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> *"The object of philosophy is the logical clarification of thoughts. Philosophy is not a theory but an activity."*
>
> *– Ludwig Wittgenstein*

Hot Topic

The Ethics of Allowing Patients to Make Bad Decisions

Challenging patient discharges are common events with strong ethical implications. They present in many different forms. Each is unique to the particular patient, and each requires knowledge and navigation skills that involve social services, legal aspects and ethics. Typical challenging discharge situations may arise when the patient is medically ready for discharge but refuses to leave, when the family insists on an unsafe discharge, or when the patient himself/herself insist on an unsafe discharge.

In this piece, we will explore the ethical implications of the latter example, when the patient personally insists on an unsafe discharge. And, for sake of argument, we will focus only on patients that have been determined to have capacity and are actively choosing a discharge location determined to be "unsafe" by the medial team. We will explore the meaning of "unsafe" location further, but first address the underlying ethical principles.

Autonomy versus Beneficence

Since the patient in these situations has been determined to have capacity, the central ethical conflict is between the principles of respect for autonomy versus beneficence. The medical team wants to do what is best for the patient and promote *good* for him/her, but also to be mindful of the patient's right to self-determination. So which should take priority? And does defaulting to patient autonomy mean that the team is violating their obligation to beneficence?

To override the patient's preference would imply that the medical team is operating under the idea of *paternalism*, which Beauchamp and Childress (2007) define as, *the intentional overriding of one person's preferences or actions by another person, where the person who overrides justifies this action by appeal to the goal of benefitting or of preventing or mitigating harm to the person whose preferences of actions are overridden* (p. 215).

Paternalism comes with some ethical complications because it requires an active use of a difference in power dynamic and creates greater potential for biases. In my opinion, it also sets a dangerous precedent of the provider ignoring the medical and personal preferences of a patient with capacity. Regarding patient discharge, it also requires personal judgment regarding the meaning of the word "unsafe".

Safe versus Unsafe

When determining a discharge location for a patient, the medical team is required to avoid a so-called "unsafe" discharge location or "unsafe" environment. But what qualifies as an "unsafe" environment?

As described by Barbara Chanko, an "unsafe" environment is one that is deemed (by the medical team) to "lack the necessary medical and/or social supports to meet the medical needs of a unique patient" (p. 2). This is also outlined in the Centers for Medicare & Medicaid Service (CMS)'s 482.43 Condition of Participation: Discharge Planning, which requires hospitals to perform particular steps when planning discharge. These include conducting a discharge planning evaluation, which should address "the likelihood of a patient needing post-hospital services and of the availability of the services and the likelihood of the patient's capacity for self-care or the possibility of the patient being cared for in their pre-hospital environment. Also, the hospital must, when possible, respect the patient and family's preferences for discharge location.

Trust Patients

While these types of discharges remain challenging situations for the healthcare team, with these considerations in mind, it is typically considered ethically permissible to allow the patient to choose their own discharge location, even if it is determined to be "unsafe" by the providing team. Swidler, Seastrum, & Wayne (2007) support this directly stating, "the patient's right to autonomy rather clearly prevails over the beneficence goal…when the patient's decision is clear and settled, the reluctance of staff to accept the patient's choice is paternalistic and indefensible" (p. 26).

It is important to understand that these are considerations of ethical permissibility, and that there are additional legal, system and personal aspects that need to be considered. But, fundamentally, the argument is that patients with capacity are able to understand their own personal goals of care and preferences, and that it would be unethical for the medial team to interfere and act overly paternalistically.

Patients do not make decisions is a vacuum. Rather, they utilize their whole history, social situations and medical preferences when making a decision such as discharge location. Oftentimes, patients do not share all of that information with the medical team. This puts the team in a morally compromised state, which is likely to increase the moral distress among them. But we should trust our patients, and trust that they are making the right decision for themselves. While we may not agree with the decision, which may be against the medical advice of the providing team, it may still be the *right* decision for that patient, and thus should be honored and respected. To phrase as a maxim: It is ethical to allow patients to make bad decisions.

Bioethics in the News

An Incoherent Proposal to Revise the Uniform Determination of Death Act

The Real Epidemic: Not Burnout But 'Moral Injury' Of Doctors Unable To Do Right By Patients

23andMe lays off 100 people as DNA test sales decline, CEO says she was 'surprised' to see market turn

IT Department to design new, creative mays to lock you out of your EMR account [Satire]

Can a foetus feel pain as early as 12 weeks?

