

## Discharge to the sidewalk? Yes, if they choose.

**ROBERT FULBRIGHT, J.D., M.A.**

There is no doubt that homelessness is a growing problem in California and the Bay Area. California's homeless population is approximately one fourth of the homeless population in the United States. There are a multitude of factors that led to this crisis and, unfortunately, there is no easy solution to resolve homelessness as a whole. Healthcare, however, may be able to make a meaningful improvement with respect to how this vulnerable population is treated within our society. As physicians, nurses, and other care providers continue to treat homeless patients as all patients should be treated, healthcare may pave the way in setting a tone necessary for positive change within the larger social context.

Since 2001, California Health and Safety Code 1262.5 has required hospitals to have a written discharge policy and process for all patients. In January 2019, hospitals were obligated to add a homeless patient discharge component to their policy and process. It was a pleasant surprise to learn from hospital staff that the biggest change for them with respect to treatment of homeless patients has been the increased documentation of their efforts, as required by the law. There has been no significant change in how the medical team and hospital staff treat homeless patients with respect to medical treatment or discharge planning. However, the law now reads as though the hospital has significant and new obligations when discharging homeless patients. For example, such obligations include referring a patient to follow-up care, offering a safe discharge plan, and offering a meal and weather appropriate clothing. These aforementioned obligations were written into law with the intent of helping prepare homeless individuals for their return to the community. Connecting this vulnerable population to available community resources, outpatient treatment, housing shelter, or supported services within the community will improve their opportunity for success following their hospitalization. Fortunately, many hospitals had already made these obligations common practice before the law became effective.

In hindsight, I should not have been surprised, as I have seen firsthand how physicians, nurses, and other caregivers do their best to ensure all patients have a safe discharge, especially when a patient's options are limited. I know this is true from the moment patients come into the hospital. In fact, I have found that the legal changes have acted as an affirmation that all patients should be treated equally whether the patient has a permanent residence or the patient is struggling with homelessness.



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▶ If you would like to receive this newsletter electronically, please email us at [ethics@sutterhealth.org](mailto:ethics@sutterhealth.org).





## 3 Reasons to Come to Paris This Summer!

### Neuroethics Network

The Neuroethics Network will be held **June 17-19, 2020, at ICM, the Brain & Spine Institute, Paris**. Brain scientists, clinicians, ethicists, and legal scholars will address the newest developments and application of neuroimaging, predictive biomarkers, animal rights in neurological research, placebo, and organoids. Discussion will center upon what these advances mean for the patient—and society—both at present and in the near future.

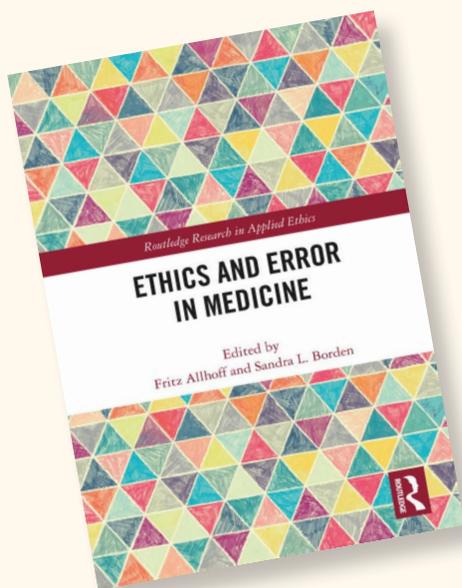
### International Bioethics Retreat

The International Bioethics Retreat will be held **June 24-26, 2020, at Reid Hall, Paris**. The retreat is unique among bioethics meetings in that experts in medicine, philosophy, law, and health policy are invited from around the world to present their current research projects.

### Cambridge Consortium for Bioethics Education

The 10th Cambridge Consortium for Bioethics Education will be held **July 1-3, 2020, at Reid Hall, Paris**. Tackling the hard questions and finding practical answers in teaching bioethics is the aim of the Cambridge Consortium for Bioethics Education. The meeting brings together international leaders in bioethics education and focuses on “how to” methods of teaching bioethics.

For details, visit [icmbioethics.com](http://icmbioethics.com). Please contact us if you would like further information about these conferences or have an interest in presenting at a future conference.



### Publication Spotlight: Ethics and Error in Medicine

Our Clinical Ethics Fellow Dr. Kelsey Gipe published a book chapter titled “Error and Determinations of Decision-Making Capacity in Mentally Ill Patients”.

Edited by **Fritz Allhoff**, Western Michigan University, and **Sandra L. Borden**, Western Michigan University.

**Routledge**, 2019

This book is a collection of original, interdisciplinary essays on the topic of medical error. The contributors include top scholars and practitioners working in bioethics, communication, law, medicine and philosophy. Their contributions examine preventable causes of medical error, disproportionate impacts of errors on vulnerable populations, disclosure and apology after discovering medical errors, and ethical issues arising in specific medical contexts, such as radiation oncology, psychopathy, and palliative care.



