The Ethics of Challenging Hospital Discharges

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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
• 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
• 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
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

Before Work  After Work

And you thought there was stress in your life!
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

![Chart showing change in hope levels before and after information]

• 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
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).
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?
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