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The Plight of ALC Patients: A Call to a “Revolution of Tenderness”

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WHAT IS AN ALC PATIENT?

“ALC” stands for “Alternate Level of Care.” In Ontario, a patient is classified as ALC when the person “is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting...The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination (or when the patient’s needs or condition changes and the designation of ALC no longer applies).”¹ In other words, patients who continue to occupy hospital beds while no longer needing the high level of care normally provided in the hospital setting are to be designated as “ALC.” In Ontario at the end of February 2014, acute care beds were occupied by 2416 ALC patients; of these 29% were waiting for transfer to long-term care facilities.²

This article will focus on a particular ALC population: those persons who have been treated for an acute illness or event but who cannot be discharged because underlying chronic conditions prevent them from living independent lives, and for whom there are neither the needed community services nor institutional spaces available post-discharge. They have no place to go.

WHY ARE ALC PATIENTS A “PROBLEM”?

From a Catholic bioethics perspective, health care exists to serve persons. This means, among other things, that persons should receive the care that they require in the setting most conducive to their needs. To keep a patient in an acute care setting when acute care is no longer needed does not serve the patient. Indeed, acute care hospitals can be harmful environments for elderly persons with chronic conditions, exposing them to risk of infections, and leading to confusion and loss of independent functioning.³ Being left to linger in a hospital bed usually does not serve the best interests or wellbeing of patients and so is problematic.

For those who may be more centred on the wellbeing of the health care system, ALC patients pose a very different problem. They are perceived as being bed-blockers, as consuming costly, inappropriate resources in an already burdened system, and as being at least partly responsible for long emergency waits, delayed admissions and cancellations of elective surgeries and procedures.⁴ In this view, the patients themselves are the problem, contributing to inefficiencies in a hospital-based health care system. Of course the questions are: Why are the patients still occupying those beds? Why is there no place for them to go?

THE PRIORITY OF ACUTE CARE

At this time in Ontario, a great deal of money goes into health care, with hospitals receiving the greatest single portion of that money. In 2010-2011, for instance, 40.3% of the government's spending on programs, or almost \$45 billion, was allocated to health care. Thirty-four percent of the health care budget (or \$15.53 billion) was spent on hospitals—while long-term care facilities and community care received \$2.68 billion and \$3.44 billion, or 6.0% and 7.7% respectively.⁵

Hospitals can be miraculous places with technological interventions saving lives that would otherwise be lost, and treatments for acute conditions returning people to health. But not all patients in Ontario are in need of acute care. According to the Quality Hospice Palliative Care Coalition of Ontario, one out of every three people in Ontario lives with one or more chronic conditions. For persons 65 and older, that rate climbs to four out of five people, with 70% of them having two or more chronic conditions.⁶ This means that many people being treated for acute episodes also have chronic conditions, conditions that will remain even after the acute condition has been resolved. The fact is, the patient population profile in Ontario is changing even as we continue to give priority in funding to acute care.

PATIENT-CENTRED CARE

Treatment has value only insofar as it serves the patient. And while it is easy to be mesmerized by the developments in acute care, there are many, many people who, while not needing an ICU bed or an organ transplant or surgery, nevertheless require care. They have chronic conditions that

necessitate monitoring and ongoing interventions; they need help with tasks of daily living; they may have mobility issues or perhaps cognitive impairments. They have conditions that cannot be cured and yet these patients may have a life expectancy of many years.⁷ Furthermore, their loved ones may need assistance in caring for them if they are to remain in their homes, or the reassurance that patients won't be "warehoused" if they are institutionalized. There is a need for a robust, well-funded program of palliative care.

PALLIATIVE CARE

Often palliative care is equated with care of the dying. While end-of-life care may be a common component of it, in fact, palliative care has a more general meaning, referring to care that is not aimed at cure. It attends to patients in their chronic illnesses and infirmity, addressing their needs and quality of life. With the focus of health care set so firmly on acute care, it can be easy to reduce palliative care to being the thing that isn't acute care, or perhaps its fallback when acute interventions don't work. However, palliative care has a great deal of value in its own right:

"The palliative care approach focuses on person and family, and on their quality of life throughout the illness, not just at the end of life. It reinforces the person's autonomy and right to be actively involved in his or her own care—and strives to give patients and their families a greater sense of control ... [It is] an approach to care that can enhance quality of life throughout their illness."⁸

Palliative care is patient-centred and holistic, addressing not only symptom management

but psycho-social and spiritual aspects of wellbeing. It is multidisciplinary and relies on communication and connection, respecting the skills and compassion that all caregivers bring to the table. It recognizes that the patient exists within a network of relationships; families, too, are involved and may themselves be the receivers as well as givers of care. While unable to provide cure, palliative care can nevertheless do a great deal to empower patients and enhance the quality of their lives in their given circumstances.

These are good things. However, there are further benefits: studies show that palliative care keeps patients out of emergency rooms and leads to shorter hospital stays when there are admissions, both of which lower health care costs overall.⁹ Palliative care also benefits loved ones who provide care. It was found, for instance, that “Caregivers of people with cancer who have access to a palliative care approach early in their loved one’s treatment reported significantly less decline in their psychological, social, and spiritual quality of life scores.”¹⁰ It is care that serves patients and their families and contributes to a more effective health care system.

