July 2021

Ethics Dispatch

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

Hot Topic

Continuity of Care: The Discharge Challenge

Healthcare in the United States today is delivered across a spectrum of locations. In addition to the doctor's office and the hospital, patients are treated at clinics, standalone emergency departments, hospitals, out-patient, long-term care, skilled nursing, rehab, and hospice facilities.

This can create complications for patients, particularly regarding aspects of continuity of care, and where integrated EMRs, POLST/TPOPP, advance directives and other initiatives can be extremely beneficial to maintaining care that aligns with the patients' expressed goals of care and right to autonomy. These programs are designed to keep patients involved and in control of their medical preferences. But there is one aspect of the continuum of care that is outside of the patient's control, and even outside of the control of many healthcare providers. That is when the need arises to find a location to discharge a patient that is in line with the patient's goals, can maintain the needed level of care, and, most importantly, accepts the patient.

Barriers to Acceptance

Finding a location for a patient can be challenging due to several issues, including the Patient, Process, Reimbursement, Regulatory, Guardianship, Insufficient Available Alternatives (including resources, number of staff and training), and Failure to Use Available Alternatives (Skilled Nursing Facility/Acute Care Hospital (SNFACC) Work Group, 2017).

Many patients face a combination of these complications, which can create additional barriers to finding an accepting location. And this is only likely to increase, according to SNFACC:

> *The number of medically complex patients and the complexity of their problems is increasing. These patients require high or intense skilled nursing care or regularly scheduled treatments such as therapies, dialysis, wound care, methadone and ventilator/tracheostomy care. This group includes bariatric patients who require intense therapy to increase endurance and balance, and recover their independence and ability to perform self-care (SNFACC work group, 2017, p. 12).*

The Noncompliant/Nonadherent Patient

Finding an accepting location can become even more complicated when a patient has been determined (or viewed) to be noncompliant/nonadherent. This can be a harmful label given to patients, in that it may severely restrict their ability to access care, find an accepting location, and even properly engage with care/treatment recommendations.

Take, for example, a patient suffering from renal disease and receiving dialysis. The Decreasing Patient Provider Conflict (DPPC) manual from the Forum of ESRD Networks reports:

> *At the time of the study, these 12 networks were serving 202,293 dialysis patients and 2,889 dialysis facilities, representing 71% of all facilities and patients. The study found that 458 (0.2% of prevalent*

> *dialysis population) involuntary discharges occurred in 2002. Of those discharges, 25.5% were related solely to noncompliance with treatment-related issues. The next-highest reason for discharge was verbal threat, which accounted for 8.5% of the discharges.*

This shows how noncompliance can lead to patients receiving limited or reduced access to care. These types of difficult behaviors, specifically by dialysis patients…

> *…pose not only a risk to the patient's well-being but also to other patients' treatment patterns, … they create a hostile environment in which aggressiveness can escalate. Death or significant morbidity can ensue from nonadherence; the care of patients on shifts during and after a confrontation may also be adversely affected. Severe behavioral issues resulting in involuntary discharge or transfer of the patient from the dialysis facility cause loss of continuity of care, significant emergent healthcare burden, and an investigation of the dialysis unit in question for the action (Janosevic, Wang, & Wish, 2018, p. 256).*

An additional difficulty is the association of these types of behaviors with clear decision making. This is to assume that patients who engage in difficult behaviors are knowingly and informedly acting, essentially giving informed refusal when patients are being noncompliant. However, this is arguably not the case, as these behaviors and actions may result from other conditions. As stated by Janosevic et al:

> *Prior reviews and meta-analyses have revealed that anxiety, depression, and cognitive impairment of dialysis patients may contribute toward disruptive behaviors. Furthermore, socioeconomic challenges ranging from transportation or lack of a stable home and/or income, education level, and lack of or toxic social support system also tie into behavioral challenges in dialysis patients. In the aforementioned AKF survey, a significant finding was that many of the behaviors across all age groups were attributable mainly to depression, which was present in over 40% of surveyed patients" (Janosevic, Wang, & Wish, 2018, p. 255).*

Thus, it may be argued that patients with difficult behaviors who are refused discharged locations are being additionally and unfairly limited in their treatment options.

