Received: 2013.08.04
Accepted: 2013.08.06
Published: 2013.10.02

Mercy health promoter: A paradigm for just health care

Authors' Contribution:
Study Design A
Data Collection B
Statistical Analysis C
Data Interpretation D
Manuscript Preparation E
Literature Search F
Funds Collection G

A 1 **Peter A. Clark**
DF 2 **Sam Schadt**

1 Jesuit Community, St. Joseph's University, Philadelphia, PA, U.S.A.
2 Research Fellow, Institute of Catholic Bioethics, Saint Joseph's University, Philadelphia, PA, U.S.A.

Corresponding Author: Peter A. Clark, e-mail: pclark@sju.edu
Source of support: Self financing

The foreign-born population in the United States, according to the "Current Populations Report" published in 2010, is estimated to exceed 39.9 million, or "12.9 percent of the U.S. population." The increase in foreign-born peoples and their need for health care is a complicated issue facing many cities, health systems and hospitals. Over the course of the past few years Mercy Hospital of Philadelphia has treated increasing numbers of foreign-born African patients. The majority have been presenting in the late stages of disease. The increase of foreign-born documented and undocumented African patients seen by Mercy Hospitals seems to reflect a foreign-born population "boom" in Philadelphia over the past decade. To meet the needs of this growing population, the Mercy Hospital Task Force on African Immigration and the Institute of Catholic Bioethics at Saint Joseph's University designed a program that centers on the third world concept of "Health Promoters." This program is intended to serve as one possible solution for hospitals to cost-effectively manage the care of this growing percentage of foreign-born individuals in the population. This notion of a "Health Promoter" program in Philadelphia is unique as one of those rare occasions when a third world concept is being utilized in a first world environment. It is also unique in that it can serve as a paradigm for other hospitals in the United States to meet the growing need of health care for the undocumented population. As of November 2012 the Mercy Hospital of Philadelphia clinic became operative for patients who were referred from the Health Promoter clinics. To date, a total of forty-two patients have actively participated in the screenings, sixteen of which have been referred to Mercy Hospital of Philadelphia clinic for further evaluation. More than 75% of patient referrals were a result of high blood pressure. According to the American Medical Association, readings of 140–159 mmHg and above are indicative of stage 1 hypertension. Among those who presented at the Health Promoter screenings the mean systolic pressure for males was 140 mmHg and for females was 140.48 mmHg.

Key words: **health care • African immigrants • undocumented population • health promoter • ethics • uninsured • underinsured**

Full-text PDF: <http://www.medscimonit.com/download/index/idArt/889651>

8215 — — 20

Case Study

Mr. A. presents at the Emergency Department (ED) of Mercy Hospital of Philadelphia with symptoms of generally feeling run down and fatigued. He is a 35-year-old, African male who appears apprehensive and withdrawn. He states that he is from Tanzania and his first language is Swahili, however he also speaks English. He is also experiencing headaches, weight loss, loss of appetite, nausea, and edema (swelling of feet and hands). After numerous tests the physician informs Mr. A. that he has End-Stage Renal Disease (ESRD).

End stage kidney disease is the final stage of chronic kidney disease (CKD), which is also known as chronic renal disease (CRD). This final stage, stage 5 CKD, is also known as chronic kidney failure (CKF), chronic renal failure (CRF) or end stage renal disease (ESRD). The US government typically refers to the condition as ESRD. End-stage kidney disease occurs when the kidneys are no longer able to function at a level needed for day-to-day life. It usually occurs when chronic kidney disease has worsened to the point at which kidney function is less than 10% of normal. ESRD almost always follows chronic kidney disease. A person may have gradual worsening of kidney function for 10–20 years or more before progressing to ESRD. Patients who have reached this stage need dialysis or a kidney transplant. The most common causes of ESRD in the U.S. are diabetes and high blood pressure.

The physicians on the case recommend immediate dialysis. Mr. A. then informs the physicians that he is in the United States illegally, that he has no family here in Philadelphia and that he is unemployed. The physicians immediately consult the social worker but she informs them that illegal immigrants are not eligible for any health care benefits. The physicians are well-aware of the fact that under the Federal Emergency Medical Treatment and Labor Act (EMTALA) [also known as the Patient Anti-Dumping Law] hospitals are required to provide an examination and needed stabilizing treatment, without consideration of insurance coverage or ability to pay, when a patient presents to an emergency room for attention to an emergency medical condition. The standard of care to stabilize Mr. A. is to begin dialysis. The physicians admit Mr. A. and start dialysis.

The Social Worker immediately informs the Administration that Mr. A. has started dialysis and will need to continue dialysis indefinitely. Because he has no insurance and is an illegal immigrant he is not eligible for any out-patient dialysis units. He is also unable to afford any medical treatments. The question confronting the physicians now is that once he is stabilized do they discharge him informing him that he will need dialysis three times a week, which means he will have to be readmitted through the ER or do they keep him in the hospital until some accommodations can be determined? Without dialysis or

a kidney transplant, death will occur from the buildup of fluids and waste products in the body. Both of these treatments can have serious risks and consequences. The outcome is different for each person.

The Director of the ED immediately consults the hospital Ethics Committee. The Chairperson reviews the case and calls for a full ethics consult. You are members of the ethics committee and are asked to render a recommendation on this case. Are there any viable options? Do you need to take into account that there are over 40,000 illegal African immigrants in West Philadelphia who most likely will come to Mercy Hospital of Philadelphia when they are ill? Do you need to examine this situation in light of the Mission of the Sisters of Mercy and the “Ethical and Religious Directives for Catholic Health Care Services?”

