What is it that you want me to do? Guidance for ethics consultants in complex discharge cases

Abstract: Some of the most difficult consultations for an ethics consultant to resolve are those in which the patient is ready to leave the acute-care setting, but the patient or family refuses the plan, or the plan is impeded by deficiencies in the healthcare system. Either way, the patient is "stuck" in the hospital and the ethics consultant is called to help get the patient "unstuck." These encounters, which we call "complex discharges," are beset with tensions between the interests of the institution and the interests of the patient as well as tensions within the ethics consultant whose commitments are shaped both by the values of the organization and the values of their own profession. The clinical ethics literature on this topic is limited and provides little guidance. What is needed is guidance for consultants operating at the bedside and for those participating at a higher organizational level. To fill this gap, we offer guidance for facilitating a fair process designed to resolve the conflict without resorting to coercive legal measures. We reflect on three cases to argue that the approach of the consultant is generally one of mediation in these types of disputes. For patients who lack decision making capacity and lack a surrogate decision maker, we recommend the creation of a complex discharge committee within the organization so that ethics consultants can properly discharge their duties to assist patients who are unable to advocate for themselves through a fair and transparent process.

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The following cases are constructed from the clinical experience of one of the authors ([redacted for review]) in the acute-care adult hospital setting. The cases have been de-identified and lightly fictionalized to protect patient privacy. None of the cases represent experiences had at our currently affiliated institutions.

Case 1: Patient who lacked decision-making capacity was admitted for an elective neurosurgery in consultation with the family. Patient was stable for discharge after a week, but unable to return to previous living situation because the family said they were no longer capable of providing caregiving resources. More than a month later, insurance ceased payment, and an accepting facility was found six hours away from the nearest family. Patient's goal was to rehabilitate the ability to walk. Closer facilities were not accepting due to COVID-19 outbreaks (crisis standards of care were not invoked). The patient consistently voiced a preference not to go despite lacking capacity. The family refused to authorize transport because of the distance, leading to a heated exchange with the attending who expressed to the family that they were being selfish for taking up a bed someone else could use. The transport service required the family's consent to place her on the gurney and they refused to give it. The ethics consultant was asked if it would be permissible to invalidate the family's surrogate decision-making authority and transport the patient anyway.

Case 2: Patient with history of chronic pain presented after a fall with a lower-left extremity fracture. The patient had decision-making capacity and was stable to discharge for more than two months but unable to walk. A local facility was willing to accept, but the patient refused, believing it would not offer effective treatment. The transport service required the patient's consent to place her on the gurney and she refused to give it. The patient made two appeals to Medicare to dispute the cessation of payment, but both were rejected. Hospital administration considered pressing trespassing charges. The ethics consultant was asked about the appropriateness of unplugging her television and was asked to help persuade the patient to adopt the team's plan before involving the authorities.

Case 3: Non-ambulatory patient with dementia and complex chronic care needs complicated by a sexually transmitted infection. The patient lacked decision-making capacity, had no surrogates, and was represented by the hospital ethics committee while hospitalized. The patient was medically stable for discharge for over three months with no accepting facilities due to unrepresented status and complex needs. The COVID-19 outbreak further limited options (crisis standards of care were not invoked). The team found an accepting facility six hours away and the patient voiced a preference not to go. The ethics consultant was asked to approve of the discharge plan.

Introduction

Some of the most difficult consultations for an ethics consultant to resolve are those in which the patient is ready to leave the acute-care setting, but the patient or family refuses the plan, or the plan is impeded by deficiencies in the healthcare system as a whole (Jankowski et al. 2009). Either way, the patient is "stuck" in the hospital and the ethics consultant is called to help the team get the patient "unstuck" (Meo et al. 2020). These encounters, which we call "complex discharges," are beset with tensions between the interests of the institution and the interests of the patient as well as tensions within the ethics consultant whose commitments are shaped both by the values of the organization and the values of their own profession.[1] Nonetheless, the clinical ethics literature on this topic is limited with little guidance about how to approach cases like those above. Specifically, guidance is needed for consultants operating at the bedside and for those participating at a higher organizational level. To fill this gap, we offer guidance for facilitating a fair process designed to resolve the conflict without resorting to coercive legal measures that will be beneficial to trainees and experienced consultants alike.[2]

