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Abstract: *The United States has seen a significant shift to chronic conditions leading to tremendous negative impact on individual health. A shift from curative care to carative care is seen throughout U.S. healthcare. Meanwhile, the undocumented immigrants in the U.S. face several social, cultural, and economic impediments, further restraining their access to health care. Medical care initiatives to decrease health risks, increase disease prevention, and provide education regarding disease treatment is of significant need for Hispanic immigrants. The Institute of Clinical Bioethics (ICB) at Saint Joseph's University with the administrators of Mercy Hospital of Philadelphia established a program with the above intent; enactment of the carative care model to achieve success in serving immigrant communities. To accomplish this, the Mercy Hospital Task Force was formed to cultivate a model for healthcare in the Philadelphia area. As a result, the Mercy Health Promoter Model was first introduced in 2010 and the ICB launched the "Health Promoter" program. Utilizing a carative care approach, the Mercy Health Promoter program strives to meet the needs of multicultural populations implementing key aspects of Watson's Theory of Human Caring and integration of Tucker's Cultural Competence and Patient Centered Healthcare criteria for health care prevention. This healthcare care program fits the methodological ideal of carative care and obtains great success in serving the Hispanic immigrant community. Within the past year, to support use of this method within this patient population, students of Saint Joseph's University in collaboration with the university's ICB and the Mercy Health Promoter program developed disease and preventative health care related information pamphlets addressing common chronic issues in the United States specific to Hispanic immigrants. Pamphlets were created using key aspects of carative care. Student research included disease prevention, health and wellness, acute to chronic illness, and curative to carative care. Students addressed topics such as nutrition, prenatal care, vision screening, oral health, diabetes, heart disease, mental health, and vitamin deficiencies. Utilizing the Mercy Health model, carative care and patient centered philosophies, and integration of the caring approach to graduating students with anticipated careers in healthcare, it is expected that positive outcomes will continue to be seen in multicultural care and preventative health. We recommend the discussed caring method should be embraced and applied as the practical methodological approach to healthcare for the clinicians and administrators serving the culturally diverse and socially challenged population. Ongoing collaborative efforts within the Philadelphia areas, Saint Joseph's University ICB, and students within the university are being developed to provide increased medical education, in this population, utilizing a carative care philosophy.*

Keywords: *Health promotion, carative healthcare, curative healthcare, undocumented immigrants, culture.*

INTRODUCTION

In 1990, the immigrant population in the United States, comprising of mainly Latin Americans, was 7.1 million and increased to 12.1 million in 2010.[1] In 2014 it was estimated over 40 million people in the United States were foreign born.[2] Philadelphia has especially faced growth in the Hispanic immigrant population, particularly those undocumented. It is predicted that by 2050, the Hispanic population will consist of over 30% of the United States' population. As a result, more Hispanics will add to America's middle-aged and elderly population. The reason for this population growth will be more due to an increase in births within the United States, rather than immigration from Latin and South America.[3]

However, cultural and socioeconomic impediments limit their access to health care, while their legal immigration status is considered one significant factor as well. Hospitals face escalation of patients from the immigrant population, both insured and uninsured. The Mercy Health System, previously Regional Health Corporation of Catholic Health East, is a Regional Health Ministry within Catholic Health East Trinity Health, the second largest Catholic Health System in the United States.[4] Specifically, Mercy Suburban Hospital (currently Suburban Community Hospital) Montgomery County, Pennsylvania has experienced a 4% increase in Hispanic patients.[5] It is approximated over 180,000 undocumented immigrants live in Pennsylvania alone facing negative impact on access to health care and medical treatments.[6] A study conducted with undocumented Mexican immigrant women, asking experiences of attempting to seek health care in the United States, shows many were faced with lack of recognition of their human struggle and felt devalued.[7]

Mercy Suburban seeks to deliver quality health care regardless of socio-economic status and legal status in order to aid the vulnerable and disadvantaged in the surrounding community. Due to the increased number of patients who are undocumented, hospitals such as this are placed in a financially strained position and determining statistics on the number of undocumented individuals visiting a hospital is often difficult to obtain.[8] In addition to legal immigration status, other socioeconomic and cultural impediments faced by undocumented Hispanic immigrants in the United States which constrain their access to health care include lower levels of education attainment and language barriers. This can often cause the disease to progress, leading to a greater chance of being admitted into a hospital.[9] There are higher rates of undocumented individuals who have no insurance when compared to American citizens or immigrants who are documented[10] and continual growth in undocumented residents has been seen throughout the Philadelphia area. Many of the socioeconomic and cultural barriers that these individuals face have a negative impact on their access to health care medical treatments. For example, it is more likely for undocumented and uninsured Hispanic immigrants to delay treatment until the condition or disease has advanced. Median state level costs for chronic illnesses continue to increase and costs rise substantially when delayed treatment and advanced disease are present. These overall state

[1] The United States Census Bureau, The Size, Place of Birth, and Geographic Distribution of the Foreign-Born Population in the United States: 1960 to 2010, by Elizabeth M. Grieco, Edward Trevelyan, Luke Larsen, Yesenia D. Acosta, Christine Gambino, Patricia de la Cruz, Tom Gryn, and Nathan Walters, (Washington, D.C. 2012), http://paa2012.princeton.edu/papers/121103.

[2] The United States Census Bureau, "Foreign Born Statistics 2016," http://census.gov/topics/population/foreign-born.html (accessed November 2, 2016).

[3] Pew Research Center, "II. Hispanics and Chronic Disease in the U.S.," Hispanic Trends, http://www.pewhispanic.org/2008/08/13/ii-hispanics-and-chronic-disease-in-the-u-s/ (accessed November 2, 2016).

[4] Clark et al., "Mercy Health Promoter Model: Collaborating with Hispanic Immigrant Communities for Just Health Care," *The Internet Journal of Public Health* 2, no.1 (2014): accessed October 24, 2016, http://ispub.com/IJPH/2/1/19945.

[5] Mercy Suburban Hospital, *Mercy Suburban Hospital: 2013-2015 Community Health Needs Assessment*, (Philadelphia, PA: Community Benefit Plan, 2013).

[6] Pew Research Center, Unauthorized Immigrant Population: National and State Trends, 2010, by Jeffrey S. Passel and D'Vera Cohn, (2011) http://www.pewhispanic.org/2011/02/01/unauthorized-immigrant-population-brnational-and-state-trends-2010/.

