
Testimony Before the Special Committee on Aging United States Senate

May 21, 2014

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Good afternoon. I am Dr. Dan O'Brien (PhD), Senior Vice President of Ethics, Discernment and Church Relations for Ascension Health, whose headquarters are in Saint Louis, Missouri. Ascension Health is the nation's largest nonprofit and Catholic health system. Our goal is to transform healthcare by providing the highest quality care to all, with special attention to the poor and vulnerable. Our Health Ministries employ more than 150,000 associates serving in over 1,500 locations in 23 states and the District of Columbia.

Our mission in Catholic healthcare drives us to deliver person-centered, holistic care from conception through natural death. We have a long history of caring for persons with life-threatening illness and our tradition also provides us with direction on many of the issues that arise in care at the end of life. In particular, we are called to care, even when we cannot cure. Because human beings are created in the image and likeness of God, we hold that every human life is a great gift and has inherent dignity. As Pope Saint John Paul II taught, our lives have "inestimable value," but we are also "called to a fullness of life which far exceeds the dimensions of [our] earthly existence, because it consists in sharing the very life of God..." Therefore, "life on earth is not an 'ultimate' but a 'penultimate' reality; even so, it remains a sacred reality entrusted to us" (*Evangelium Vitae*, n. 2).

The governing ethical document for Catholic health care institutions in the USA, called the *Ethical and Religious Directives for Catholic Health Care Services*, identifies comfort and care for the dying as one of the primary purposes of healthcare. It states that above all, "a Catholic health care institution will be a community of respect, love,

and support to patients or residents and their families as they face the reality of death. What is hardest to face is the process of dying itself, especially the dependency, the helplessness, and the pain that so often accompany terminal illness” (Part V, Intro). Given the dignity of every human life, we believe that persons in our care must be provided with sufficient pain and symptom management, psychosocial and spiritual support, compassion and empathy. Our faith teaches us that euthanasia and the inappropriate prolongation of dying are both wrong. John Paul II said, “Both the artificial extensions of human life, and the [deliberate] hastening of death, although they stem from different principles, conceal the same assumption: the conviction that life and death are realities entrusted to human beings to be disposed of at will. It must be made clear again that life is a gift” to be responsibly stewarded (*Address at the Rennweg Hospice in Vienna, June 1998*).

Given our vocation to care for the seriously ill and dying, palliative care, in particular, is one specific approach to care for patients with serious illness that we must support and grow because it focuses on caring for the patient as person, regardless of diagnosis. This type of care, which can be delivered concurrently with disease-modifying treatment, is one of the best ways to assist people with serious illness: it focuses on identifying and addressing the goals of care that are meaningful to them; it provides quality pain and symptom management; and it focuses on caring for people in the right place at the right time. Pope Benedict XVI said, “It is necessary to stress once again the need for more palliative care [services] which provide integral care, offering the sick the human assistance and spiritual accompaniment they need. This is a right belonging to every human being, one which we must all be committed to defend” (World Day of the Sick, February 2007).

Given our mission imperative to deliver this type of care, in 2004 we began working on a system-wide Palliative Care Initiative. We started out by creating several pilot sites which enabled us to identify and test leading palliative care models and practices, create standardized measures and outcomes, demonstrate financial feasibility and sustainability, examine organizational systems and processes, identify programmatic barriers, and analyze other key findings that would assist all our local health systems develop a palliative care program that best fit their needs and populations served. The second phase of our initiative began in late 2009 and focused on increasing the capacity of the rest of our local health systems to develop palliative care programs both within our acute care facilities and throughout the continuum of care. In the last few years our system leaders began recognizing the strategic

imperative of developing robust palliative care programs. Due to this gained insight, our system added palliative care to our system-wide scorecard and our at-risk executive compensation measures. Due to this important step, our system grew from approximately a 20% compliance rate with leading practice teams in place in our acute care facilities, to an 80% compliance rate in the course of one year.

Another important endeavor in which we were a part was working with the Florida Catholic Conference of Bishops' Committee for End of Life Care on a POLST form that was modified to address any concerns under Church teaching. Bishops in some states have opposed POLST legislation outright, mostly due to specific problematic features of POLST paradigms in those states. The Florida bishops, by contrast, requested that the Committee for End of Life Care, including ethicists from multiple Catholic systems including our own, examine the POLST initiative in Florida to find out whether we could be supportive of it or not. After making recommendations to add a few additional protections to the form, the majority of the Committee recommended to the Bishops' Conference that we allow piloting of our edited POLST in our Catholic hospitals. The Committee accepted the recommendations and the President of the Florida Conference thanked us for our important contribution to End-of-Life policy discussions in Florida.

Even despite all this success, our palliative care teams still struggle to receive appropriate funding and constantly have to make the financial case for their expansion, given the budget shortfalls that many hospitals, including Ascension hospitals, are experiencing, especially over the last two years. Given that clinical palliative care consults are not adequately reimbursed and care planning sessions are not reimbursed at all, hospitals find it financially difficult to invest in the resources necessary to provide high quality palliative care, despite the fact that our palliative care teams increase the quality of care while reducing costs, reducing length of stay, and increasing patient and family satisfaction. We ask that this Committee support greater funding of palliative care and advanced care planning sessions to ensure that patient's wishes and concerns are heard and addressed by everyone involved in their care.

We thank you for your time and support!