# The Ethicist Is In: Communicating with a Patient on a Breathing Machine

KELSEY GIPE, PH.D.

## The Case:

Henry, a 69-year-old man, was found unconscious at home by his building manager. He was brought to the hospital Emergency Department and subsequently admitted to the Intensive Care Unit (ICU). He was placed on life support, including a breathing machine connected to a tube placed down his throat. Henry was very malnourished. Medical records indicated that he had a history of missing doctor's appointments and not keeping up with physical therapy or taking his prescribed medications after recent hospitalizations for an underlying heart condition. In the past, Henry had always made his own medical decisions. He lived alone and kept to himself, had no listed emergency contacts in his medical chart, and had never filled out an advance healthcare directive. An ethics consultation was requested because Henry had no one in his life to make medical decisions on his behalf.

## The Ethicist:

As the medical team worked on providing appropriate treatments to Henry, he seemed to become more alert and aware of what was going on around him. It was now time to determine whether Henry had regained the ability to make his own medical decisions and, if so, what his treatment preferences might be.

With the breathing tube in, Henry could not speak. He was also too weak and uncoordinated from his illness to write. We were, however, able to establish a way of communication so that Henry could respond to our questions. A nod meant "yes" whereas a shake of the head meant "no." When Henry was unsure of the answer to a question or (as became clear) simply didn't want to discuss a topic further, he would perform a particular "so-so" motion with his hand and/or make a disgruntled-sounding gurgling noise.

The fact that we could establish this makeshift language was a good sign; perhaps Henry was approaching or was again at his previous mental baseline. However, we still needed to establish that he actually understood the relevant features of his situation. Illness and taking certain medications can alter a patient's mental status, sometimes in ways that aren't apparent from simply observing them or asking how they feel. It is necessary to determine that a patient is oriented to place and time and has some understanding of their medical situation before moving on to more complex questions.

Although Henry's infection was responding to antibiotic treatment, he was too weak and malnourished to go home any time soon. At the very least, Henry would need to go to a

nursing facility for rehabilitation before he could be discharged home. The medical team anticipated that Henry would likely spend the rest of his life in a nursing facility unless he was motivated to adhere to a strict physical therapy regimen and take his medications consistently. We wanted to determine how Henry felt about going to a nursing facility and whether he was motivated to do what was needed in order to get better. We also wanted to know what Henry would want done if he experienced a medical crisis in the future and we were again unable to communicate with him and ascertain his wishes.

The Ethicist spoke with Henry on multiple occasions. On the first day, Henry was barely able to open his eyes and engage in a conversation. He appeared to be extremely uncomfortable and was chewing on the tube connected to the breathing machine. On the second day, Henry was more alert but appeared tired. He responded appropriately to some basic orientation questions, such as his name, the date, which city he was in, and whether he was in a hospital. We moved on to discuss more complex questions regarding Henry's understanding of his medical situation and goals for medical care. He expressed understanding that he was on a machine to help him breathe and endorsed that the tube was not currently causing him any discomfort. When asked whether he wanted the medical team to continue life-prolonging treatment, Henry vigorously nodded yes. When asked how he felt about rehabilitation and potentially life in a long-term care facility, he signaled uncertainty with a hand gesture and pointedly looked away.

## TIPS FOR COMMUNICATING WITH A PATIENT ON A BREATHING MACHINE

1. Limit the conversation to Yes/No questions.
2. Establish reliable responses (Yes, No, Unsure, Don't Wish to Discuss).
3. Start with basic orientation questions.
4. If the patient can answer basic questions reliably, move to more complex questions.
5. Ask the patient to write answers if they are able.
6. Speak with the patient multiple times as their mental status may vary from day to day.

On the third day, Henry appeared more awake and alert than he had been previously. Once again, he responded appropriately to basic orientation questions. He expressed that he was experiencing some discomfort with the breathing tube that day. The Ethicist reaffirmed that the patient wanted the medical team to continue life-prolonging treatment; and again, Henry emphatically nodded yes. We discussed what Henry would want done if he were to again become very sick and unable to communicate. Henry confirmed that there was no one in his life to make medical decisions on his behalf if he were to become incapacitated. The Ethicist explained that this meant that it was important for Henry to make his wishes known in advance. Henry nodded in agreement. We discussed whether he would want to be resuscitated if his heart were to stop in the future; he shook his head no. He also indicated that he would not want the tube put back down his throat if he were unable to breathe on his own once the medical team judged it was time to remove him from the breathing machine. Henry expressed that he was willing to go to a nursing facility for rehab; but when asked whether he would want to live the rest of his life in a nursing facility, he was uncertain. We explained that Henry would need to listen to his doctors, adhere to a physical therapy regimen, and take his medications if he were to have a chance of eventually going back home. He indicated that he understood and agreed.

