Death After Discharge—What Would You Do?

Robert Stall, MD

In the usual pile of paperwork was a newspaper clipping. Joe (not his real name to respect confidentiality) had died 2 weeks after his discharge to another facility. I had a feeling it would happen, but it greatly upset me nevertheless. The questions were the usual ones a doctor asks when a patient dies. Could I have done anything to prevent it? What should I do now to better understand what happened and to prevent it from happening in the future? Usually the answers are relatively straightforward. But this situation was different from other patient deaths I had experienced. What would you have done? What would you do now?

Joe was in his eighties, with multiple medical problems and cognitive impairment. He told his son years before that he would rather be dead than go to a nursing home. Time passed, his health and thinking deteriorated, and finally his wife could no longer care for him at home. As his health care agent, she brought him to live at a nursing home (at which I am medical director and one of the attending physicians) with some resistance but not the vehemence with which he spoke to his son in the past.

Early on, Joe's son replaced his wife as the legal health care agent. The son said it was because his mother was too upset to make objective decisions for her husband anymore. She was agreeable to the change.

For 2 years, the son tried to convince me to stop the one life-sustaining medication his father was taking in order to fulfill his father's previously stated desire never to live in a nursing home. That medication was insulin. My immediate response was to discuss the matter with Joe, who could carry on a simple conversation, understand and make jokes, and had never expressed to staff that he wished he were dead or hated living in the facility.

Joe told me he wanted to live and understood that his insulin was necessary for that to happen. He did not want me to stop it. He was content (though not exuberant) living in the nursing home, and enjoyed visits from staff, friends, and family, especially his grandson, with whom he had especially enjoyed playing golf years before. The grandson likewise enjoyed seeing his grandfather, and visited often.

I explained to Joe's son that based on what Joe told me, I could not stop the insulin despite what Joe may have said in the past. To make sure there were not other factors I had not considered, I reviewed the case with a local palliative care expert. He agreed that the insulin should be continued.

Meanwhile, the son had contacted an out-of-town ethics expert, who he said supported his position to stop the insulin, as did a local case manager who the son had retained to help coordinate his father's care. He also told me he reviewed the matter with his attorney. I suggested all involved parties, including his father, sit down and reconcile what Joe told his son to what he told me. The son did not want to do that and no such meeting ever occurred.

After several months of no direct communication with Joe's son, I was told by staff that Joe would soon be transferred to another facility, which took place the following week.

The discharge summary provided to the receiving facility described the issue regarding the son's periodic requests to discontinue his father's insulin, and why it had not been stopped. Joe died 2 weeks after his discharge. It is not known whether Joe was being given insulin when he died.

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