CHA
Catholic Health Association of the United States

Understanding and Applying the *Ethical and Religious Directives for Catholic Health Care Services:*

AN EDUCATIONAL RESOURCE FOR THE CATHOLIC HEALTH MINISTRY



Part One - The Social Responsibility of Catholic Health Care Services

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CASE STUDY

CASE #1: ALLOCATION OF RESOURCES

You practice at a 320-bed community hospital that has just entered into a newly-formed multi-hospital Catholic health care system. The system board and CEO as well as the St. Francis hospital board have charged the CEO with making cost management her number one priority during the first year of the merged entity. The CEO has already moved quickly to begin consolidating departments and cutting marginal services to reduce costs. She has avoided a massive layoff, but the selective job reductions and various cost control measures have had a perceptible impact on employees' morale as measured by a variety of internal feedback mechanisms. Among these have been very visible internal "town hall" forums in which the CEO has been accused of short-changing patient care.

The CEO is approached by the city administrator to partner with the city in funding and operating a clinic for a relatively large Hispanic population on the outer western edge of your service area. This rather impoverished community is approximately five miles from the hospital. One of your physicians has volunteered her time at a very small store-front clinic for the past three years and has been a strong advocate both for the move to a larger facility with expanded services and for your hospital's active partnership with the city. The current facility has long been inadequate to meet the needs of the community. Up-front costs to your hospital are expected to be in the vicinity of $250,000. The annual contribution would be approximately $300,000. Your health system's and hospital's mission speaks directly to your commitment to improve the health status of the community, and community outreach is one of the organization's explicit priorities.

However, the CEO has another proposal on her desk — from the oncology group at the hospital. They wish to start up, in collaboration with the hospital, a specialty oncology hospital that would not only provide the latest technology, but also conduct cutting-edge genetics research, and offer a very active program of susceptibility testing for various forms of cancer, in particular, breast, ovarian and colon. The oncologists believe that an aggressive testing program and state-of-the-art equipment, together with their reputations, would attract many individuals from the adjoining affluent suburb and from the entire region (especially

private-pay individuals and those whose insurance covers susceptibility testing) for the testing itself and also for follow-up care and treatment down the road for those who develop cancer. A state-of-the art cancer hospital will also attract other cancer patients from the area. They see this as potentially very lucrative for themselves and an excellent investment for the hospital. The hospital would be part owner and share in the profits.

As envisioned, Salus Cancer Institute would provide all-encompassing care, from prevention to after-cancer, in one fully-integrated facility, supported by a multidisciplinary team of health professionals, advocates, and counselors. Also on staff would be physicians who are leaders in palliative care, education, and research. Patients and their families would find not only the best evidence-based treatments and new cutting-edge treatments, the latest technology and comforts, but the largest integrative medicine program in the region featuring prayer, meditation and yoga, acupuncture, massage, music therapy, and diet and nutrition counseling. The hospital would also contain a care store, a one-stop location, that would provide cancer patients with special clothing items designed for their comfort, including wigs and headwear, swimsuits, bra and prosthetic fittings for mastectomy patients, skin care products for patients undergoing radiation, and much more.

A further pressing reason for the specialty hospital is that another oncology group in the region apparently is considering doing the same. The advantage that the St. Francis group has is that most of the oncologists trained at a very prestigious university, they are very active researchers and tops in their specialties, they are doing a large number of experimental protocols, and they are relatively high admitters. The group is looking for considerable capital from the hospital to build the specialty clinic. They have insinuated that if the hospital chooses not to participate in this venture they will look elsewhere, and perhaps even partner with the other oncology group.

This matter is brought by the CEO to the administrative council of which you are a member.

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CASE RESPONSE

CASE #1: ALLOCATION OF RESOURCES

1. What ethical issues do you see here?

- ✦ Just treatment of employees.
- ✦ Fidelity to the organization's mission.
- ✦ Prudent stewardship of resources.
- ✦ Contributing to the common good.
- ✦ Care for the poor and vulnerable.

2. Which Directive(s) apply to the case?

- ✦ 7, 6, 1, 3, 4. The Introduction and the values identified in the Introduction are also relevant to this case.

3. How might the Directive(s) help address the case?

- ✦ In this case, there are competing values. The Directives in question do not resolve the case, but rather highlight important considerations/values that are core to Catholic health care.
- ✦ Also pertinent to this case are the "normative principles" delineated in the Introduction to Part One—defend human dignity, care for the poor, contribute to the common good, exercise responsible stewardship for available health care resources.

