our problems would not be over. In fact, we would then have 50 problems rather than just one, since each state would become a battle ground. In addition, I do

not believe legal interdiction is the best approach. Making abortion illegal does not mean there would be no abortions. We would still have the reality of non-surgical abortion (RU-486 [mifepristone and misoprostol]) now readily available in prescription form. We would also face the problem of illegal abortions anew.

St. Thomas Aquinas refers to this when he asks whether human law should forbid all vice. It cannot he says, “because human law is framed for a number of human beings, the majority of whom are not perfect in virtue. Therefore human laws do not forbid all vices, from which the virtuous abstain, but only the more grievous vices, from which it is possible for the majority to abstain; and chiefly those that are to the hurt of others, without the prohibition of which human society could not be maintained; thus human law prohibits murder, theft and such like.” (ST 1-2, 96, 2). Of course, we see abortion as murder, but the problem is that many others do not. We do not even have consensus on the moral status of the early embryo. Therefore overly restrictive laws which the majority of people will not respect end up bringing about even worse evils.

The point is that law depends on human understanding and assent. We should not invest all energy in the possibility of change in federal law.

We must also continue to work to build a consensus around the value of human life.

EMRs

The ACA required significant spending on electronic medical records and penalized hospitals that had not achieved “meaningful use.” If the new administration sees this as a “big government” mandate, it could be in trouble. This would raise questions of stewardship since we have already spent a great deal on software and training. There may be ethical questions about privacy, but it is important to remember that EMRs are not just about having the latest electronic gadgets. EMRs enhance portability of medical records and enable us to collect unprecedented amounts of patient data that will help us assess outcomes and see correlations among genomics, behavior and disease. The potential of electronic data is perhaps the most important, if least known, aspect of the Affordable Care Act.

Balancing Public Health, Individual Choice and Profit

Trump has not said much about scientific research and funding for same, but has indicated that he is concerned about “throwing money at” federal

research. This may sound good to fiscal conservatives, but if government spends less on research others will spend more. That in turn means private ownership of life-sustaining drugs and higher prescription drug prices. We must be vigilant that research that has such impact on the common good does not become solely proprietary. This applies equally to genomic research, which is moving ahead quickly and often in a less-than-transparent way.² Are we willing to risk outsourcing the human genome? Should there not be greater public scrutiny of schemes to develop for profit therapies based on human genetic information?

We all know about Trump's skepticism on climate change. Rolling back environmental regulations and the EPA itself could have serious consequences for public health. Vaccines are another area in which public health clashes with individual freedom. In the past Trump said he thought vaccines were connected to autism. Today he says, "I am NOT anti-vaccine, but I am against shooting massive doses into tiny children. Spread shots out over time." Who knows what that would mean in policy terms?

Focus on the Social and Organizational Aspect of Ethics

As the Trump administration continues to organize the various departments in the federal bureaucracy,

I do not see much in their sketchy policies that would impact clinical ethics. It seems that our bigger concerns will be with policy questions, e.g., the contraception mandate, assisted suicide, and transgender policies. Even though some observers think the administration will favor strong religious and conscience protections, I don't think we should take anything for granted.

The immediate issues we face involve social and organizational ethics – especially justice and the common good. For example, what are the best ethical arguments we can make as we confront the efforts to repeal the Affordable Care Act? How do we persuade voters – and legislators – that reduced insurance coverage is in no one's interest? It is clear that ethicists will need to spend more time working with our policy and advocacy teams to clearly articulate our principles. We must also improve our efforts to educate the public (especially Catholics, nearly 40 percent of whom voted for Trump) about the threat to our moral values. Given the complexity of the structure of health care and health financing, this is no small challenge.

¹ Linda J. Blumberg, Matthew Buettgens and John Holahan, "Implications of Partial Repeal of the ACA through Reconciliation" (Dec. 6, 2016). Available at <http://www.urban.org/research/publication/implications-partial-repeal-aca-through-reconciliation>

² See Robert Weisman, "4 Companies Band Together in Fight over Gene-Editing Tool that Could Help Cure Diseases,"

Boston Globe (Dec. 16, 2016). This partnership will attempt to leverage CRISPR-Cas9, a gene-editing tool, to develop therapies. In a variation on the public/private financing of new drugs, see Matt Richtel and Andy Pollock, “Harnessing the U.S. Taxpayer to Fight Cancer and Make Profits,” *The New York Times* (Dec. 20, 2016), Science section. The article points out that the owners of a new immunotherapy drug are using government research, but privatizing ownership of the drug. This kind of collaboration between public and private is good in theory, but it could also result in taxpayers getting stung twice – first in financing research and development, then in high consumer prices.