Introduction

The foreign-born population in the United States, according to the “Current Populations Report” published in 2010, is estimated to exceed 39.9 million, or “12.9 percent of the U.S. population” [1]. The increase in foreign-born peoples and their need for health care is a complicated issue facing many cities, health systems and hospitals. Over the course of the past few years Mercy Hospital of Philadelphia has treated increasing numbers of foreign-born African patients. The majority have been presenting in the late stages of disease. The increase of foreign-born documented and undocumented African patients seen by Mercy Hospital seems to reflect a foreign-born population “boom” in Philadelphia over the past decade. This pattern of immigration in Philadelphia was described in detail by the University of Pennsylvania’s Fels Institute of Government and the Philadelphia Department of Community and Economic Development document *Recent Trends in Immigration to Philadelphia, Pennsylvania: Who Came and Where Do They Live?* This document shows an approximate 30% population increase in foreign-born Philadelphians throughout the 1990s, which occurred in conjunction with a US-born population decrease of 6.7%, and an overall decrease of 4.3% in the population of Philadelphia over that same period [2]. The Fels Institute document further describes the settlement of many generalized foreign-born groups in localized regions of Philadelphia. The Elmwood region of Southwest Philadelphia, the area of the city in which many of the foreign-born Africans have settled, is also one of five such areas of the city that has seen an overall population increase of 4% and a foreign-born population increase of 83% [2]. The report goes on to predict:

Though no single African nation placed in the top twenty, immigration from Africa grew from less than 2% during the 1970s

to nearly 6.5% in 2001 and 2002. If trends continue, the rate of African immigration will exceed that of Central America and South America during this decade, and that of the Caribbean in the next decade [2].

If these predictions come true, then those hospitals in Southwest Philadelphia serving a concentrated foreign-born African population, like Mercy Hospital and Mercy-Fitzgerald Hospital, and the other areas of the city experiencing this immigration boom would presumably be overwhelmed with a population of uninsured, underinsured, documented and undocumented patients.

To meet the needs of this growing population, the Mercy Hospital Task Force on African Immigration in conjunction with the Institute of Catholic Bioethics designed a program that centers on the third world concept of "Health Promoters." This program is intended to serve as one possible solution for hospitals to cost-effectively manage the care of this growing percentage of foreign-born individuals in the population. This notion of a "Health Promoter" program in Philadelphia is unique as one of those rare occasions when a third world concept is being utilized in a first world environment. It is also unique in that it can serve as a paradigm for other hospitals in the United States to meet the growing need of health care for the undocumented population.

The intended purpose of this article is fourfold: first, to present the three models that serve as the basis for the Mercy Health Promoter program; second, to present the "Mercy Health Promoter" model as a paradigm for first-world urban healthcare that is based on practices of education, prevention, and early treatment espoused by three successful community-based models; third, to examine the ethical arguments justifying sponsorship of "Mercy Health Promoters" as a paradigm for first-world healthcare; and fourth, to show collected data indicative of the effectiveness of the "Mercy Health Promoters" since its start in November, 2012.

Three Models of Health Promoters

In 2010, administrators at Mercy Hospital of Philadelphia and the Institute of Catholic Bioethics at Saint Joseph's University instituted the Mercy Hospital Task Force on African Immigration. The Task Force was instituted as part of Mercy Hospital's effort to address the growing problem of providing adequate healthcare to the growing undocumented and uninsured African immigrant population in Philadelphia. The mission of the Task Force was to develop and implement a healthcare program for the undocumented and documented African community that would meet two distinct needs: 1) provide health care for those most in need, and 2) do so cost-effectively. To begin

the development phase of this project, research was done on three different models. Two of the models studied, Partners in Health (PIH) and Creighton University's Institute for Latin American Concern (ILAC), were examined in regard to their versions of a Health Promoter program. The third model examined the work of the American-based Dominican Sisters in Las Cruces de Arroyo Hondo, Dominican Republic who have successfully organized a grass-roots effort based on community ownership and responsible stewardship. Each of the three models will be examined to show how they contribute towards a new program designed to bring the third world practice of the Health Promoter to the first world in a substantial way.

First, the *Partners in Health (PIH)* model was the initial inspiration for the design of this program. In its mission PIH states the belief "that health is a fundamental right, not a privilege. Through service, training, advocacy, and research, we seek to raise the standard of care for the poor everywhere" [3]. With its philosophy based on these tenets stated by the UN Declaration of Human Rights, PIH has "three goals: to care for our patients, to alleviate the root causes of disease in their communities, and to share lessons learned around the world" [3]. One effective methodology to accomplishing such goals is through education and preventative medicine provided by the Health Promoters of Partners in Health through a "community-based model of care." This model entails access to primary health care, free health care and education for the poor, community partnerships, addressing basic social and economic needs, and serving the poor through the public sector [3]. Based on this model, PIH has modified its established and successful programs in Haiti, Peru, Russia, Rwanda, and Lesotho for application in the Boston area. One such program, Prevention and Access to Care and Treatment (PACT), employs the use of trained individuals from inner-city Boston to improve the health of HIV/AIDS patients, and operates with a focus on poverty, substance abuse and mental illness [3]. This program has been successful in reducing patient blood viral loads, increasing CD4 counts (133 cells/mm³ to 293 cells/mm³ in the course of 1 year), and reducing medical costs via a "17 percent decrease in the number of hospitalizations and a 37 percent drop in cost per inpatient stay (as measured at one Boston-area hospital)" [3]. PACT's success is due to its utilization of home visits, patient education and a Directly Observed Therapy (DOT) program for HIV/AIDS medications.

Second, to create a more well-rounded perspective of community health not limited to PIH alone, *Creighton University's Institute for Latin American Concern (ILAC)* model was examined. ILAC is based in Santiago, Dominican Republic. One of the aspects of ILAC is the organization, training, and operation of a Health Promoter program. The program consists of ILAC nurses, doctors, and administrators; regional coordinators; and Health Promoters. The nurses, doctors, and administrators are

responsible for training, management and procurement of supplies and medicines, recruitment of specialized medical teams to the Dominican Republic, and all other operational activities and programs. Each of the regional coordinators is assigned to one of nine ILAC-designated regions for which they oversee the activities of the Health Promoters. The Health Promoters reach out and work on a personal level with the people in their individual communities. They carry out the education, primary medical care and prevention and health programs.