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CASE STUDY

CASE #2: DECLINING TO SEE MEDICAID PATIENTS

The OB-GYN group with which your Catholic hospital has contracted for years has recently decided to stop seeing most Medicaid patients because several members of the group have been complaining about the low levels of reimbursement and the "type of clientele." The group insists it has the right to do this, but several case managers are concerned that these women will "fall through the cracks" and that it "looks bad on our hospital," especially since the for-profit competitor already sees the majority of Medicaid patients in the area. Senior leadership discusses the situation and most think they must allow this or else they could lose the OB-GYN group. However, others see this as unacceptable because it runs counter to the hospital's mission. (Courtesy of Dr. Michael Panicola, SSM Health Care, St. Louis, Mo.).

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CASE RESPONSE

CASE #2: DECLINING TO SEE MEDICAID PATIENTS

1. What ethical issues do you see here?

- ✦ Failure to provide vulnerable patients with needed care.
- ✦ Failure to fulfill the organization's mission and allowing a group of physicians to act contrary to the organization's mission.
- ✦ Discrimination leading to disparity in care.
- ✦ Justice.

2. Which Directive(s) apply to the case?

- ✦ 1, 2, 3, 5, 9. The Introduction is also important. It highlights values that should characterize Catholic health care — respect for human dignity, care for the poor, contributing to the common good, and good stewardship of resources.

3. How might the Directive(s) help address the case?

- ✦ These Directives underscore that one of Catholic health care's fundamental commitments and characteristics is care for the poor and vulnerable.
- ✦ Care for the marginalized is central to the organization's identity and integrity.
- ✦ Catholic health care is committed to caring precisely for such patients — those who are vulnerable and at the margins.

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CASE STUDY

CASE #3: PROVIDING CARE FOR AN UNDOCUMENTED IMMIGRANT

Miguel V. was a 20 y/o Hispanic male originally from a rural area of Mexico. Several years prior to being hospitalized at St. Joseph's Medical Center, he entered the United States illegally, ended up residing in a small, mostly Hispanic, town about 40 miles outside of the urban area and worked for a local nursery and landscaping business. Spanish was his primary and preferred language and he was virtually unable to speak or understand English. Miguel's parents lived in Mexico and he had no other family living in the area.

In May, Miguel was diagnosed with testicular cancer—stage 4 with a poor prognosis. He presented with lower extremity numbness and weakness as well as a testicular mass. He underwent a right radical inguinal orchiectomy and was discharged. One month later, he presented to a hospital in the town in which he lived with symptoms of urinary incontinence and difficulty in ambulating. He was transferred to St. Joseph's Medical Center and admitted to a hospitalist team. He received both an oncology and radiation oncology consult.

The specialist's opinion was that radiation and chemotherapy needed to be started immediately if any type of reversal was to occur of both the neurogenic bladder as well as the lower extremity weakness. There was considerable concern as to whether Miguel's condition was reversible even with the most aggressive treatment. In the presence of a chaplain and the case manager (and with a bedside interpreter), the physician communicated to Miguel a summary of his condition and the recommended treatments. The physician also explained that the hoped-for outcome of treatment was not certain, that there was the possibility of treatment not helping. At this time, Miguel designated a main contact person who was the pastor of the church Miguel attended in the town where he lived. However, Miguel himself was looked to by his physicians for decisions about whether to accept or refuse treatments, including, as his condition worsened, CPR.

From June to November, Miguel was hospitalized 141 of 161 days. An MRI of the lumbar spine showed complete involvement of the L5 vertebral body with extension into the epidural space and compression of the L5 region. The cancer extended into the inferior sacrum with erosion through the sacrum. Miguel underwent chemotherapy and radiation treatment. He had a 10 day stay in the intensive care unit due to infection and c. diff colitis. He had a total colectomy with ileostomy and G-tube placement. He developed megacolon.

Miguel was discharged for three days in August, but returned for a new onset of seizures. Etiology was unknown. He was discharged again for two weeks and returned to St. Joseph's in October for further chemotherapy, though there was and had been concern on the part of some on the medical team that the chemo was of little or no benefit. Pain was becoming more of an issue. Because of his illegal immigration status and his lack of a social security number or identification, Miguel had no access to opioid prescriptions. The Palliative Care Service was consulted to assist in pain management and to assist with the very difficult issues of how Miguel was going to be cared for outside of the hospital.