-Charles Bouchard, O.P.

Hospitals Alter Routines to Control Drug Spending

With higher drug prices accounting for nearly 11 percent of the rise in hospital pharmacy cost last year, facilities are looking for new ways to control spending. One approach is to decrease the amount of drugs present on hospital floors (e.g. in crash carts). These facilities will still dispatch the medication from the pharmacy, but with fewer boxes less waste will occur from expiring stock. Another approach is to switch to more generic versions of popular drugs or to repackage expensive labels into smaller, more appropriate doses.

“Prompted by Valeant’s price increases last year, Intermountain Healthcare, which operates 22 hospitals, now gets eight doses of Valeant’s Isuprel from a single ampul.” This action has saved the system \$1.1 million annually. Melanie Evans. *The Wall Street Journal* (Dec. 18, 2016) www.wsj.com

Too Many People Misunderstand the 'Vegetative State'

“Research suggests that 68 percent of severely brain-injured patients who receive rehabilitation eventually regain consciousness, and that 21 percent of those are able to eventually live on their own.” Unfortunately, many patients are quickly dismissed and assigned a diagnosis of vegetative state. This

then makes them unqualified for rehabilitation services under insurance.

As Catholics, we aspire to focus on the dignity of the person, providing the necessary care that is most appropriate at the time. Dr. Rastrelli, a deacon and licensed physician, wants to move the debate back towards a focus on the patient, recognizing the gaps in knowledge on the subject of unconsciousness. He believes that, “The terminology has been so confused over the last 10-15 years, that sometimes families are not sure what kind of decisions to make when they’re faced with a neurological insult.” As a ministry of the Church, Catholic hospitals need to do more to address the needs of these patients and their families, guiding them in these troubled times. Meanwhile, Catholic health care must push for more research on the effects of brain injuries in order for better outcomes and greater respect for human dignity. Mary Rezac. *The Catholic News Agency* (Dec. 17, 2016)

www.catholicnewsagency.com

Organs Donated By Elderly Show Good Track Record

Currently, U.S. policies and practices regarding organ donation “impose caps and strict federal regulations that penalize centers for poor outcomes.” Such a system potentially restricts the pool of applicants for donation, often people over

65 years old. “Of the 9,079 deceased organ donors in the U.S. in 2015, only 618 were 65 or older, according to the Organ Procurement and Transplantation Network, or OPTN.” This has a disturbing effect on the nearly 120,000 people waiting for a transplant.

However, the University of Torino in northwestern Italy “suggests that age alone should not exclude older organs — in this case kidneys — from consideration.” The new study reveals that the 5 year patient survival rate for patients who received a liver from a donor in their 70s was 88 percent to 90 percent. For patients who received a kidney, the rate was 66 percent.

This new study gives support for those who seek a more open policy regarding acceptable organ donations. Leaders in the field understand that a liver from a 70 year old should not go into a 20 year old, but could be great for any of those over 65 who are awaiting transplant. Also, by not restricting people purely by age, we could reduce the current discard rate for organs – kidney discard rate is around 48 percent for those older than 80, “mostly because of age-related problems.” What this research and others highlight is the continued conversation on the best route for addressing organ shortages in the U.S. JoNel Alleccia. *USA Today* (Dec. 17, 2016) www.usatoday.com

Pope Denounces Corruption and Using Hospitals as a Business

Pope Francis met with leadership and staff of the Vatican’s children’s hospital, Bambino Gesù. In his address he denounced the temptation “to transform a good thing like a children’s hospital into a business, where doctors become businessmen and nurses become businessmen.”

This statement stems from the corruption investigation of the past president of the hospital who directed nearly \$440,000 in foundation money to “pay for apartment renovations of the Vatican’s retired No. 2.” Yet, his words of caution are appropriate for all of those who assist in the health ministry of the Church. *The Associated Press* (Dec. 15, 2016) www.ap.org

Ohio House GOP Weighs Options after Governor's Abortion Veto

Ohio Governor John Kasich vetoed a bill banning abortions at the first detectable fetal heartbeat, meanwhile signing into law a bill banning abortions after 20 weeks (with no exceptions for rape or incest). This split action of Kasich has forced the GOP-ruled legislature into considering a possible override vote.

