

## CHAPTER 10

# No Need to Object

### *Ethical Obligations for Interprofessional Collaboration in Emergency Department Discharge Planning*

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#### **ABSTRACT**

Emergency departments (EDs) serve a wide range of patient needs. A crucial aspect of safe and effective care in the ED is to appropriately transition patients to the next level of care. In most EDs, this disposition planning is done exclusively by physicians, which has the potential to result in unacceptable harm. A virtue ethics approach demonstrates the need for explicit inclusion of nurses in disposition planning. In utilizing this approach, it is necessary to examine four focal virtues as they relate to the work of disposition planning and the moral character of the nurse. The virtues of prudence, trustworthiness, vigilance, and courage show that interprofessional collaboration is needed during disposition planning to promote patient safety, facilitate interprofessional relationships, and prevent moral distress. The majority of literature on disposition planning is empirical in nature; this chapter adds a normative argument and a motive for policy reform.

## INTRODUCTION

Emergency departments (EDs) are serving as an ever-expanding safety net for Americans with patients presenting at higher acuties than ever before. Given the limited availability of primary care providers, patients will continue to utilize local EDs even as more patients have health insurance through the Affordable Care Act. Patients in the ED are generally in need of rapid assessments and a swift plan of action. A coordinated interprofessional team of professionals blends its skills and knowledge to ensure safe and quality interventions. Yet one of the most critical aspects of a patient's emergency stay, disposition planning, continues to be exclusive to a single discipline. Most EDs support the physician, or physician team, to determine whether and where the patient will receive ongoing care. Nurses are assumed to be in agreement with the plan unless they object. Their objections are then offered only in reaction to the already formed plan. Significantly, however, one of the key elements in planning disposition is the level of nursing care the patient will require. This chapter provides a virtue ethics analysis of this practice and argues for the inclusion of bedside nurses during ED disposition planning, in the interest of averting harm to patient safety, preserving or strengthening interprofessional relationships, and avoiding moral distress. This chapter is not arguing that one clinician's recommendation should trump that of another member of the team. Rather, it is advocating for an inclusive interprofessional policy in the disposition process.

## DISPOSITION PLANNING

Disposition planning is the process of deciding what care patients require and where they can best receive that care after being stabilized in the ED (Perimal-Lewis, Hakendorf, & Thompson, 2015). For some patients, the plan is for discharge home. For others, the plan will be admission to a unit within the same hospital or to an outside facility for specialized care. The ED team's disposition decision determines the type, intensity, and location of the patient's subsequent care.

Determining the appropriate frequency and intensity of nursing assessments is critical to ensuring safe patient disposition. Patients with minimal or no nursing care needs are considered safe for discharge to their homes where they can care for themselves or receive assistance from their families. (Some of these patients may be discharged to residential facilities where different levels of skilled nursing care are available.) Patients who require professional nursing care are admitted to one of several units within the hospital: the intensive care unit (ICU), a step-down unit, a telemetry unit, or the acute care floor. Their destination is based on a match between their level of acuity and the availability of nursing care. In the ICU, nurses continuously monitor and assess patients. In contrast,

patients on an acute care floor receive less frequently scheduled assessments and more shared care between registered nurses (RNs) and assistants. Step-down and telemetry units usually offer less frequent assessments than ICUs, but more than acute care floors. Hospital units are also differentiated by nurse–patient ratios, availability of technology, and access to other professional services.

Although the disposition determination process varies among hospitals, the potential for adverse events when the wrong disposition is selected is ubiquitous (Calder et al., 2012; Horwitz et al., 2009; Kennedy, Joyce, Howell, Mottley, & Shapiro, 2010). In the ED, a preventable adverse event is two times more likely to occur than in any other inpatient area (Fordyce et al., 2003). Patients arrive without a schedule and are in need of emergent care. As a consequence, clinicians in the ED have relatively limited experience with a particular patient and are often rushed, trying to move people out of the ED quickly and efficiently to make room for new patients. One study showed that over half of patients discharged home from the ED prematurely experienced preventable adverse events (Calder et al., 2015). Similarly, ED patients admitted to the wrong level of care within the hospital make up one quarter of all rapid response activations within their first 24 hours and are at risk for delayed intensive interventions (Considine, Charlesworth, & Currey, 2014). By contrast, transfers to an inappropriately intensive setting can result in both increased costs and poor allocation of health-care resources, intensive care unit beds, and unnecessary tests and treatments (Calder et al., 2015; Considine et al., 2014).

