The Ethics of Challenging Hospital Discharges

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PRELIMINARIES

Objectives

- Identify ethical challenges in discharge planning
- Address limitations with discharge options in or to foster good communication
- Delimit the scope of ethical authority of patients, families, and healthcare providers for discharge decisions

Code of Professional Ethics
Comm. on Rehab Counselors Cert. (2017)

- A.1.e: The Counseling Relationship – Autonomy
- A.2.a/b: The Counseling Relationship – Respecting Culture/Nondiscrimination
- A.3: The Counseling Relationship – Client Rights
- C.1: Advocacy & Accessibility – Advocacy
- G: Assessment & Evaluation – Informed Consent

Code of Ethics
American Counseling Assoc. (2014)

- A.2: The Counseling Relationship – Informed Consent
- A.4: The Counseling Relationship – Avoiding Harm
- B.1: Confidentiality & Privacy – Respecting Client Rights
- B.5: Confidentiality & Privacy – Clients Lacking Capacity
- E: Evaluation, Assessment, and Interpretation

THE CHALLENGE

Three Kinds of Discharge Challenges: Cases

- Mr. P: Lack of (safe) discharge options
  - Multiple ailments
    - Cancer
    - Renal failure
    - Muscular atrophy
  - He wants to go home
    - Family might accept “near home”
- Ms. W: AMA discharge
  - Physical and mental health issues
  - No family/friends for support
  - When (barely) strong enough, demands to leave
- Ms. V: Unwillingness to accept discharge options
  - TBI, with trach on ventilator
  - Family insists on staying in hospital until she can go home

Obligation for Safe Discharge

- Moral Considerations
  - "Patients and family have a right to participate in discharge planning decisions and a right to a safe discharge." (Schlairet 2014)
    - An appropriate, safe, discharge plan, meets with legal obligations (Jankowski et al. 2009)

- CMS Requirements
  - "The hospital must have in effect a discharge planning process that applies to all patients." (24 CFR 482.43)
    - "The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge…" (24 CFR 482.43(a))

When Patients/Families Disagree w/Providers

- Planning
  - Establishing after-care resources (Berger 2008)
  - Options can be few and far between
- Protection
  - Incapacitated patients are more vulnerable
  - Policies can help
    - Involuntary mental health hold (AR law)
    - Involuntary medical hold (*not* AR law)
  - Resources may be available
    - Care resources – home help; respite care
    - Logistical help – transportation
    - State safeguards – APS

LIVING IN THE GAP

Moral Distress

Moral distress (middle ground) **=** *stress that arises when* you experience *your actions as BOTH*

1. *required (compelled or constrained)*

AND

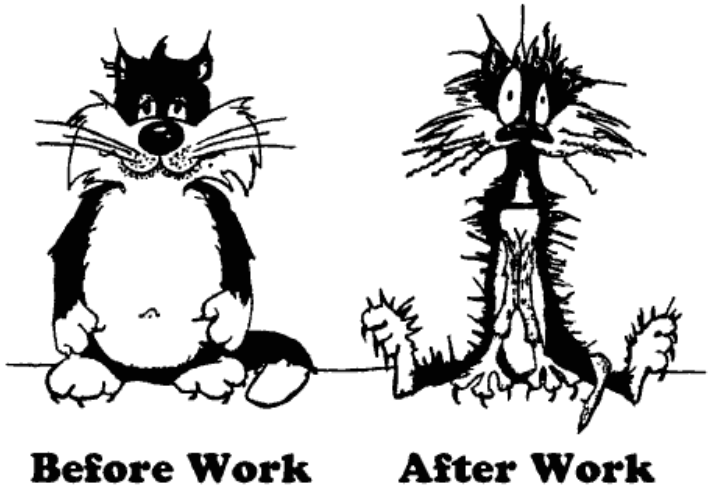
2. *as* possibly (a continuum from certitude to ambivalence) *contributing to moral badness*

Moral distress can arise when…

1. A *negative* moral evaluation is coupled with feeling compelled to act, and this produces stress
   - "X may be bad, but it's what the family wants."
2. A *positive* moral evaluation is coupled with feeling constrained from acting, and this produces stress
   - "X may be good, but I'm not empowered to do it."

What “Moral Distress” is NOT

- General Job Stress
- Purely Psychological Stress
- Everyday Moral Concern
- Negative Moral Evaluation of a Situation



MD, Part 1: Being Compelled

Compulsions

- Hierarchies within the healthcare system
- Socialization to follow orders
- Policies and priorities
- Perceived authority of others
- Fear of litigation

Constraints

- Lack of assertiveness
- Self-doubt
- Perceived powerlessness
- Lack of support
- Lack of understanding of the full situation

MD, Part 2: Possible Complicity

- Personal moral perception/evaluation
  - May evaluate with certainty: “I know the right thing”
  - May evaluate with caution: “I’m concerned that I’m contributing to bad care.”
  - May be quite uncertain: “I can’t tell what is best; so, I fear I may be doing something wrong.”