These Health Promoters, known as *cooperadores de salud*, are well-respected and well-known members of their communities. Health Promoter candidates are selected from within their own communities and receive training in Santiago, Dominican Republic from ILAC nurses and doctors. These individuals must also meet criteria and “norms” for Health Promoters that are established by ILAC. These criteria include an age requirement (22 years or older), as well as certain qualities of character (dedicated to service, kind, trusted, discreet, responsible, team oriented, etc.). If the candidate meets ILAC’s selection criteria, he/she is accepted for training. [4]

Health Promoter candidates undergo extensive and comprehensive training that spans one year and consists of education and practical training in “Health and Nursing Basics, Environmental Sanitation, Maternal and Infant Attention, Child and Adolescent Attention, Feminine Attention, Adult Attention, and Human Formation” [4]. Throughout training, candidates are required to successfully complete written tests and meet standards set by the ILAC training personnel. Having been evaluated and accepted by the ILAC training committee, the Health Promoters return to their communities “to live and work at the level of the people,” and “share their knowledge with the community” [4]. With this primary goal, the Health Promoters work with ILAC physicians to run specific health programs (Women’s Health, Diabetes, Hypertension, HIV/AIDS, Pregnancy, Nutrition, etc.), provide primary care services (checking blood pressure; screening for diabetes, glaucoma, etc.; individual patient education on diet and compliance with medications; interaction with patients on a personal level), and educate (“charlas” or chats on hygiene, sanitation, methods of prevention, etc.) [4].

The third model is sponsored by the Dominican Sisters, which focuses on the value and importance of education and community health. The Dominican Sisters have accomplished and continue to accomplish a great deal for the community of Las Cruces de Arroyo Hondo in the Dominican Republic. In helping the community establish a pre-school, an elementary school and a high school, they have afforded and continue to afford thousands of children a chance to receive an education and the opportunities for improving the community that are rooted in an educated people. By building a laboratory, pharmacy, and bakery that are all community-run, the Sisters facilitate

an improvement in the community’s nutrition, health and economy, that otherwise would be unavailable. The methodology by which the Sisters were capable of participating and aiding such crucial developments in that community was believed to be relevant to beginning a community-based program in Philadelphia. This methodology was to unite the community in common goals, empower them to take ownership for their community, train them in areas of leadership, stewardship and finances, and then step-back and allow the community to assume control.

The Sisters began by working with a group of women in the community who were the “natural leaders.” By organizing these women into a formal group, The Dominican Sisters eventually unified this diverse community and provided a venue for sharing concerns and needs. This group of women, given a sense of empowerment by the Sisters, began to undertake new initiatives. Consequently, the community began to take pride in both their accomplishments and ownership of these projects. After the Sisters provided the initial financial aid to begin the programs and to build the infrastructure, the community assumed the responsibility to operate the programs efficiently, cost-effectively, and independently of any financial aid from the Sisters. Even when the community faltered in their responsibility, the Sisters did not abandon their methodology and jeopardize the community’s sense of ownership. This was the case of the community laboratory that was losing money. No longer able to sustain its own operation, the laboratory was temporarily closed. After seeing the tremendous need for the laboratory, the community banded together to restructure the operation and create a new financial plan. The laboratory was reopened a year later and is currently making a small profit. This example demonstrates how the Sisters’ approach fostered a sense of ownership among the people of the community, led to a much greater degree of pride in the programs, and created a sense of remarkable dedication and efficiency in the operation of the programs. This valuable lesson helped in shaping the proposed methodology of the Mercy Health Promoter program.

Mercy Health Promoter Model

After examining and analyzing the three previous models, a new program was developed by members of the Mercy Hospital Task Force on African Immigration. This new program incorporated the successful and applicable aspects of the models examined above and then adapted them to the resource-poor conditions in the developed world, and particularly the city of Philadelphia. The hope is that this “Health Promoter” program could serve as a paradigm for other United States hospitals to adapt to the challenges of reducing health care costs, particularly, in light of immigration. The main focus of the Mercy

model is designed for the prevention of complex diseases and management of chronic conditions through education and observation. The "Mercy Health Promoter" model was created with the following goals and objectives:

- Create a community-based program involving a high degree of community participation.
- Provide quality health care services by partnerships with other already established organizations in the area.
- Reduce the costs of health care for uninsured or underinsured individuals and demonstrate cost-effectiveness for all members of the partnership (hospitals, health care providers, sponsors of the program, and the members of the community).
- Improve the health of the poor and marginalized individuals of the immigrant and impoverished communities of Philadelphia using education and increased access to primary health care services in the prevention and/or management of illness.

Since its implementation, the Mercy Health Promoter model has been a cooperative effort, including community members, the Mercy Hospital administration, Mercy health professionals, and the city of Philadelphia. With respected community members serving as Health Promoters, the hope is that community has viewed this program as being grounded in transparency and trust. Ideally, it has and will continue to generate a sense of community ownership, by encouraging the active participation of community leaders to address the wants and needs of their communities through services provided by the Mercy Health Promoters.