### IMPORTANCE OF NURSING CONTRIBUTION

Given the importance of nursing care for the determination of disposition, it is surprising that nurses are not systematically involved in the process. Nurses can offer valuable assessment and knowledge of institutional practices, but they are often constrained in their participation in disposition planning due to structural hierarchies.

Assessment skills are fundamental to nursing practice, referred to as “patient surveillance” by the Institute of Medicine, and one of only three components consistently tied to lower patient mortality (Page, 2003). The nursing assessment collects valuable information, both implicitly and explicitly, about the patient’s physical, psychological, spiritual, and sociological status. A nursing assessment begins implicitly, noticing the particulars of a patient from across the room, from a patient’s ability to sit in a chair and hold a spoon correctly to the pattern of breathing and tactile features of the skin. An explicit nursing assessment includes monitoring vital signs, the sounds of a patient’s heart and lung, and a countless other formal examinations. There is no substitute for the nurse’s expertise.

Nurses are often holders of institutional knowledge, in part due to their longevity and consistency in the hospital. In teaching hospitals, physicians rotate through the ED on an intermittent basis. Even in community hospitals with a more stable physician population, physicians often see their primary location as their office or other community setting. Nurses then have a heightened knowledge of patterns of disposition, treating like cases alike. They are likely to know the institutional issues related to departmental specialties, staffing, and acuity, which affect disposition beyond the particulars of the patient case.

Nurses' relative lack of institutional power, however, can make it difficult to contribute these elements of assessment and knowledge during disposition planning. Structural hierarchical relationships limit the ability or willingness of the nurse to collaborate in the interprofessional planning of care. Explicitly empowering nurses, through policy or system change, would facilitate the shared goal of patient well-being.

### BRIEF OVERVIEW OF VIRTUE ETHICS

Virtue ethics focuses on a person's habits and character traits that tend to guide him or her to right action. The word *virtue* comes from an ancient Greek word *arête*, which translates as "an excellence of character." Aristotle claimed that virtues are states of character, separated into intellectual and moral virtues. Intellectual virtues are taught through instruction. Moral virtues are habitual, acquired only through practice and discipline (Armstrong, 2006; Timmons, 2006).

As defined by Aristotle:

Excellence is an art won by training and habituation. We do not act rightly because we have virtue or excellence, but we rather have those because we have acted rightly. We are what we repeatedly do. Excellence, then, is not an act but a habit. (as cited in Durant, 2006, p. 98)

Virtues in health care are the expression of a collective understanding of the moral obligations of clinicians for the patients in their care. Virtues are important not only to the moral agent who acts in accordance with them, but also to the profession itself and to the patients who benefit from the providers' virtuous actions. Each profession is responsible for defining the relevant virtues and for guiding its members toward the development of these virtues.

The Society of Academic Emergency Medicine (SAEM) endorses a set of virtues physicians should embrace. Prudence, courage, temperance, justice, unconditional positive regard, charity, compassion, trustworthiness, and vigilance are considered "vital" to the practice of emergency medicine (SAEM, 1996). Emergency nurses should be guided equally by these virtues to promote

the shared goal of patient health and welfare (Armstrong, 2006; Gardiner, 2003; Meyer & Lavin, 2005). Although all are important, disposition planning requires four virtues in particular: prudence, trustworthiness, vigilance, and courage.

Prudence is the ability to weigh virtues and vices in order to discern the wise choice in a particular situation. Aristotle called this virtue *phronesis* or practical wisdom. This virtue is considered the necessary prerequisite used to weigh other virtues (Larkin et al., 2009). Virtues are always held in tension with one another, and choosing the prudent action can be difficult. Clinicians' prudence is a form of expert clinical decision making. It facilitates their ability to see what is important, to be aware of what is missing, and to attend to potential biases in order to arrive at a morally sound and reasoned course of action (Dhaliwal, 2011).

