MEDICAL ETHICS

By James Wright, MD, PhD, MATS, CMD

The Ethics of Discharges Against Medical Advice

Mr. G is ticked off. The 58-year-old man arrived at your facility about two days ago after a hospital stay for alcohol withdrawal and sepsis. Upon admission, you fielded several questions from him about how soon you would “let me out of here.”

“This is not a prison, Mr. G. You can leave anytime you want,” you tell him. “But your family was hoping that you would stay until you’re able to get around your apartment safely. You also need to finish your IV antibiotics for your infection. I’m worried you might end up in the hospital again if you don’t.” He seemed fairly placated by this until today, when he was caught smoking in his room for the second time.

This time, the administrator conducted a sweep of his room and took a half-pack of Winstons as well as Mr. G’s lighter, promising to return them at the end of his stay. “The end of my stay is right now,” says Mr. G, shoving his socks and underwear into a grocery bag. “I’m getting out of this hellhole, and I’m taking my smoke with me.” As you try to reason with Mr. G, the receptionist appears in the doorway, “Did someone order an Uber?”

There are times when our skilled rehabilitation centers and long-term care communities simply don’t meet the expectations of our patients. Against medical advice (AMA) discharges occur only a minority of the time, but when they do, they always represent a crisis for the patient, family, facility, and provider. Ethically speaking, it confronts the provider with a potential conflict between two ethical principles: autonomy and beneficence. Should you step aside and allow Mr. G to get in that Uber (autonomy), or should you step in to provide the care you know he needs (beneficence)? My answer is a resounding ya/.

Autonomy

As a modern health care professional you are obligated to recognize patients’ right to make decisions (good and bad) for themselves. Mr. G seems to be reacting to a situation in which his autonomy is being threatened. He’s being forbidden to practice a habit (smoking) that is a legal activity in all 50 states, he’s had his personal property confiscated, and he suspects you are trying to hold him against his will. It may seem counterintuitive, but the one thing that could most convince Mr. G to stay is letting him know how he can leave.

One of the primary things that drives people to leave AMA is the loss of control over their health (Acad Emerg Med 2014;21:1050–1057). Reassure Mr. G by telling him the truth: “You can leave anytime you want.” Then work to encourage him to stay by helping him regain control over his situation. How can you partner with Mr. G to maximize his autonomy? Perhaps there is some wiggle room in the center’s smoking policy. Can you allow him to smoke e-cigarettes? Can the facility designate a smoking area? (I do think that nonsmoking policies in nursing communities are one of the greatest violations of resident autonomy in the industry, but I digress.)

One caveat: Mr. G’s decision must be informed, and he must have medical capacity. He must be able to appreciate his disease and the risks and benefits of treatment. He must also be able to express his decision about his care. This is all involved in assessing his medical capacity. Learn how to use a tool like the Joint Centre for Bioethics’s Aid to Capacity Evaluation (ACE) (available for free at https://secure.medical.letter.org/w1301c), and document that your patient is capable of an informed decision. You can do this in 10 minutes or less, and it’s really helpful in case you’re threatened with legal action in the future.

Let’s say you have established that Mr. G has medical capacity, you’ve reminded him that you will respect his autonomy, and you’ve expressed your concern for his health, but he still plans on leaving — right now, with his Winstons and lighter in hand. Everyone’s in a bit of a panic — you huddle with the unit supervisor, director of nursing (DON), and the administrator. You’re all worried about Mr. G and his health, of course, but maybe everyone’s a little worried about something else: no one wants to get sued.

Beneficence

The DON suggests that you follow the typical procedure and sign the AMA form, avoiding any further involvement with Mr. G — you don’t want to be seen as enabling dangerous behavior, after all. Here’s the ethical conflict again: if you follow the advice of the DON, you’re stepping aside and letting autonomy take precedence over beneficence. But does it have to be? Here’s the good news: being a good, beneficent provider (and documenting it) is always the best protection against litigation.

Putting off the Uber driver, you use your Sanford guide to find an oral anti-biotic that at least has some of the same spectra of activity and prescribe it for him. You quickly put together a discharge summary and medication list and give it to him. Have the nurse call in any medications Mr. G might need to tide him over, and have the facility make an appointment with his primary care doctor. Following the advice of the DON and avoiding any role in Mr. G’s discharge may actually be seen as a violation of standard of care (J Fam Pract 2000;49:224–227).

As usual, document the steps you have taken not only to determine capacity but to express your concerns for a poor outcome, as well as the steps you have taken to mitigate harm to the patient. If you’re concerned about his safety at home, it wouldn’t hurt to call Adult Protective Services. Get buy-in from your DON and administrator to reassure Mr. G he can return to the facility within the

Continued to next page
Dear Editors,

It is always useful to remind practitioners that nonpharmacologic interventions are most effective for the treatment of neuropsychiatric symptoms of dementia, and the review in the recent issue of Caring (2020;21[2]:19) provides excellent guidance. However, the summary of interventions is provided only evidence from randomized controlled trials (RCTs) on treatment of verbal agitation, sometimes called disruptive vocalization, and it states there are “no effective interventions.” There are no RCT results for treatment of this condition because, fortunately, it is relatively rare. However, loud vocalization can cause significant disruption, affecting residents, staff, family members, and visitors. We would like to alert readers to two case studies describing an effective treatment for disruptive vocalization and suggest one simple, effective intervention.

