

Moving Ethics into Ambulatory Care: The Future of Catholic Health Care Ethics in Shifting Delivery Trends

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(Editor's Note: In an effort to further this conversation, we invite brief (500-700 word) responses/commentaries to this article dealing with 1) additional ethical issues in the outpatient setting, and/or 2) efforts being made to move ethics (or mission) into ambulatory care. As many responses/commentaries as possible will be published in the summer issue of HCEUSA. Responses/commentaries can be emailed to rhamel@chausa.org).

Introduction

Until recently, health care delivery tended to take place in inpatient settings. As the landscape of health care changes, a growing proportion of care is delivered in the outpatient setting. In outpatient (or ambulatory) care, the patient is admitted, treated and discharged on the same day. Outpatient visits include primary and preventive care through a range of services such as wellness exams, diagnostic procedures, minor surgeries, and cancer treatments.

Significant changes are occurring in the use of outpatient services. For example, inpatient

admissions to community hospitals decreased by 10 percent between 1987 and 2007, and the number of total inpatient days for admitted patients declined by more than 30 percent. Following this same trend, the percentage of outpatient surgeries at community hospitals rose from 44 percent to 63 percent between 1987 and 2007. Moreover, the shift from inpatient to outpatient care is manifest in revenue trends. In 1987, 19 percent of revenue for community hospitals was from outpatient visits. By 2007, the percentage of outpatient revenue doubled.¹ In 2011, there were over 100 million outpatient visits at Catholic hospitals.²

Several factors contribute to the shift from inpatient to outpatient care. First, although the expansion of outpatient care began prior to recent health reform initiatives, ongoing reform and the Affordable Care Act (ACA) will sustain the trends. As a result of the ACA, fewer patients will be uninsured and thus demand for services will increase.³ Pay-for-performance models (replacing fee-for-service models) incentivize preventive care delivered in outpatient offices.⁴ Moreover, Medicare reimbursement policies encourage reduction in readmissions to hospitals.⁵ Second, technological development contributes to increased use of ambulatory care. Better diagnostic tools enable providers to address issues before they require inpatient care, and minimally invasive surgery allows more procedures and treatments to be done without inpatient admission. Finally, chronic disease is rising across various demographics.⁶ Management of chronic disease increases demand for outpatient services and delivers better results than simply treating acute episodes. Because of the ACA, technological developments, and the rise of chronic disease, outpatient care is becoming and will remain the locus of patient care.

As outpatient settings become the primary site for care delivery, providers experience new kinds of ethical issues. Yet, ethics services (that is, the department or group of individuals that provide ethics education, consultation, and policy development in a given entity or group of entities, a.k.a., “ethics”) tend to lack a presence in outpatient facilities, and outpatient providers are often not aware of ethics services or how to access ethics resources. Ethics services should reach all providers in an organization and the resources that “ethics” provides should be applicable to

the particular contexts within which providers work.

In this article, we will first explain two aspects of outpatient care that give rise to new ethical issues. Then, we will argue for the necessity of developing new ethical tools and procedures to adequately address the kinds of ethical issues outpatient providers experience. We will conclude with some reflections on the sorts of tools and procedures that ethics may need to cultivate in order to improve and expand its presence in outpatient settings.

Ethical Issues in Ambulatory Care: A Sampling

Ethical norms and practices emerged in the second half of the 20th century in acute care facilities. The development of ethics within the acute care context had two primary effects on the structure and content of ethics. First, it caused the structure of ethics to take the form of the ethics committee and consultation service. With this structure, ethics resembles other medical specialties a hospital caregiver can consult for an expert’s opinion. In-person conversations and consultations are practically convenient because stakeholders are immediately accessible within the hospital. Second, the acute care context caused the content of ethics to emphasize a narrow range of issues pertaining to acute, inpatient crises at the beginning-of-life and end-of-life. It has tended not to focus on broader issues often encountered in outpatient settings, including practical issues such as managing chronic illness, and broader theoretical notions such as virtue, prudential judgment, or the meaning of healing.