[7] Chandler et al., "'No Me Ponían Mucha Importancia': Care-Seeking Experiences of Undocumented Mexican Immigrant Women with Chronic Illness," *Advances in Nursing Science* 35, no. 2 (2012): doi:10.1097/ANS.0b013e31825373fe.

[8] Clark, "Mercy Health Promoter Model: Collaborating".

[9] "Health Care: See Why Being Insured Matters," Centers for Disease Control and Prevention, last modified November 8, 2010, https://www.cdc.gov/Features/VitalSigns/HealthcareAccess/.

[10] "Facts on Immigration and Health Insurance," Center for Immigration Studies, last modified August 2009, http://cis.org/HealthCare-Immigration.

costs (median) include arthritis ($217 million), asthma ($410 million), congestive heart failure ($5 million), and diabetes ($1.8 billion) [11] all of which are shown to be untreated and increased in the Hispanic immigrant population.

To decrease these costs, hospital programs are necessary to support preventative health education for the immigrant population. With support of a recently developed Mercy Hospital Task Force, new initiatives are brought to the forefront providing preventive care and medically treat the undocumented Hispanic immigrant population. One initiative is the Mercy Health Promoter developed by the Institute of Clinical Bioethics at Saint Joseph's University. Philadelphia, PA, with administrators of Mercy Hospital of Philadelphia. Introduced in 2010, execution of the Mercy Health Promoter program at Saint Patrick's parish in Norristown, PA for the Hispanic community, Mercy Suburban Hospital offers the ability to provide prevent health care to the poor while maintaining financial stability.[12]

The goal of this paper is five-fold: 1) Discuss various chronic medical issues becoming increasingly common among this community; 2) discuss the social and cultural issues that impede the Hispanic community's access to health care; 3) introduce the notion of "carative care" and a current shift from curative care to carative care in the U.S. health care systems; 4) present that the carative approach better serves to obtain health care outcome in the Hispanic immigrant community where the members' healthcare issues are complicated by the social and cultural issues as outlining the Mercy Health Promoter program to be a model for the carative care; 5) display how Saint Joseph's University's Interdisciplinary Health Services curriculum incorporates this ideal which we believe can be the paradigm for all similar university curriculum. Before we proceed, however, it should be noted that we will use the term "non-Hispanic Whites" to refer to the White populations not of Hispanic origin in the U.S. The U.S. Census Bureau defines the non-Hispanic Whites as a subcategory of White populations in the U.S., the counterpart of which is White Hispanic populations. In this study, the Hispanic immigrant populations include White Hispanics, as opposed to non-White Hispanics.

A CLINICAL DIAGNOSIS OF THE HISPANIC IMMIGRANT COMMUNITY

According to the Center for Disease Control and Prevention (CDC), health problems such as cancer, diabetes, obesity, and heart disease are some of the most common and costly chronic diseases in the United States, yet some of the most preventable conditions. The CDC reported, in 2012, that approximately half of all adults in the United States had at least one chronic medical condition. One quarter of the U.S. population's adults had at least two chronic medical conditions.[13]

On the other hand the immigrant population groups are at higher risk for developing chronic diseases as a result of inadequate access to health care. Additional pressure is placed on physicians and health care systems because these patients are likely to present with advanced conditions.[14] Prevention and management of chronic diseases in this population has become a focal point of study for the U.S. healthcare system. Ethnic minorities, including Hispanics, have been found to exhibit higher rates of certain chronic health conditions when compared to the non-Hispanic White populations.[15] Focusing on the Hispanic populations, Hispanics are more likely to develop diabetes, uncontrolled hypertension leading to heart disease, decreased cancer screening, infant mortality, and obesity compared to non-Hispanic whites.[16] Studies find total diabetes occurrence, diagnosed and undiagnosed, among Hispanic groups are approximately 16.9% (both men and women) compared to 10.2% for non-Hispanic whites.[17] Rates of uncontrolled blood pressure in Hispanics are 57.5% compared to 48.4% for non-Hispanic Whites.[18] Cancer screenings are lower in Hispanic vs. non-Hispanic Whites including pap tests 77.1% vs. 82.8%, mammograms 64.3% vs. 68.9%, colorectal screening 44.9% vs. 60.5% respectively.[19] Infant mortality rates are higher for Hispanic women (5.25%) vs. non-

[11] Trogdon et al., "Costs of Chronic Diseases at the State Level: The Chronic Disease Cost Calculator," *Preventing Chronic Disease* 12 (September 3, 2015): doi:10.5888/pcd12.150131.

[12] Clark, "Mercy Health Promoter Model: Collaborating".

[13] "Workplace Health - Business Case - Reasons for Investing - Rising Health Care Costs," Centers for Disease Control and Prevention, last modified 2013, http://www.cdc.gov/workplacehealthpromotion/businesscase/reasons/rising.html.

[14] Shommu et al., "What Is the Scope of Improving Immigrant and Ethnic Minority Healthcare Using Community Navigators: A Systematic Scoping Review," *International Journal for Equity in Health* 15, no.6 (2016): doi:10.1186/s12939-016-0298-8.

[15] Gretchen Livingston, Susan Minushkin, and D'Vera Cohn, "II. Hispanics and Chronic Disease in the U.S."

[16] "Workplace Health."

[17] "Diabetes Among Hispanics: All Are Not Equal," American Diabetes Association, last modified July 24, 2014, http://www.diabetes.org/newsroom/press-releases/2014/diabetes-among-hispanics-all-are-not-equal.html.

[18] "Health, United States, 2015 - Hispanic or Latino Population," Centers for Disease Control and Prevention, last modified April 27, 2016, http://www.cdc.gov/nchs/hus/hispanic.htm.

[19] American Cancer Society, *Cancer Fact and Figures for Hispanics/Latinos 2015-2017*, (Atlanta, GA: American Cancer Society, 2015).