Complex discharges are often challenging. Nearly always, some kind of barrier to a safe discharge exists. These barriers are usually financial, logistical, or legal in nature. In some cases, trust may have eroded, adding to the complexities. All of this adversely affects efficient "throughput"—getting patients in and out of the hospital as quickly and

[1] A discharge becomes "complex" when barriers to safe discharge create "the need for extended and labor-intensive discharge planning" (Cesta 2016).

[2] We realize that some conflicts will be intractable and a legal solution to the conflict will be needed. The following recommendations are meant to provide a process that is to be explored before the legal system is invoked.

safely as possible—a major organizational interest so more patients can be seen. Nonetheless, this interest could potentially conflict with the institution's commitment to provide patient-centered care which, under ideal conditions, would allow for more time and attention for admitted patients to heal and recover (Angell 1987; Churchill 1997; Paul and Lin 2012; Sweet 2012, 2018). In general, patient-centered care entails a duty to respect refusals of treatment, which may include a prima facie (overridable) right to refuse the offered discharge plan. While it may be legal and less problematic to discharge an able-bodied patient who refuses a safe discharge plan, things are much more complex with patients who, as in the cases above, are non-ambulatory and a gurney must be used to safely move them. Even if the patient has no legal or ethical right to stay in the hospital and ought to be removed (Wilson et al. 2016), third-party providers of non-emergent transportation services may require consent to place the patient on the gurney (so as to avoid liability), which means the patient (or surrogate) is able to halt the discharge process. In any event, there remains a conflict about whose interests matter more, the patient's or the institution's, and the ways of resolving the conflict risk involving coercion, a risk ethics consultants are called upon to help avoid or minimize.

Perhaps the most excruciating case illustrating this conflict is the case of the injured (non-ambulatory), undocumented worker who is unable to be placed locally because of a lack of insurance and who refuses to be repatriated to an accepting facility in their country of origin (Parsi and Hossa 2012). What is distressing about cases like these is that (1) there are strong ethical reasons that support the positions of the conflicting parties, and (2) it is hard to find concrete guidance from medical and legal authorities

about how to resolve them. The perception of unresolvable conflict leads to feelings of moral uncertainty, which are deeply unwelcome when one's responsibility is to formulate ethically acceptable recommendations to resolve the conflict.

Complex discharges are also beset with broader systemic problems such as the cost of care, limited insurance coverage, and the multifaceted disadvantages patients suffer because of low-income status, stigma, and discrimination. Although how to adequately address these large and difficult topics requires further research, we focus narrowly on the challenge ethics consultants face in determining how they can improve the discharge process in ways that are more ethical, humane, and ultimately restorative of trust. The cases above were chosen not because of their ethical complexity, but because they illustrate occasions in which the tension between acting as an agent of the institution and providing patient-centered reasons in one's recommendations for action is acutely felt. As such, they provide opportunities for crafting responses at the individual and organizational level that can help clarify the consultant's approach in working towards a resolution.

Centering Trust

While ethics consultants have different specialties, institutionally defined roles, and contractual responsibilities, their professional responsibility is "to resolve uncertainty or conflict regarding value-laden concerns that emerge in health care" (Core Competency Task Force 2012, p. 2). But to what end? We submit that it is to safeguard and promote trust between the relevant stakeholders in ways that are consistent with generally accepted ethical standards. The many "hats" an ethics consultant wears in an

institutional setting, whatever they may be, ought to be ordered to the protection and promotion of trust as one works towards an ethically justified resolution to value-laden problems. This can take various forms. In the organizational setting, the ethics consultant should promote policies that will make the institution more trustworthy, both to whom it serves and those who labor to deliver its service. In the clinical setting, the ethics consultant should promote trust between patient and provider by ensuring clear communication either in terms of informed consent, policy communication, or boundary setting. Ethics consultants have a special responsibility to promote conditions in which everyone's interests are taken seriously.