As it currently stands, however, Catholic ethics lacks attention to outpatient care. The setting of care delivery shapes the ethical questions providers experience. Ethics services should be aware of the particular ethical questions and needs providers in different care settings experience and provide ethics resources across the entire continuum of care. Although some ethics topics such as informed consent, advance care planning, and privacy are relevant in both inpatient and outpatient care, the outpatient setting presents other distinct issues to which ethics must attend.

One challenge of the outpatient setting that has special relevance for ethics is coordination of care, compliance, and follow-up.⁷ In the inpatient setting, patient compliance is less challenging because of the controlled environment. In contrast, the efficacy of outpatient medical care relies upon patient compliance and disclosure. What are providers to do when patients continue to seek outpatient services but do not or cannot comply with the agreed upon treatment regimens? And, motivating and enabling providers to take time to do appropriate follow-up on patients, especially non-compliant patients, is challenging. Although a phone call is a small gesture that can dramatically improve compliance or coordination of care, providers cannot bill for this efficient means of follow-up.

Moreover, providing care in outpatient settings often results in a lack of communication between providers and thus a lack of coordination of treatment plans. Failure to coordinate care or help patients coordinate care is ethically problematic because it may lead to poor patient experience and outcomes.⁸ When patients face the

challenges of being bounced between providers, they may not only feel frustrated but also give up on pursuing care. Difficulties with the coordination of care are also problematic because they generate unnecessary use of repeat services.

A second new issue for outpatient providers concerns questions of justice and discrimination. Because of the 1986 Emergency Medical Treatment and Active Labor Act (EMTALA), inpatient providers are not personally responsible for determining whether or what kind of insurance is required for admission.⁹ In an outpatient setting, however, providers may confront the pressures of managing payments and excluding some patients more personally and directly. Outpatient providers must ensure their practice is sustainable. Managing the sustainability of a practice means choosing what kinds of insurance to accept and what to do about requests for care from patients without insurance. For example, providers may realize that their Medicaid patients are so numerous that the fiscal stability of the practice is jeopardized. Providers may be personally faced with the tension between sustaining their practice and discriminating against certain patient populations or insurance plans.

Coordinating care and sustaining outpatient practices are two of the many examples of the kinds of moral issues that arise in outpatient settings. In general, ethics does not reach outpatient providers very effectively or specifically. Ethics education tends to focus on inpatient cases and topics. Catholic health care must develop new moral tools, procedures and modes of engagement to

adequately address moral issues that arise in outpatient care.

The costs will be high if Catholic health care fails to cultivate ethics practices and resources specific to outpatient care. Equipping outpatient providers with moral tools and resources promotes quality patient care. Moreover, as more care is delivered in the outpatient setting, the coherency and internalization of organizational mission and ethics depends upon its presence. If ethics does not reach out to outpatient providers, it will become distanced from what is becoming the primary site of contact between patients and providers.

Expanding Ethics to the Outpatient Setting

Becoming aware of changes in health care delivery and new challenges for ethics in the outpatient setting is the first step in developing an ethics program that responds to ethical issues system-wide, across the whole continuum of care. Once aware of the deficiency in attention to outpatient settings, the first task of ethics must be to help providers recognize ethical dilemmas in those settings. The dilemmas that arise in outpatient care are not the flashy kinds of moral issues ethicists have discussed for the last forty or so years. Often, the dilemmas are easier to overlook or to write off as insignificant. Ethics services will need to initiate conversations with providers to raise awareness of moral issues and develop new ethics resources and procedures to make ethics accessible and useful beyond the hospital. In short, expanding ethics to the outpatient setting means that ethics services must begin to engage outpatient providers in conversation.