Hispanic White women (5.18%).[20] Adult obesity affects approximately 42.5% of Hispanics compared to 34.5% for non-Hispanic Whites.[21] Particularly, the two leading causes of death in the Hispanic population are cancer and heart disease.[22] Also, a continued lack of proper diet counteracts medication treatment for conditions to include hypertension. [23] All of the above demonstrates need for the adoption of better dietary and lifestyle practices within the Hispanic immigrant community. With early medical education and improved dietary practices, chronic diseases and associated medical conditions can be prevented and healthy lifestyles maintained.[24]

SOCIAL AND CULTURAL CHALLENGES

A study performed on the general Hispanic population by the Pew Hispanic Center concluded that major constraints to healthcare for immigrants include language barriers. Twenty-three percent of Hispanics report the belief that their lack of quality care is due to low level of fluency of the English language.[25] A fear of not understanding the healthcare system, and the language utilized during assessment and treatment, can cause disempowerment among immigrant communities.[26] Also, the lack of higher education, related to their linguistic challenge, poses another serious challenge. In 2008, 52% of Hispanic immigrants did not have a high school diploma.[27] A 2014 National Journal poll shows 66% of Hispanics who did not apply to college states that they needed to acquire a job or enroll in the military as a necessity to support their family compared with 39% of non-Hispanic Whites. In 2014, only 15% of Hispanics held a bachelor's degree or higher (ages 25 to 29, 2014 statistics) compared to approximately 41% of non-Hispanic Whites and for those that do attend higher education close to 50% of Hispanics attend 2-year colleges.[28]

On the other hand, there are cultural issues. Cultural reservations associated with seeking formal health care may place more value on self-care or homeopathic remedies. A 2003-2004 survey reports that over 80% of Hispanics admitted using herbs for cough, stomach pain, sore throat, menstrual cramps, headache, and chest pain. The types of herbs they used includes a list of over 25 commonly used herbs such as cinnamon, cloves, cumin, chamomile, garlic, onion, grass syrup, aloe vera, oregano, and lemon. Reports also show that the individuals taking these herbs were neither educated about their use nor had the knowledge of the English terms for the herbs.[29] Many users of the herbs for medicine stated that the herbs were recommended to them by their own family members. In a recent study of the patients diagnosed with colorectal cancer, according to self-reports from 631 Hispanic patients, 40.1% are found to have utilized complementary and integrative health (CIH); 35.3% reported herbal products/dietary supplement use; 16.5%, use of bodywork (body to heal itself); 7.8%, use of mind–body practices; and 6.7%, use of homeopathy. On the other hand, CIH was reported by 60% of participants to address specific health conditions. It is disclosed that 76.3% of these same patients did not discuss CIH use with their physicians. Hispanic women reported higher CIH use compared to Hispanic men, and the total CIH use was no different when clinical stage, time since diagnosis, or preferred language were compared.[30]

Also, the cultural concept of "machismo," the expectation that Hispanic men as household's breadwinners are to act "manly" places pressure on men to be healthy.[31] Machismo embodies the expectations of men in society including values, attitudes, and

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[20] "Infant Mortality Rates by Race and Hispanic Ethnicity of Mother — United States, 2000, 2005, and 2010," Centers for Disease Control and Prevention, last modified January 10, 2014, https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6301a9.htm.

[21] "Overweight and Obesity," Centers for Disease Control and Prevention, last modified September 1, 2016, https://www.cdc.gov/obesity/data/adult.html.

[22] "Health of Hispanic or Latino Population," Centers for Disease Control and Prevention, last modified October 7, 2016, http://www.cdc.gov/nchs/fastats/hispanic-health.htm.

[23] Livingston, Minushkin, and Cohn, "II. Hispanics and Chronic Disease in the U.S."

[24] Julie A. Patten, "Dietary Patterns of Hispanic and White College Freshmen," 28 (1994): 39–45.

[25] Fry, "Hispanics, High School Dropouts and the GED."

[26] Tangela Towns, "Barriers to Care," *Sociology Compass* 7, no. 10 (October 2013): 854-65. doi:10.1002/soc4.12074.

[27] Fry, "Hispanics, High School Dropouts and the GED."

[28] Jens Krogstad, "5 Facts about Latinos and Education," Pew Research Center, last modified July 28, 2016, http://www.pewresearch.org/fact-tank/2016/07/28/5-facts-about-latinos-and-education/.

[29] Howell et al., "Use of Herbal Remedies by Hispanic Patients," *The Journal of the American Board of Family Medicine* 19, no. 6 (November 1, 2006): 566–78. doi:10.3122/jabfm.19.6.566.

[30] Black et al., "Complementary and Integrative Health Practices Among Hispanics Diagnosed with Colorectal Cancer," "Complementary and Integrative Health Practices Among Hispanics Diagnosed with Colorectal Cancer: Utilization and Communication with Physicians." *Journal of Alternative and Complementary Medicine* (New York, N.Y.) 22, no. 6 (June 2016): 473–79. doi:10.1089/acm.2015.0332.

[31] Peak et al., "A Needs Assessment of Latino Men's Health Concerns," *American Journal of Men's Health* 4, no. 1 (March 2010): 22–32. doi:10.1177/1557988308327051.

beliefs regarding masculinity and the role of the man in the family. Machismo includes aspects such as bravery, honor, dominance, aggression, sexism, sexual prowess, and reserved emotions. For Hispanic women this is called "marianismo" and includes the role of the woman as the caretaker, family based, and self-sacrificing.[32] Machismo and marianismo can place Hispanic men and women at higher risk for cardiovascular disease/stroke,[33] HIV/AIDS,[34] anxiety, depression,[35] and even suicide.[36]

This expectation may lead to Hispanic men's avoidance of health care, as resorting to health care would indicate weakness and lack of good health. The reason may explain why Hispanic adults are more likely to have a lack of health insurance than African Americans or non-Hispanic Whites.[37] The researchers, Gast and Peak explain in their 2011 study that gender "scripts" and gender-role socialization are the primary reasons for individuals to engage in less "help-seeking behavior." With the cultural concept of machismo, Hispanic men may be less likely to obtain a regular source of medical care, maintain decreased physician visits, lack use of preventive care, and lack health insurance to avoid being seen as vulnerable and to maintain self-reliance.[38]

In sum, due to difficulty in communication, lack of higher education, and cultural influence, the Hispanic immigrants are more likely to self-treat and only seek out mainstream care when their self-care attempts fail. This in turn can delay time to treatment and present more advanced disease when healthcare is sought. This trend falls in line with the acute to chronic illness shift that the healthcare system as a whole is experiencing.