In addition to the common problems of unclear communication and uninformed decision making, the problems in complex discharges involve conflict over the available options, disagreement over which one is truly beneficial, and dispute over who has the authority to decide which option to pursue. What is needed is a fair process to help resolve these problems. When everyone involved knows they are being treated with fairness, they have a good reason to trust the representatives of the institution, if not the institution itself, in which the process is implemented.

In complex discharge cases, both sides of a dispute may perceive unfairness. On the one hand, the team believes their duties to the patient have been met insofar as they have stabilized the patient's acute-care needs and provided a safe discharge plan. Therefore, the team believes discharge should happen in a timely manner to make space for other patients with acute-care needs and to avoid administrative disapproval for not meeting predefined length-of-stay targets. On the other hand, the patient or the patient's

surrogate may not have the financial resources to support the plan, or they believe they are not being given a fair opportunity for their preferences to be heard (for example, in the amount of time given to assess the options), or that their interests are automatically being discounted because their stable medical status no longer makes them a priority. Of course, more than fairness is involved. Diverging views about what will benefit the patient and the extent to which autonomous choice plays in settling the matter also complicate the matter. Nonetheless, a fair process creates the opportunity to identify diverging views of "benefit" and "harm," a basis for weighing such considerations, and a forum for settling the disputes over them to help promote trust on both sides, something that should be tried before escalating to the legal system.

How should ethics consultants ensure that all the stakeholders involved are treated fairly? We argue that the approach of the ethics consultant is generally one of mediation in these types of complex discharges.[3] This can be difficult to do because there is often pressure to take sides in the dispute. Because of potentially unfair assumptions or biases, we argue for the mediation approach. Still a problem remains: the mediation approach is unable to serve patients who lack decision making capacity and lack a surrogate decision maker. Therefore, we provide specific guidance for how to assist patients who are unable to advocate for themselves and lack representation by constructing a complex case committee within the organization so that ethics consultants can properly discharge their duties through a fair and transparent process.

[3] The sense of "mediation" here is not the "pure consensus" approach rejected by the American Society for Bioethics and Humanities "Core Competencies" but rather is in line with the "ethics facilitation" approach (Core Competency Task Force 2012, p. 11; Dubler and Liebman 2011).

Approaches to be Avoided

There are (at least) four potential approaches for the ethics consultant to avoid. Two of these may arise externally from the expectations of the team, and two may arise internally from confusion over the proper responsibilities of the consultant.

The "Threat Assessor" Approach

The first approach to be avoided, which comes up in Case 1 and 2, is the "threat assessor" approach. In this approach, the team expects the ethics consultant to not only approve of the discharge plan but also evaluate more or less coercive means for executing it. The consultant may be asked if it is "ethical" to make the patient's stay less comfortable by unplugging their TV, serving cold food, or delaying responses to non-medical requests in order to "nudge" them out of the hospital (Swidler et al. 2007). Requests for permission to ignore or invalidate surrogates, who are otherwise acting in the best interests of the patient and providing substituted judgment, are also illustrated in Case 1.

The fundamental problem with this approach is that it is biased against the patient's interests and makes the ethics consultant just another arm of the institution to be weaponized against them. Indeed, the institution may not be well-served by this approach because advising the implementation of coercive actions exposes the institution to legal risk. As obvious as this may be to the ethics consultant, it is often not obvious to the team. Oftentimes the team believes they have "tried everything" to reach a shared decision; they may be frustrated with the patient or surrogate and feel pressure

from the administration. Or they may feel compelled by the principle of justice to free up the bed for a patient with more acute needs. The ethics consultant should compassionately, but firmly, respond to these queries by saying, "My role is better suited to come up with a plan about what we can do *for* the patient, not settle questions about what we can do *to* the patient—those questions are better suited for risk management to address."[4] This is not to say that the consultant has no role to play in evaluating whether the team's plans are consistent with the law and established ethical guidelines.[5] The consultant should frame these evaluations in terms of de-escalation, thus moving away from escalating options of hostility to re-orienting the team towards non-coercive solutions (Fiester 2013).