The Palliative Care Service believed that Miguel, given his condition and prognosis, required good end-of-life care and that hospice would be best able to provide it. However, no hospice in the area would accept Miguel, partly because he was uninsured and partly because of the difficulty with opioids and the inability to get prescriptions filled.

A critical juncture had been reached about what was best for Miguel and how best to provide for his needs. To this point, the total cost of Miguel's medical care to St. Joseph's Medical Center was $500,000. (This is an adaptation of an actual case. Some details have been omitted or changed in order to maintain confidentiality of the facility and the patient).

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CASE RESPONSE

CASE #3: PROVIDING CARE FOR AN UNDOCUMENTED IMMIGRANT

1. What ethical issues do you see here?

- Providing needed care to an undocumented, uninsured immigrant in need of that care. Respecting the dignity of the undocumented immigrant.
- What does distributive justice require when providing charity care to a given individual? Stewardship of the hospital's resources. Impact on the common good.
- Self-determination: the patient was asked to make decisions about his care, but this is not the cultural norm in Mexico.
- Informed consent: given the language barrier, the patient's age, and lack of family, was this patient truly "understanding" and giving "consent"?
- Clarity about goals of treatment: what really was in the patient's best interests at various points along the way?

2. Which Directive(s) apply to the case?

- Introduction to Part One; Directives 1, 3, 6. There are also several Directives in Parts Three and Five that would apply here.

3. How might the Directive(s) help address the case?

- Directives 1 and 3 speak to Catholic health care's commitment to provide care to those in need of it with special attention to the poor and marginalized. This commitment is re-affirmed by the first two normative principles noted in the Introduction, namely, respect for human dignity and care for the poor.
- Directive 6 speaks to Catholic health care's commitment to stewardship of resources. This particular case raises the question about how much uncompensated care ought to be provided to one person, especially when much of that treatment seemed to be non-beneficial. This is a matter of justice. The next two normative principles in the Introduction—seeking the common good and stewardship of resources—are very relevant to addressing this dilemma.
- Needless to say, other Parts of the Directives are also applicable to this case, especially Directives in Parts Three and Five.

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CASE STUDY

CASE #4: STEWARDSHIP VERSUS AIDING DISABLED EMPLOYEES

You are the executive of a five-hospital system in a metropolitan area. The oldest of your facilities, St. Mary's, was founded in 1882 and has been sponsored by the congregation from its inception. The sisters take pride in the fact that they have remained in the city even though many persons fled during the "white flight" of the 1960's and 1970's.

St. Mary's has long operated a laundry that serves the rest of the system's acute and long-term care facilities. Mentally handicapped adults staff the laundry. Most of them have been referred for employment from the diocese's special education school. At a recent awards banquet, you conferred an award on one of these men for 25 years of faithful service.

Over the last few years, however your executive staff has raised questions about the laundry. First, as the system has grown, it seems that the quality of the laundry's work has diminished. You have received reports of late delivery and dingy looking sheets and towels. The laundry's ancient machinery is badly in need of replacement. It is only through the excellent maintenance staff that it is still running. And the laundry supervisor has some serious safety concerns working with old machines.

You have hired an outside agency to do an assessment of the laundry service and the agency recommends that you outsource this service. They predict that you will save a sizeable amount of money and be able to eliminate a significant number of FTEs.

When you bring this proposal to the Board of Directors, one of the members mentions that the system has as one of its stated values care of those who are poor and vulnerable.

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CASE RESPONSE

CASE #4: STEWARDSHIP VERSUS AIDING DISABLED EMPLOYEES

1. What ethical issues do you see here?

- ✦ Care for the poor and vulnerable.
- ✦ Fidelity to the organization's mission.
- ✦ Just treatment of employees.
- ✦Prudent stewardship of resources.

2. Which Directive(s) apply to the case?

- ✦ Directives 1, 3. 7 and 6. At least three of the normative principles in the Introduction to Part One are also relevant.

3. How might the Directive(s) help address the case?

- ✦ In this case, there are seemingly competing values. The Directives in question do not resolve the case, but rather highlight important considerations/values that are core to Catholic health care.

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CASE STUDY

CASE #5: WORKPLACE JUSTICE

The President/CEO and CFO of Marian Services for the Aged bring to the Board at the April board meeting a budget proposal that includes a substantial deficit. In his presentation to the Board, the CEO indicates that the projected deficit is due to two factors.