The primary role of the Mercy Health Promoter will be providing health and nutrition education, monitoring patient health and compliance with a prescribed medical course of treatment, and referring patients to a clinic or hospital when needed. The Health Promoter screenings take place every Sunday each month at St. Cyprian's Church in Philadelphia from 3 to 5:30 pm. Three Health Promoters are available for consultation to the St. Cyprian Church community, which is the designated Church for the Nigerian community. In addition, Health Promoters also work with those patients who come to the Mercy Health Promoter program from other communities. To meet the needs of West Philadelphia's communities, Mercy Hospital of Philadelphia has opened a clinic staffed by Mercy Hospital physicians, interns and residents in November 2012. At the clinic the physicians review any documentation by the Mercy Health Promoters; evaluate the patient; and prescribe diet, patient education, medications, or any other medical course of action. The Mercy Health Promoters will then be responsible for patient follow-up to ensure compliance. Social services will also be available to initiate enrollment in Medical Assistance programs to provide a more long-term and sustainable solution.

Secondarily, the Mercy Health Promoters will be asked to provide cultural and religious sensitivity training and education to hospital professional and clerical staff. This approach of reciprocity makes the Mercy Health Promoter program even more unique. It is believed that this practice will also increase the stature of the Health Promoters as well as increasing respectful interactions with the community in general. Ultimately, the hope is that such sensitivity will encourage community trust, participation and cooperation.

Having established the role of the Mercy Health Promoter, it is then necessary to establish the qualifications and criteria to be used in selecting Mercy Health Promoters. The Health Promoters will work exclusively within their own individual immigrant communities. This is an important aspect because there are numerous African immigrant groups represented in the West Philadelphia area. This cultural, linguistic and religious diversity has led to some tensions between the various groups represented within the community. Therefore, it is necessary that individuals and community leaders within these specific neighborhoods spearhead the selection process. To ensure the Mercy Health Promoter will create a cooperative and trusting environment between the community and Mercy Hospital of Philadelphia a number of criteria to serve the community as guidelines in their selection of a candidate have been created. The qualifications recommended for Mercy Health Promoter candidates include:

- Well-respected in the community.
- Trustful and trusted.
- Committed to stay in the community during their time as Health Promoter.
- An individual with extensive knowledge of the members, history, and life in the community.
- Respectful of the ideas and traditions of the community.
- An individual who possesses a spirit of service.
- Devoted to the community (not seeking individual economic interests).
- Able to read, write, and communicate effectively.
- A responsible, unbiased individual.
- Aware of their own limits and capabilities.
- Dynamic.
- Capable of honoring patient confidentiality.
- Team-oriented.
- Bilingual.

The training of the Health Promoters will be contingent upon the concerns of the community and what they communicate as their wants and needs. To determine the wants and needs of the African immigrant community in West Philadelphia, members of Mercy Hospital met with the administrative staff at the Lutheran Children and Family Services Center in West Philadelphia, as well as various community religious leaders. Based on the information obtained at these meetings and

information obtained from the Mercy Hospital Emergency Department staff, it was determined that the Mercy Health Promoters will need extensive education and training in the areas of nutrition, exercise, sanitation, and compliance with medications to address the four primary medical concerns: hypertension, diabetes, obesity and tuberculosis. They should also be trained in clinical techniques such as documenting patient history, symptoms, and notes on the patient's condition; taking blood pressure, blood sugar levels, and heart rate; and performing Directly Observed Therapy (DOTs) for patients, who are unable to comply with medication (i.e. insulin and TB antibiotics). In addition, non-clinical, practical training is also important and should include such issues as protection of patient confidentiality, cultural sensitivity, communication skills, etc.

Training and education should include lectures, clinical demonstrations, and practical components for the Mercy Health Promoter candidates in preparation for their various responsibilities. The materials for such education and training should be readily available in most hospitals or should be easily attainable at a relatively low-cost, but may vary depending on community needs. The recommended basic training materials would include:

- A training manual which would be composed by the medical team in the hospital responsible for the training. It would include information covered in lectures (i.e. nutrition/diet, confidentiality, a glossary of applicable medical terminology, instruction on proper documentation and basic procedures, as well as basic medical background on hypertension, diabetes, tuberculosis, etc.) as well as any other useful information as determined by the medical staff educating team. Once again, this will be dependent on the needs of the community.
- Sphygmomanometers and stethoscopes for demonstration purposes as well as for post-training practical duties of the Health Promoters.
- Dry-erase boards or chalk boards, and projectors as needed for instructional purposes.

To determine the curriculum, establish requirements for completion of the training, and to organize and supervise the training, an education and training committee has been formed. This committee is responsible for determining the locations, times, and instructors for said training, as well as for assessment and evaluation of the Mercy Health Promoter candidates. Mercy Hospital of Philadelphia, like many hospitals, has classroom or conference room spaces that are ideal for the training of the Health Promoters. Qualified instructors for the education and training components can be health care professionals from within the hospital community. This will not only reduce costs, it will also give hospital personnel additional opportunities to volunteer their services, which is part of

the Mercy charism that promotes humanitarianism and medical excellence.

The education materials, instruction, and training will be provided at no charge to Mercy Health Promoter candidates however, there will be a tremendous amount of work and dedication expected from the trained Mercy Health Promoters. Considering the significant commitment to training and service, the individual Mercy Health Promoters and the communities they support should be offered some incentives for participation. The following are some recommendations for incentives:

- Paid employment depending on duties and responsibilities as well as qualifications.
- Scholarships awarded to deserving members of the community for continuing education.
- College level classes provided to the Health Promoters through partnerships with local universities.
- Community projects through partnerships with city development programs (i.e. community center to hold after-school programs, a youth leadership program, or adult education classes; parks; etc.).

These incentives can be funded through government grants and philanthropic foundation grants.

It is hoped that such incentives will attract candidates willing to dedicate themselves to serving their communities. As trained medical professionals, the Mercy Health Promoters will be capable of delivering the primary care desperately needed within the untrusting and fearful immigrant communities. For the positive impact of this cost-effective mechanism of primary health care delivery to be observed, communication and confidential record keeping is critical. Secondly, it would be ideal to do so with little or no infrastructure, storage space, or computers.