According to Potter as cited by McLeod (2014), a clinician who is trustworthy is "one who can be counted on, as a matter of the sort of person he or she is, to take care of those things that others entrust to one" ("The Nature of Trust and Trustworthiness," para. 23). Clinicians enact trustworthiness and earn their patients' confidence through the development and maintenance of skills, honesty, and stalwart attention to patients' needs. Trustworthiness allows for vulnerable patients to receive treatment knowing they will be cared for, not exploited (Pellegrino & Thomasma, 1993). Clinicians who reduce their relationships with patients to a financial or legal enterprise are not trustworthy and jeopardize the very foundation of the therapeutic relationship (Larkin et al., 2009).

Vigilance is "a state of watchful attention, of maximal physiological and psychological readiness to act, and of having the ability to detect and react to danger" (Hirter & Van Nest, 1995, p. 96). Although some definitions of vigilance focus on the detection of enemies and the physical states that contribute to or detract from one's ability to be vigilant, in the health-care setting, this virtue is primarily interpreted as diligent watchfulness (Kooken & Haase, 2014).

Virtuous clinicians attempt to do what is right by being thorough and attentive to the obligations of their role. They protect their patients by foreseeing and avoiding or preventing potential harm, and by managing and overcoming adverse events (Kooken & Haase, 2014). Vigilance is necessary to respond to the directive of *primum non nocere* or "first do no harm."

Clinicians express moral courage when they speak up to ensure patient safety, are present even when it is difficult, and step in when needed. Moral courage is the "fortitude to do what is required, what is right, in the face of unpleasant or adverse conditions" (Larkin et al., 2009, p. 53). Clinicians who evade difficult situations, surrender to fear, or choose their course of action based merely on what is easy are not courageous (Larkin et al., 2009). Established hierarchies and

institutional barriers to collaborative communication require, sometimes unreasonably, clinicians to have moral courage when caring for patients (Gordon & Hamric, 2006).

These four virtues are critical to the practice of disposition planning in the ED. The clinicians' shared goal to promote a safe discharge of their patients drives their commitment to habitually practice these virtues. In the chaotic environment of the ED, clinicians must be vigilant and prudent to efficiently discern the appropriate course of care. In order for the shared goal of patient well-being and safety to be achieved, all must be trustworthy and have their trustworthiness recognized by others. In this setting, courage is often called for by the traumatic nature of the patient presentation. Unfortunately, the current policies do not include nurses as a stakeholder, undermining the nurses' trustworthiness and requiring additional courage to participate.

### PATIENT SAFETY RISKS

Patients' safe passage through their hospital stay depends critically on the work of virtuous clinicians to guide their journey. Incorrect patient disposition jeopardizes their safety and is linked to increased patient mortality and avoidable adverse events (Metcalf, Sloggett, & McPherson, 1997; Trinkle & Flabouris, 2011; Vlayen et al., 2012). A noninclusive disposition process limits a clinician's ability to practice virtues and thus risks the virtues themselves. Similarly, a noninclusive disposition process may result in harm to the clinician on whom patients depend.

Nurses practice the virtue of vigilance through the nursing assessment. Some describe the nursing assessment as evidence of the presence of vigilance (Kookan & Haase, 2014; Meyer & Lavin, 2005). Experienced nurses refine their assessment skills through pattern recognition and have an accelerated development of clinical intuition, most likely due to the sheer number of hours they spend at the bedside of patients (Hurst, 2010; Odell, Victor, & Oliver, 2009). Pattern recognition is an unconscious assessment expressed through a clinician's intuition, often referred to as a *gut feeling*, which clinicians then learn to trust over time (English, 1993; Hathaway, 1956; Lyneham, Parkinson, & Denholm, 2008; Odell et al., 2009; Pretz & Folsie, 2011; Ruter, Marcille, Sprekeler, Gerstner, & Herzog, 2012; Smith, 2009; Truman, 2003).