The "Behavior Management" Approach

The second approach that the ethicist may be expected to take, which comes up in Case 2, is the "behavior management" approach. According to this approach, the ethics consultant takes on the responsibility of getting the patient (or the surrogate) to behave

[4] Acts of coercion expose the institution to legal risk and therefore require an analysis outside of the expertise of the ethics consultant.

[5]One might sense a tension here since it is within the role of the ethics consultant to weigh in on the moral permissibility of the means a hospital might use to influence a patient in a complex discharge case. While we agree that judging various interventions as "threatening" or "coercive" is to make an assessment, it is in the sense of assessing the proposed means as "threats" or not, which is not the same thing as assessing threats as being "acceptable" or not (which is what we take the "threat assessor" approach to be). The team treats the consultant as a "threat assessor" when they presume there is some acceptable range of threats they can impose and they seek the consultant's guidance to find out what they are. By contrast when a consultant affirms to a physician that they may make a recommendation or use presumptive communication to persuade the patient toward a decision, the consultant is not acting in a way that conflicts with our argument, because the consultant is not assessing the physicians' activity to determine whether it is an "acceptable threat" (since those activities do not even fall into the category of threats). In short, it is appropriate for the consultant to determine whether something is a threat and advise against imposing them for the sake of expediting a non-coercive resolution, but it is not appropriate for the consultant to share the team's assumption that it is permissible to impose threats and then offer advice on how severe those threats should be. We appreciate an anonymous reviewer drawing attention to this tension.

in the way the team desires for the sake of expediting their discharge plan. This manifests in a crude way when recommendations are sought for how to draw up or enforce the terms and conditions of a "behavioral contract" for the patient (something that tends to favor the team) (Fiester and Yuan 2021; Tarzian and Marco 2008). In these situations, the ethics consultant is expected to persuade a "difficult" patient to adopt the team's plan, correct the problem of "non-compliance" and communicate expectations for acceptable behavior and the consequences of not meeting those expectations.[6] The consultant is expected to be allied with the team's position and be used as a tool for achieving the team's preferred outcomes. The patient's interests and position are prejudged as obstacles to the desired outcome of the team. If the consultant is asked to take this approach, the consultant should respond to requests for behavioral management by stating, "I'm sorry, but how to best manage the behavior of patients is a practice outside of my area of expertise; what do you believe the ethical issue is?" Certainly, it may be prudent to highlight persuasion strategies that have worked in the past and suggest transparent and effective ways to engage the patient borne out of clinical experience, but sharing this advice is appropriate only if the patient's interests have been accounted for and given due consideration. In short, the problem with the behavior management approach is that, as a matter of bias, it prioritizes the team's or institution's interests over the patient's as if this prioritization is just to be expected.

[6] It is important to note that we are not saying that there is no place whatsoever within the consultant's job description to assess and address a patient's behavior. When patients are verbally abusive and make discriminatory remarks to staff it is permissible, if not obligatory, for the consultant to support the judgment that such behavior is not acceptable and help communicate the expectations and hospital policy concerning such behavior. Rather, our focus is more narrowly concerned with managing the patient's behavior for the sake of expediting discharge.

The "Autonomy Guardian" Approach

The third approach to be avoided, which threatens to take shape in Case 2, is the "autonomy guardian" approach. Here, the ethics consultant seeks to protect the patient's autonomous choice as the decisive moral factor. Pressure to take this approach can be internalized when the team believes that the ethics consultant is unduly biased in favor of the patient when the ethics consultant refuses to take the two previously mentioned approaches and recognizes that the patient's interests and voiced preferences cannot be set aside. Ethics consultants are often consulted about issues involving patient autonomy in other clinical settings and they may be disposed to understand their role in terms of guarding patient autonomy against paternalistic medical practice (Wasson et al. 2016; Clements and Sider 1983). While autonomy considerations may genuinely be at stake, avoidance of this approach should be understood as avoidance of bias in favor of the patient's position. To be sure, patients with decision-making capacity "can make a decision to be in an environment that's not safe" (West 2020). For example, patients with decision making capacity are allowed to leave the hospital "against medical advice"—even if it is not in their best interests. However, patients are not allowed to "stay against medical advice" (Chen 2015). Their autonomous choice to stay generates no right to live in the hospital when their acute-care needs have been met and a safe discharge plan has been provided. Considerations of the just allocation of resources conflict with the "autonomy guardian" approach, because there are other patients in the acute-care setting who need the bed more than the one who is stable for discharge (Schlairet 2014). Therefore, gathering more information about why the patient wants to

stay and to determine the range of options available to the patient is the first duty of the ethics consultant.

