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Article abstract

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COMMENTAIRE CRITIQUE / CRITICAL COMMENTARY (ÉVALUÉ PAR LES PAIRS / PEER-REVIEWED)

"Home to Fail" Discharges: A Question of Motivation

Christinia Landry[a]

Résumé
Renvoyer des patients "chez eux pour échouer" tout en anticipant leur réadmission rapide est, à première vue, troublant d'un point de vue éthique, comme le sont toutes les sorties non sécurisées. Toutefois, les cas de retour "chez eux pour échouer" peuvent également être discrètement troublants sur le plan éthique dans la mesure où ils soulèvent des questions de paternalisme médical en raison d'une composante motivationnelle qui conduit à ce type de cas : en renvoyant un patient "chez elle pour échouer", elle en viendra à comprendre que vivre chez elle n'est pas sûr et donc pas judicieux, ce qui l'incitera à choisir différemment à l'avenir.

Mots-clés
planification de décharge, sécurité, prise de décision, paternalisme, autonomie

Abstract
Sending patients "home to fail" while anticipating their speedy readmittance is, prima facie, ethically troubling as are all unsafe discharges. However, "home to fail" cases may also be covertly ethically troubling insofar as they raise questions of medical paternalism due to a motivational component which drives these types of cases: by discharging a patient "home to fail" she will come to appreciate that living at home is unsafe and thus unwise, prompting her to choose differently in the future.

Keywords
discharge planning, safety, decision making, paternalism, autonomy

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INTRODUCTION

During my tenure as a clinical ethics fellow in acute care, "home to fail" was often voiced during discharge planning but remains unstudied. In fact, a quick search of PubMed in Winter 2023 did not yield any mention, unlike its parent term "unsafe discharge", which returned over two hundred and seventy hits. In my experience, "home to fail" cases presented in a number of different shapes and sizes, but they were all characterized by a fully-informed, decisionally-capable, and medically-stable patient requesting to be discharged home despite the medical team's warning against it. The medical team predicted that the patient would not be able to care for herself properly (or receive the care she needed) and would quickly return to acute care. "Home to fail" was then part of an individual's larger patient narrative insofar as her decision to return home did not conclude this chapter of her medical story.

This phenomenon is not to be confused with signing oneself out Against Medical Advice (AMA). Although, both phenomena fall under the umbrella of unsafe discharge, what is key to the "home to fail" case is that the patient is medically stable unlike the AMA case. After discharging "home to fail", the patient often returned to hospital after a brief stay at home, generally sicker and more decompensated than before her initial admission – perhaps she did not take her medication properly, clean her wound adequately, avoid the stairs, or abide by her diet. Conversations with the patient regarding appropriate aftercare continued upon her readmission with the hope on the part of the medical team that after a (few) failed discharge(s) and numerous attempts to be clinically persuasive, that the patient would realize that returning home was unsafe; and she would agree to move into supportive housing or a more supportive living environment.

Sending patients "home to fail" while anticipating their speedy readmittance – because they are predicted to fail to thrive – is *prima facie* ethically troubling as are all unsafe discharges. However, it is my contention that "home to fail" cases may also be covertly ethically troubling. Unlike other types of unsafe discharges, "home to fail" cases raise questions of medical paternalism due to a motivational component that drives these types of cases: by discharging a patient "home to fail", she will come to appreciate that living at home is unsafe and thus unwise. In my brief investigation of this phenomenon, I will use a vignette to frame and unpack my experience of "home to fail" cases, explore the principles and values at work, and finally conclude that "home to fail" discharges warrant further normative and empirical exploration.

"HOME TO FAIL:" A VIGNETTE

Ms. Smith is a 75-year-old widow without any living relatives who was hospitalized after a neighbour found her unconscious in her own entryway. The house itself was in a state of extreme neglect, providing some evidence that Ms. Smith was failing to look after her basic needs for food and hygiene in addition to failing to control her insulin levels. She presented at the hospital as confused and was discovered to be suffering from diabetic shock. After a few days of treatment and monitoring, Ms. Smith was deemed medically stable and demanded to go home. The medical team was reluctant to discharge her home because they suspected that she would quickly decompensate and return to the hospital, or worse, that she would die. She has no

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family and home care cannot provide her with the level of care that she requires to safely remain at home. The medical social worker compiled a number of long-term care facilities that were accepting new residents which he discussed with Ms. Smith over a number of bedside visits, but each time she adamantly refused, finally stating: “All of my best memories are in that house. You can’t make me go to a nursing home! If I die, at least I’ll die at home!”