In order to meet these record keeping criteria, a solution was adopted from the contemporary practice in Africa. As is the case in many African countries, patients will maintain possession of their own charts. This solution meets the goals of confidential documentation with little infrastructure in using a practice familiar to many of the African immigrants. The possession of one's own medical records will also assist members of this population in maintaining continuity of care despite frequent relocations of such individuals due to employment or personal concerns. This solution will relieve one issue of patient trust in the program by removing the possibility of the inclusion of material in the patient's chart without the patient's knowledge. It places more responsibility upon the patient, which will hopefully have the effect of increasing a sense of ownership of the Mercy Health Promoters program throughout the community.

If a patient should be referred to a clinic or hospital, they would bring their chart with them. With consent, the patient's medical chart will be copied and included among the regular institutional records. This record will serve as a contingency in the event that a patient loses his/her chart, forgets to bring such documentation with him/her to the hospital or clinic, or arrives at a hospital or clinic in acute or emergency circumstances in which the patient is unable to bring this documentation.

In addition to individual patient documentation and record keeping, records of the number of patients seen, the most prevalent medical needs and costs will be recorded. This will be done by assigning an anonymous personal identification number to each participant in the Mercy Health Promoter's program. The number will also be included in the patient's medical record and a log will be compiled. This log will consist of ID numbers and the corresponding conditions of patients that will be collected through weekly reports submitted by the Mercy Health Promoters as well as through data collected at the clinics or hospital. These data will be compiled with the additional purpose of a financial assessment of the cost-effectiveness of the Mercy Health Promoter program.

Financial assessment will include a comparison of the program costs with previously compiled data on the costs of treating undocumented individuals to date at Mercy Hospital of Philadelphia. Such record-keeping techniques can also be utilized for quality assessment of the Mercy Health Promoter program and individual Health Promoters via community surveys, Health Promoter comments and physician feedback.

In our society, which is quite litigious, questions arose about liability coverage for the Mercy Health Promoters. After consultation with legal counsel, it was determined that legal liability for the Mercy Health Promoters would be of minimal concern. However, to protect all parties concerned, individuals seen by the Mercy Health Promoters could be asked to sign an acknowledgement in which the person receiving services acknowledges that the Mercy Health Promoter is not a physician or licensed health care professional. Consideration could also be given to asking the person receiving services to waive any potential legal claims against the Mercy Health Promoters [5].

The fact is that this program will cost money and will utilize significant resources in the short-term; however, it is believed that the Mercy Health Promoters program will prove tremendously beneficial and cost-effective in the long-term. To help defray the costs for Mercy Hospital of Philadelphia, funding will be sought for financial support of the program through federal, state and local grants as well as through private grants. Currently, funding is being obtained from the Sisters of Mercy of Merion and Saint Joseph's University. In addition, other grants and donations are being explored.

Ethical Analysis

In the last four decades, this nation has been trying to improve the quality of our health care delivery system. Despite the efforts to increase the quality in health care, disparities continue to be prevalent and have led to unjust consequences for racial and ethnic minorities. Advances in technology and a better understanding of the disease process have greatly improved due to research in the field of medicine. This has contributed to better management of the disease process, which has in turn improved the morbidity and mortality rates of many patients and increased life expectancy in this country. Unfortunately, this effect is being seen predominantly among white Americans while other ethnic groups are still vulnerable, especially inner city African American and African populations [6]. Even though, our health care system, in principle, is considered to be the best in the world it has its own flaws and has left millions of Americans as well as documented and undocumented individuals with inadequate health care or no access to basic health care services.

The West Philadelphia community is predominantly African American with a new influx of a significant number of documented and undocumented African immigrants. According to some estimates, there are now at least 50,000 African immigrants living in West Philadelphia, constituting 8 percent of the total immigrant population. Thirty-seven percent of African immigrants in this area arrived between 1990 and 1999, and 45 percent have arrived only after the year 2000 [7]. This population has special needs which physicians and hospitals are not well-equipped to provide. The majority of this community is suffering from chronic diseases such as hypertension, diabetes, obesity and with some of the new arrivals from Africa even TB. As health care providers, our duty is to improve the health of the community we serve. To achieve this goal it is important to understand the diseases prevalent in this community and to develop services tailored to meet these needs. This is certainly a medical problem, but it is also an ethical problem for all Americans. To allow race and ethnicity to play any role in providing health care to our fellow brothers and sisters goes against the basic principles of ethics. It will be argued that – according to the ethical principles of respect for persons, beneficence/nonmaleficence, and justice – action must be taken immediately to address these concerns. Such action will not only save lives, but will also do much to rebuild a sense of trust between the minority community and the medical establishment.

Respect for Persons

This principle incorporates two ethical convictions: first, that persons should be treated as autonomous agents; and second,

that persons with diminished autonomy are entitled to protection. The principle of respect for persons thus divides into two separate moral requirements: the requirement to acknowledge autonomy and the requirement to protect those with diminished autonomy [8]. Respect for human persons refers to the right of a person to exercise self-determination and to be treated with dignity and respect. All people deserve autonomy and to be treated with dignity and respect. Failure to provide any person with adequate health care, regardless of their race, creed, color, national origin, sexual orientation, etc., violates this basic right of respect for persons. Fear that undocumented individuals will be turned over to the INS if they seek medical care violates personal freedom. It subjects all undocumented persons to the most terrible form of slavery, to be constantly afraid, not knowing their condition or fate, and constantly fearing not living. This way of living does not promote human rights, it violates them.