"CURATIVE CARE" AND "CARATIVE CARE"

Curative care and carative care are two areas ethically of focus within the U.S. medical system. And the current shift being made from the former to the latter in the national scale is also what is clinically and ethically necessary as we provide health care for the Hispanic immigrant population. Michael Brenner (1999) writes about the transitions in health care that have been occurring in stages over the past several centuries. In the past, mortality was determined by a specific event or medical condition. The Western populations saw a decrease in mortality rates with the advent of the agricultural and industrial revolutions, which provided a reliable distribution of food and brought about an increase in the standard of living.[39] At the same time that the spread of disease was decreasing, advances in medicine, in particular the invention of diagnostic tools, led to the introduction of the scientific method into medicine. Soon the advent of biomedical research produced the wide use of antibiotics and vaccinations, even further expanding the average lifespan and decreasing the rates of infectious disease. The third stage is characterized by scientific advancements that led to the invasive use of medicine to fight disease. Here, procedures such as organ transplants were introduced, but issues such as cost and scarce resources arose. The final stage's focus is on combating the complications associated with chronic and degenerative diseases. These stages utilize curative medicine to combat disease and extend life for as long as possible. Curative care has gone to new extremes in this last stage of the transition of health care to use costly and invasive treatments to stave of death.[40]

Traditionally, the medical professions focus on the curative model of care. In this practice, health care professionals seek to provide patients with medical treatments and therapies with the intent to improve symptoms and seek cures for existing medical issues. In curative-based therapies, removing the disease is the focus. The curative model is contingent upon the patient presenting with a current illness, effective diagnosis, and treatment derived from pathophysiology. Treatment is derived from empirical research and clinical outcomes and integrated heavily in a scientific bio-medical approach. Symptoms that are

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[32] Nuñez et al., "Machismo, Marianismo, and Negative Cognitive-Emotional Factors: Findings from the Hispanic Community Health Study/Study of Latinos Sociocultural Ancillary Study." *Journal of Latina/o Psychology* 4, no. 4 (2016): 202–17. doi:10.1037/lat0000050.

[33] Rodriguez et al., "Status of Cardiovascular Disease and Stroke in Hispanics/Latinos in the United States," *Circulation* 130, no. 7 (August 12, 2014): 593–625. doi:10.1161/CIR.0000000000000071.

[34] Ibañez et al., "'Love and Trust, You Can Be Blinded.': HIV Risk within Relationships among Latina Women in Miami, Florida," *Ethnicity & Health*, October 21, 2016, 1–18, doi:10.1080/13557858.2016.1244737.

[35] Nuñez et al., "Machismo."

[36] Mascayano et al., "Suicide in Latin America: A Growing Public Health Issue," *Revista De La Facultad De Ciencias Medicas* (Cordoba, Argentina) 72, no. 4 (2015): 295–303.

[37] Towns, "Barriers to Care."

[38] Julie Gast and Terry Peak, "It Used to Be That If It Weren't Broken and Bleeding Profusely, I Would Never Go to the Doctor': Men, Masculinity, and Health," *American Journal of Men's Health* 5, no. 4 (July 2011): 318–31. doi:10.1177/1557988310377926.

[39] Vincent Navarro, "From Public Health to Health of the Public: The Redefinition of Our Task," *American Journal of Public Health* 64, no. 6 (June 1974): 538–42.

[40] M. J. Brenner, "The Curative Paradigm in Medical Education, Striking a Balance between Caring and Curing," The Pharos of Alpha Omega Alpha-Honor Medical Society. *Alpha Omega Alpha* 62, no. 3 (1999): 4–9.

associated with a specific organ or body system are focused upon. Thus, measurable outcomes are the main area of concentration and often takes priority over subjective patient experiences.

Curative care can be challenging for any patient when chronic illnesses present themselves, and more so for those with barriers such as cultural, language, and decreased access to health care. The curative paradigm separates disease from illness, as the cure-oriented medical professionals are to place their focus on objective clinical facts with an unintentional disregard for a patient's emotional standing, in order to quickly and efficiently find a cure. Medical practice such as this transforms the patient from a person with unique conditions into an entity that can be itemized, taken apart, and broken down based on clinical factors in order simplify the diagnosis and treatment process. Brenner writes that, in this model, success is measured by the eradication of diseases, rather than the enhancement of quality of life. Thus, aggressive treatment is the preferred course of action when curative medicine is common practice. And in critical care setting, despite the terminal nature of some patients' disease, intrusive medical care is nonetheless commonplace within this paradigm. Besides, this model of care seems ineffective for certain patient populations. For example, the Hispanic immigrant population may not be eligible for the said treatments requiring needed health insurance. Also, for all patient populations and particularly the uninsured populations including the Hispanic immigrants, preventive health care is a much-needed focus in health care, so the focus that curative medicine emphasizes is largely irrelevant.[41] In addition, curative care can be challenging for any patient when chronic illnesses present themselves, and more so for those with barriers such as cultural, language, and decreased access to health care.

An alternative paradigm of medical care is "carative care," which encourages a care-oriented approach to medicine. The term, "carative care," first coined by the nurse theorist, Jean Watson's influential essay first published in 1979, *Nursing: The Philosophy and Science of Caring*. Watson, drawing on the Greek word "caritas" which refers to love or endearment or cherishment, argues that a primary focus of medicine should be to help the person attain or maintain health or die a peaceful death.[42] Carative care is sensitive to the patient's life experiences and to the patient as a whole person. It cares for sustaining human dignity of the person and creating wholeness in the patient. Carative care stands out as the medical care that provides relief while setting the overall goal to control symptoms and achieve restoration of functional capacity, yet assumes that cure is *not* the goal and strives to develop relief of suffering.[43] Treatment is important, yet is worthwhile only if it contributes to the subjective welling of the patient. The care-oriented paradigm employees the personalist medical view that diseases do not automatically become illnesses because the patient's subjective value-laden interpretations of diseases determine whether the diseases are to be taken as illnesses for the patient or not.