Brad Miller, spokesman for the Republican Speaker Cliff Rosenberger said in a statement, “The speaker

will be working with caucus members to determine possible options and the outcome will be decided after further consideration." The Ohio House and Senate would need a three-fifths majority vote for an override to take effect. Gov. Kasich vetoed the heartbeat bill because he believes it would not survive a court challenge and did not want to spend taxpayer money for large legal fees. Andrew Welsh-Huggins. *The Associated Press* (Dec. 14, 2016) www.ap.org

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 Merlow Dunham (J.D./M.H.A. anticipated 2019) and Joshua Rose (J.D. anticipated 2018).

Colorado Becomes Sixth State to Pass a Medical Aid in Dying Measure

The Denver Post reports that Colorado passed its "End of Life Options" ballot measure, modeled after Oregon's "Death with Dignity" law that passed 22 years ago. Colorado's law permits a person choosing to die to self-administer a prescribed dosage of secobarbital, historically used as a sleeping pill in small doses, after two physicians agree the person is mentally competent and has less than six months to live. Those with dementia or Alzheimer's are not eligible for the prescription

under the law. Opponents argue that the law lacks safeguards by not requiring that a physician is present at time of death, by not preventing "doctor shopping," and by not preventing an heir from plotting the death of a relative to gain inheritance. Colorado became the sixth state to pass a medical aid in dying measure, joining Oregon, Washington, Vermont, Montana and California. Jennifer Brown, *The Denver Post* (November 8, 2016)

<http://www.denverpost.com/2016/11/08/colorado-aid-in-dying-proposition-106-election-results/>

Congress Passes the 21st Century Cures Act

The 21st Century Cures Act passed with unusually overwhelming bipartisan support this legislative session with a 392 to 26 vote in the House followed by a 94 to 5 vote in the Senate, as reported by *The Washington Post*. The act increases medical research funding, eases the drug development and approval process, and reforms mental health care federal policy. The act includes an allocation of \$4.8 billion in new funding for the National Institutes of Health, with \$1.8 billion earmarked for the "cancer moonshot" launched by Vice President Biden, \$1.6 billion for brain disease research, \$500 million for new Food and Drug Administration funding, and \$1 billion for state grants aimed at fighting opioid abuse. Mike DeBonis, *The Washington Post* (Dec. 7, 2016)

<https://www.washingtonpost.com/news/powerpost/wp/>

[2016/12/07/congress-passes-21st-century-cures-act-boosting-research-and-easing-drug-approvals/?utm_term=.d0aad9b84dea](http://www.congress.gov/114/legislation/2016/12/07/congress-passes-21st-century-cures-act-boosting-research-and-easing-drug-approvals/?utm_term=.d0aad9b84dea)

Facing Addiction in America: The Surgeon General's Report on Drugs, Alcohol, and Health

In November 2016, the Surgeon General released his report entitled "Facing Addiction in America: The Surgeon General's Report on Drugs, Alcohol, and Health," which a *Health Affairs* article designates as the first report to ever place addiction and substance abuse front and center in discussions about how to improve health in America. The report promotes a comprehensive public health model to address substance misuse and related consequences by reforming the current policy and practice of addiction prevention, treatment and recovery in America. The proposed public health approach is referred to as "Screening, Brief Intervention, and Referral to Treatment" (SBIRT), which provides a framework to prevent or delay substance misuse, especially in young people. The report emphasizes a need "for enhanced public education to improve awareness about substance use problems," for "widespread implementation of evidence-based prevention policies and programs," for "improve[d] access to evidence-based treatment services, integrated with mainstream health care," and for an investment in "recovery support services (RSS) that can support people in sustaining their

recovery and preventing relapse." Alexa Eggleston, *Health Affairs* (Dec. 16, 2016)

<http://healthaffairs.org/blog/2016/12/16/facing-addiction-in-america-its-about-time/> The Surgeon General's Report:

<https://addiction.surgeongeneral.gov/>

CMS Launches Two New Compare Websites

On December 14, CMS launched two new Compare websites where patients can obtain consumer-oriented information about the quality of inpatient rehabilitation facilities and long-term care hospitals. A *Modern Healthcare* article explains that the new Compare websites will report quality measures such as the percentage of residents or patients with new or worsened pressure ulcers, and unplanned readmissions, for any reason, within 30 days after discharge. Despite the praise the websites have received for publishing data and informing consumers, the Compare websites are controversial due to industry concerns that the websites and methodology behind the quality star rating system used by the Hospital Compare site may lack accuracy and precision. Nevertheless, the growing list of CMS' Compare websites demonstrates a push for increased transparency regarding quality and engagement of patients in their health care. Elizabeth Whitman, *Modern Healthcare* (Dec. 14, 2016)

<http://www.modernhealthcare.com/article/20161214/>

[NEWS/161219960?utm_source=modernhealthcare&utm_medium=email&utm_content=20161214-NEWS-161219960&utm_campaign=am](https://www.healthaffairs.org/content/35/11/2030.full)

Assessment Shows that Public Libraries are Well Positioned to Improve Population Health

A *Health Affairs* article presents findings from an assessment of how public libraries can be used to improve population health. The assessment analyzes the effectiveness of the Healthy Library Initiative in Philadelphia, a partnership that provides support programs through the city's public library system for vulnerable populations, including the homeless, those with mental illness and substance misuse, recent immigrants, and those suffering from trauma. Of the 5.8 million in-person Free Library visits in 2015, 500,000 included attendance at programs focused on addressing health determinants such as housing and literacy. The assessment indicates that public libraries are well positioned to provide programming to address social determinants of health. Anna Morgan, et al., *Health Affairs*, 35(11) (Nov. 2016)

<http://content.healthaffairs.org/content/35/11/2030.full>

ACLU, HHS Ask Court Not to Delay Obamacare Nondiscrimination Rule

On May 18, the U.S. Department of Health and Human Services (HHS) interpreted a nondiscrimination provision of the Affordable Care Act (ACA) to include discrimination on the basis of gender identity. In effect, Section 1557 precludes health care providers in receipt of federal funds from discriminating against patients seeking gender transition or similar procedures. In *North Dakota v. Burwell*, religiously-affiliated providers in North Dakota, Minnesota and Michigan are challenging the HHS rule as an infringement of religious freedom under the Religious Freedom Restoration Act. Specifically, the providers claim the HHS rule imposes a "transgender mandate," where religiously affiliated providers are forced to perform gender orientation procedures against religious belief, medical judgment and concern for patient care. A similar case, *Franciscan Alliance, Inc. v. Burwell*, was brought by eight states in early December. In response, HHS argued Section 1557 inherently protects against the type of harm purported by the religiously affiliated providers, including administrative procedures and a right to counsel patients in accordance with medical judgment. Further, at the preliminary injunction stage, HHS argues, the claims are not ripe for consideration. To date, no plaintiff to *North Dakota v. Burwell* has been sued for gender identity discrimination. The

American Civil Liberties Union, by way of amicus curiae, described the providers' request as a "blanket right to engage in federally funded healthcare discrimination." Of note, the providers are especially concerned with application of the rules to children. Matthew Loughran, *Bloomberg BNA Health Law Reporter* (Dec. 15, 2016)

Health Insurers Get Only 1.6% of \$6 billion They Are Owed for Costly ACA Customers

Inherent in the Affordable Care Act (ACA) is an effort to deter marketplace insurers from solely targeting individuals with lower-than-average medical costs. Known as "risk corridors," annual costs for marketplace insurers are estimated and benchmarked. Insurers with costs below the benchmark remit earnings to a fund, from which insurers with greater costs than anticipated are compensated. In essence, risk corridors are designed to offset the cost of accepting individuals with higher-than-average medical needs, where high-cost individuals receive coverage and insurers receive compensation for the added risk. The program, designed to run from 2014 through 2016, is vastly underfunded. In 2015, insurers covering customers with unexpectedly high medical expenses were slated to receive nearly \$6 billion; to date, the insurers have received \$96 million. At origination, the risk corridor program was to be funded through a combination of the remittance payments and