CAREFUL CONSIDERATIONS

Respect Patient Autonomy and Surrogate Authority

- Narrative Considerations (Hester 2001 & 2010; Torke, et al. 2008)
  - Based on a "reading" of the patient's life story
  - Complex, contextual, and relational
    - Places patient at the center of a confluence of family, culture, and environment
  - Fluid, dynamic, and inventive
    - Adjusts the "storyline" according the conditions that prevail and/or are anticipated to prevail
- Refusal, like consent, should be *informed*
  - "Dignity of risk" (Mukherjee 2015)
- Goals of Care

Goals of Medicine

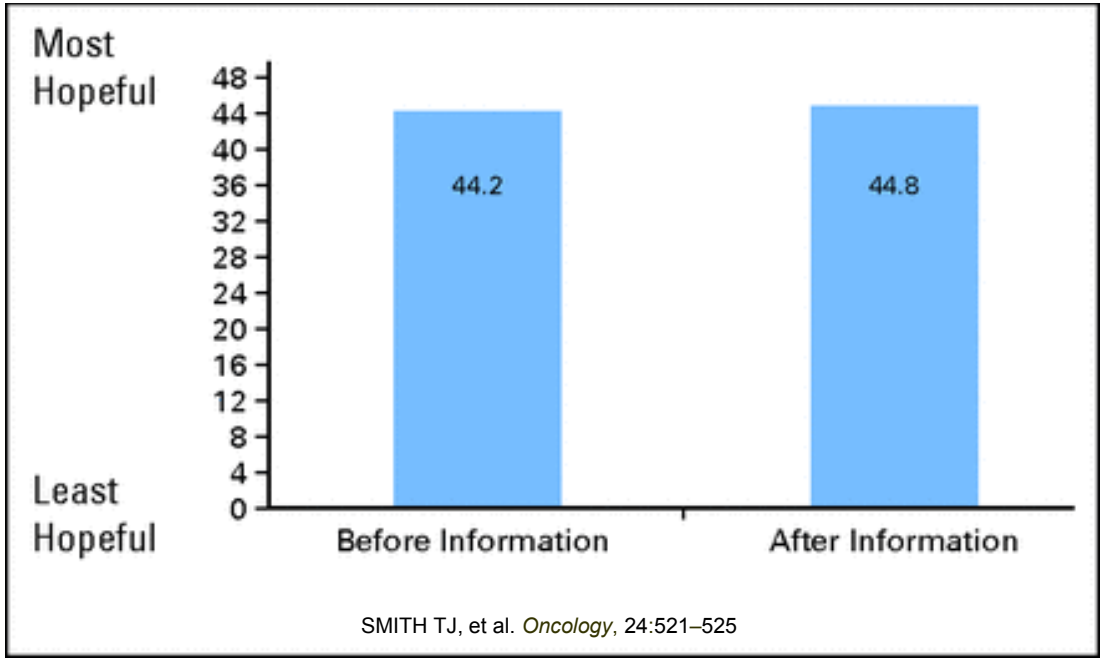
- Not “cure”
  - Negative
  - Limiting
- Living healthily
  - Positive
  - “Whole patient”-focused

Determining Goals of Care…

- What are the goals of care according to the patient/family? (What do they hope for and what do they fear?)
  - Why do they hold the goals they do?
    - What facts/information do they refer to in support of those goals?
    - What values and interests do they express in support of those goals?

The Role of Hope

- Patients (and families) carry hopes and fears
- HCPs should recognize those hopes and fears
- Information honestly and compassionately given does not undermine hope



SMITH TJ, et al. *Oncology*, 24:521–525

… Determining Goals of Care…

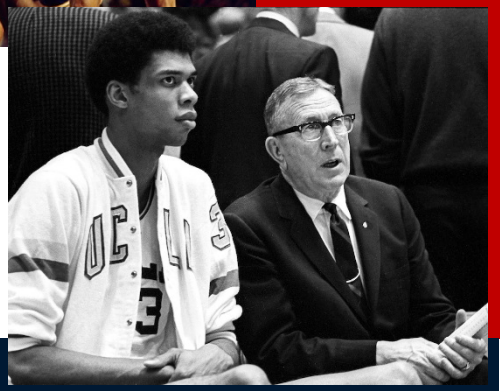
- Given their expressed interests and goals, what means (if any) are available and appropriate?
  - Are there significant barriers to achieving the goals?
    - Do those barriers arise from a conflict with
      - the law?
      - financing?
      - commonly accepted moral norms?
      - cultural differences?
      - psychological/cognitive factors?
      - your personal values?
      - your professional obligations?
      - your skills and abilities?
      - the limits of current medical science and technology?