LAYING THE GROUNDWORK: “HOME TO FAIL” CASES

The first question that comes to mind in a case like this is whether or not Ms. Smith is in fact capable of deciding where to live upon discharge. Although evaluating and/or assessing capacity entails negotiating legal criteria and navigating situational nuances, for the sake of this vignette we can look to Allen Buchanan’s and Dan W. Brock’s famous work on competence. In “Deciding for others,” they detail three interconnected components of competence or decisional-capacity necessary for directing one’s own health care (1). One may argue that these criteria are used to determine capacity for treatment decision-making and not capacity for where and how to live once one is medically stable. Indeed, choosing where and how to live requires a different sort of capacity than, for instance, refusing life-saving medical treatment or commencing chemotherapy. However, we may think of Buchanan’s and Brock’s criteria as the gold standard of decisional-capacity which can be applied not only to treatment decisions, but also to risky discharge decisions. Indeed, capable people may freely choose to live at risk, provided that they are not harming others, but we must first confirm their decisional-capacity to do so.

Buchanan’s and Brock’s first criterion is the *capacity for communication and understanding*. We always want to ensure the patient is able to express an understanding of her diagnosis and prognosis and how her illness will be helped or hindered based on where and how she lives. In the case of Ms. Smith, as in other cases of this nature, patients are found to have a capacity for communication and understanding. They can verbally work this part of their story into a larger narrative. However, they may not yet fully appreciate that this is not the end of their patient experience.

Buchanan’s and Brock’s second criterion is the *capacity for reasoning and deliberation*. According to Buchanan and Brock, Ms. Smith needs only to demonstrate a capacity for reasoning and deliberation and not necessarily a well-reasoned and well-deliberated decision on where to live. She does not yet comprehend the larger narrative involved in “home to fail” cases like her own. There is a desire on the part of some bioethicists to claim that poor reasoning is a marker of a lack of decisional-capacity and that life and death decisions should not be permitted to be made on weakly-reasoned choices (2-3). While it is true that medical teams are not keen to see patients make poorly-reasoned decisions that put their safety at risk, many of us would be deemed incapable of directing our own care or post-treatment care if our choices needed to be free of fallacious reasoning and biases.

One of the most common pitfalls of reasoning and deliberation that may yield irrational choices in “home to fail” cases is the cognitive bias toward the present and near future at the cost of the distant future. Dan W. Brock and Steven A. Wartman explain that patients may fail to give adequate consideration to how their present decision-making will harm them in the future (4). This bias may be at work in Ms. Smith’s decision to return home. Perhaps she fails to truly appreciate how quickly she will be readmitted to acute care despite the medical team’s prognosis should she return home. But does her dismissal of their warnings render her decision irrational or just imprudent?

Buchanan’s and Brock’s third criterion is patient *capacity for a concept of the good and reasonably consistent and stable values*. Namely, can the patient tell you what is important to her; is her explanation coherent and consistent over time? What is clear in this case is that Ms. Smith values living independently; perhaps she even values this more than living longer in supportive care as per her claim, “If I die, at least I’ll die at home.” Certainly, we can appreciate her decision given the state of many long-term care facilities and the loss of self-determination that many people experience when they move into care (5-7).

TWO POSSIBLE ANSWERS TO THE ETHICAL DIFFICULTY OF “HOME TO FAIL”

The short answer to the problem of unsafe discharges accepted by most clinical ethicists is that in all but extreme cases the principle of respect for patient autonomy trumps beneficence and justice (8). Principlism is the most often-used normative theoretical perspective in biomedical ethical decision-making (9-11). The famous principlists, Tom L. Beauchamp and James F. Childress explain, “Respect involves acknowledging the value and decision-making rights of autonomous persons and enabling them to act autonomously.” (11, p.104) In health care, this means patients need to be free from coercion or influence and they must be fully informed of their diagnosis, prognosis, and treatment options so they can reasonably choose what is in their own best interest. For Ms. Smith this choice is to live at home. And certainly, we are welcome to dislike our patients’ choice to live at risk but we are not welcome to derail it – this would constitute overt paternalism. Indeed, “the dignity of risk is smothered by paternalistic concerns” with failure (12, p.10). The action of discharging patients “home to fail” as with other unsafe discharges honours patient autonomy and their right to self-determination by releasing control over their well-being and allowing them to fail (or succeed) on their own terms (13).

