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Hospital Discharge: Is It Safe Enough?

SHILPA SHASHIDHARA, PH.D.

Ms. Peters, who recently had a below-knee amputation, shouted from her hospital room, "I am not going to a nursing facility, I'm going home!" On another floor, a doctor tried to persuade Mr. Sims, who was packing his belongings, to complete his IV antibiotics course instead of leaving the hospital against medical advice. And when a case manager informed Ms. Roberts that she was medically stable and would be discharged, she responded, "I'm not ready; I need more time; I'm not leaving" – while multiple patients in the emergency room were awaiting a bed. In all three situations, the medical team wondered, "What do we do now?"

Discharging patients is a multifaceted process that can be filled with challenges. Prematurely leaving the hospital against medical advice or insisting on a discharge home without adequate caregiver support often results in a hospital readmission. Barriers that arise while developing an appropriate discharge plan may prolong hospitalization, which may not be in the patient's best interest. And in recent years, many hospitalized patients are more critically ill, medically complex, and socially complex than ever before.

Hospitals across the country are facing situations like those of Ms. Peters, Mr. Sims, and Ms. Roberts – patients who possess decision-making capacity and who refuse the safe discharge options presented to them. Discharge planning can raise multiple ethical issues, including a patient's capacity, the ability to consent, and autonomy. A discharge plan that's less than ideal, appropriate, or safe causes understandable unease and distress. Providers may ask, "What is my obligation to this patient?" and "How do I respect a patient's wishes yet ensure discharge is 'safe enough' and doesn't cause harm?"

DEFINING A SAFE DISCHARGE

The Centers for Medicare and Medicaid Services (CMS) requires that hospitals develop a safe discharge plan for each patient; specifically, hospitals must identify patients' post-hospital needs and determine an appropriate post-hospital disposition, such as a private home, nursing home, rehab facility, or shelter. A multidisciplinary team, which includes doctors, nurses, case managers, social workers, therapists, and spiritual care providers, collaborates to develop a patient-centered care plan. This team considers the patient's mental and functional status, family or friend support, ability to obtain food and medications, ability to travel to doctors' visits, barriers in the home (such as stairs), and assistive resources and services for ongoing care.

Continued on Page 5

IN THIS ISSUE

Ethics Corner 2
Education Spotlight 2
The Ethicist Is In 3
Roots of Bioethics 6

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Ethics Corner: Resident Education

Sara Martin, M.D.

Former SSRRH resident, now attending physician and teacher in the residency program

Sutter Santa Rosa Regional Hospital Family Medicine Residency

"Without the bioethics service and its roundtable teachings on ethics, I would have had no framework for the difficult decisions and ethical dilemmas that we family physicians face daily. I received only a handful of ethics lectures in medical school, which were certainly not enough to prepare me for the weight of responsibility I feel as a young doctor making decisions that impact another human being's autonomy, health, liberty, and sometimes, death. The frequent discussions in a supportive setting about difficult ethical cases gave me the framework I need to feel confident that I'm doing the right thing for my patients, even when it's scary or uncomfortable. Now, as a teacher of other physicians, I find myself regularly referencing these lessons with a new generation of doctors. I'm convinced that without these lessons, my moral trauma and burnout would be worse. I'm so grateful I have these tools to share with my residents as I prepare them to be empathetic and thoughtful clinicians."

Education Spotlight: Pediatric Palliative Care

WEST COAST SUMMIT
PEDIATRIC PALLIATIVE CARE
REFRAMING HOPE

Senior Clinical Bioethicist **Shilpa Shashidhara, Ph.D.**, and Program Director **Ruchika Mishra, Ph.D.**, conducted a breakout session at the West Coast Summit Pediatric Palliative Care on March 29 in San Jose. George Mark Children's House hosted the on-site national conference. Participants came from a wide variety of disciplines in pediatric palliative care. The summit's goal was to address both the impact and the way forward when families must adjust their hopes and aspirations to a different reality in the context of a terminal illness. PMHV team members spoke on "How to Reframe Hope and Communicate Effectively: Skills and Strategies." Their session reported the highest attendance at the conference.

The Ethicist Is In

RUCHIKA MISHRA, PH.D.