Facts, Values, and Meaning

- Facts are important
  - Good practice begins with good facts
- Values influence how we understand facts
  - All understanding results from interpretation
- Meaning is what really matters
  - Values give meaning to facts

Relation of Facts and Meaning
Non-Medical Example

Claim: ***Kareem Abdul-Jabbar is the greatest basketball player ever.***



Fact: KA-J scored more points (38,387) than any other player in the history of the NBA.

Fact: KA-J won 6 NBA championships with 2 different teams.

Fact: KA-J won 6 NBA MVPs.

Fact: KA-J won three finals MVPs while leading UCLA to three consecutive NCAA championships (he was not allowed to play as a freshman on the varsity team).

Relations of Meaning to Facts
Medical Example

Claim: If Patient X arrests, ***CPR is futile for Patient X.***

Fact: Patient X is 78 years old.

Fact: Patient X has congestive heart disease.

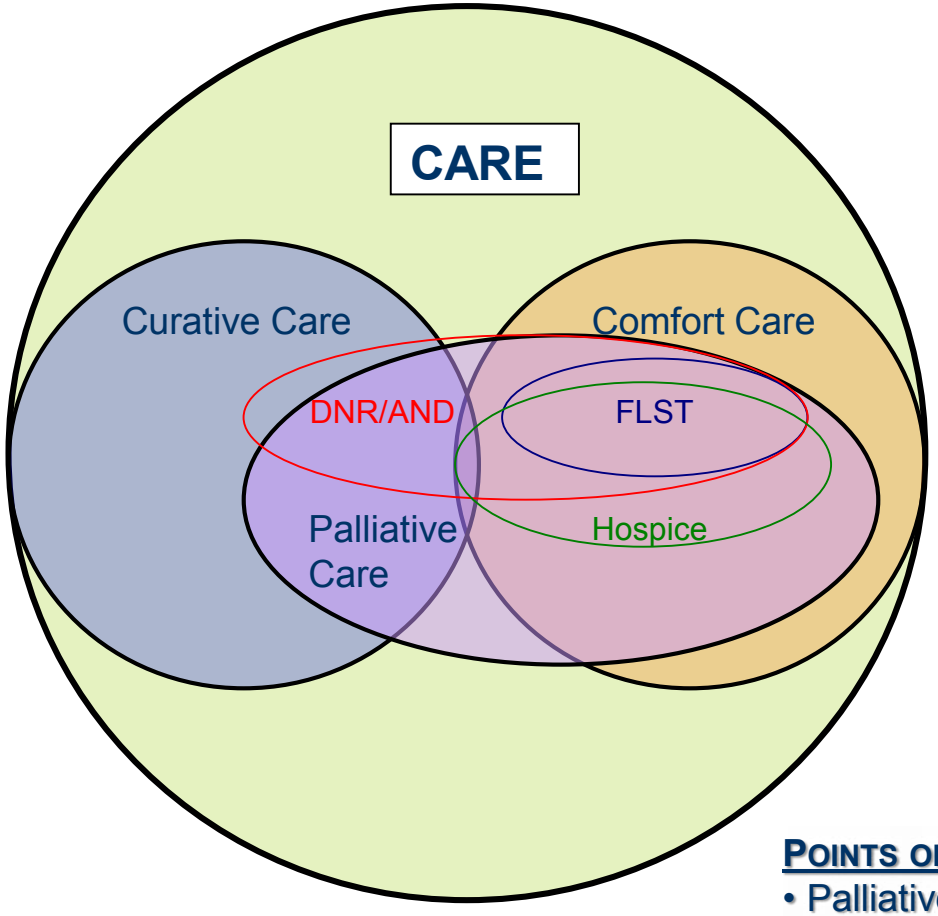
Fact: Patient X has arrested once already at another hospital before being transferred.

Fact: Less than 25% of adult patients who arrest in a hospital will leave the hospital alive. (FYI: approx. 10% who arrest outside hospital will survive)

… Determining Goals of Care

- Are there more reasonable goals for the patient/family to have (that is, should their goals be redirected)?
  - *Why* are they more reasonable given what you have learned about the condition and prognosis of the patient as well as the interests and goals of the patient/family?
  - What are the appropriate means to achieving these “more reasonable” goals?

Spheres of Care



Definitions

- **Curative Care** = primary focus on providing treatments intended to eradicate or diminish the effects of disease, injury, or illness
- **Comfort Care** = primary focus on providing treatments and support that provide comfort during the dying process.
- **Palliative Care** = specific focus on caring for the pain and suffering (physical and emotional) of patients and their support systems
- **DNR/AND** = Do Not Resuscitate/Allow Natural Death
- **FLST** = Forego Life-sustaining Treatments

Points of Interest

- Palliative Care is broader than Comfort Care
- DNR orders may exist even when other curative measures continue
- FLST entails Comfort Care and DNR orders
- Though atypical, hospice does not always require FLST
- Comfort Care allows a limited use of curative measures for the purpose of palliation