The first case was that of Evelyn, a woman who had lived in a facility for nine years (Gerontol Nursing 2012;38:52–56). She was originally admitted after breaking her hip, and she was a pleasant person with only mild memory loss. However, as her cognitive impairment worsened, she became a very difficult person to care for. She began to resist all attempts to provide personal care, especially bathing. Evelyn spent most of her time in her wheelchair, speaking to her clenched fist. Her speech would become distraught as she described horrific situations that she remembered from her work as a police dispatcher. Several medications were attempted to wipe away terrible images of unwrapping them. Another day, she asked the staff member to buy her a teapot, which prompted stories about tea parties she had hosted in her younger days. Evelyn changed from a deeply disturbed woman who did not like to be touched into one who not only enjoyed being touched but occasionally offered to massage the arms of the staff. Another miracle occurred with Agnes — her behavior changed immediately after being brought to the Namaste Care room: she stopped crying out, “Help me!” The staff were very gentle with her, and they welcomed Agnes to the group. They transferred her from her wheelchair into a comfortable recliner, gently tucked a soft blanket around her, and offered her coffee with cream and sugar, her favorite drink. She would sip it silently, observing the other residents. In the last months of her life, Agnes continued her Namaste sessions. Comfortably seated in the Namaste room, she allowed staff to give her hand massages and fuss with her hair, and she almost never cried out. Agnes also did not need for her bath. Because the other residents found Agnes’s cries disturbing, she was rarely brought to an activity. Namaste was placed in front of a nurse’s station where she could be observed. She also did not like to be touched, and several aides were needed for her bath.

Both facilities where Evelyn and Agnes lived established a new program for residents with advanced dementia called Namaste Care (Simard, The End-of-Life Namaste Program for People with Dementia, 2nd ed., Health Professions Press, 2013). This group activity program was designed for residents who were no longer benefitting from the usual activities because of progression of their dementia. In a Namaste Care room, a calm environment is maintained with relaxing music and pleasant scents permeating the air. An unhurried, loving touch approach to all interactions is provided by dedicated staff. Although Evelyn and Agnes were not considered ideal program participants because their vocalizations could disrupt the calm environment, the staff members had seen the beneficial effect of Namaste Care for other residents and were desperate to help Evelyn and Agnes as well.

When Evelyn was brought to the Namaste Care room, she was offered some baby roses. To everyone’s surprise, Evelyn stopped talking, took the roses, and smelled them. After Evelyn offered the roses to the Namaste Carer, she yanked them back and hit herself in the face — then, surprisingly, she laughed, which she had not done in months. After Evelyn had continued her daily sessions in the Namaste Care room, she retreated less and less into her life as a police dispatcher and was mostly quiet except for conversations with staff members. At one point Evelyn asked for some books to look through; she wanted them to be wrapped in brown paper because she enjoyed the process of unwrapping them. Another day, she asked the staff member to buy her a teapot, which prompted stories about tea parties she had hosted in her younger years. Evelyn changed from a deeply disturbed woman who did not like to be touched into one who not only enjoyed being touched but occasionally offered to massage the arms of the staff. The staff proclaimed this change to be a true miracle!

Another miracle occurred with Agnes — her behavior changed immediately after being brought to the Namaste Care room: she stopped crying out, “I want to go home.” Again, there was no medication or consoling that would stop her vocalizations. When she was initially brought to the Namaste Care room, she continued to tell staff over and over that she wanted to go home. However, her cries stopped when she was offered — and she accepted — a lollipop. When she finished the lollipop, she would cry out again until she was given another lollipop. This simple intervention allowed her to become accustomed to the Namaste Care room, and she eventually stopped asking to go home, even without the lollipop intervention.

Of course, these cases provide only a few examples of the amazing changes that have occurred when residents with verbal agitation and disruptive vocalization are brought into the Namaste Care program. Some residents who had rejected personal care before attending Namaste Care continued to accept touch after they left the program. Their time in the Namaste Care room provided a “trickle-down effect” to other personal care, which was a welcome change for the staff.

Conflict of Interest: Ms. Simard published a book describing Namaste Care.

Dr. Wright is the chair of the Society’s Ethics Committee. He is medical director of three communities in Richmond, VA.

For more information or to order, visit https://paltc.org/.

AMDA’s Know-It-All™ system is designed to maximize quality care and avoid unnecessary emergency room visits and hospitalizations.

It includes:

- Know-it-All™ Before You Call
- Data Collection System in PA/LTC and Assisted Living Settings
- Know-It-All™ When You’re Called
- Diagnosing System

For more information or to order, visit https://paltc.org/