When experienced clinicians use intuition in patient care, it reflects both clinical and moral wisdom; both are developed through habit and time. As novices, everyone needs rules and procedures to guide correct behavior (Dreyfus & Dreyfus, 1986). Over time, clinicians develop their own expertise and vigilance. Just as they develop moral wisdom, so too they develop clinical intuition to

respond to subtle situational clues with deep knowledge and instinctive behavioral responses (Kooken & Haase, 2014). For instance, in emergent situations, experienced clinicians will often rely on their clinical intuition first to guide interventions and treatments, rather than a formal explicit patient assessment (Bjork & Hamilton, 2011; Dhaliwal, 2011). The subtle signs and symptoms of clinical deterioration can be detected through clinical intuition long before there are perceived changes in lab values or vital signs (Bjork & Hamilton, 2011; English, 1993; Luntley, 2011; Lyneham et al., 2008; Odell et al., 2009). Expert nurses may be able to articulate, immediately, the objective details they are noticing through intuition, but many nurses cannot. Osler once remarked that “there is no more difficult art to acquire than the art of observation, and for some men it is quite as difficult to record an observation in brief and plain language” (Osler & Silverman, 2003, p. 99).

A nurse’s relative lack of institutional power often makes it difficult to contribute his or her intuition to patient care decisions. During all patient–nurse interactions, from the moment the nurse sees the patient, they are continuously assessing the patient for potential threats. Once a threat of harm is identified, nurses diligently attend to this threat to prevent patient harm (Kooken & Haase, 2014). However when their intuitive knowledge is dismissed, ignored, or silenced, they must call upon moral courage to make their concerns heard (Kooken & Haase, 2014).

Expression of nurses’ clinical intuition can be supported through institutional structures. Rapid response teams (RRTs) were developed to protect patients from harm, provide an immediate responses to all requests, and to increase patient safety through early recognition of a deteriorating patient (Bristow et al., 2000; Chaboyer, Thalib, Foster, Ball, & Richards, 2008; Chan, Jain, Nallmothu, Berg, & Sasson, 2010; Chan et al., 2008; Hughes & Clancy, 2005; Trinkle & Flabouris, 2011; Vlayen et al., 2012). Nurses are the primary users of RRTs, with the highest call origination, which suggests they are the first to recognize when a patient might be at risk for harm (Wynn, Engelke, & Swanson, 2009). The RRT system allows for nurses to identify clinical warning signs presenting through clinical intuition *without* having to articulate or identify specific clinical symptoms, challenge the hospital’s hierarchy, or rely on trustworthiness between clinicians. RRTs are triggered 39% of the time by the categories of “worried” or “intuition” (Chen, Bellomo, Hillman, Flabouris, & Finfer, 2010). Retrospective chart reviews showed other triggers such as “respiratory problem” could have been selected instead of “worried” or “intuition” that support the creation of these seemingly ambiguous categories (Chen et al., 2010).

This example illustrates a policy, which affirms that the trustworthiness of nursing clinical intuition has been instituted successfully in other clinical areas.

Creating similar policies in the ED to include nurses in disposition planning would facilitate the practice of nursing vigilance and prudence. Full expression of these critical virtues will foster the goal of patient safety.

### **DAMAGE TO INTERPROFESSIONAL COHERENCE**

The structure of high-functioning teams is a focus of patient safety literature, with particular attention to the need to promote clinicians' shared virtues as well as the welfare of patients (Storch & Kenny, 2007). Good teamwork and effective interprofessional communication increases patient safety and improves patient outcomes (DeJoy et al., 2011; Manser, 2009; Storch & Kenny, 2007). However, the coherence of the interprofessional team is at risk when clinicians are unable to fully express their professional recommendations.

Interprofessional trustworthiness is essential to the goals of health care and clinicians typically see all members of the health-care team as trustworthy; yet it is still very difficult to establish trustworthiness as habitual in health care. Recognizing trustworthiness in another person requires a strong correlating relationship (McLeod, 2014). The development of relationships over time is not always possible in the clinical setting, and often there is a member of the health-care team who is new to the unit or floor. This is especially true in academic teaching hospitals and in organizations that utilize agency per diem clinicians. When such clinicians attempt to go beyond their predefined roles to provide input, team members use prudence to decide whether the unknown clinician's assessment should be valued.

