TIDINGS!

Newsletter of the Catholic Health Association of Minnesota DECEMBER 2015

Believing in the worth and dignity of the human person made in the image and likeness of God, the Catholic Health Association-Minnesota assists its members to fulfill the healing mission of the Church.

Mark Your Calendar

January 11, 2016
World Day of the Sick

June 5-7, 2016
Catholic Health Assembly
Orlando, Florida
FF: www.chausa.org

As I See It

Toby Pearson
CHA-MN Executive Director

The 2016 Legislative Session

By Toby Pearson

The Minnesota Office of Management and Budget (MMB) has recently announced that Minnesota's 2016-17 budget outlook has improved from previous estimates despite a weaker economic outlook. MMB is now projecting a forecast balance of $1.871 billion, doubling the original $865 million projection from the end of last session. Of this projected surplus, $665 million is allocated to reserves and repayments, leaving an available $1.206 billion for fiscal year 2016-17.

This projected surplus guides the framework for the discussions in the upcoming legislative session. The February forecast (which usually comes out in the beginning of March) will be the official forecast used to determine any projected surplus. The good news here is that as the budget continues at a steady pace, it looks like there will be money on the table as the legislature begins its deliberations in March. The 2016 session is likely to focus on the struggle between taxes, transportation, bonding and any agreement to supplemental spending.

With this background, what can we expect? A short legislative session will drive a short, focused agenda. The next legislative session starts relatively late, March 8, and will need to adjourn by May 23, 2016. Because lawmakers passed a two-year budget in 2015, this short 10-week session will be focused on unfinished business, policy items and a bonding bill. Policy committees will have limited time for hearings—only about two to three weeks maximum. With this small window, fully vetted proposals will receive more serious consideration. Although, there could be political "bomb throwing" with elections around the corner, legislators will be motivated to adjourn on time because all house and senate seats are up for election in November 2016.

Issues that have been mentioned as important to address next year are as follows:

Transportation funding. A Governor Dayton and GOP priority on the campaign trail, key issues remain with how to fund the proposal and how to divide the funding between transit and roads/bridges. It is quite possible that nothing will pass unless there is a bipartisan coalition that can come together to resolve these issues.

Sex Offenders. This is an issue that remains unfinished, and will only pass if there is bipartisan support, despite a federal court order that Minnesota must revamp its program.

Bonding Bill. The second year of the legislative session is considered the "bonding bill year". Expect Governor Dayton and Senate DFL members to push for a higher total dollar amount while House Republicans push to keep the number down. Despite differences in spending, this is a huge bargaining chip to reach agreement on other issues, and at the end of the day, it is unlikely that lawmakers will go home without a bonding bill.

Tax Cuts. Lawmakers went home without a tax bill last year, and aside from senior care, tax cuts were a top GOP campaign promise. It is possible the House GOP will not hold votes on a bonding bill until there is agreement on tax cuts, and the Senate will not vote on tax cuts without Transportation.

Policy Issues. Last session was heavily focused on budget, this is the year they look toward Policy. One of the Policy Issues that gained attention last year was Physicians.

Assisted Suicide. While supporters for these proposals are largely on the DFL side of the aisle, and will likely be blocked by the Republican-controlled House, it is certainly an issue that will pull in Catholic Health.

The 2016 session will be about positioning for the elections.

- Governor Dayton (DFL) is not up for re-election in 2016, however, he has made clear that he is not running

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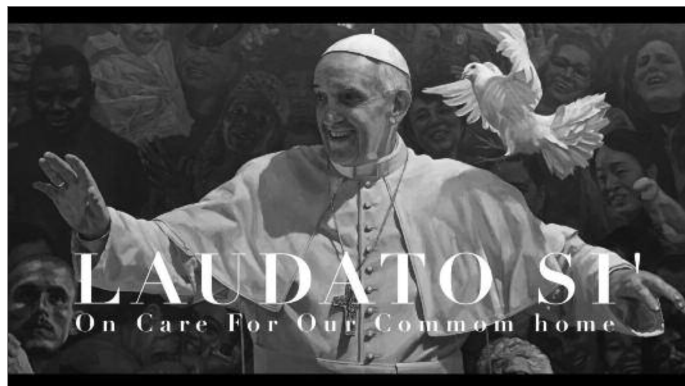
Laudato Si' and Catholic Healthcare

Excerpts from Birgitta Sujdak Mackiewicz



The Catholic Health Association of Minnesota was pleased to have Birgitta Sujdak Mackiewicz, Director of Ethics at OSF Saint Francis Medical Center & Children's Hospital of Illinois, as keynote speaker at the Annual Meeting in October.