A caveat is in order. Avoidance of the "autonomy guardian" approach should not be confused with avoidance of advocating for the patient, something ethics consultants are involved with in certain jurisdictions that utilize hospital ethics committees to make decisions on behalf of patients who lack capacity and have no surrogates (Pope et al. 2020). Yet, as Case 3 illustrates, advocating for the patient can be difficult to do in a complex discharge because ethics consultants are never free from setting aside the interests of the institution that hired them or the interests of other patients who are in need of the bed.[7] To alleviate the conflict between these responsibilities, we recommend the formulation of a multi-disciplinary committee in which the ethics consultant can properly discharge their duties to the patient, something we describe in further detail below (Parsi 2022).

The "Resource Allocator" Approach

The concern over dual loyalties to the patient and the institution is related to the fourth approach to be avoided, the "resource allocator" approach, in which the ethics consultant takes on the responsibility for advising decisions involving patient welfare based on hospital rationing interests (present in all three cases). It is understandable for teams to reinforce the strength of their positions by appealing to the just allocation of

[7] See ASBH Code: "Promote just health care within HCEC. HCE consultants should work with other healthcare professionals to reduce disparities, discrimination, and inequities when providing consultations" < https://asbh.org/uploads/ASBH_Code_of_Ethics.pdf>.

resources, the failure of which may be a source of moral distress among team members and of economic interest to the institution. This sense of distress was deeply exacerbated during the COVID-19 pandemic (Fins and Prager 2020), and ethics consultants were often involved with crafting hospital policies about resource allocation decisions during that difficult time.

Even though it is a legitimate ethical concern, we recommend that when communicating with the patient, the ethics consultant make every effort to avoid letting resource allocation drive the decision as if the patient's interests and welfare are secondary. If a patient-centered resolution is to be sought, it will not help to treat resource allocation interests as primary and the patient's interests as secondary. While it is understandable to consider the needs of other patients, presenting those needs to the patient or the surrogate decision maker as the primary reason the patient should discharge is just to tell the patient to put aside their interests for those others. This may be morally satisfying, but we believe it is counterproductive, something the attending physician in Case 1 discovered much to the frustration of everyone involved. Unless the circumstances are extraordinary,[8]the reasons given for discharge should be "patient-centered" meaning they should explain how the plan benefits and avoids harm to the patient. Long length of stays in the acute-care setting put patients who are stable for discharge at risk of hospital-acquired infections and delay the benefits of physical and occupational therapy that can only be found in long-term care settings. The consultant

[8] Extraordinary circumstances would include those under which "crisis standards of care" are invoked, or when there is an identifiable patient with acute needs in the emergency department that needs the bed or when the hospital administration is involved with deciding the issue.

should acknowledge and communicate, if appropriate, that continuing to reside in the acute-care setting is not an option for the patient and should redirect the team to consider reasons for discharge that directly bear on the patient's welfare such as the medical risks posed by a prolonged hospital stay.[9]

The Approaches to be Pursued

A fair process can take on two forms, either in the form of neutrality between the positions of the two conflicting parties in the role of mediation, or in the form of representation and advocacy within a committee designed to resolve the discharge dispute. These forms require further specification.