Two major clinical components of carative care are preventive medicine and palliative medicine. Preventive medicine is a major element of the care-oriented paradigm which promotes health independent of the active presence of disease. On the other hand, palliative care is another important component of carative medical practice, as it strives to develop relief of suffering and symptom management instead of targeting on cure as a goal. The overall goal of carative care in the palliative medicine particularly for patients with a terminal diagnosis is to control symptoms and achieve restoration of functional capacity.[44] A systematic review of previous palliative care studies in the past decade has identified pain management as one of the most common burdens in end-of-life care. The studies have also identified the need for better communication, scientific knowledge, and educational materials surrounding pain and symptom management. It specifies that it is especially important to further investigate the needs and cultural barriers of patients as a result of the growing diversity in the United States.[45]

Watson introduces 10 carative factors (see Table 1) also known as the "Caring Model" or the "Theory of Caring Science" in which the person-centered care values the well-being of the patient over the elimination of disease. In the Caring Model, Watson claims that the increased aspects of quality of life for patients, including those with hypertension, is correlative to an overall increased feeling of well-being, increased physical activity, and statistical significance of decreased systolic and diastolic measurements.[46] In a clinical setting, Watson's Theory of Human Caring practiced based on the Caring Model shows positive

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[41] Ibid.

[42] Jean Watson, "Theory of Human Caring," (2010): http://www.watsoncaringscience.org/images/features/library/THEORY%20OF%20HUMAN%20CARING_Website.pdf.

[43] Liz Gwyther, Frank Brennan, and Richard Harding, "Advancing Palliative Care as a Human Right," *Journal of Pain and Symptom Management* 38, no. 5 (November 2009): 767–74. doi:10.1016/j.jpainsymman.2009.03.003.; Jean Watson, "Social Justice and Human Caring: A Model of Caring Science as a Hopeful Paradigm for Moral Justice for Humanity," *Creative Nursing* 14, no. 2 (2008): 54–61.

[44] Ibid.

[45] Nai-Ching Chi and George Demiris, "Family Caregivers' Pain Management in End-of-Life Care: A Systematic Review," *The American Journal of Hospice & Palliative Care*, March 14, 2016. doi:10.1177/1049909116637359.

[46] Erci et al., "The Effectiveness of Watson's Caring Model on the Quality of Life and Blood Pressure of Patients with Hypertension," *Journal of Advanced Nursing* 41, no. 2 (January 2003): 130–39.

effectiveness in caring for patients with rheumatoid arthritis,[47] pediatric care,[48] critical care environments,[49] home care settings,[50] and treatment of patients in multicultural environments.[51] Her theory has played a part supporting health care professionals in the management of burnout[52] and critical care environments and health promotion.[53] Also, use of Watson's Caring Model has shown increased aspects of quality of life for patients; increased feeling of well-being, increased physical activity, and statistical significance of decreased systolic and diastolic measurements in those diagnosed with hypertension.[54] Studies have shown carative care to have increased better decision-makings among patients, more family participations, and positive cultural integration as related to patient health well-being. Contributions to quality of life and positive health outcomes have been also observed.[55]

The effectiveness of Watson's theory is found in its emphasis on care as an obligation, as Watson says that "caring in health care" is an ethical-clinical "obligation to patients, families, communities and the universe.[56]" To fulfill the obligation, the medical professionals should focus on patient well-being by placing significance on the patient's subjective experience to their illness, which requires that the clinicians should take into account psychological, cultural, and spiritual concerns while providing treatment. Also, from the perspective of the care-oriented paradigm, a treatment is deemed worthwhile only if it has value from the patient and family's personal point of view.

Table 1: Watson's 10 Carative Factors [57]

10 Carative Factors	10 Caritas
1. Humanistic-altruistic values	Practicing Loving-kindness and Equanimity
2. Instilling/enabling Faith and Hope	Being authentically present to/enabling/sustaining/honoring deep belief system and subjective world of self/other
3. Cultivation of Sensitivity to one's self and other	Cultivating of one's own spiritual practices, deep self-awareness, going beyond ego self
4. Development of helping-trusting, human caring relationship	Developing and sustaining a helping-trusting, authentic caring relationship
5. Promotion and acceptance of expression of positive and negative feelings	Being present to, and supportive of, the expression of positive and negative feelings
6. Systematic use of scientific problem solving caring process	Creativity using presence of self and all ways of knowing/multiple ways of being/doing
7. Promotion of transpersonal teaching-learning	Engaging in genuine teaching/learning experiences that attend the whole person

[47] C.S. Nyman and K. Lützen, "Caring Needs of Patients with Rheumatoid Arthritis," *Nursing Science Quarterly* 12, no.2 (April 1999): 164-69.

[48] Gillespie et al., "Caring in Pediatric Emergency Nursing," *Research and Theory for Nursing Practice* 26, no. 3 (2012): 216–32.

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[57] Erci et al., "The Effectiveness of Watson's Caring Model."

8. Provision for a supportive, protective, and/or corrective mental, social, spiritual environment	Creating a healing environment at all levels
9. Assistance with gratification of human needs	Assisting with basic needs with a spirit of individuality
10. Allowance for existential-phenomenological spiritual dimensions	Opening and attending to spiritual dimensions of life-death, soul care

In today's medical environment, we witness a shift from acute care to chronic care in the United States. According to the Agency for Healthcare and Research Quality, in 2010, more than 51.7% of Americans were affected by one chronic condition and close to 31.5% of all Americans were affected by multiple chronic conditions.[58] By 2020, 157 million US citizens are predicted to have more than one chronic disorder with 81 million having multiple conditions and 86% of healthcare spending is for patients with one or more chronic condition.[59] This transition requires a new approach to medical practice to accommodate United States' healthcare needs. A transition from a curative to carative paradigm seeks to effectively address the needs of an aging population that is experiencing morbidity rather than mortality. It is undoubtedly the case that health care should provide curative and carative care. However, the transition to the carative paradigm in medical field will hold health care professionals responsible for creating a balance between curing and caring.