The Case:

Lily, a 65-year-old woman, was brought to the hospital after being found in a pool of blood at home. In the previous few days, her husband had noticed that her skin had turned unusually yellow. At the hospital, doctors discovered that the bleeding source was a large tumor in her colon. Further examination revealed that the tumor was malignant and that the cancer had spread to other areas, including the liver, pancreas, and lymph nodes. Due to the extent of disease, Lily was not a candidate for aggressive cancer treatments and was not expected to survive beyond a few weeks. The team unanimously recommended that goals of care should focus on ensuring comfort at the end of her life.

Lily's mental status was fluctuating, and the physicians had been speaking with her husband, who spent every day at her bedside. The team was struggling to develop an appropriate plan of care because Lily's husband continued to question and dismiss the diagnosis. He asked how his wife could have cancer when she had been fine until the bleeding episode just a few days ago. He was ready to take her home, saying she would be fine once she was in familiar surroundings. He was adamant that he did not need additional help with her care because he was fully capable of attending to all her needs. The medical team asked for an ethics consultation because they were concerned about the lack of a care plan, the patient's safety at home, and what they considered an unsafe discharge plan.

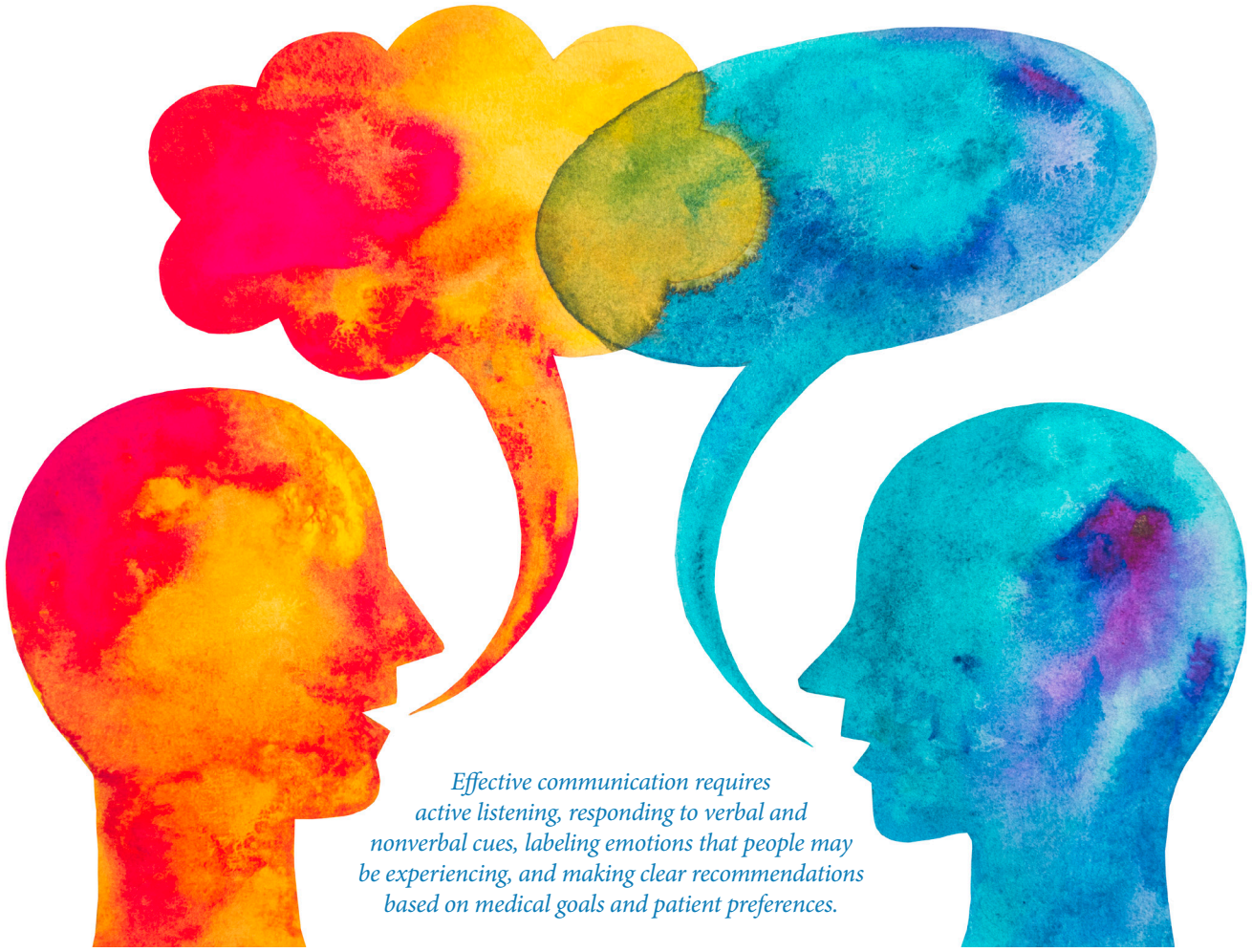
Ethicist:

Although the medical team requested the ethics consultation specifically to address the patient's safety and the lack of a safe discharge plan hampered by the husband's decision making, it's helpful to view this case in the larger context of the patient's recently diagnosed illness. Ethical issues arise due to a conflict of values, so psychological and emotional processes often play a part. In this case, Lily's husband's inability to fully appreciate her current medical situation impeded effective planning.

The husband's difficulty in grappling with such devastating facts is not unusual. It can be extremely challenging for patients and families to process a new diagnosis – especially a life-limiting one. In such situations, anticipatory grief is not uncommon and can take the form of disbelief, anxiety, shock, anger, emotional numbness, guilt, or fatigue. During critical decision making, these emotions may manifest as outright denial of the patient's condition or questioning the team's judgment about the medical workup, especially if the patient hasn't displayed previous symptoms or experienced any recent health issues. In this case, the patient's husband appeared to lack a support system to help with decision making. He was alone in struggling to come to terms with the new reality they faced.

How should the ethics consult proceed? The first step is to determine the patient's ability to participate in discussions regarding her care. Although Lily's mental status may be compromised, she may still have moments where she's able to understand her overall health situation and share her wishes regarding how she'd like to spend her remaining time. It's important for the medical team to be honest and transparent with the patient regarding her condition and their recommendations about treatment options. This includes being upfront about interventions for which she's no longer a candidate, as well as those that would only prolong pain and suffering. If Lily can participate in such discussions, it would be helpful to have a family meeting in her room so both husband and wife can grieve together about their impending loss and decide how they'd like to proceed. Hearing the patient express her emotions and wishes would be extremely beneficial for her husband so he doesn't have to shoulder the decision-making burden alone.

The importance of communication skills in such situations cannot be overstated. Effective communication requires active listening, responding to verbal and nonverbal cues, labeling emotions that people may be experiencing, and making clear recommendations based on medical goals and patient preferences. These crucial conversations are the cornerstone



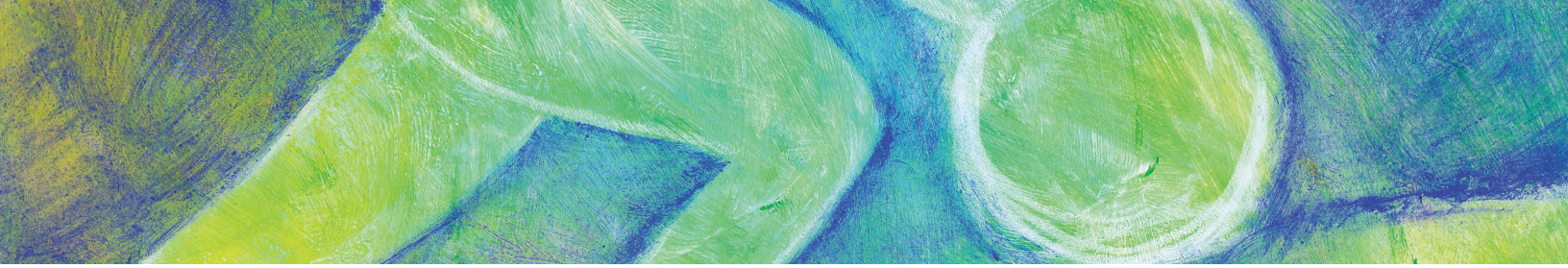
Effective communication requires active listening, responding to verbal and nonverbal cues, labeling emotions that people may be experiencing, and making clear recommendations based on medical goals and patient preferences.

of trust, especially when planning for a patient's end-of-life journey. An attentive team that demonstrates care for both patient and family is foundational for building all-important trust and rapport.