A CAVEAT

With the fears that our current health care system is unsustainable and the priority that is given to acute care, at this point, palliative care for chronic conditions seems to be used as a way of moving patients out of costly hospital settings and into the hands of poorly paid, and even unpaid, caregivers. It is as if this very vulnerable patient population and its caregivers are targeted to bear the brunt of cost savings in our system of health care.

This degradation of patient and caregiver becomes an issue of justice.

How is it fair to tell an elderly woman that her husband’s acute episode has been resolved, that he will be released into her care, and that she will have ten hours a week of assistance when he may have dementia or perhaps mobility issues? Unless she has family members to call on, or the means to hire further assistance, she will be left on her own for the remainder of that week, leaving her open to health problems brought on by stress and the physical challenges of caring for her husband.

In the same way, among the most poorly paid health care workers are those whose job it is to spend hands-on time with patients—the personal support workers. Our most vulnerable patients are literally in their hands, and yet, if judged solely by pay scales, their importance and skills are hardly recognized by the health care system.

It might be argued that bathing a patient with mobility difficulties is not the same as, say, performing brain surgery and so it only makes sense that acute care should have priority and receive the bulk of Ontario’s health care funding. On the other hand, is bathing a patient unimportant? For the person who does not need brain surgery but who does need a bath from someone who is skilled and kind, who talks to the patient and treats her as a person with dignity, the bath becomes a point of healing contact and can be very important indeed.

To serve patients and the community properly, palliative care for chronic conditions must be recognized as a vital

piece in the process of continuity of (patient-centred) care—and funded that way.

CONCLUSION

How valuable is palliative care for chronic conditions? In his exhortation, *Evangelii Gaudium*, Pope Francis wrote about the importance of open and authentic encounters between persons:

“Many try to escape from others and take refuge in the comfort of their privacy or a small circle of friends, renouncing the realism of the social aspect of the gospel. For just as some people want a purely spiritual Christ, without flesh and without the cross, they also want their interpersonal relationships provided by sophisticated equipment, by screens and systems which can be turned on and off on command. Meanwhile, the Gospel tells us constantly to run the risk of a face-to-face encounter with others, with

their physical presence which challenges us, with their pain and their pleas, with their joy which infects us in our close and continuous interaction...The Son of God, by becoming flesh, summoned us to the revolution of tenderness.”¹¹

Rather than being a “problem” it is possible that ALC patients are pointing to the need for a more patient-centred and effective health care system that includes a coordinated, well-funded system of palliative care for those living with chronic conditions. In this, they may be calling us to a “revolution of tenderness.” ■

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Note: This article is based on “Transitions in Care Planning: Ethical Issues,” a presentation made by Bridget Campion, PhD, at the CCBI Symposium, Transitions in Care Planning, in April 2014.

¹ Cancer Care Ontario, “Alternative Level of Care” <https://www.cancercare.on.ca/ocs/alc/> (accessed April 2014).

² Access to Care, “Alternate Level of Care (ALC)” www.oha.com/Current/Issues/Documents/Feb%2014%20OHA%20Release.pdf (accessed April 2014).

³ Rory Fisher, “The Frail Elderly and the Health Care System” in *Proceedings of Our Lords the Sick, Our Lords the Poor: A Symposium in Honour of the 900th Anniversary Year of the Order of Malta*, ed. Bridget Campion and Rory Fisher (Toronto: CCBI, 2014), p. 10.

⁴ UBC Centre for Health Services and Policy Research, “How Are Hospitals Funded in Canada?” <http://healthcarefunding.ca/current-funding/post-acute-care/> (accessed April 2014).

⁵ Ontario Ministry of Finance Committee on the Reform of Ontario’s Public Services, ch. 5, “Health” <http://www.fin.gov.on.ca/en/reformcommission/chapters/ch.5.html> (accessed April 2014).

⁶ The Quality Hospice Palliative Care Coalition of Ontario, “Hospice Palliative Care Facts” www.hpcco.ca/qhpcco/ (accessed April 2014).

⁷ The Way Forward, “Backgrounder: The Palliative Approach: Improving Care for Canadians with Life-Limiting Illnesses” [www.hpcintegration.ca/media/36484/The%20Palliative%20Approach%20\(final\).pdf](http://www.hpcintegration.ca/media/36484/The%20Palliative%20Approach%20(final).pdf) (accessed April 2014) The Backgrounder notes that “people with chronic illnesses are living much longer between diagnosis and death, and the burden of chronic disease on individuals, families, and the health care system is growing.”

⁸ Ibid.

⁹ Ibid.

¹⁰ Ibid.

¹¹ Pope Francis, *Evangelii Gaudium* (November 2013) http://w2.vatican.va/content/francesco/en/apost_exhortations/documents/papa-francesco_esortazione-ap_20131124_evangelii-gaudium.html (accessed April 2014).