Recommendations for Finding Locations

But, still, the reality is that these patients are difficult and finding discharge locations can be challenging. So what can be done? To find locations for "challenging patient situations," which include locations for patients described as "assaultive, fire starters, walk away, substance/drug abuse with or without Methadone, sex offenders, sleep disorder, self-harm, behavioral health, personality disorder, criminal history, homeless, dementia and Alzheimer's, intellectual disability and Traumatic Brain Injury (TBI)," the Skilled Nursing Facility/ Acute Care Hospital Work Group makes these recommendations:

- Develop more specialized post-acute facilities, including memory care units.
- Expand Enhanced Service Facility (ESF) model as some facilities with Expanded Community Services (ECS) contracts cannot take some of these clients.
- Develop providers with Mental Health Training and provide incentives for providers to accept behavioral health clients.
- Educate payers about available options; they do not know all the options available and think SNFs are the only choice for patients discharging from hospitals.
- Look at regulatory challenges with RCS/DOH, such as smoking. Provide increased support and

training for DSHS staff working with hard-to-place clients.

- Share information on available programs and funding to support these patients.
- Peer-to-peer outreach regarding behavioral health. Increase options for medical respite/IV drug use, e.g., Edward Thomas House. Provide more supportive settings in high density cases. Use sitters and counselors for clients with behavioral health and substance use disorder (SUD) conditions in SNFs

Discharge challenges are likely to become even more challenging as healthcare continues to change, care gets spread across multiple care locations, and patients develop more complicated medical conditions. Further work is needed to increase access, increase location options, and engage with patient who are deemed "difficult" so that these patients continue to receive proper medical and supportive care.

Bioethics in the News

Can we replace human empathy in healthcare?

3 Experts Have Resigned From An FDA Committee Over Alzheimer's Drug Approval

After 20 Years, Concerns About Hospital Ethics Consultation Services Remain

Vatican seeks all-out effort to combat vaccine hesitancy

Computer Program Predicts When Seniors have 6 Months left to Live

Biden Nominates Amy Gutmann as Ambassador to Germany

Case Study

The patient is a 78-year-old male, suffering from ESRD, among other ailments. The patient is known to the hospital staff as being a "problem patient." He has a history of noncompliance and also behavioral issues, including being verbally abusive to family and staff. He has been discharged from most other hospitals and health facilities in the area, with them having him sign behavior contracts that he violated. He will not be accepted at any other hospital. Due to his ESRD, he is not able to be discharged to home because he does not have adequate means of transportation for dialysis. No local SNF or other care facility will accept him due to his noncompliance and behavioral issues. The only accepting facility is in Salt Lake City (1000+ miles away). The patient and the family are refusing discharge to Salt Lake City. Social Work has requested ethics support.

Ethical Musings

Equal Opportunity Depends on Capabilities

We have explored previously the different arguments surrounding the questions of justice and fairness, specifically the debate between equal opportunities versus equal results, and highlighted some of the major philosophical opinions from Rawls, Nagel, and Nozick (see Ethics Dispatch July 2020). Equal opportunity is almost universally agreed upon notion, that individuals should all have the opportunity to pursue health and prosperity, but the realistic application is challenged. What does it mean for all individuals to have equal opportunities?

Take for example a patient situation as described above. A patient is ESRD and is deemed to be "noncompliant" because the patient had "no showed" to his/her previous three appointments. It might be this patient "no showed" because his/her car was being borrowed by his/her daughter for a few days. While this patient might be determined to be having an equal opportunity to access dialysis and care, the patient may not have the same capability to access that care. This demonstrates that "equal opportunities" are more complicated than due to a single variable.