Addressing Pope Francis' encyclical, Laudato Si': On Care for Our Common Home, Birgitta was able to capture how the document is not limited to simply concerns for the environment in the traditional sense, but has implications to Catholic healthcare itself.

The encyclical has a particular focus on the dignity of the human person, in connection with the environment. Francis' understanding of environment is holistic, encompassing the physical, social and human aspects of being. Care for the earth necessitates care for the human person. Francis posits that a "true ecological approach always becomes a social approach" allowing us to "hear both the cry of the earth and the cry of the poor" (LS 49).

In health care we often speak of the patient-physician relationship or the patient-professional relationship, but rarely of the relationship of Catholic health care to creation, to the environment, or to the larger world.

Rapid advances in medicine and ongoing changes in health care delivery find ethics committees in Catholic health care facing more and more complex ethical issues both clinical and organizational.

Though medicine has and continues to change rapidly ethics committees in Catholic health care continue to function much as they have since their inception focusing on the traditional functions of consultation, education and policy development and review - not examining the organizational ethics component to the issues. Solving the problem once, for one patient during one stay does not necessarily improve the care of the patient and may also not improve the care of future patients.

One can argue that the traditional reactive model of ethics committees, especially in their consultative function, does not promote or even fails to respect the dignity of patients and health care professionals. Most ethics committees in their different functions are responding to a request for assistance – this reactive model presumes a robust moral formation of patients and health care providers that asks them to identify ethical issues, or articulate them fully and know when to seek the assistance of an ethics committee when the majority of professionals may have limited if any sort of formation beyond the presentation of an ethical dilemma via case study. This reactivity also signals a lack of integration with institutional and macro-ethical issues and quality improvement signaling limited influence on and value to the organization and

The healing ministry of Christ was necessarily relational. His healings most frequently involved touching the human person and were physical and always restored the human person to relationship with others: the healing of the lepers, the restoration of sight to the blind man at the pool of Bethsaida, the resurrections of Lazarus and the servant's daughter. It seems appropriate then to adopt, as many theologians and ethicists have argued, a theological anthropology for health care.

> *...The healing ministry of Christ was necessarily relational.*

This approach to health care "would boldly challenge all unjust relationships that objectify and demean individuals be they patients, family members, or other members of the team—professional or lay, and community and populations groups". The adoption of this theological anthropology challenges ethics committees to promote the dignity of human persons and the common good at each level of the organization and in relation to the broader community. It also provides a solid foundation from which to address the specific ethical issues that arise given the technical nature of modern health care which has led to a dehumanization and objectification of the human person—both of patients and of those who serve them—that occurs within the everyday world of health care

Theologian Charlies Taylor outlines five ways in which the adoption of a theological anthropology impacts heath care. [It] provides guidance on how to:

1. find meaning in the vulnerabilities that accompany birth, aging and its developmental challenges, acute and chronic illness, and dying;

LAUDATO SI' *cont. on page 3*

LAUDATO SI' *cont. from page 2*

2. organize and deliver health care;
3. approach all parties receiving and providing health care, especially the most vulnerable;
4. make individual health care decisions as both patients/surrogates and health care professionals; and
5. prioritize health care decisions as institutions.

This relational approach to those providing and receiving health care and the institutions within which the care is provided leads to a framework that is attentive not only to the individual, but also to the relationships and value conflicts between individuals within the context of the health care encounter: among professionals, between patients and professionals, or patients and their loved ones, as well as interactions within the organization, and between the organization and its local community, the local diocese, within the broader Catholic health care ministry, and in some situations, beyond.

Practically speaking, what impact does this encyclical have on Catholic health care? More specifically, what might Laudato Si' imply for the work of ethics committees and ethics professionals in Catholic health care? The work of ethics committees is centered around the promotion of the dignity of the human person. The advent of next generation ethics committees calls for ethics committees in Catholic health care to be integrated into the entire organization and to utilize systems thinking. Committees should be equipped to examine organizational and clinical ethics issues, and engage in proactive preventative ethics. It does not take much imagination to see that organizational ethics in Catholic health care should support environmental stewardship via minimization of medical waste, recycling, and forming business relationships with companies who seek to do the same. Yet it is rare that ethics committees or ethics professionals are engaged in such decision making.