The Mediation Approach

An attitude of neutrality between two positions is justified when one is called upon to resolve a conflict between parties whose inconsistent positions are justified by well-established ethical principles. In disputed discharge cases, the team has the legal right to discharge the patient when the patient's acute-care needs have been met and a safe-discharge plan has been provided (Wilson et al. 2016). Nonetheless, the effort to provide patient-centered care typically includes an effort to seek agreement from patients (or their surrogates) on the acceptability of the discharge plan, which implies that they have a prima facie (non-overridable) right to refuse a plan they believe is not in their best interests. Even if the effort to provide patient-centered care has been exhausted,

[9] Again, things may be different under crisis-standards of care. In this paper, we are concerned with what might be called "ordinary standards of care"—standards which seemed to be preferred even under the stress caused by the COVID-19 pandemic.

patients who are not able-bodied can refuse to be placed on a gurney by the transport service, and transport services typically will not move patients without consent. Thus, a serious practical conflict remains about what to do that needs resolving even if legal and ethical reasons support discharging the patient without their consent.

Yet this conflict identifies the opportunity for establishing an approach that is appropriate for the ethics consultant to take: the mediation approach (Fiester 2015). The goal of this approach is to facilitate a process that fosters trust through its fairness and rebuilds trust by showing itself trustworthy to the parties involved. To do this as a mediator, the consultant is to be neutral with respect to the *resolution* while ensuring all voices are heard and every interest articulated. It is important to stress that this form of neutrality is consistent with the imperative to provide equitable treatment to the parties involved, which may require supporting and uplifting the voices of stakeholders that are vulnerable to social marginalization and signaling comprehension of the reasons for their mistrust (Fiester 2012; Sullivan 2020). The consultant is to carefully monitor and guide the dialogue to a shared resolution that aligns the interests of the parties involved. In short, the consultant is to be an advocate for everyone involved so that they can communicate their values.

The neutrality of the mediator does not preclude exploring different ways of getting the patient "unstuck" from the hospital. The starting point should always be an exploration of everyone's interests that motivate their positions. Pre-meeting alone with each party is helpful because it allows them to privately disclose what they believe the fundamental problems are. The ethics consultant should be on the lookout for any miscommunication

or false assumptions at this stage. The next step is to determine if there are any shared interests and to highlight those if the parties are willing to meet with one another. If there is to be a meeting between the parties, the consultant should begin by highlighting the shared interests despite the conflicting positions, explore all possible options with everyone, raise "what if" scenarios to determine what is acceptable, and then communicate timelines about the next steps in the process or how to implement a resolution if one emerges from the discussion.

After following this process in the first two cases, the teams and the patients/surrogates learned that they were unified in their pursuit of recovery and avoidance of further delays and deterioration. The alignment of the parties around these shared goals reduced the adversarial nature of their interactions and reoriented the parties to a shared project. This sense of shared responsibility empowered the patients and their families to be creative in the search for solutions. In Case 1 and 2, both patients felt like passive objects being moved around when in fact they had done their own research into various options. Solutions presented themselves shortly after the patients started working with the ethics consultant and the case manager more closely. Like many long length-of-stay patients who cycle through several physician rotations, important details about their situation had slipped through the cracks. While the patients in both of those cases were aware of incurring costs, they were not as aware that their care was being compromised by remaining in the acute-care setting and that the administration was seeking legal counsel about how to remove them from the premises. When these facts were disclosed, the patients became more involved in finding and securing outside care

that aligned with their goals and eventually left the hospital (one in a matter of days, the other in a matter of weeks).

The Complex Case Committee Member

Case 3 illustrates a problem for consultants who are involved with authorizing decisions for unrepresented patients. The dual loyalties to the patient and institution are hard to manage if there is no forum in which the consultant is empowered to discharge their duty to advocate for a course of action that is in the best interest of the patient in consultation with other organizational stakeholders.

