Volume 1 | Number 1 (Spring/Summer 2015)
www.jheaonline.org
ISSN 2474-2309
doi:10.224621/jhea.4.7162


ETHICAL COMMENTARY

# End Stage Renal Disease

*This article appeared originally in The Internet Journal of Catholic Bioethics (Summer 2008)*

PETER A. CLARK, PH.D., S.J.

*The Institute of Clinical Bioethics, Saint Joseph's University, Philadelphia, Pennsylvania, U.S.A.*

*Address correspondence to: The Institute of Clinical Bioethics, Saint Joseph's University, 600 City Ave, Philadelphia, PA 19131, U.S.A.

Volume 1 | Number 1 (Spring/Summer 2015)
www.jheaonline.org
ISSN 2474-2309
doi:10.224621/jhea.4.7162

**ETHICAL COMMENTARY**

# End Stage Renal Disease

*This article appeared originally in The Internet Journal of Catholic Bioethics (Spring 2011)*

PETER A. CLARK, PH.D., S.J.

*The Institute of Clinical Bioethics, Saint Joseph's University, Philadelphia, Pennsylvania, U.S.A.*

This is a complex case that has medical, legal, ethical and financial implications. As a Catholic hospital this case has to be examined within the context of the "Ethical and Religious Directives for Catholic Health Care Services" (ERDs) and the mission of the Sisters of Mercy. The ERD's state that "In accord with its mission, Catholic health care should distinguish itself by service to and advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination: the poor; the uninsured and the underinsured; children and the unborn; single parents; the elderly; those with incurable diseases and chemical dependencies; racial minorities; immigrants and refugees. In particular, the person with mental or physical disabilities, regardless of the cause or severity, must be treated as a unique person of incomparable worth, with the same right to life and to adequate health care as all other persons" (#2). The mission statement of Mercy Hospital and the Sisters of Mercy states that "we are dedicated to being a transforming, healing presence that supports healthy communities, addresses the diverse health needs of our neighbors at every stage of life, and is accessible to all, including the often forgotten poor and disadvantaged."

Both the ERD's and the mission of the Sisters of Mercy make it clear that all patients who come to the hospital will be treated with dignity and respect and no one will be turned away. This is in direct contrast to the rules of the federal government regarding undocumented individuals. The Emergency Medical Treatment and Labor Act (EMTALA) states that all patients who come to an Emergency Department (ED) must be stabilized but this does not include further treatment. It is also not clear who will pay for undocumented individuals. The new Obama health care plan is very specific that undocumented individuals will not be covered financially. The standard of care in this case to stabilize this patient would be to start dialysis. Unfortunately, once dialysis is started it must be continued until the patient is no longer in need of it. The dilemma for this Catholic hospital is to find a way to continue dialysis for this individual in a cost-effective way.

There are a number of options open to the hospital. First, there is peritoneal dialysis. This is less expensive than hemodialysis but will still require medical resources and supervision. The patient's quality of life is thought to be better with peritoneal dialysis because the patient would spend less time in dialysis centers. What would have to be determined is whether the patient is a candidate for peritoneal dialysis and if a visiting nurse could help supervise the patient. This would entail medical resources and a commitment from a visiting home health agency Second, the hospital could try to make arrangements with an out-patient dialysis unit to see if they would accept the patient as part of their "charity care." One can presume that most out-patient units would not accept this patient because of the time duration for the care and the cost factors. Third, the patient could be discharged and told to come back to the ED every three days for dialysis. This would be very expensive because each time the patient comes into the ED he/she will have to undergo a complete medical evaluation. Fourth, the patient could be brought into the ED every three days under observational status and then be dialyzed. This would be less expensive than coming through the ED directly. However, the hospital would bear the direct cost of the dialysis indefinitely. Fifth, a cost/benefit analysis could be done in regards to sending the patient back to Tanzania. The hospital could contact a Catholic hospital in the capital of Dar es Salaam to verify that the patient would be accepted for dialysis. If accepted, the hospital could do a cost-benefit analysis to determine how much it would cost to send the patient back to his country on a private plane. This is contingent on the fact that the patient would be willing to return to his country. I would presume that most undocumented individuals would not want to return to the country that they came from considering all it took for them to come to the United States. Sixth, if the patient could not be dialyzed, then the patient has an end-stage medical condition and hospice would become an option. After contacting a few hospices they all agreed that under the circumstances they would take the patient under their charity care policy. Finally, depending on the country and why the undocumented individual is

in the United States, one could consult an immigration lawyer to determine if political asylum is a viable option. This would be rare but it could be an option contingent on the status of the patient.

All of these options are viable but the truth is that most will not become a reality. This patient would have to be on dialysis for the rest of his life, which at the age of thirty-five could be for many years. This would be a very expensive undertaking. In the short-run the best solution would be for the hospital to provide dialysis for the patient every three days under an observational status. The hospital administration could establish a contract with the patient stipulating a payment schedule with the hopes that if the patient becomes financially stable he could help to pay for some of the costs of the dialysis. In the long-run, the hospital is going to have to set some parameters to deal with the undocumented patient issue. Catholic hospitals will have to draw a line between the mission of their hospitals and when the mission places the hospital in financial jeopardy. The undocumented problem is going to continue and only get worse. Most undocumented individuals are going to appear at the EDs of Catholic hospitals and if every person is going to be treated long-term this will definitely place the hospitals in financial jeopardy. The best option would be to start programs in the immigrant communities that stress preventative care and to work with these communities to help resolve some of these issues in a collaborative way.