A fundamental element of clinical judgment is to determine the value of all presented information. This task is complicated by the perceived trustworthiness of the presenter. Not identifying someone as trustworthy when he or she acts outside of the role means valuable information is lost. By contrast, uncritically accepting recommendations based on established trustworthiness of a colleague risks overvaluing possible faulty information (Marshall, West, & Aitken, 2013). Whether a clinician is identified as trustworthy or not does not change the obligation of clinicians to value and assess all information presented to them (Dhaliwal, 2011; Marshall et al., 2013).

Although trustworthiness is generally understood as individually earned, a respect for trustworthiness can be mandated through policy. For example, advanced cardiovascular life support guidelines promote a shared team mentality to promote the perception of trustworthiness in other team members. This is seen as so fundamental to safe practice that an entire chapter is dedicated to "Effective Resuscitation Team Dynamics" in the 2010 guidelines (American Heart Association, 2011). Although during cardiac resuscitation, every team



member is assigned a specific role, all members are also seen as trustworthy to provide input on any aspect of the code. The team promotes knowledge sharing and monitoring of one another. All clinicians are stakeholders in the decisional process, even when outside their defined role, because it promotes the team's shared goal.

The absence of an institutional policy explicitly including nurses in the disposition planning process leaves clinicians to question trustworthiness in others. This uncertainty has repercussions for patients and clinicians. Patients do not receive the benefit of the full range of available clinical knowledge. Additionally, to maintain virtues, clinicians must be able to practice them and consistently have them affirmed as valuable and meaningful. When they are not perceived as trustworthy, nurses are denied the opportunity to practice the virtue of trustworthiness. A policy explicitly including nursing in disposition planning would improve interprofessional function for the benefit of patient welfare.

### MORAL DISTRESS

Moral distress was first defined by Jameton as “the painful psychological disequilibrium that results from recognizing the ethically appropriate action, yet not taking it, because of such obstacles as lack of time, supervisory reluctance, and inhibiting health care power structure, institutional policy, or legal considerations” (Jameton, 1984, p. 6). More recently, moral distress has been further refined as “the experience of being seriously compromised as a moral agent in practicing in accordance with accepted professional values and standards. It is a relational experience shaped by multiple contexts, including the socio-political and cultural context of the workplace environment” (Varcoe, Pauly, Webster, & Storch, 2012, p. 59). This latter definition takes into account professional values and standards that are compromised due to numerous constraints, most of which involve a blend of virtues clinicians must have to care for patients.

There are many practical reasons why health-care institutions should be concerned about moral distress and work to manage it. Moral distress has been found to endanger the retention of nurses, as many cite it as a reason for a nurse to leave a position (Bell & Breslin, 2008). Moral distress also carries a high financial cost for employers as it costs approximately eighty thousand dollars to train a new nurse (Boyle & Miller, 2008; Jones, 2008). Moral distress can also cause physical or emotional distress and result in moral residue or moral blunting (Austin, 2012; Austin, Rankel, Kagan, Bergum, & Lermeyer, 2005; Bell & Breslin, 2008; Corley, Elswick, Gorman, & Clor, 2001; Corley & Minick, 2002; Kalvemark, Hoglund, Hansson, Westerholm, & Arnetz, 2004; Pauly, Varcoe, & Storch, 2012; Pavlish, Brown-Saltzman, Hersh, Shirk, & Rounkle, 2011; Rice,

Rady, Hamrick, Verheijde, & Pendergast, 2008). Moral residue is what is left after moral distress, when a person has been seriously compromised; it can shape future events and attitudes and can even damage or end a career (Epstein & Hamric, 2009). Moral blunting is similar to the well-known terms *professional burnout* and *compassion fatigue* and results in a muted conscience allowing the virtues to be compromised without the associated distress (Hanna, 2004).

One solution is the establishment of institutional systems that affirm nursing credibility, limiting the need for nurses to act with courage and affirming them when they do. One effort in this direction is hospitals becoming accredited to Magnet status. Magnet status is awarded by the American Nurses' Credentialing Center for excellence in nursing and addresses moral distress through the creation of inclusive system processes. There are many reasons hospitals strive to gain Magnet status: Nurses in Magnet hospitals yield better patient outcomes, work in a healthier environment, and are more productive (Kramer, Maguire, & Brewer, 2011). Magnet hospitals emphasize structural empowerment, which seeks to examine and reform the processes of accomplishing shared goals and desired outcomes (Kramer et al., 2011). Structural empowerment simultaneously tackles moral distress through including and valuing nursing input.