Second, minorities in this country and especially the undocumented are the most vulnerable people. When African refugees, asylees and immigrants arrive, they are often traumatized and shocked. They usually have no jobs and no financial support to fall back on. In addition, they are in poor health, often because they have moved from town to town or from one refugee camp to another. The children may have not been in school for several years, or they may have not been to school at all. As is often the case in refugee-producing situations, women and children become the most vulnerable members of the refugee community. According to the 2000 Census data, there are 24,136 Africans in the City of Philadelphia. Eleven percent (11%) of these families are on public assistance compared to nine percent (9%) for the city of Philadelphia. Twenty six percent (26%) of the families have incomes below the poverty level compared to 22% for the city as a whole. Many of the African families have settled mostly in the southwest areas of the city. According to 2000 Census data 34% of families with children under 18 from these tracts have incomes below the poverty level compared to 9% for the city as a whole, and that 18% are on public assistance compared to 9% for the city of Philadelphia [9]. This vulnerability compounded with racial disparities give these individuals diminished autonomy. In 2002, an Institute of Medicine (IOM) report, which was requested by Congress, reviewed more than 100 studies that documented a wide range of disparities in the United States health care system. This study found that racial and ethnic minorities in the United States receive lower health care than whites, even when their insurance and income levels are the same [10]. The IOM report made it clear that disparities between whites and minorities exist in a number of disease areas [10]. These disparities are even greater among the undocumented population. Giselle Corbie-Smith, MD, and her colleagues found that African Americans were “more likely to believe that their physicians would not explain research fully or would treat them

as part of an experiment without their consent” [11]. Medical abuses have come to light through the oral tradition of minority groups and published reports. African Americans believe that their physicians cannot be trusted, that physicians sometimes use them as guinea pigs in experiments, and that they are sometimes not offered the same medical procedures that whites are offered, even though they have the same clinical symptoms [11]. This fear and mistrust among the African American population in the United States is magnified with documented and undocumented individuals. The result is that many undocumented and even documented African immigrants in the West Philadelphia area are not seeking medical care until they are in the last stages of their disease. The reason for this, according to those who work with this population and have gained their trust, is a mistrust of the medical establishment and a fear that if they present to an Emergency Department and are found to be undocumented that they will be turned over to the Immigration and Naturalization Service (INS) for deportation. Unfortunately, this has happened in a number of cases. Even though Mercy Hospital of Philadelphia, and in fact, all the Catholic hospitals in the Philadelphia area will not contact INS in these situations, there is still a great fear among this population [12]. Because of this fear, these individuals enter the medical system only out of desperation, when they can no longer stand the pain or have collapsed in a public setting. In most cases, the disease has progressed to the extent that treatment is often futile or extremely expensive. This sense of fear among the undocumented population violates the basic principles of respect for persons. Failure of the medical establishment to give this population adequate health care or to withhold treatment that is the “standard of care” because the individual is undocumented or unable to afford said treatment is denying these individuals their basic rights of dignity and respect. The medical profession is based on treating all people with dignity and respect. Until we can show an improvement in the overall quality of care and work to aggressively promote public health interventions on such diseases as hypertension, diabetes, obesity and even TB for minorities in general and the undocumented specifically, we will never gain the trust of the minority communities and will never close the ever-widening gap in quality of care.

The failure of the medical profession to be proactive in addressing the medical needs of this most vulnerable population is causing needless suffering and even death. This clear form of prejudice clearly violates the ethical principle of respect for persons. Minority patients’ autonomy and the basic respect they deserve as human beings, is being violated because they are allowed to endure pain, suffering, and even death when such hardships could be alleviated. All hospitals, and especially Catholic hospitals, governed by the *Ethical and Religious Directives for Catholic Health Care Services*, have a moral and ethical obligation to address the medical disparities

that exist in the minority communities [13]. If Catholic hospitals are committed to treating every person with dignity and respect, then the barriers to health care must be lifted to ensure this commitment, and emphasis must be placed on patient dignity and empowerment.

Beneficence/Nonmaleficence

The principle of beneficence involves the obligation to prevent, remove, or minimize harm and risk to others and to promote and enhance their good. Beneficence includes nonmaleficence, which prohibits the infliction of harm, injury, or death upon others. In medical ethics this principle has been closely associated with the maxim *primum non nocere* ("Above all, do no harm"). Allowing a person to endure pain and suffering that could be managed and relieved violates the principle of beneficence, because one is not preventing harm and, therefore, not acting in the best interest of the patient. The duty to act in the patient's best interest must take preference over a physician's self-interest.

Physicians have, as moral agents, an ethical responsibility to treat their patients in a way that will maximize benefits and minimize harms. Failure to adequately assess and manage medical conditions, for whatever reason, is not in the best interest of the patient. Literature and research studies have confirmed the disparities in health care among racial and ethnic groups. African Americans and American Indians/Alaska Natives have higher overall mortality rates than any other population group. These two groups have almost double the infant mortality rate for whites [14]. The death rate from all cancers is 34% higher for blacks than for whites [15,16]. There are eight times as many blacks as whites with AIDS, and blacks are nearly twice as likely as whites to die from diabetes [15,16]. These statistics are based on facts; the statistics on the documented and undocumented African populations are unknown. One can assume that if the situation is as bad as it is with African American citizens, the situation with the documented and undocumented foreign population must be even worse.

It is clear, after reviewing these statistics and identifying the biases and stereotyping that exist in the medical profession, that disparities in U. S. health care expose minority patients, especially the undocumented Africans, to unnecessary risks, including possible injury and even death. Physicians have a moral responsibility to do what is good for their patients. Should a physician be impeded in the exercise of his or her reason and free will because of prejudice or bias on the part of the medical establishment, then that physician has an ethical responsibility to overcome that impediment and do what is demanded by the basic precepts of medicine – seek the patient's good. Hospitals also have a responsibility to their communities. If

hypertension, diabetes, obesity and TB are major issues in the undocumented community of people that a particular hospital serves, then it is the ethical responsibility of hospital administrators and health care professionals to formulate programs that address this immediate need. Failure to recognize prejudice and bias is a failure not only of the test of beneficence; it may also be a failure of the test of nonmaleficence.