federal funding. Yet, Republican critics of the ACA defeated a funding bill for the risk corridor program, which contributed to the shortfall. At present, approximately 70 percent of marketplace insurers are owed money under the risk corridor program, with a mere 15 percent of insurers with costs below benchmarks and contributing to the fund. The shortage in funding for the risk corridor program is but one example of insurer dissatisfaction with the ACA. Citing losses from sicker-than-expected insureds, United Healthcare and Aetna have withdrawn from the marketplace in the majority of geographies. Amy Goldstein, *The Washington Post* (Dec. 15, 2016)

https://www.washingtonpost.com/national/health-science/health-insurers-get-16-percent-of-6-billion-theyre-owed-for-costly-aca-customers/2016/12/14/510bc490-be4d-11e6-91ee-1adddf36cbe_story.html?utm_term=.7abe19f7a3f8

AARP Sues U.S. Over Rules for Wellness Programs

In May, the Equal Employment Opportunity Commission (EEOC) issued a rule for employee wellness programs, capping the incentive to participate at 30 percent of the annual cost of a worker's health insurance coverage. On average, the Kaiser Family Foundation reports, the annual cost for individual coverage is \$6,435. Thus, as of the latest EEOC ruling, an employee's refusal to

participate in an employee wellness program could cost a worker up to \$2,000. To participate, however, employees are often required to complete health risk assessments and biometric testing. Requiring workers to release private medical or genetic information, AARP argues, violates anti-discrimination laws protecting employee health information. Further, given the significant cost associated with not participating, AARP "questions whether the programs are truly voluntary." Granted, many employers cap incentives to participate below the maximum allowed, and employers often utilize third-party services to collect employee information in a confidential manner. Yet, AARP insists the incentive hike ultimately forces workers to choose between reducing the cost of health care and divulging personal health information, a predicament AARP believes violates anti-discrimination laws of the Americans with Disabilities Act. Critics of the AARP point to the voluntariness of the programs and a lack of evidence to indicate employers actually discriminate against employees on the basis of health information received through wellness program screenings. The AARP has filed a request to enjoin the EEOC from enforcing the rule. The courts have yet to weigh in on the issue. Reed Abelson, *The New York Times*, (Oct. 24, 2016)

http://www.nytimes.com/2016/10/25/business/employee-wellness-programs-prompt-aarp-lawsuit.html?_r=0

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Associate editors: Rev. Thomas Nairn, OFM, Ph.D., CHA senior director, theology & ethics; Tobias Winright, Ph.D., Hubert Mader Chair of Health Care Ethics, Albert Gnaegi Center for Health Care and Ethics, Saint Louis University. CHA's Theologian/Ethicist Committee serves as an advisory committee to the editorial board.

Managing editor: Ellen B. Schlanker, CHA director, communications

Layout design: Jennifer M. Harris, CHA communications specialist

Of Note Contributors: Amy N. Sanders, assistant director, Center for Health Law Studies, Saint Louis University School of Law, Lori Ashmore-Ruppel, mission program and research associate, Catholic Health Association and Nathaniel Hibner, graduate student, Albert Gnaegi Center for Health Care Ethics, Saint Louis University.

ETHICS WEBINAR

Promoting Dignity, Stewardship and Justice in Behavioral Health Care

April 25, 2017

Noon - 1:15 p.m. ET

Presenters:

Mary Hill, JD, BSN, MA
Vice President of Ethics

&

Steve Lindquist
Vice President of Behavioral Health Services
Avera Health
Sioux City, SD

This webinar explores the stigma of mental illness and the ongoing challenges associated with access and reimbursement for behavioral health care. Presenters will discuss how Avera Health has addressed these challenges through a commitment to human dignity, stewardship and justice in the development, funding and provision of behavioral health services. Unique and emerging ethical issues in clinical behavioral health care will also be explored.



To learn more, go to chausa.org/calendar

NEW END-OF-LIFE GUIDE Palliative and Hospice Care



This new ethics publication from CHA helps patients, families, physicians and care givers with decisions about palliative care and hospice care. The guide is part of a collection that addresses advance directives, serious illness and end-of-life care.

CHA developed the guides in collaboration with physicians, nurses, theologians and ethicists within Catholic health care. Although the guides reflect the perspective of the Catholic tradition, the information is helpful to people from any religious tradition. Available in both English and Spanish.



Copies of all three guides are available to order or download at www.chausa.org/store