We therefore recommend that institutions provide a formal mechanism such as a multidisciplinary complex case committee tasked with resolving challenging discharges, in which the consultant can properly fulfill their duties as an advocate for those who lack capacity and lack surrogates (MacKenzie et al. 2012). The complex case committee is an appropriate forum to acknowledge the emotional distress these cases have on the care team and allow for a safe protected space where members can freely share their concerns without judgment. Critical to the success of this committee is its structure, which requires leadership from a senior authority within the organization, such as a senior physician leader, and several departments within the institution to ensure key disciplines contributing to patient care are represented, inclusive of the primary attending who has ultimate responsibility for the patient (Parsi 2022). Examples of disciplines represented are risk management, finance, psychiatry, social work, case management, physical/occupational therapy, palliative medicine, and ethics. A collaborative forum like this allows the ethics consultant to be free to represent the

patient's best interests, ask probing questions, and explore creative options, including leadership collaborating with agencies outside one's own institution. It is also necessary for the leader to create a safe space, be adept and challenge the committee with probing questions geared to avoid "group think," and allow members to come up with creative solutions that are safe and in the best interest of the patient. The need for such a mechanism is all the more pressing since the COVID-19 pandemic created challenges for placement and acute-care facilities had to get creative in finding places where patients can go.

Although the patient in Case 3 did not benefit from a complex case committee, it is easy to understand how it could have benefited her. Not described in the case is the fact that she had a loyal and caring Primary Care Provider (PCP), who strongly advocated for the patient to either be placed locally or for the institution to create a plan to transfer the patient back to the area in which the PCP practiced. This person could have been invited to a meeting to help the patient navigate the limitations of an acute-care hospital and network with other providers and heath care resources. Ultimately, the help of legal counsel would have to be obtained to increase the chances of the discharge plan succeeding with key stakeholders involved.

Summary

The cases reported here illustrate the potential challenges an ethics consultant may face with regard to complex discharges. Sometimes patients have no interest in leaving the hospital at all and display symptoms of "malingering" or other more serious psychiatric conditions (Moran et al. 2010). The proper approach of the ethics consultant in any

complex discharge must be characterized by a commitment to establishing a fair process for resolving them either through mediation or participation in a multi-disciplinary complex case committee. Unfortunately, today's acute-care center cannot afford space for convalescence due to space and financial constraints. Without stewardship, the next patient who needs the acute-care bed may not be able to get care. Yet, "Too often," as Lydia Dugdale says, "patients find themselves on medical conveyor belts that move swiftly and efficiently through treatments and procedures" (Henderson and Dugdale 2020). When the time for discharge comes and a patient refuses the plan or some other barrier prevents a seamless discharge, trust between the patient and the team may break down, making for a difficult situation to resolve. While we believe the consultant's service can be helpful in these situations, it is also limited; as we state at the end, a useful innovation is the creation of a standing "complex case committee" where the ethics consultant is one of several stakeholders involved in the discharge planning of the patient. Such a committee can mitigate against some of the potential approaches described here and can offer creative and effective solutions for the discharge of a patient in such complex circumstances.

Table

Approach to Avoid	Indications	Problem	Response
Threat assessor	Team requests an evaluation of proposed means to get the patient out of the hospital; the means are designed to cause discomfort or be coercive.	Biased against patient's interests; reinforces adversarial relationship; escalates conflict; outside of expertise	Rule out any proposals that clearly cross legal or ethical boundaries. Clarify that the consultant's role is better suited to come up with a plan about what to do *for* the patient, not *to* the patient.
Behavioral manager	Team requests help in addressing patient non-compliance; setting boundaries and behavioral expectations; persuading the patient to adopt the team's position	Biased against patient's interests; manipulative; reinforces adversarial relationship; outside area of expertise	State that behavioral management is outside their area of expertise and then inquire about what the team believes the ethical issue is.
Autonomy guardian	Failure of the consultant to distinguish between the right to refuse treatment and the right to request treatment that is not indicated; disposition to give patient autonomy the most weight in the analysis; undue fear of any sort of coercion	Biased against the team's interests; reinforces adversarial relationship; fails to acknowledge limits of the patient's options; fails to acknowledge justice considerations	Gather more information about the conflict to determine the range of options available to the patient.
Resource allocator	Decisions concerning patient welfare are based on hospital rationing interests; crisis standards of care have not been invoked.	Lack principled criteria for decision making; disposition to give justice the most weight in the analysis; outside of prescribed role.	Communicate that continuing to reside in the hospital is not an option; direct team to consider reasons for discharge that highlight patient welfare.

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