The Ethicist returned over the next few days and Henry consistently reaffirmed the answers he had previously provided. It became clear that the level of insight and alertness he



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A few days later, Henry was successfully removed from the breathing machine and was able to breathe on his own. Once his throat had recovered enough from the tube, Henry was able to speak. He confirmed all of

the answers he had provided while he was connected to the breathing machine. Henry acknowledged that he hadn't taken adequate care of himself in the past; but after being so sick, he now realized that he had to do better. He expressed optimism regarding rehabilitation and a desire to work hard at getting stronger so that he could return home. Henry also completed an advance healthcare directive to document his wishes if he were to be hospitalized in the future. It was rewarding to know that we had been able to ascertain and respect the patient's wishes while he was connected to the breathing machine, even though communication was a challenge requiring additional patience, time, and effort—not only on our part, but Henry's as well.

# Discharge to the sidewalk?

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On a basic level, what are the hospital's ethical obligations to all patients? Patients have the right to receive clinically indicated treatments, including a medical screening and evaluation upon presentation to the hospital. Information about one's medical needs, both inpatient and outpatient follow-up, should be provided to every patient, surrogate, or healthcare agent. No patient should be discriminated against, whether that discrimination is due to age, gender, sexual orientation, nationality, language, religion, or their housing status. Patients have a right to a safe discharge plan as recommended by their supervising physician when they are medically stable for discharge. Finally, it is imperative that healthcare providers respect the autonomy of all patients, including the patient's right to refuse treatment and the right to refuse a recommended discharge plan.

Respecting the patient's autonomy begins the moment the patient presents to the hospital and continues throughout their hospitalization. Whether a patient has the capacity to make medical decisions, including the right to refuse treatment, should be constantly evaluated as capacity may fluctuate by the hour or day. Decision-making capacity may also vary depending on the complexity of the decision before the patient, including the patient's ability to understand the risks and benefits involved in a recommended discharge plan. When speaking with patients, especially patients without a permanent housing status, it is crucial they are able to demonstrate an understanding and an ability to seek basic needs like food, shelter, and treatment, whether their health care needs are chronic or emergent.

Efforts to determine whether a patient is homeless should begin shortly after the patient's admission to the hospital. A patient may qualify as being homeless due to a variety of factors, including residing in transitional housing, a sober living center, or a tent encampment. A patient may also qualify when a patient relies on friends or family for temporary housing. The length of time that the patient has been without permanent housing status should be taken into account when assessing a patient's status. When in doubt, it is likely in the patient's best interest to offer housing resources available to homeless patients, even if the individual does not self-identify as such. When speaking with patients, it is important to emphasize that all are treated equally, especially in a situation where the individual may not identify as homeless, or when a patient appears to show vulnerability when discussing their housing status.

Of course, equal treatment also means all patients are subject to certain limitations. There is limited right to stay in the hospital when there is no acute need. Although there is no obligation for the hospital to create resources that are not already available in the community, reasonable short-term accommodations may be considered. A safe discharge plan may mean a patient will be discharged to a skilled nursing facility that they do not find ideal, or, in the case of a homeless patient, to a shelter of which they do not approve for a number of reasons.

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It is important to remember that patients who have been determined to have decision-making capacity by their supervising physician have the right to refuse treatment and the right to refuse a recommended discharge plan. Once a patient has been informed of the benefits the safe discharge provides, as well as the risks associated with refusal of the plan, the patient will be required to make a decision. It can be emotionally challenging for a treatment team when a patient decides against a safe discharge plan. However, the patient's right to refuse should be respected, even if the providers disagree with that decision.

Treating all patients equally, regardless of their housing status, will not resolve the homelessness crisis we are currently observing. And there will always be challenging cases, regardless of the patient's housing status. We must learn from the cases where there was a missed opportunity to improve a patient's treatment or discharge planning, accepting the fact that no healthcare system is perfect. If, however, physicians, nurses, and other care providers can continue to demonstrate that all persons will be treated with honesty, respect, and concern for their well-being, there is reason to believe this will contribute to a positive shift in how all persons are treated within our society.

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**Save the Date!**  
**2020 Summer Ethics Workshop**

**PROGRAM IN MEDICINE & HUMAN VALUES  
SUTTER HEALTH BAY AREA**

**Refining Your Communication  
Skills: Ethics In Action**

**SATURDAY, JUNE 6, 2020  
8:30 a.m. – 5 p.m.**

More details available on our website.

**REGISTRATION OPENS APRIL 1.**

PLEASE NOTE: Due to limited space, we expect this workshop to fill quickly.  
Registration will close when the workshop is at capacity of 50 attendees.