

Immigration, Charity Care and Ethics: What Should Catholic Hospitals Do?



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In July 2008, *The New York Times* started a special series titled "Getting Tough," which the newspaper described as an exploration of "efforts by government and others to compel illegal immigrants to leave the United States."¹ Two of the articles in this series described attempts by U.S. hospitals to return immigrants to their country of origin rather than continue non-emergency but costly health care for which they would not be reimbursed.

One article told the story of an undocumented worker in Florida who was forcibly returned to Guatemala by a hospital in Stuart, Fla. Although a lower court ruled in favor of the hospital, an appeals court overturned this judgment, stating that deportation was the prerogative of the federal government, not of a private institution.²

Another article shared the story of a 19-year-old legal immigrant and an Arizona hospital that "disregarded the strenuous objections of his grief-stricken parents"³ and sent the comatose young man back to Mexico. Days later the young man, still in a coma, was again transported over the border via a donated ambulance to a California hospital. The Arizona hospital criticized in the article is a Catholic facility.

These articles led to a public outcry. The hospitals received dozens of letters and e-mails severely critical of their actions. In November, the American Medical Association's House of Delegates voted to study whether forced repatriation is an inappropriate discharge of a patient.⁴ Although the *Times'* series served well to publicize the distress of the patients and their families, they were less adequate in describing the constraints under which the hospitals were operating. The newspaper did note, however, that "hospitals have limited options in discharging immigrant patients who need continuing care: keeping them indefinitely, with or without providing rehabilitation; finding them charity beds or subsidizing them at nursing homes; sending them home to relatives; or repatriating them."⁵ Nevertheless, health care institutions need to find a more satisfying answer, because the question of how to care for the U.S. immigrant population, especially when a hospital's own resources are increasingly limited, is not restricted to the medical centers mentioned in the articles. The issue is currently being faced by a growing number of hospitals in every region of the country.

EXAMINING BOTH SIDES

For those who see Catholic health care as a continuation of the healing work of Christ, these stories pose a troubling question: Given our articulated values and mission, what should a Catholic hospital do? Catholic health care acknowledges that our vision is based upon a range of values. The Catholic Health Association's "A Shared Statement of Identity for the Catholic Health Ministry," for example, contains such a list:

- Promote and defend human dignity
- Attend to the whole person
- Care for poor and vulnerable persons
- Promote the common good
- Act on behalf of justice
- Steward resources
- Act in communion with the church⁶

CHA Convenes Dialogue on Care of Uninsured Immigrants

A task force of ethicists, mission leaders, legal counsel, a physician and various administrators met at the Catholic Health Association's St. Louis office in December 2008 to investigate the ethical limits and possibilities of charity care for uninsured immigrants. The task force has not yet reached any conclusions regarding how Catholic health care can proceed, but would like feedback from CHA members on what they have been doing in this area. Contact task force member Tom Nairn, OFM, Ph.D., at tnairn@chausa.org to share information about your institution's methods in dealing with issues of charity care or care for immigrant populations. Data will be compiled for sharing among all CHA members, along with possible discernment processes and other resources. The task force plans to meet again during a general session at the 2009 Catholic Health Assembly, June 7-9, in New Orleans.

When making concrete ethical decisions, however, one value often dominates. For example, in the pastoral letter *Welcoming the Stranger Among Us* the U.S. Catholic bishops used the dignity of the immigrant as the basis for their moral stance: "Without condoning undocumented migration, the Church supports the human rights of all people and offers them pastoral care, education, and social services, no matter what the circumstances of entry into this country, and it works for the respect for the human dignity of all — especially those who find themselves in desperate circumstances."⁷ The bishops decried the fact that undocumented workers "fear that they or their children will be denied medical care."

The U.S. bishops quoted the apostolic exhortation *Ecclesia in America*: "Attention must be called to the rights of migrants and their families and to respect for their human dignity, even in cases of non-legal immigration." They concluded by calling for respect of basic human rights (one assumes that these include the right to health care) and provision of direct assistance to immigrants.⁸

Even Pope Benedict XVI's encyclical *Deus Caritas Est* at times exhibits this tendency. Distinguishing the work of charity from that of justice, he then clarifies that the work that corresponds to the proper nature of the church is that of charity. Acknowledging that the church's charitable organizations cannot "fully resolve every problem,"⁹ he nevertheless exhorts Catholic institutions: "Christian charity is first of all the simple response to immediate needs and specific situations: feeding the hungry, clothing the naked, caring for and healing the sick, visiting those in prison, etc. The Church's charitable organizations ... ought to do everything in their power to provide the resources and above all the personnel needed for this work."¹⁰

On the other side of the debate, Mark Meaney, Ph.D., a health care ethicist and president of the National Institute for Patient Rights, believes charity is a principle that actually limits what a Catholic institution should be obliged to do.¹¹ He maintains that "distributive justice places constraints on the proper exercise of charity"¹² and suggests that Catholic health care can only understand its duties according to charity appropriately by returning to the Thomistic notion of a proper ordering of charity. Analyzing Thomas Aquinas's *Summa Theologiae*, Meaney concludes that assessing a hospital's responsibility should be

governed by "right reason," which Meaney takes to mean the following:

- Hospitals have a responsibility to give from "surplus."

- Acknowledging a hierarchy of obligations and attachments, hospitals should give priority to those who are more closely united to the hospital "by reason of place, time and circumstance."

- Acknowledging the limited resources of the hospital, hospitals must not place a higher value on the interests of a particular individual than on their responsibility to the common good.

- Hospitals have a particular obligation to "those who could not be cared for if we did not care for them."¹³

Meaney adds that the needs of immigrants, especially undocumented immigrants, have less priority than others within the community.

