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ETHICS CASE

Safety and Ethical Considerations in Discharging Patients to Suboptimal Living Situations

Commentary by James Hill, MD, MPH, and William Filer, MD

Dr. Wayne, a physiatrist, is part of an interdisciplinary team that provides comprehensive services for people with conditions that result in long-term cognitive and physical limitations, such as stroke, spinal cord injury, amputation, major trauma, and brain injury. Dr. Wayne and the rehabilitation team are meeting with Martha, a 45-year-old woman who has spent the last six weeks in an acute inpatient rehabilitation unit. Martha sustained a T12 complete spinal cord injury and a moderate traumatic brain injury as the result of a car accident.

Dr. Wayne is pleased with Martha's rehabilitation course and overall adjustment to her injuries. Martha is able to use a manual wheelchair without assistance for mobility and is independent with her bowel and bladder management. She has also made excellent progress from her [traumatic brain injury](#) and has been evaluated to make sure she is competent to make her own decisions. Based on her functional and medical status, Martha is ready for discharge, and she wants to go home with her 22-year-old son, Brett, who lived with her prior to her accident. The social work team has secured disability status for Martha, and her social security disability payments—which Martha hopes will be enough to cover her bills—will begin in a month. Dr. Wayne hopes to discuss some of the issues related to the current discharge plan with Martha and Brett.

A physical therapist has performed a home evaluation and noted that the apartment is not optimal for Martha. The bathroom is too narrow to maneuver her wheelchair, and there are no handrails near the toilet and shower to help with her transfers. Her apartment unit also lacks an appropriate ramp to allow Martha to enter and exit the apartment without assistance. While the initial discharge planning identified these concerns, Brett has refused to find more appropriate housing for his mother, stating that he prefers to stay in the same apartment. The social work team members who have interviewed Brett say that his only employment is doing odd jobs for others in the apartment building. Without Martha's income in the last four months, the electricity in the apartment had been turned off once. The nursing staff has also raised some concerns about Brett's behavior with his mother and report that he smells of alcohol when he visits her on the rehabilitation unit. Many of his visits with his mother end in his becoming angry and raising his voice at her before he stomps out of the hospital. Despite these concerns, both Martha and Brett insist that she will be safe at home.

Commentary

Discharge planning is of paramount importance in inpatient rehabilitation care. The Centers for Medicare and Medicaid Services mandate that an anticipated discharge plan be documented *before* a patient is admitted to an inpatient rehabilitation facility [1]. However, the question of what constitutes a safe discharge plan is a subjective one. Rehabilitation physicians are familiar with the challenges a person with a new physical disability will face after discharge. This case brings up the importance of caregiver trustworthiness and a patient's autonomy to accept less-than-ideal living conditions.

Martha has had a formal assessment during her rehabilitation course that indicates that she has decisional capacity—this is an important consideration in many trauma cases, particularly after brain injury. She clearly expresses that she wants to go home, and Dr. Wayne believes it would be medically appropriate to discharge her. Often, financial and hospital administrative pressures can lead to early discharge, but, in this particular case, both Martha and the physician feel that she is ready to leave the hospital. The environmental barriers to independent living at home (lack of ramp, inaccessible bathroom) are concerning, but protections afforded by the Americans with Disabilities Act and Fair Housing Act might allow Martha to break her lease without penalty and find more accessible housing.

Questions about Martha's Wishes

Being declared competent does not mean Martha is free from all cognitive limitations that can affect her ability to live independently. For example, mild deficits in memory or executive function can lead to difficulty keeping track of finances or paying bills. There are also concerns about her son, Brett, who will serve as her primary caregiver. A picture is painted of a young man who lacks employment and is suspected of abusing alcohol. It bears noting, however, that evidence of alcohol or drug abuse by a family member does not alone constitute a safety hazard for the patient, nor does it always indicate a physically or emotionally abusive relationship. Dr. Wayne should seek to clarify the content of the arguments with those who observed them. Furthermore, the discordance between the patient's accounts of her son's visits and those reported by staff signals the possibility of denial or "reaction formation," a psychological defense mechanism whereby the patient responds to an anxiety-producing situation by exaggerating the opposing tendency. Denial is common in victims of abuse by relatives, highlighting the need for greater watchfulness among health care professionals [2].

A physician is ethically and, in most cases, legally obligated to report suspected abuse [2]. This includes not only physical abuse, but also psychological abuse and financial exploitation. We are given little detail regarding the arguments that took place between Martha and Brett. Certainly, any observed threatening or belittling language should prompt notification of Adult Protective Services.

Discussing Martha's Wishes

Exploring the patient's relationship with her son using neutral and nonjudgmental questions may offer further insight into the problem. Does Brett have a history of addiction, mental illness, or disability? Why is he refusing to move apartments? It appears he has needed to rely on his mother for housing and financial support. Caregiver financial dependency has been shown to be a risk factor for abuse [2]. Other factors that should be explored include Martha's pre-injury employment, educational background, financial resources, and social support network. Interviewing the patient and family member separately is recommended [3].

Dr. Wayne has several ways to address his concerns with the patient. Emanuel and Emanuel outline four basic models of physician-patient interaction related to medical decision making [4]. In the *paternalistic model*, the physician takes responsibility for deciding what interventions are best for the patient's health and well-being. As applied to this case, it may be that the optimal discharge plan for Martha would be to find a new, accessible apartment where she could live alone independently—without needing to rely on, and perhaps free from the destructive behaviors of, her son. This kind of paternalism is flawed, however, in that it does not take into account the patient's right to self-determine.

In the *informative model*, the physician only provides information, unbiased by his or her own values, and the patient makes an informed decision about how best to pursue his or her values given that medical information.

In the *interpretive model*, the physician elicits information about the patient's values and then helps the patient make a medical decision consistent with them. This may involve further exploring Martha's relationship with Brett. Perhaps there are cultural or other values that have played a role in Martha's cohabitation with her adult son beyond simple financial dependence.

Finally, the *deliberative model* involves the physician's helping the patient form or choose health-related values. In other words, the physician facilitates the patient's own "moral self-development," taking great care not to project his or her own moral beliefs upon the patient and refraining from taking up moral issues unrelated to health care decisions. In this case, Dr. Wayne must be careful not to inadvertently shame Martha, which would be detrimental to the patient-physician relationship. Formulating questions in a judgmental way—for example, asking Martha "Why do you choose to live with your unsupportive son?"—is unlikely to foster open communication.

Lastly, it is important to respect patient preference and autonomy. Martha has, in fact, expressed her wish to go home, which she is competent to do. A decision to return to

suboptimal living conditions is an autonomous, competent person's prerogative and may be perfectly rational, in the context of her belief and value system. However, it is important that this decision is not coerced by her son [5].

After Martha Returns Home

As Martha prepares to leave the hospital, various social services may be available to her. Many newly disabled people need assistance when they first transition to home. If Martha does return to her apartment, home visits would facilitate information gathering about matters including living conditions and Martha's relationship with Brett. It is vital that Dr. Wayne follow up with the home health practitioners who are able to observe the home environment and family social dynamics. In addition, one recognized (and we believe modifiable) risk factor for abuse is social isolation [3]. Many newly disabled people find community socialization more difficult because of mobility barriers. It is important to identify support groups, transportation assistance, and other programs that can promote social reintegration.

While a physician may not be able to solve social and environmental issues such as these for every patient, it is important to assess these factors as part of comprehensive discharge planning.

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