> *...There is ample opportunity for bioethics to attend to the moral well-being as well as the moral formation of clinicians*

Ethics committees in Catholic health care operating within this context are called to examine how they ought to relate to the organization and those they serve. The identity of ethics committees in Catholic health care is relational precisely because they are Catholic. In turn the relational nature of the committees highlights the impact of the impact the Catholic understanding of the dignity of the human person has on a committee, its members, and its work. Though it has long been understood that one of the goals of ethics committees is the promotion of the human dignity of patients and the good of the patient, we must highlight the need to be attentive to "encounters with" all those who "enter the patient's experience of illness, suffering, and dying". This includes those caring for the patient. The "sizeable and troublesome blind spots" of bioethics is the "generally neglected" area of the integrity—physical, mental, spiritual, unitary—of health care practitioners….there is ample opportunity for bioethics to attend to the moral well-being as well as the moral formation of clinicians. A theological anthropology for bioethics can call the discipline to recognize and honor, to speak to and reason about, the integrity of all persons engaged in clinical encounters.

BIRGITTA SUJDAK MACKIEWICZ

The application of a theological anthropology to health care, the Catholic moral tradition's emphasis on the dignity of the human person and the relational aspect of that dignity as well as the teleological ethic of prudential personalism establish particular goals ethics committees in Catholic health care ought to embrace given an institution's Catholic identity and its institutional responsibility as a moral actor to address clinical and organizational ethics issues.

The current, 5th edition, ERDs outline five norms for Catholic health care: 1) the promotion and defense of human dignity, 2) the "biblical mandate to care for the poor," 3) the contribution to the common good, 4) the exercise of "responsible stewardship of available health care resources," and 5) the refusal of the provision or permission of medical interventions contrary to Catholic moral norms.

From the five norms found in the ERD's, one may discern four goals of ethics committees in Catholic health care. Two of the goals stem directly from their correlative norms: the promotion and protection of human dignity and the promotion of the good of the human person and the promotion of the common good. From the norms flow the

LAUDATO SI' *cont. on page 4*

LAUDATO SI' *cont. from page 3*

other two goals, the promotion and protection of institutional identity, integrity and ethical culture and the improvement of the quality of patient care.

We can't improve the quality of patient care and of ethics if we don't understand the system in which the care is provided. As ethics committees strive to become more integrated within their organizations in areas such as quality and safety which are heavily data driven, they have a particular duty to keep human persons at the forefront of health care. Francis cautions against the negative impact that data and media overload can have and the resulting depersonalization. A focus on objective data points may also constitute an institutional blind spot:

A Catholic understanding of human dignity leads to a bioethics founded on a commitment to relationality and responsibility that often stands in stark contrast to that of its secular counterparts where autonomy often appears to be the default and thus the primary foundational value

In the spirit of Laudato Si', ethics committees and ethics professionals in Catholic health care should engage in reflection about how their work contributes to the care of our common home and thus of the common good, recognizing the need for integration within and outside of the organizations in which they serve, for participation with "politics and economics" in "a frank dialogue in the service of life, especially human life". ■

SESSION *cont. from page 1*

for reelection in 2018, and is very publicly positioning his Lt. Governor, Tina Smith to be his "heir apparent." She has been a regular in cabinet meetings, and keeps her own very visible schedule of events.

- The GOP continues its control on the Minnesota House with a 72-62 majority, with most swing districts being from seats in greater Minnesota. The Speaker of the House remains Kurt Daudt (R-Crown). Left on the agenda were the expressed priorities of transportation and tax cuts.
- The House Minority Leader remains Rep. Paul Thissen (DFL-Mpls.), and the House DFL caucus is heavily influenced by a core set of DFLers, primarily from the urban core and the Iron Range. The House DFL will seek to drawn contrast between their caucus and the House Republican Caucus, as they position to try to take back the majority, even if it means that it will take positions that also contrast with the more moderate Senate DFL caucus.
- There is no change in the State Senate. However, they will be up for election next year. That means Senator Tom Bakk (DFL-Cook) will remain Senate Majority Leader through 2016. Given that many of the rural DFL Senators occupy seats in districts that also host one or two House GOP seats, on many issues, it is likely that there is more common ground between two Majority Caucuses than one would first think. Expect the Senate DFL Caucus to focus on priorities that show support for rural Minnesota, just as the House Majority Caucus will do.
- Sen. David Hann (R-Eden Prairie) will continue to serve as Senate Minority Leader through 2016. The Senate GOP caucus is the most fiscally conservative of the four caucuses, and will likely serve as the vocal, opposition to any global agreement that involves new spending.