A different and more difficult answer to the problem of “home to fail” is that acute care facilities are legally and ethically obligated to ensure a safe discharge and sending someone “home to fail” suggests risking a significant magnitude and probability of harm (14,15). Therefore, in these cases respect for patient autonomy meets a competing moral consideration calling into question autonomy’s place as the decisive principle. Any unsafe discharge compromises the medical teams’ adherence to the principle of beneficence and nonmaleficence which requires that medical practitioners ensure patients’ well-being (11,16-19).

Although one may argue that prohibiting Ms. Smith from returning home does just that; it inflicts further suffering through the loss of self-determination – paramount to which is the ability to take risks and the right to return home to fail – but is this sort of suffering undue given the stakes?

Now, we would be remiss if we skipped over the strong paternalism in this different and more difficult response to the problem. Strong paternalism has been ethically and legally troubling since the advent of the 1970's patient-centred model of care which encourages patients to determine their own conception of the good and choose accordingly (20-21). Hints at exercising one's own will over that of a patient may lead to a rupture in the health care relationship and could result in legal trouble. If we take Ms. Smith's values and interests seriously, it is clear that she would rather die at home than live in a long-term care facility. Indeed, the patient-centred model entails that there may be times when respecting patient autonomy may make patients physically worse off because they privilege their mental well-being over their physical well-being, if we can separate the two.

Interestingly, there may be a more subtle form of paternalism at play in the first answer to the problem. It may be the case that one of the key motivations for medical teams' decisions to send patients "home to fail" is not merely an honouring of patients' autonomy or freedom over safety, but also the hope that their failure garners. Medical teams hope that patients will make a different decision the next time they are discharged from acute care, a decision that aligns with the values and interests of the medical team – the decision to be discharged into a safe living environment. This hope champions beneficence and nonmaleficence rather than autonomy and is also what makes "home to fail" cases different from your run-of-the-mill unsafe discharge. The case, in some sense, remains open insofar as it is merely part of the individual's larger patient narrative: she will return home; she will take risks; she will fail; she will be brought back into care; she will choose to be discharged to a safer living environment. And her autonomy will be preserved at every stage.

Further "home to fail" not only compromises the principle of beneficence and nonmaleficence, it also undercuts the principle of justice as responsible resource stewardship which is the fair, equitable, and appropriate distribution of scarce medical resources (11). Discharging Ms. Smith home with the anticipation that she will be readmitted sicker and more decompensated entails that more public funds are spent than if she were discharged into some form of supportive living. Of course, she may be entitled to public funds to (help) cover her care costs, but this type of care is in no way financially comparable to the cost of acute care, particularly if it is intensive. However, privileging distributive justice concerns in discharge planning would be, for all but the steadfast (act) utilitarian, highly troubling; health care practitioners are generally discouraged from bedside rationing and encouraged to advocate for the patient to whom they are attending (22,23). Nevertheless it bears noting, we as a society pay a very steep price in honoring patient autonomy given that they may make poor health care decisions that result in more acute care admissions, but alas this is the cost of the patient-centred model of care – a cost some may be willing to bear if they favour patient autonomy and the right to take risks and fail.

CONCLUSION: DISCHARGING PATIENTS "HOME TO FAIL"

Discharge often raises complex clinical, legal, financial, organizational, and ethical issues (15). In terms of the ethical, we often find that the principles, values and duties they represent come into conflict with one another. In all cases of unsafe discharges, we must weigh the patient's right to self-determination and the duty to protect them from harm or failure (24,25). However, in unsafe discharges where the patient is medically stable, decisionally-capable, fully informed, and choosing an unsafe living environment, the principle of autonomy is paramount. I argue that "home to fail" cases are ethically troubling in the way that any unsafe discharge is ethically troubling. Nevertheless, "home to fail" presents its own challenges insofar as these cases are framed by a problematic motivational component that is unaccounted for if one is focusing on the ethicality of the action alone, i.e., honoring patient autonomy. However, integral to the full ethical assessment of any action are the agents' intentions. One of the medical team's intentions is that by discharging a patient "home to fail" that she will eventually appreciate that living at home is unsafe and makes her worse off. Is "home to fail" then not problematically motivated and potentially paternalistic? Certainly, discharging a decisionally-capable patient "home to fail" is a morally appropriate action from a patient-centred perspective. Giving patients the freedom to take risks, fail, and try again (and often again) preserves their dignity even though they may pay for it with their health and we as a society pay for it with our health care resources. Nevertheless, we are left wondering, might one of the central motivations informing the action of discharging patients "home to fail" not in fact be morally wrong, and might this influence our ethical assessment of the practice? If so, to what extent does this particular motivation matter if the action is *prima facie* ethically right?

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