Capabilities Theory

One theory that puts the idea of equal opportunities into a more understandable perspective is called Capabilities Theory, which "starts from the premise that the opportunity to reach states of proper functioning and well-being are of basic moral significance and that the freedom to reach these states is to be analyzed in the language of 'capabilities'" (Beauchamp & Childress, p. 259). Pioneered separately by Amartya Sen and Martha Nussbaum, this theory says that the quality of an individual's life is defined by that individual's ability to achieve, sustain, and exercise several core capabilities, those being:

1. *Life*
2. *Bodily health*
3. *Bodily integrity*
4. *Senses, imagination, and thoughts*
5. *Emotions*
6. *Practical reason*
7. *Affiliation*
8. *Other species*
9. *Play*
10. *Control over one's environment*

These basic capabilities must be upheld and developed for an individual to be able to flourish. Nussbaum holds that "all ten of these plural and diverse ends are minimum requirements of justice" and that for something to uphold justice it requires "that we, as a society, ensure that the world does not interfere with individuals' development of their core capabilities or block political participation in a way that stunts or harms them" (Beauchamp & Childress, p. 260).

This is a unique and compelling approach because of "its shift of attention away from the means (e.g., resources) for achieving well-being to what persons "can do and be," which is particularly important with regards to Nozick's critique of welfare theories "because they did not take into consideration what we could do and be, they rested on an implausible account of the outcomes about which we should be most concerned" (Powers and Fade, p. 37).

No Completely Equal Opportunities

When the focus of the system of justice is on equal outcomes, there is a lot of room for discussion and debate. Many prominent philosophers like Nozick (anarchy), and popular thinkers like Kurt Vonnegut in the short story Harrison Bergeron, have argued that equal outcomes is not the ideal system. Capabilities theory argues against equal outcomes while also dissipating the perceived myth that there are complete equal opportunities. It also gives an outline of what is expected from a just and fair healthcare system, and, through that, a just and fair government that supports the system.

Making a more direct connection to health, the World Health Organization argues that the health status of an individual is dependent on multiple factors, noting that, "the conditions in which people live their daily lives and the structural influence on these conditions…ultimately reflect the distribution of power and resources" (World Health Organization, 2012, p. 9). It is well established that social determinants "such as political institutions, and intermediate determinants, such as income, educational level, housing, neighborhood, and working conditions" (WHO, 2012) have a large impact on an individual's health. Health is intimately linked to all other aspects of the individual, with social determinants, mental health, physical health, etc. all impacted by each other.

This is not to say that capabilities theory is a complete approach to individuals health, as Barreda et al. argue, "any attempt to assess health based on only one of these dimensions may provide a partial account. Hence, a health assessment from the CA [capabilities approach] perspective should include indicators based on the achieved dimension (health functioning), and resources and conversion factors (health capability)." (Barreda, Robertson-Preidler, & Garcia, 2019, p. 25).

Capabilities Theory as Framework for a Just System

Capabilities theory is not the basis for a theory of justice, but rather a framework that can help conceptualize what is needed for individuals to be able to be free in a just system. It is a multiple-part approach that requires consideration of the individual's desired function and their capability to achieve said junction, as Rugar 2006 states,

> *Capability relates to well-being in two ways. First, if a set of functions, such as the ability to feed oneself and walk unaided, constitute a person's well-being, then the capability to achieve those functions will constitute the person's freedom to have well-being. This is important if freedom is valued for itself, not just for instrumental purposes. (p. 14).*

These principles can be applied easily to the Covid-19 pandemic, vaccine distribution, and the ongoing health crisis caused by all. The pandemic has greatly impacted so many, particularly those of lower socio-economic status and racial minorities. Viewed through a capabilities theory perspective, the Covid-19 pandemic has disproportionately impacted individuals' capabilities, such as health, emotions, affiliation, play, etc., while others of higher socio-economic status have had the ability to continue those capabilities, albeit in a modified way. This is likely to lead to a widening gap between the socio-economic classes, and those with full capabilities and those without, therefore perpetuating the social injustices that are already present.

While capabilities theory is not a complete theory for establishing justice, as mentioned, it is a useful framework for the discussion surrounding equal opportunities. We strive to achieve a fair and just society, and the healthcare that comes with it. One step towards achieving that could be the prioritization of equal opportunity to achieve well-being for individuals based on their capabilities.