Justice

This principle recognizes that each person should be treated fairly and equitably, and be given his or her due. The issue of medical disparities among minorities and especially among the undocumented also focuses on distributive justice: the fair, equitable, and appropriate distribution of medical resources in society. At a time when reforming healthcare in this country has become a high priority, failure to initiate preventative measures that would save medical resources in the long-run violates the principle of distributive justice. The justice principle can be applied to the problem under discussion in two ways.

Inequality concerning adequate health care for Americans is a well-documented fact. For years this inequality was attributed to socioeconomic causes resulting in a lack of access to care. With the publication of the 2002 IOM report, however, it is apparent that subtle racial and ethnic prejudice and differences in the quality of health plans are also among the reasons why even insured members of minorities sometimes receive inferior care. Prejudice and negative racial and ethnic stereotypes may be misleading physicians and other health care professionals. Whether such bias is explicit or unconscious, it is a violation of the principle of justice. It has been documented that members of minority groups are not receiving the same standard of care that whites are receiving, even when they have the same symptoms. One example is a 2006 study of more than one million women that found that inadequate breast cancer screening may be the chief reason that black women tend to be diagnosed with larger and more advanced-stage tumors than white women. Financial barriers, lack of access to facilities that perform mammography and multiple personal and cultural reasons may explain the difference in screening rates of white women compared with black women and other minorities [17]. Other examples mentioned above also confirm the fact that death rates from heart disease are twice as high among blacks as whites with similar gaps existing for obesity, cancer and infant mortality [18]. All of these statistics can be applied to the undocumented African population and the rates will probably be even higher. This is a blatant disregard of the principle of justice.

The principle of justice also pertains to the fair and equitable allocation of resources. It has been documented that

members of minorities are less likely than whites to be given appropriate cardiac medicines or undergo coronary bypass surgery. Minorities are less likely to receive kidney dialysis, kidney transplants, or the best diagnostic tests and treatments for cancer. Minorities are also less apt to receive the most sophisticated treatments for HIV and diabetes. As of 2002, the total cost of diabetes in the United States (direct and indirect) was \$132 billion. Direct medical costs were \$92 billion, indirect costs (related to disability, work loss, premature death) was \$40 billion. The average annual health care costs for a person with diabetes are \$13,243, whereas the average annual health care costs for a person without diabetes is \$2,560 [19]. If African Americans are twice as likely to die from diabetes than whites, in many cases because of a lack of adequate medical treatment, then the principle of distribute justice would dictate that programs should be implemented to screen, assess and treat African Americans and other minorities, especially the undocumented African population, not only for their benefit but also to benefit society as a whole.

We Americans espouse the belief that all men and women are created equal. Equality has also been a basic principle of the medical profession. If we truly believe in equality, we should insist that all men and women must receive equal medical treatment and resources. Denying certain minorities medical treatment, when whites receive them as a standard of care, is an unjust allocation of resources and violates a basic tenet of justice. Physicians and the medical profession have an ethical obligation to use available resources fairly and to distribute them equitably. Failure to do so is ethically irresponsible and morally objectionable. To compromise the basic ethical foundations upon which medicine stands is destructive not just to minority patients but to society as a whole.

Patient Data Analysis and Future Progress of the Program

As of November 2012 when the Mercy Health Promoter program partnered with Mercy Philadelphia Hospital Clinic, a total of forty-two patients have been seen through St. Cyrian's Church. Among the patients observed at the Health Promoter screenings, twenty-nine were females and thirteen were male. A total of sixteen patients were referred to Mercy Philadelphia Hospital Clinic for follow up appointments. Data collected at these sessions revealed that a majority of patients had high readings for systolic and diastolic blood pressure indicating an underlying condition of hypertension in the community. The mean systolic and diastolic averages for females were 141 mmHg and 92.0 mmHg, respectively. The mean systolic and diastolic averages for male were 141.2 mmHg and 91.5 mmHg, respectively.

The American Diabetes Association considers ideal levels of blood glucose to be between 70 mg/dl and 130 mg/dl before meals, and under 180 mg/dl following a meal [20]. Among females who presented at the Health Promoter screenings the average glucose reading was 92.04 mg/dl and for males was 95.83 mg/dl.

Having screened these patients in the Nigerian community at St. Cyrian's Church in Philadelphia, the Health Promoters are able to give individual patients educational information with a focus on maintaining blood pressure and blood glucose levels. Additional health and exercise information is made available for individual patients following the Health Promoter screenings. When a patient is confirmed to have high blood pressure or high glucose levels in addition to any other factors (BMI, oxygen levels, weight etc.) he or she is given a card to make an appointment at the Mercy Hospital of Philadelphia Clinic. As previously described above under the record keeping criteria, the identification number that is used for confidentiality in data collection is also written on the patient's referral cards. The patients are encouraged to bring their referral cards with them to their appointments in order to verify with the clinic that they presented at the Health Promoter. This system of communication between the Health Promoters and the Mercy Hospital of Philadelphia clinic allows for the Health Promoters to gauge compliance among patients who were advised to make appointments. Further, once advised to make an appointment the patients are encouraged to return to the Health Promoter the following Sunday in order to follow-up and monitor their health moving forward.

Due to the success of the Mercy Health Promoter program, from the number of confirmed visits at Mercy Hospital of Philadelphia Clinic, both directly from Health Promoter referrals and indirectly via word of mouth, the program administrator has been approached by the elders of the West African, French speaking communities including: Benin, Senegal, Togo, Côte D'Ivoire, Niger, and Cameroon. Their intent is to incorporate the Health Promoter program into their community, which also meets at St. Cyrians on Sundays. A meeting took place between the elders of the French speaking community, the Health Promoter Director and administrators from the Institute of Catholic Bioethics and from Mercy Hospital of Philadelphia to assess the incorporation of the new French speaking communities into the Mercy Health Promoter program. It was decided that four new Health Promoters selected from the French speaking community would begin their medical training every Saturday in August. The medical training would be done by 4–5 medical residents at the Mercy Catholic Medical Center following the same curriculum as stated above.