HOUSE CHAMBER, MINNESOTA STATE CAPITOL

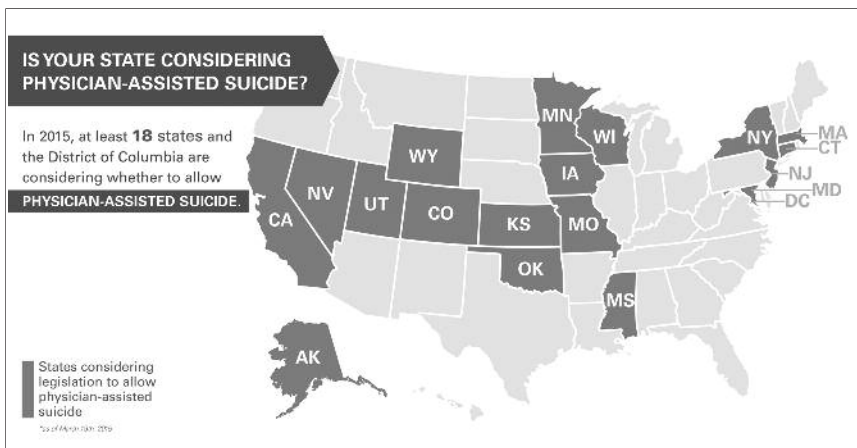
- Health and Human Services (HHS) chairs and committee members will remain the same: Senate Finance – Tony Lourey (DFL-Kerrick), Policy – Sheran (DFL-Mankato), House Finance – Dean (R-Dellwood), Reform – Mack (R-Apple Valley), and House Aging Committee – Schomacker (R-Luverne).

What is CHA-MN's primary focus for this short session? We will continue to fight to protect conscience clauses for Catholic health organizations, especially as physician-assisted suicide gains more attention. We will continue to advocate for a 5% increase for the Elderly Waiver providers. Further, we will continue to advocate regarding Health Care disparities. ■

Physician-Assisted Death Legislation in Minnesota

Legislation that would allow terminally ill Minnesotans to take medication ending their own lives was the subject of a public meeting recently at the University of Minnesota Duluth, similar to recent sessions in Minneapolis and Brooklyn Center.

If passed, the Minnesota Compassionate Care Act would make Minnesota the fifth state to have a so-called "death with dignity" law. The most recent was signed by California Gov. Jerry Brown in October, although it is not yet in effect; it is already legal in Oregon, Vermont, Washington, and Montana, due to a court ruling.



The Minnesota legislation is unlikely to go anywhere in the 2016 short session, said state Rep. Jennifer Schultz, DFL-Duluth, an author of the House version of the bill. The earliest it would have a good chance of becoming law is 2017, Schultz said.

And that might depend on the 2016 elections, said the bill's primary author, state Sen. Chris Eaton, DFL-Brooklyn Park. The death option has broad public support, said Eaton, but it's a partisan issue in the Capitol, she added. "I will expect to have a hard time getting a hearing in the House with Republicans in control," Eaton said.

But opposition is widespread as well. The Minnesota Catholic Conference opposes the legislation, stating: "There are better ways to address the needs of and care for people with serious illness than to legalize physician-assisted suicide in Minnesota." The Minnesota Family Council, a Christian advocacy group, describes the bill as "this latest tentacle of the culture of death."

The Minnesota Medical Association still opposes such legislation, spokesman Dan Hauser said, although it is the subject of continuing conversation. As written, the bill would require that the medication be self-administered and taken only with the agreement of two physicians that the patient is terminally ill and in the last six months of life. That might exclude Alzheimer's patients who could be considered incompetent to make such a decision in the last six months of life and ALS patients who might not be able to swallow, she has been told.

The Catholic Health Association of Minnesota will watch such proposed 'end-of-life' legislation in the coming sessions closely. ■

To Live Each Day with Dignity: A Statement on Physician-Assisted Suicide

United State Conference of Catholic Bishops

To live in a manner worthy of our human dignity, and to spend our final days on this earth in peace and comfort, surrounded by loved ones—that is the hope of each of us. In particular, Christian hope sees these final days as a time to prepare for our eternal destiny.