HIERARCHY OF VALUES

When committing to a range of values, such as those already listed as part of CHA's "Shared Statement of Identity," it is always tempting to try to establish a hierarchy among them. This hierarchy then becomes the means to adjudicate among the values should they enter into conflict with one another. Instead of subjugating some of the values to which we are committed, is it possible to hold them in creative tension?

Within the Catholic moral tradition, attempts at keeping this tension have usually been associated with virtue ethics, which is generally defined as a moral philosophy emphasizing character over rules or consequences as part of ethical thought. For example, in his consistent ethic of life, Cardinal Joseph Bernardin demonstrated that the moral life consists not only of obeying moral principles but also of maintaining what he called the proper "attitude" of respect that arises from our moral vision.¹⁴ Ron Hamel, Ph.D., CHA's senior director of ethics, has reminded us that "such an attitude undergirds a concern for and activity on behalf of a host of life issues and must be cultivated in society if there is going to be any hope that public actions will respect human life and dignity in concrete cases."¹⁵

Similarly, ethicist William Spohn, Ph.D., spoke of "moral perception" by suggesting that "the main components of moral perception are habits of considerateness and attentiveness to the data, virtues of respect and empathy, imagination capa-

ble of understanding the other's hopes and fears, experience that has taught us how to place this situation in a larger perspective, honest self-knowledge about our preferences and prejudices, and humility to seek the advice of others to expand our own vision."¹⁶

SEEKING MINISTRY FEEDBACK

In an attempt to respond to the issue, a task force composed of ethicists, mission leaders, legal counsel, a physician and various administrators met at CHA's St. Louis office in December 2008 to investigate the ethical limits and possibilities of charity care (read sidebar on pg. 6 for more information). Following the examples of Cardinal Bernardin and Spohn, the task force tried to look at the issue with a certain amount of moral creativity. Among the conclusions was the expressed need for a process of discernment available for those who face these questions. Such a discernment process complements many of our methods for making moral decisions by engaging spirituality and moral creativity as well as intellect. As one of our health care systems has suggested, it "reaches into the heart of our beliefs about God, creation, others and ourselves," and "requires structured time for reflection and prayer."¹⁷

As one attempts to view this issue in such a spirit of prayer, it is permissible to ask whether morally creative ways exist out of the current impasse. Members of the task force tried to open themselves to such possibilities. One participant raised the question regarding what the ministry can do collectively that would be impossible for individual hospitals or health care systems. Building on this, another asked whether it might be possible for the various health systems to contribute a certain amount of their charity care monies into a fund that would be used for medical care for immigrants.

Task force members asked, too, whether there might be creative ways to reduce the need for charity care. According to a 2007 study, most immigrants (at least those from Mexico who come to the United States primarily for work) are relatively healthier than their U.S.-born counterparts when they arrive. Their health, however, deteriorates over time.¹⁸ Reasons given for this include adopting unhealthy eating habits, living in unhealthy environments, and having poor access to health care.¹⁹ Is it possible that monies spent in ensuring early access to health care, espe-

cially preventive health care, might reap benefits in terms of both a healthier immigrant population and less total cost to health care systems in the long run? ■



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NOTES

1. Deborah Sontag, "Deported in a Coma, Saved Back in U.S.," *The New York Times*, Nov. 8, 2008. This quote was used to describe the special series titled "Getting Tough" where this article appears. This series is available online at www.nytimes.com.
2. Deborah Sontag, "Immigrants Deported by U.S. Hospitals," *The New York Times*, Aug. 3, 2008.
3. Sontag, "Deported in a Coma, Saved Back in U.S."
4. "Doctors Study Repatriation of Uninsured," *The New York Times*, Nov. 8, 2008.
5. Sontag, "Deported in a Coma, Saved Back in U.S."
6. Catholic Health Association, "A Shared Statement of Identity for the Catholic Health Ministry," www.chausa.org.
7. United States Conference of Catholic Bishops, *Welcoming the Stranger Among Us: Unity in Diversity* (Washington, D.C.: USCCB, Nov. 15, 2000).
8. United States Conference of Catholic Bishops. Also see Pope John Paul II, *Ecclesia in America* (Washington, D.C.: USCCB Publishing, 1999), par. 65.
9. Pope Benedict XVI, *Deus Caritas Est*, (Washington, D.C.: USCCB Publishing, 2006), par. 36.
10. Pope Benedict XVI, par. 31.
11. Mark E. Meaney, "The Ordering of Charity Medical Care in an Era of Limits," *HEC Forum* 13, no. 2 (2001): 196.
12. Meaney, 200.
13. Meaney, 208-209. The two direct quotes come from the *Summa Theologiae* (II-II, Q26, a6 and III, Q32, a5).
14. Cardinal Joseph Bernardin, *The Seamless Garment: Writings on the Consistent Ethic of Life* (Maryknoll, N.Y.: Orbis Books, 2008), 12.
15. Ron Hamel, "Twenty-Five Years Later: Cardinal Bernardin's Consistent Ethic of Life," *Health Progress* 89, no. 6 (November-December 2008): 57.
16. William C. Spohn, *Go and Do Likewise: Jesus and Ethics* (New York: The Continuum Publishing Company, 1991), 98.
17. Ascension Health, "Organizational Ethics Discernment Process," www.ascensionhealth.org/ethics/public/organizational_ethics.pdf. Pope Benedict XVI also speaks of the importance of prayerful discernment in *Deus Caritas Est* (referenced in note 9).
18. Kathryn Pitkin Derosé et al., "Immigrants and Health Care: Sources of Vulnerability," *Health Affairs* 26, no. 5 (September-October 2007): 1263.
19. Derosé et al.