The practice of excluding nurses from patient disposition can inhibit nurses from being able to meet the standards held by the profession of nursing. When nurses are either unable to be courageous or are courageous and then unsuccessful, they may become unable to see themselves as "good" nurses. This is moral distress in action. The resulting moral residue or blunting can lead to erosion of the nurses' ability to care for their patients. Nurses may become silenced and no longer courageous, ineffective in their role, or leave their position. Moral distress is not completely avoidable but can be managed through policies, like inclusion in disposition planning, which promote virtues vital to the profession.

### OVERCOMING OBJECTIONS

Although explicitly including nurses in disposition planning has the potential to improve patient safety, facilitate team cohesion, and prevent moral distress, it would be a significant change in current practice. Like any change, including nursing assessment and intuition in the planning of patient disposition could face a range of objections. Key among these would be the unreliability of nursing intuition and the increased time necessary to complete the process. While both of these are important considerations, neither is sufficient to override the benefits of the inclusion of nursing in disposition planning.

Nursing intuition and assessment ought not to trump other sources of data and the evaluations of other health-care providers. However, much, if not most,

of the information used for clinical decision making is imperfect. Discernment is required even for applying data commonly considered “objective.” For example, many lab tests have both false-positive and false-negative findings that must be accounted for in determining their meaning and relevance. The D-dimer blood test, which assesses for the presence of a clot or embolism in the body, is one such example. If the test is negative, it is very accurate for ruling out a clot in the lungs or legs. However, a positive result is more difficult to interpret. A recent study found that out of 237 people who tested positive, only 11 had an embolism (Vossen, Albrektson, Sensarma, & Williams, 2012). Nursing contributions can be similarly evaluated. If nursing judgments align with those of other providers, this would be a confirmation of the disposition plan. However, a judgment at odds with other assessments would call for further consideration.

Nurses are well equipped to participate in disposition planning. Nurses are already routinely involved in assessing discharge readiness in other clinical areas. Nursing expertise contributes to both decreasing length of stay (Gotz, Thompson, & Jones, 2014) and predicting the likelihood of 30-day readmission (Pace et al., 2014). The predictive value of combined physician and nurse assessment are likely to yield higher accuracy than either alone (Brabrand, Hallas, & Knudsen, 2014). The other key objection to the inclusion of nursing in disposition planning is the time required to consult with additional providers. Historically, the involvement of nurses has actually lowered the cost and time spent on patient care (Der, 2009; Durbin, 2006; Gonzalo, Masters, Simons, & Chuang, 2009; O’Leary et al., 2011; O’Leary et al., 2010; Sehgal & Auerbach, 2011). In the past decade, similar concerns were raised when ICUs began including the bedside nurse in patient care decisions. Team rounds actually reduced time spent on communication, decreased the length of stay, and increased patient safety, team morale, and interprofessional communication (Der, 2009; Durbin, 2006; Gonzalo et al., 2009; O’Leary et al., 2011; O’Leary et al., 2010; Sehgal & Auerbach, 2011).

## CONCLUSION

Hospital policies should not only ensure patient health and welfare but also promote professional virtues and inspire collaborative practice. In the current structure, individual nurses may be valued as trustworthy—or may act with courage to intervene in an established plan—but their professional role in the process is not acknowledged. Routinely including nursing in disposition planning would facilitate the expression of their virtues of prudence, trustworthiness, courage, and vigilance. As these are virtues that are shared among all clinicians, honoring them in nurses would also facilitate their habitual practice by all team members.

The current practice of patient disposition planning in EDs carries high ethical hazards by not explicitly including the bedside nurse and results in unacceptable harm. Admittedly, there will be challenges to implementing a structure such as the ones being proposed. Establishing good interprofessional communication, overcoming historical behavior patterns, and concern about added time and resources need to be addressed. As ambassadors of health, we must continue to improve our system to support our shared goal to increase the ethical quality of in-hospital patient care.

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