To help their decision-making process, Lily and her husband would benefit from the support of an interdisciplinary team for care in the hospital and for an outpatient plan after discharge. Given the husband's struggles, it's important to involve multiple services, including palliative care, social work, and spiritual care. The goal is to build a support structure for the patient and her husband with a coordinated and proactive approach to help them through this intensely challenging time. Given the patient's terminal condition, hospice services would be an additional resource, whether the patient is discharged home or to a facility. Hospice care can also provide grief support, which may be extremely beneficial for Lily's husband after she passes.

The medical team's role is multilayered and complex. It has an obligation to provide medically appropriate care, support the patient and her husband through a shared decision-making process so they may plan for their remaining time together, and develop a safe discharge that will ensure protection for this vulnerable patient at the end of her life. When obstacles arise in achieving the most appropriate course for a dying patient, an ethics consult can help the affected people reflect on and consider what they're going through, allowing them time and space to process new information. This can help them feel heard and respected while having to make perhaps the toughest decisions in their lives.

To align goals and resolve perceived differences, it's vital to regroup and compassionately discuss the issues at stake and the need to focus on the patient. If, despite best efforts, consensus cannot be reached regarding a medically appropriate care plan and safe discharge, a clinical ethicist can directly mediate the conflict to bridge the gap. However, if mediation efforts fail, the ethics consultation can advise the medical team regarding their professional obligations. This may include options such as discharging the patient against medical advice or involving adult protective services for welfare checks. Above all, it's crucial to make a best-faith effort, keep all parties engaged, and keep moving forward so that the focus rests squarely on the most important factor – what's best for the patient.



Hospital Discharge: Is It Safe Enough?

Continued from Page 1

Healthcare providers have an ethical and legal obligation to ensure a patient is discharged to a safe environment that meets their needs. However, several factors may prevent providers from formulating such a plan.

In all three scenarios discussed here, each patient has decision-making capacity, so they have the right to refuse the discharge option and to make decisions that may not be optimal for their health or in their best interest. While providers must accept their patients' decisions, they may experience moral distress from discharging their patient into what they believe is an unsafe setting. To mitigate moral distress, providers should focus on what they can offer a patient for a successful, safe discharge.

The Program in Medicine and Human Values' ethics service at Sutter Health helps healthcare providers determine the right course of action when faced with challenging discharge decisions while respecting a patient's values and preferences. The ethics consultant seeks to arrive at a mutually agreeable decision that's in the patient's best interest and meets the patient's needs. The ethicist also empowers the medical team to feel comfortable with "safe enough" discharge plans.

Scenario 1:

After a below-knee amputation, Ms. Peters insisted she would only discharge to home. The ethics consultant advised the medical team to:

- Understand Ms. Peters' reluctance about discharge to a nursing facility.
- Clarify that a nursing facility would likely be short-term for rehab, with the goal to return home.
- Help the patient work with therapy to determine if she could manage at home on her own.
- Identify potential caregiver support at home.
- Develop a discharge plan in line with the patient's desire to return home and maintain independence, including offering resources and services to assist her.

Scenario 2:

Mr. Sims wanted to leave before completing his IV antibiotics course. The ethics consultant advised the medical team to:

- Understand Mr. Sims' desire to leave against medical advice.
- Problem-solve with Mr. Sims to help him remain in the hospital, if possible.
- Clarify Mr. Sims' understanding of the consequences of not completing his antibiotics course.
- Explain the suboptimal medical option if he continued to want to leave against medical advice.
- Explain the high risk of hospital readmission if he leaves against medical advice.

Scenario 3:

Ms. Roberts indicated "I'm not ready; I'm not leaving" when informed that she would be discharged. The ethics consultant advised the medical team to:

- Inform Ms. Roberts that she no longer needs acute care and is safe to discharge.
- Listen to her concerns and fears about discharging.
- Offer supportive services and solutions.
- Work on an acceptable timeframe to discharge.
- Inform her that the hospital has no obligation to allow her to stay since she does not meet medical criteria.

Patients will continue to refuse recommended discharge plans for many reasons, from exerting control to fear of losing independence. Hospitals and healthcare providers have an obligation to develop and offer a patient-centered, safe discharge plan. Even if a patient chooses an alternative discharge option, the most ethically appropriate plan is for the medical team to respect a patient's wishes and attempt to ensure discharge is "safe enough."

PROGRAM IN MEDICINE & HUMAN VALUES

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ROOTS *of* BIOETHICS

Watch for the announcement of our second Roots of Bioethics seminar. It will be held in late summer.

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