However, a concern was raised regarding the language barrier among members in these new communities joining the Health Promoter program. Because a majority of the illegal immigrants from these French speaking countries are not bilingual there

may be a potential problem with communication between the Health Promoters, Mercy Hospital of Philadelphia Clinic, and other members of the program. It was agreed that the four new Health Promoters selected from the French speaking community would be bilingual and therefore could effectively communicate in both French and English thus preserving the effective communication throughout the Health Promoter program. The hope is that this new program will be up and fully operational in September 2013. If this is successful then there will be additional outreach to the other African communities in the Philadelphia area.

Conclusions

To address these medical and ethical concerns, Mercy Hospital of Philadelphia has designed a comprehensive education

and prevention model that will meet the needs of the West Philadelphia undocumented African community. The Mercy Health Promoters Program is an initiative whose foundation is based on an established program in the third world, which has not only increased medical care in these areas but has also saved countless lives. As the undocumented population continues to increase in the United States, and health care costs continue to skyrocket, this new initiative can become a paradigm for all hospitals in the United States. Racial and ethnic disparities in health care constitute a complex issue that pertains to individuals, institutions and society as a whole. Unless we Americans address these disparities and begin to eradicate them, we will never attain the goal of equitably providing high-quality health care in the United States. The Mercy Health Promoters model will not only save valuable medical resources; it will also save precious human lives. If we do not make this a priority now, everyone will pay a price in the future.

References:

- Grieco EM, Yesenia DA, de la Cruz GP et al: "The Foreign-Born Population in the United States: 2010." American Community Survey Reports 19. ACS 19 (2012): 1–22. The United States Census Bureau. Web. 29 July 2013
- Ceffalio J, Patuskus C: Recent Trends in Immigration to Philadelphia, Pennsylvania: Who Came and Where Do They Live? Philadelphia, Pennsylvania: University of Pennsylvania's Fels Institute of Government and Philadelphia Department of Community and Economic Development. 2003. The report is based on data collected from the Bureau of Citizenship and Immigration Services (BCIS) considering U.S. Immigration data from 1997–2002
- Partners In Health. PIH Model of Care-Partnering with poor Communities to Combat Disease and Poverty. 2006. <http://www.pih.org/what/PIHmodel.html>
- ILAC Staff. Health Promoters: ILAC Training Stages and Formation of New Health Promoters Manual. Translated by Ann Marie Jursca, Faith Justice, Saint Joseph's University. ILAC Center, Santiago, Dominican Republic, 2004
- Mikus C: Conversation with Mercy Legal Counsel. Mercy Health System One West Elm Street Conshohocken, Pennsylvania 19428. January 22, 2007.
- Gale K: Healthcare Inequities in U.S. Widening Among Hispanics, Medscape-Reuters Health Information, 2006: 1–2. http://www.medscape.com/viewarticle/521243_print
- Tsou A, Edmonds BT, Scobie J et al: "Emergency Preparedness for African Immigrants in West Philadelphia." Robert Wood Johnson Clinical Fellows. University of Pennsylvania, 23 Sept. 2009, pp. 1–54. Web. 10 July 2013. <http://www.med.upenn.edu/rwjcsf/documents/CSPSummerProjectFinalReport2009.pdf>
- National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research, U. S. Government Printing Office, Washington, D.C., 1979: B-1
- African Cultural Alliance of North America (ACANA): Fact Sheet – 2007. <http://acanaus.org/index.html>
- Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, Institute of Medicine, "Unequal Treatment: What Healthcare Providers Need To Know About Racial And Ethnic Disparities in Health Care," (Washington, D.C.) National Academy Press; March, 2002; 1–764
- Corbie-Smith G, Thomas S, St. George D: Distrust, Race, And Research. Arch Intern Med, 2002; 162: 2458–63
- Togbah YW: Conversation on Status of Documented and Undocumented African Immigrants. June 20, 2006, Lutheran Children and Family Services Center 231 North 63rd Street Philadelphia, Pennsylvania 19139. Yvonne is a Case Manager
- United States Conference of Bishops. Ethical and Religious Directives for Catholic Health Care Services Fourth edition. Washington, D.C. 2002
- Lillie-Blanton M, Rushing O, Ruiz S: Key Facts: Race, Ethnicity, and Medical Care. (Menlo Park, Calif.) Henry J. Kaiser Family Foundation; June 2003: at 9
- Frist WH: Overcoming Disparities in U.S. Health Care, Health Affairs. 2005; 24: 445–51. http://www.medscape.com/viewarticle/500298_print
- U. S. Department of Health and Human Services: Progress Review: Cancer. Healthy People 2010, December 22, 2004
- Smith-Bindman R et al: Does Utilization of Screening Mammography Explain Racial and Ethnic Differences in Breast Cancer? Ann Intern Med, 2006; 144: a541–53
- Ghassemi J: Not Just Black and White. The Washington Post July 24, 2006: at 1–2. http://www.washingtonpost.com/wp_dyn/content/article/2006/07/24/AR2006072400793_p
- Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion: Diabetes: Disabling, Deadly, and on the Rise. 2006. www.cdc.gov/nccddphp/aag/aag_ddt.htm
- "Tight Diabetes Control – American Diabetes Association®." American Diabetes Association Home Page – American Diabetes Association®. N.p., n.d. Web. 1 Aug. 2013. <http://www.diabetes.org/living-with-diabetes/treatment-and-care/blood-glucose-control/tight-diabetes-control.html>