Case Study

Patient is a 74-year old male, suffering from COPD and ESRD. Patient requires oxygen and twice weekly dialysis. After a ten-day hospital admission, the attending physician has determined that the patient is medically cleared for discharge and recommends discharge to a SNF. The patient insists on being discharged to home, where his two children live with him and provide support. The patient says that they will help him make his dialysis appointments, as he is now wheelchair dependent, although this had not been true in the past.

The medical team strongly suspects that the children living at home are active drug users and are likely to neglect the patient and not help him make his appointments. The team recommends him going to a SNF instead, which specializes in the dialysis required by the patient. The cost would be easily manageable. The patient says that he understands and appreciates their recommendation, but insists that he does not care and will be going home. The medical team requests an ethics consult.

Ethical Musings

The Study of Autonomy

The principle of respect for autonomy plays an undeniable role in the American healthcare system. Indeed, the right of the individual to self-determination – to make medical decisions for himself/herself -- is a cornerstone of modern medical ethics. The fact that patients have the right to make their own medical decisions is so accepted within western medicine that the idea of autonomy is often not intellectually contemplated, and certainly not nearly as much as the other principles.

There is extensive work dedicated to furthering understanding of what truly is meant by beneficence (good), nonmaleficence (harm) and justice. But autonomy is only truly studied when it is either compromised (such as the patient losing the ability to make medical decisions, and what the patient would say is in question), or when it is not understood (such as the patient making a decision that goes strongly against medical advice).

Autonomy has such a strong place in ethics that Immanuel Kant focused on it in his third formulation of the categorical imperative, coming as a rational sequel to the first two formulations. The first requires one to act only in a way that should be the universal standard, and the second requires one to not use others as a means but rather solely as an end. From there, Kant argued that to uphold the first two, individuals need to have personal autonomy, or having the ability to self-govern stating, "The concept of every rational being as one who must regard himself as giving universal law through all the maxims of his will, so as to appraise himself and his actions from this point of view, leads to a very fruitful concept dependent upon it, namely that of a kingdom of ends" (Groundwork of the Metaphysics of Moral, 4:433, p. 41).

The Ship of Theseus

But today I want to explore the idea of autonomy as it relates to personhood. What do we mean when we say that a person is a person? Who are we really? Are we our body? If we are to say that we are our body, must that be understood to be the collection of cells? But our cells are every changing, how are we to understand who we are? This is the central question of the philosophical thought experiment of the ship of Theseus, which goes,

> *"The ship wherein Theseus and the youth of Athens returned had thirty oars, and was preserved by the Athenians down even to the time of Demetrius Phalereus, for they took away the old planks as they decayed, putting in new and stronger timber in their place, insomuch that this ship became a standing example among the philosophers, for the logical question of things that grow; one side holding that the ship remained the same, and the other contending that it was not the same…over the years, the Athenians replaced each plank in the original ship of Theseus as it decayed, thereby keeping it in good repair. Eventually, there was not a single plank left of the original ship. So, did the Athenians still have one and the same ship that used to belong to Theseus? (https://faculty.washington.edu/smcohen/320/theseus.html)*

The Self: More Than a Collection of Cells

Many would say that the ship is the same ship, even if all of the individual wooden planks are replaced. Similarly, even if a human's individual cells are replaced, there still remains a central idea of a *self* that those cells represent. Bertrand Russell understood a *self* to exist in the individual passing moments of time, and it is our understanding of the connection between those moments that creates the idea of *self.* He put it more clearly stating, "I say 'I sit at my table', but I ought to say: 'One of a certain string of events causally connected in the sort of way that makes the whole series that is called a "person" has a certain spatial relation to one of another string of events causally connect with each other in a different way and having a spatial configuration of the sort denoted by the word "table". (p. 269). But, he adds, he does not say that because "life is too short".

These limitations of the idea of *self* relate directly to the principle of autonomy. If a patient has the right to self-determination, the question that follows is, who is the *self* making such a determination? If we are only a loose connection of a concept of *self,* can that *self* from the past really make appropriate medical decisions for the current *self* and, more importantly, the future *self*?