Structural differences between inpatient and outpatient settings create practical challenges for the expansion of ethics to outpatient care. Whereas the structure of the hospital enabled the delivery of education through large ethics programs during grand rounds or over lunch, the delivery of ethics educational programs throughout many small, disparate, independently functioning outpatient offices raises practical challenges. In addition to education, ethics also needs to provide a consultation resource for outpatient providers when they face a taxing dilemma for which some assistance would be helpful. The consultation formats of the interdisciplinary ethics committee or the in person consultant both seem inapplicable for outpatient providers because of the practical and geographical hurdles of the more isolated context of outpatient care. Providers working in disparate locations may connect most easily on conference calls or video meetings. Perhaps a virtual gathering akin to the ethics committee could happen between outpatient providers. Or, a committee model may be altogether unrealistic. Perhaps a single professional ethicist should be hired to provide consultation and to facilitate collaboration and communication among outpatient providers.

Most importantly, ethics needs to be attentive to preserving, applying, and interpreting the content of its Catholic identity as it moves into the outpatient setting. One necessary way to do so will be to carefully examine how themes of Catholic moral theology, traditions in medical ethics, and in particular the *Ethical and Religious Directives for Catholic Health Care Services* (ERDs) provide guidance in the context of outpatient care. Ethics may also realize that the ERDs are not currently

sufficient to addressing these new issues. For example, interpreting the tradition of ordinary and extraordinary means¹⁰ for a decision made prior to an acute crisis (as has occurred in recent discussions of advance directives and POLST forms) raises new questions.¹¹ Can the notions of ordinary and extraordinary be determined in the outpatient context such that an outpatient provider could write an immediately and universally effective DNR order? Understanding the meaning of these long-standing principles in the context of outpatient care will not only provide guidance in resolving moral dilemmas, but also become prescriptive for good practices and patient care. Conversation among clinicians, health care ethicists and academicians is crucial to developing new ideas for new situations based upon sustained moral ideologies.

Conclusion

The reality is that the ethics practices of education, committee meetings, and consultation have emerged because they are compatible and convenient within the context of the hospital. They are unrealistic ways for ethics to function well in the outpatient context. The procedures by which ethics will be practically able to expand into the outpatient setting require creative and innovative thinking. Ethics needs to provide more moral guidance on the more vague and underemphasized issues that arise in outpatient care. Ethics needs to help providers think about caring for patients with chronic diseases, managing the health of populations, dealing with non-compliant patients and relating organizational values to decisions about the provision of care. Most of all, ethics

needs to reach out to outpatient providers and support them with relevant resources. This move is of utmost importance. If ethics does not expand the content of moral reflection and the structure by which outpatient clinicians can engage ethics, it will fail to reach the bulk of care delivery and thus, underserve the mission and identity of Catholic health care.

(Ms. Barina and Ms. Trancik are also graduate students in health care ethics at Saint Louis University's Albert Gnaegi Center for Health Care Ethics).

¹ Tracy K. Johnson, "Ambulatory Care Stands Out Under Reform," *Healthcare Financial Management* 64 (2010): 57.

² "2011 American Hospital Association Annual Survey."

³ Kaiser Commission, "Medicaid and the Uninsured," <http://www.kff.org/uninsured/upload/1420-14.pdf>.

⁴ Johnson, "Ambulatory Care Stands Out Under Reform," 58-9.

⁵ Centers for Medicare & Medicaid Services, "Affordable Care Act Update: Implementing Medicare Cost Savings," <http://www.cms.gov/apps/docs/aca-update-implementing-medicare-costs-savings.pdf>.

⁶ Johnson, "Ambulatory Care Stands Out Under Reform," 59-61.

⁷ Ernlé W.D. Young, "Ethics in the Outpatient Setting: New Challenges and Opportunities," *Cambridge Quarterly of Health Care Ethics* 6 (1997): 294-5.

⁸ Perry A. Pugno, "Ethical Considerations of Electronic Communication in the Clinical Outpatient Setting," *The Journal of Clinical Ethics* 13, no. 4 (2002).

⁹ American Academy of Emergency Medicine, "EMTALA," <http://www.aaem.org/em-resources/regulatory-issues/emtala>.

¹⁰ USCCB, *Ethical and Religious Directives for Catholic Health Care Services*, 5th ed. (Washington, DC: USCCB, 2009), nos. 56, 57.

¹¹ Ron Hamel, "Ethical Currents: POLST Under Fire," *Health Care Ethics USA* 20, no. 1 (2012).