THE CARATIVE CARE APPROACH TO HEALTHCARE FOR THE HISPANIC IMMIGRANT COMMUNITY AND THE MERCY HEALTH PROMOTER PROGRAM

Given that the carative care approach emphasizes the balance between curing and caring, the application of this model to healthcare for the Hispanic immigrant community is extremely relevant, though it is true that the need for ongoing health-related carative collaboration holds true for all patient populations. As addressed earlier, there exists the growth and severity of chronic illness in the Hispanic immigrant community, and this problem is being complicated by the social and cultural issues. First, we argue that this caring approach should be adopted and implemented as the practical methodological approach to healthcare for the clinicians and administrators serving the culturally diverse and socially challenged population. As discussed above, the carative model focuses on the patient and family's subjective experiences to illnesses and the collective values they hold to decide on the treatment decisions; the care-oriented medical professionals are to work with the patient and family to figure out what treatment and how much of it are proper. This personalized approach naturally respects for the patient and family's cultural background and their family values. In this personalist manner, the carative care model seeks to maintain the subtle balance between care and cure. Utilizing Watson's 10 carative factors as the clinicians treat the socially vulnerable and culturally diverse populations is providing universal as well as multicultural-conscious care for the groups.

We would like to introduce, now, the healthcare care program the methodological ideal of which follows the carative care model and obtain a great success in serving the Hispanic immigrant community. The Institute of Clinical Bioethics (ICB) at Saint Joseph's University with the administrators of Mercy Hospital of Philadelphia developed a program with the above intent, and obtained success in serving the community by implementing the carative care model. The Mercy Hospital Task Force was created to develop a model for healthcare for African immigrants in the Philadelphia area in order to help provide quality healthcare to the increasing number of African immigrants who are uninsured in Philadelphia, regardless of socioeconomic or legal status. The aim of this task force was to provide clinical interventions which are, first, preventive in nature and, second, patient-provider education which was lacking in this population. In 2010 the Mercy Health Promoter Model was first introduced and subsequently the ICB launched the "Health Promoter" program. And success of the Mercy Health Promoter program for the African populations in Philadelphia inspired the ICB to initiate a program for the Hispanic community as well. This additional program was implemented in Saint Patrick's Catholic Church in Norristown, PA, to meet the needs of the Hispanic immigrant populations.[60]

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[58] "Multiple Chronic Conditions Chartbook 2010 Medical Expenditure Panel Survey Data," *Agency for Heathcare Research and Quality*, 2010, http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/prevention-chronic-care/decision/mcc/mccchartbook.pdf.

[59] Ibid.; "Tackling the Burden of Chronic Diseases in the USA," *The Lancet* 373, no. 9659 (2009): http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(09)60048-9/fulltext.

[60] Clark, "Mercy Health Promoter Model: Collaborating"; Aloysius Ochasi and Peter A. Clark, "Mercy Health Promoter Model: Meeting Needs of Specific Immigrant Communities," *Health Progress* (Saint Louis, Mo.) 95, no. 2 (April 2014): 32–37, https://www.chausa.org/publications/health-progress/article/march-april-2014/mercy-health-promoter-model-meeting-needs-of-specific-immigrant-communities.

Individuals from the community were trained to become Mercy Health Promoters. Qualifications for the Health Promoter candidates included bilingual language capacity, while trusted and respected in the community, service-oriented, knowledgeable about the community and its members, team-oriented, responsible, and unbiased. The main role of these leaders has been to screen patients and to offer medical and health-related advice and education based on blood pressure readings, blood glucose, and cholesterol levels, and height and weight measurements. Training of Health Promoters depends on the specific needs and concerns of the community determined by the administrative staff of Saint Patrick's Church, the ICB, and Mercy Suburban Hospital. Health Promoters are trained in exercise, sanitation, nutrition, and chronic medical diseases. They are also trained in patient documentation, communication skills, patient confidentiality and sensitivity, and clinical techniques as stated above. Each patient is given an identification number representing the patient has been screened and recorded by a Health Promoter to protect patient privacy.[61] Mercy Suburban Hospital's Pharmacy Department has agreed to provide preventive immunizations such as influenza and pneumococcal vaccines offering protection for individuals within the community and the greater population. Mercy Suburban Hospital's Physician Network arranged for a family practice physician to attend each monthly screening. The physician meets with patients at Saint Patrick's Church, provides recommendations, and organizes for follow-up appointments or referral to additional health care professionals. For referrals, his or her information is sent with consent to the staff of the Mercy Health Center to prepare ahead of time.[62] Dental school residents attend monthly Health Promoter sessions, examining patients' dental status, offering recommendations, and refer to locations for low cost dental treatment or teeth cleaning. Fellows of the ICB have volunteered at each screening, assisting the Health Promoters and provide translation for language barriers.

The Mercy Health Promoter program has sought to include cultural competence and culturally sensitive healthcare in its development, training of Promoters, and in their ongoing community programs and treatment of patients. Without such competence and sensitivity, studies could have shown lack of adherence towards medication regimens, therapy, and health promotion and disregard of general medical advice within the Hispanic population. As trust increases between physicians and patients of Hispanic decent, perception of control increases and in turn adherence to treatment recommendations is enhanced.[63] A trusting environment is of great importance in the development of the Mercy Health Promoter model.

As the theoretical backbones of the Program, Watson's Theory of Human Caring has been utilized and emphasized throughout the Mercy Health Promoter program. Meanwhile, what Watson may call "medical caritas" has been applied by taking cues from Carolyn Tucker and her colleagues' need for "culturally competent and culturally sensitive healthcare" for individuals of cultural diversity.[64] Tucker's Three criteria of Cultural Competence/Patient Centered Healthcare are as follows:

(a) it emphasizes displaying patient-desired, modifiable provider and staff behaviors and attitudes, implementing health care center policies, and displaying physical health care center environment characteristics and policies that culturally diverse patients identify as indicators of respect for their culture and that enable these patients to feel comfortable with, trusting of, and respected by their health care providers and office staff;

(b) it conceptualizes the patient-provider relationship as a partnership that emerges from patient centeredness; and

(c) it is patient empowerment oriented.[65]

The Mercy Health Promoter program serves as a methodological ideal proving success in multicultural populations relating to preventative health care and successful treatment of disease and illness via integration of Watson's 10 carative factors and 10 caritas practices and acknowledging Tucker's criteria (a-c) of Cultural Competence/Patient Centered Healthcare. We find the need for integration of these philosophies to be particularly a critical requirement to provide adequate care for the Hispanic

[61] Ibid.; Peter A. Clark and Sam Schadt, "Mercy Health Promoter," *Medical Science Monitor: International Medical Journal of Experimental and Clinical Research* 19 (2013): 807–17. doi:10.12659/MSM.889651.; Ochasi and Clark, "Mercy Health Promoter Model."