Today, however, many people fear the dying process. They are afraid of being kept alive past life's natural limits by burdensome medical technology. They fear experiencing intolerable pain and suffering, losing control over bodily functions, or lingering with severe dementia. They worry about being abandoned or becoming a burden on others.

Our society can be judged by how we respond to these fears. A caring community devotes more attention, not less, to members facing the most vulnerable times in their lives. When people are tempted to see their own lives as diminished in value or meaning, they most need the love and assistance of others to assure them of their inherent worth.

The healing art of medicine is an important part of this assistance. Even when a cure is not possible, medicine plays a critical role in providing "palliative care"—alleviating pain and other symptoms and meeting basic needs. Such care should combine medical skill with attention to the emotional as well as spiritual needs of those facing the end of life. ■

End-of-Life and our Tradition

"In the rush of today's world we can often forget the value of time spent at the bedside of the sick. We forget about giving ourselves freely, taking care of others, being responsible for others." So expressed Sr. Patricia Talone, RSM at the CHA-MN Annual Meeting in October. "The experience of suffering can become a privileged means of transmitting grace and a source for gaining and growing in wisdom of the heart. Take time to visit the sick, time to be at their side."

With the backdrop of five states that have legalized assisted suicide, and several other states pending, Talone discussed our society's discomfort with suffering and death. Modern medicine has difficulty balancing its two most important goals—cure & prolongation of life with comfort & quality of life. Modern medicine, in a sense, has created the need for true palliative care, which is not really something new.

SISTER PAT MALONE AND TOBY PEARSON

The core elements of palliative care -- caring, comforting, palliating, healing, journeying with -- have roots in and are impelled by the Christian tradition. Bishop John Wester wrote that the right we have is not to choose when or who dies, it is to live a life of dignity. "Death with dignity" is not achieved by ending one's life, but by ensuring that the dying have loving care during their final days and are not artificially deprived of the experience of God's grace before he calls them to himself.

Talone addressed how our Catholic Tradition guides us with death and suffering. In the Gospels, Christ brought healing by restoring right relationships. He welcomed the sick. He modeled compassion to his followers, and compassion and mercy are the hallmarks of a follower of Christ.

In considering compassionate care in early Christianity, the Acts of the Apostles emphasized a care for the sick and suffering. Later, there emerged a group of Christians called the Parabolani, because of their devotion in caring for the sick during pestilence. The first hospitals were established in the 4th century, which became a model for others in the subsequent centuries. In the early Middle Ages, bishops extended hospitals to cathedrals and provided refuge, later extending them to monasteries.

As incorporated into Rule of St. Benedict. "Particularly in the stages of illness when proportionate and effective treatment is no longer possible, while it is necessary to avoid every kind of persistent or aggressive treatment, methods of 'palliative care' are required. As the Encyclical Evangelium Vitae affirms, they must 'seek to make suffering more bearable in the final stages of illness and to ensure that the patient is supported and accompanied in his or her ordeal."

In his Apostolic Letter, Salvifici Doloris, John Paul II holds up the Parable of the Good Samaritan as intrinsic to "the Gospel of suffering." It indicates what the relationship of each of us must be towards our suffering neighbor. Every individual must feel as if called personally to bear witness to love in suffering. The institutions are very important and indispensable; nevertheless, no institution can by itself replace the human heart, human compassion, human love or human initiative, when it is a question of dealing with the sufferings of another.

From the late 15th through the mid-17th century, a significant devotional literature developed on the subject of "dying well." Much focused on the final battle with Satan and resisting the five deadly sins. Some shifted focus and encouraged the reader to prepare for dying well primarily by living well; Christian life well-lived is the best preparation for death.

The three virtues emphasized within Catholic Tradition in caring for the sick are hope, compassion and patience. In providing compassionate care, we remove the sense of isolation, and assure the sick of their on-going dignity, humanity and place in the community. Talone effectively concluded her presentation with an emphasis that though we care for the sick in order to help them, *we* benefit most because of the kinds of people it makes each one of us. ■

Project H.E.A.L. **2015 Sister Mary Heinen Award Recipient**

The Sister Mary Heinen Award is intended to recognize a member of the Catholic Health Association of Minnesota which exemplifies the healing ministry of Jesus and the values of Catholic Social Teaching by providing necessary and accessible health services to the medically underserved.