First, a substantial wage increase is projected for CNAs. The administration feels that as a Catholic sponsored facility committed to social justice, Marian should try to move toward paying a "living wage" to CNAs. Further, from a purely pragmatic point of view, a wage increase is needed to retain the CNAs they have and to attract people to fill several vacant positions.

Second, Marian presently has a nursing home and independent and assisted living units, but would like to add an adult day care center. Such services, the CEO explains, would greatly assist older persons living with adult children who must often go to work during the day. An adult day care center would permit many of them to remain longer in a home setting instead of having to opt for assisted living or a nursing home. And the results of a recent survey indicate a need for more adult day care services in the area. This might also be a good way to interest potential clients in Marian. The CEO admits, however, that it is likely to take several years before Marian begins to break even on an adult day care operation. Nonetheless, he wants to go ahead with the project because of Marian's mission to serve the aging and the community's need for adult day care services.

In general, board members are supportive of the idea of increasing wages for CNAs and the concept of an adult day care center. However, the majority of board members also express concern over the amount of the projected budget deficit. In the past few years, Marian has been running a deficit but this was covered by the annual community fund drive and interest from their endowment. However, because of general economic conditions, interest rates and contributions to non-profit organizations are down. Board members insist that caution is in order in formulating the budget.

One board member suggests trying to trim the projected expenditures for buildings and grounds. Another board member, comments that these sorts of cuts are not sufficient to solve the problem. He suggests downsizing administrative staff where there seems to be some duplication, including several people in management and four people in development, and sharing secretaries for the remaining administrative positions.

(This case has been adapted with permission from Janine Idziak, PhD, Organizational Ethics in Senior Health Care Services, Dubuque: Simon & Kolz Publishing, 2003, pp. 163-164).

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CASE RESPONSE

CASE #5: WORKPLACE JUSTICE

1. What ethical issues do you see here?

✦ Just treatment of employees.

✦ Prudent stewardship of resources.

✦Contributing to the common good.

✦Providing care to those in need of it.

2. Which Directive(s) apply to the case?

✦ Directives 7, 6, 1, and 3. At least four of the normative principles in the Introduction to Part One are also relevant—respect for human dignity, responsible stewardship, care for the poor and vulnerable, and contributing to the common good.

3. How might the Directive(s) help address the case?

✦ Directive 7 underscores the need to treat employees justly which includes a living wage and laying off employees in a fair and respectful manner.

✦ Directive 6 is an important reminder that the organization must steward its resources wisely—for the good of the organization, its employees, and those it serves.

✦ But then there is also the organization's responsibility to provided needed care (within its means) and to contribute to the common good of its residents and the community.

✦ The Directives and the Introduction to Part One, here as elsewhere, point to important considerations but do not resolve the case.

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DISCUSSION/REFLECTION QUESTIONS

- What are some concrete ways that you are able to foster human dignity through your work?

- The Directives and the video speak about the "common good." What does this mean to you? How do you see this operative within your organization?

- Give examples from your family life, civic life or work life that illustrate the notion of common good?

- Catholic health care, the Directives state, should distinguish itself by service to and advocacy for those vulnerable individuals and populations at the margins. How is this realized by your organization? Are there areas where it can do better?

- Directive #7 speaks to the necessity of a Catholic health care organization treating its employees respectfully and justly. What are examples of this in your organization? Are there any gaps?

- The introduction to Part One underscores the normative principles of Catholic health care. Which of these principles is most evident at your organization? Is there any principle upon which your organization can improve? Which is/are most challenging?

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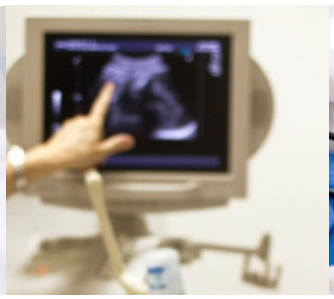
PRAYER RESOURCE

OPENING PRAYER

O God, comfort of all who suffer, your words and deeds show a special love for the poor and vulnerable. Instill within our hearts the same compassion you showed to those who were poor, hungry, sick, and dying. Fill our hearts with zeal to change the unjust structures of our society so that all women, men and children may flourish. We ask this in your Holy Name. Amen.

READING

For I was hungry and you gave me food, I was thirsty and you gave me something to drink, I was a stranger and you welcomed me, I was naked and you gave me clothing, I was sick and you took care of me, I was in prison and you visited me. (Matthew 25:35)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