[62] Clark, "Mercy Health Promoter Model: Collaborating."

[63] White et al., "Health Literacy, Physician Trust, and Diabetes-Related Self-Care Activities in Hispanics with Limited Resources," *Journal of Health Care for the Poor and Underserved* 24, no. 4 (November 2013): 1756–68. doi:10.1353/hpu.2013.0177.; Marylyn Morris McEwen and Joyceen Boyle, "Resistance, Health, and Latent Tuberculosis Infection: Mexican Immigrants at the U.S.-Mexico Border," *Research and Theory for Nursing Practice* 21, no. 3 (2007): 185–97.; Traylor et al., "Adherence to Cardiovascular Disease Medications: Does Patient-Provider Race/ethnicity and Language Concordance Matter?" *Journal of General Internal Medicine* 25, no. 11 (November 2010): 1172–77. doi:10.1007/s11606-010-1424-8.; Nam et al., "Barriers to Diabetes Management: Patient and Provider Factors," *Diabetes Research and Clinical Practice* 93, no. 1 (July 2011): 1–9. doi:10.1016/j.diabres.2011.02.002.; J. Hornberger, H. Itakura, and S. R. Wilson, "Bridging Language and Cultural Barriers between Physicians and Patients," *Public Health Reports* (Washington, D.C.: 1974) 112, no. 5 (October 1997): 410–17.

[64] Carolyn M. Tucker et al., "Assessments for Measuring Patient-Centered Cultural Sensitivity in Community-Based Primary Care Clinics," *Journal of the National Medical Association* 99, no. 6 (June 2007): 609–19.

[65] Ibid.

population due to differences in cultural beliefs, language barriers, differences in lived experiences, barriers of trust, and perceived loss of control when seeking health care.

In the following, we will explain how the carative concerns are relevant to the health promotion program, as we lay out the goals of the Mercy Health Promoter Program correlative to the Watson and Tucker's criteria.

Goal #1: Establish a community-based environment involving the participation of trained Health Promoters and volunteers within the community. This Mercy Health Promoter goal is achieved through implementation of carative factors 1-3 of Watson's Theory of Human Caring and criteria (a) of Tucker's Cultural Competence/Patient Centered Healthcare.[66] To accomplish this, Mercy Health Promoters maintain bilingual languages and seek to understand one's culture as an effort to gain trust. Also, the Mercy Health Promoters, as part of the Catholic Healthcare System, do not report to the U.S. Citizenship and Immigration Services (USCIS), formerly called the Immigration and Naturalization Service (INS), and Mercy Health Promoters acknowledge and disclose to the people that Philadelphia is a sanctuary city. This particular commitment, the Promoters find, is to be of the basic trust essential to build the community-based environment mentioned here.

Goal #2: Focus on preventive care and/or the management of chronic diseases and other complex conditions through medical and health education in order to improve the health of marginalized people of the impoverished immigrant communities of Philadelphia. This Mercy Health Promoter goal is achieved through implementation of carative factors 4-6 of Watson's Theory of Human Caring and criteria (b) of Tucker's Cultural Competence/Patient Centered Healthcare.[67] As stated above, the Mercy Health Promoters seek to understand one's culture as an effort to gain a trusting and caring relationship. Mercy Health Promoter qualifications include; trusted and respected in the community, service-oriented, knowledgeable about the community and its members, team-oriented, responsible, and unbiased. This is manifested in our gestures and attitude through our greeting and collaborative efforts with patients and the community.

Goal #3: Provide adequate health care services with the help of local organizations in the surrounding area, as well as, guide patient health with a proposed course of treatment. This Mercy Health Promoter goal is achieved through implementation of carative factors 7-10 of Watson's Theory of Human Caring and criteria (c) of Tucker's Cultural Competence/Patient Centered Healthcare.[68] The main role of the Mercy Health Promoters is to; screen patients and to offer medical and health-related advice and education based on blood pressure readings, blood glucose, and cholesterol levels, and height and weight measurements. Health Promoters are trained depending on the specific needs and concerns of the community determined. Health Promoters are trained in exercise, sanitation, nutrition, and chronic medical diseases. They are also trained in patient documentation, communication skills, patient confidentiality and sensitivity, and clinical techniques as stated above.

Goal #4: Lower or eliminate the costs of health care for uninsured and underinsured individuals and exhibit cost-effectiveness for the community, hospitals, program sponsors, and health care providers.[69] This goal is achieved through implementation of all Carative Factors 1-10 of Watson's Theory of Human Caring and all criteria (a-c) of Tucker's Cultural Competence/Patient Centered Healthcare.

THE INTERDISCIPLINARY CARATIVE CARE CURRICULUM

The Interdisciplinary Health Services (IHS) major at Saint Joseph's University, has developed a unique curriculum focusing on the carative model of health care with emphasis on public health disease prevention.[70] Instituted in the Health Services Department, all senior undergraduate students in the IHS major are required to take a capstone class as a way to synthesize key themes in healthcare by review of critical concepts and material learned throughout their time at the university. This major relies heavily upon the student's ability to take real-world examples of health care issues and develop appropriate interventions based upon readings, concepts presented in other health services classes, and healthcare resources from research and governmental

[66] Erci et al., "The Effectiveness of Watson's Caring Model."; Tucker et al., "Assessments for Measuring."

[67] Ibid.

[68] Ibid.; Tucker et al., "Assessments for Measuring."

[69] Clark and Schadt, "Mercy Health Promoter"; Clark, "Mercy Health Promoter Model: Collaborating."

[70] "Curriculum," Saint Joseph's University Academics College of Arts and Sciences Interdisciplinary Health Services, last modified May 10, 2016, http://www.sju.edu/int/academics/cas/interdisciplinaryhealthservices/curriculum.html.