Project H.E.A.L. (Health, Education, Access, Link) is an outreach program of CentraCare Family Health Center, a St. Cloud Hospital clinic, which provides free health screenings to the uninsured and underinsured.

The goal of Project H.E.A.L. is to overcome the barriers to health care for the under-served population of Central Minnesota: Barriers of transportation, inadequate or lack of insurance, financial resources for co-payments and medications, follow-up care, language and culture. Project H.E.A.L. often is the first point of contact for recent immigrants or transient population accessing health care services.

The mission of Project H.E.A.L. is to provide access to primary health care for the under-served and uninsured through:

H — Health: Volunteer providers provide treatment when possible and appropriate. Referrals are made in most instances to Mid-Minnesota Family Medicine Center (MMFMC), the safety net provider for the region.

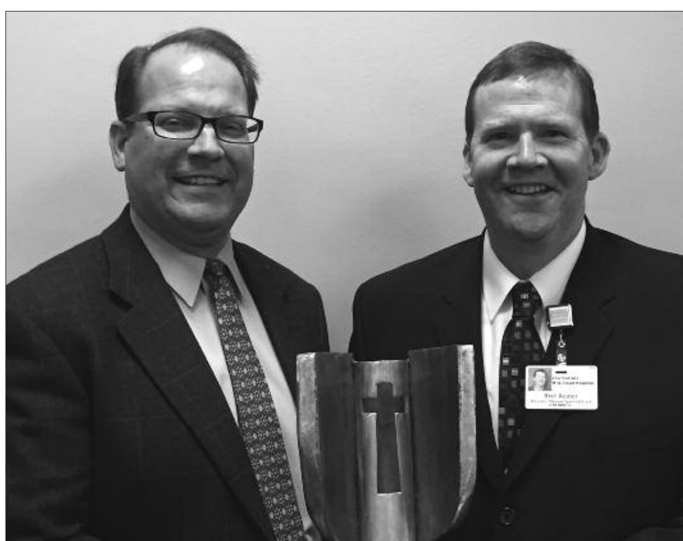
E — Education: Educate uninsured and underinsured people about public insurance programs and eligibility, appropriate use of emergency services, how to manage minor health problems and avoid unnecessary care provision.

A — Access: By reaching out to those in need right where they are, barriers to access is removed. Volunteers assist eligible uninsured and underinsured people with enrollment in public insurance plans; refer to them to St. Cloud Legal Services for further assistance in submitting the necessary documentation to qualify for public insurance.

L — Link: Through the free health-screening clinics, a relationship between the patient and the health care provider is established. If follow-up care is needed, the patient is referred to Mid-Minnesota Family Medicine Center or other clinic.

Project H.E.A.L. resulted after Pastors Gerry and Carol Jean Smith of Place of Hope Ministries contacted St. Cloud Hospital seeking help to provide free medical care to their clientele, many of whom were poor and homeless. St. Cloud Hospital answered their request by providing the first free health screening on May 16, 1999 to 15 people at Place of Hope.

As the word spread about the health screenings at Place of Hope, the need in the community became apparent. To reach more uninsured and under-insured people, Project H.E.A.L. was expanded to the Catholic Charities facility in St. Cloud. Since Catholic Charities already was reaching out to families and children in need, the free health care screenings were a natural extension of the services. To serve Hispanic immigrants, a site was added at Casa Guadeloupe in Cold Spring. Other sites now include St. Mary's in Melrose, St.



BRETT REUTER AND PAUL HARRIS ACCEPT THE SISTER MARY HEINEN AWARD ON BEHALF OF ST. CLOUD HOSPITAL.

Joseph in Waite Park and the Salvation Army in St. Cloud which attends to the needs of the street-level homeless.

Project H.E.A.L. is a success because of the vision of a handful of people and the dedication of its volunteers. It is made up of approximately 70 volunteers including physicians, nurses and lay people from local parishes. Project H.E.A.L. is provided medical oversight by a medical director.

A project leader coordinates screenings with the help of Parish Nurses who recruit volunteer medical teams and others from their church congregation. Team members are volunteers of

St. Cloud Hospital; Health care providers must supply proof of licensure and all volunteers undergo a background check. Each clinic site is staffed with volunteer medical teams from local churches working to break down barriers to health care while building trust within the community. ■

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Ask your public relations or communications director to put us on the news release list: CHA-MN, 1890 Randolph Ave., Suite 300, St. Paul, MN 55105. ■

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