[71] Ibid.

agencies. Primary learning objectives for this course include "demonstrating how the biopsychosocial determinants of health affect an individual's physical and mental well-being; demonstrating an understanding of the complexities of the United States health care delivery system and constructing a framework to address these issues; demonstrating knowledge of the process of health promotion planning; and demonstrating how healthcare is impacted by a vast interdisciplinary network of forces such as the legal, economic, political, sociological, ethical, technological, and global."[71]

The Mercy Health Promoter program communicated a need for informational health material to both train community health promoters and educate members of the Hispanic community in Norristown, PA. Based on the data from CDC, Saint Joseph's University's ICB has identified nineteen medical conditions the Hispanic immigrant populations are particularly vulnerable to as compared to the most common leading causes of death in the United States – that is, heart disease, hypertension, diabetes, sexually transmitted diseases, obesity, nutrition, women's health, mental illness, prenatal care, tobacco/alcohol use, drug abuse, cancer screening, vision screening, HIV/AIDS, oral health, health literacy, maternal health, newborn care and vitamin deficiencies.

Based upon these 19 disease states, collaboration between the IHS senior students and the ICB was formed in the fall 2015 to meet the need described above. As part of a senior research project, students in the IHS Senior Capstone course researched, created, formatted, finalized, and brought to print 19 detailed health and wellness educational pamphlets for this purpose. The prevalence of medical issues, in the United States, is addressed in each of the 19 pamphlets, and each pamphlet is designed specifically for the Hispanic immigrant population. Pamphlets discuss the signs and symptoms, risk factors, treatment options, warnings, statistics, and recommendations for disease prevention in support of patient educational needs of the Mercy Health Promoter program.

Research for these pamphlets included the use of Watson's Theory of Human Caring and Tucker's Cultural Competence/Patient Centered Healthcare criteria. To include Watson's Theory of Human Caring, students researched information which would develop a trusting caring relationship between Hispanic patients and Mercy Health Promoters. This included information which was based upon current reading level of patients and the inclusion of diagrams which could be easily understood regarding symptoms, diagnosis, treatment and prevention of medical conditions. Students utilized researched materials which provided Mercy Health Promoters with teaching experiences and tools to help with problem solving and disease state challenges. This included blood pressure charts, diabetes monitoring, and nutritional calorie counting tools which could easily be implemented into a patient's daily routine. Students researched and utilized simple charts and tables which would provide teaching and learning of the whole person to include patients and caregivers. This included women's health check-up calendars, mental health awareness, signs and symptom charts for depression and anxiety, and cancer screening techniques. To include Tucker's Cultural Competence/Patient Centered Healthcare criteria students placed emphasis on items which displayed respect for individual culture, images providing comfort and trust, introduction of material to enhance a successful patient-provider relationship and information with specific focus on the patient. Lastly, students created the pamphlets to provoke patient empowerment utilizing text, formatting, diagrams and images to successfully accomplish this. Students had the opportunity to take their pamphlets to scheduled Mercy Health Promoter clinics and see first-hand integration of carative care during patient education sessions, the recognition of accomplished stages from Watson's and Tucker's theories, and the ongoing positive outcome which resulted from their pamphlet use. This research project and courses within the IHS curriculum utilize the carative care-based Mercy Promoter's model to educate students.

Potential strategies to improve the Mercy Health program and integrate a carative care approach for students, were continued in the spring 2016. These initiatives included; audio/visual education created for each of the 19 pamphlet topics (created within the spring Saint Joseph's University Interdisciplinary Health Services Senior Capstone course). Ongoing efforts within the ICB and the Mercy Health Program include exercise routines translated into Spanish, pedometers/jump ropes, nutritional education including health meal preparation, breast cancer awareness to include detection and awareness, ongoing dental health education to include dental caries, tooth decay and cavities, home visits and Mercy Health Promoter telephone calls. Research projects to include Saint Joseph's University students, in each area above, are currently being planned for upcoming semesters. The IHS major incorporates the philosophy of carative health care and based upon seen positive effects on health care providers, patient care, community, and multicultural backgrounds, we believe this program of study can be the paradigm for all similar university curriculum.

CONCLUSION

[71] Clark and Schadt, "Mercy Health Promoter"; Clark, "Mercy Health Promoter Model: Collaborating."

As the Hispanic immigrant population continues to grow, disease prevention is necessary and medical education to support this area is imperative. Understanding the shift from curative care to carative care is required. Implementation of Watson's Theory of Human Caring can aid in the successful understanding and implementation of this shift. The Mercy Health Promoter program was created as a collaborative effort between the Mercy Hospital of Philadelphia and the Institute of Clinical Bioethics (ICB) of Saint Joseph's University. A primary goal set forth is to offer accessible health education and awareness in poor communities where individuals do not receive the proper health care they require. An additional goal is to promote disease prevention so rising medical issues can be prevented within the local immigrant population. Additionally, there remains the ethical goal to maintain human dignity and move towards a carative care approach. By providing education on healthy lifestyles and information on locations to access affordable or fee health care, future complications and certain medical conditions can be prevented. The Mercy Health program has proven to be a success, as patient participation has grown over time and the organization has improved through the use of a carative care approach. Not only has the Mercy Health Model incorporated Watson's Theory of Human Caring but its success is also based upon the integration of Tucker's Cultural Competence and Patient Centered Healthcare criteria. Both Watson's Theory and Tucker's Criteria focus on principles needed for successful implementation of carative care. Utilization of a Saint Joseph's University interdisciplinary carative care curriculum, with the Mercy Health Promoter Program, in collaboration with the Saint Joseph's University ICB maintains focus on each goal above with specific focus to promote improved health care outcomes in the Hispanic immigrant population. This medical education initiative is consistent with the mission of Saint Joseph's University. As a Jesuit Catholic University, Saint Joseph's University strives "to be an inclusive and diverse community that educates and cares for the whole person, we encourage and model lifelong commitment to thinking critically, making ethical decisions, pursuing social justice, and finding God in all things" as stated in the Saint Joseph's University Mission Statement. Collaborative medical education efforts also prepare students to confront the social justice inequities inherent in the society, as well as, enrich the mission of the ICB providing preventive services to the undocumented and uninsured. Medical education initiatives seek to respect the fundamental dignity of these immigrants providing them with educational resources to make informed decisions about health. Distributive justice demands that we become responsible stewards of resources. Within the context of healthcare, stewardship of resources incorporates the responsibility to show concern and care for scarce medical resources. Ongoing collaborative medical education efforts will likely further improve the health of the Hispanic immigrants participating in the Mercy Health Promoter program. Given the prevalence of many chronic medical conditions along with the social and cultural issues facing the Hispanic immigrant community, there are many measures that could be taken in the future to further enhance patient health and wellness.

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