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Saying "Good-Bye": Ethical Issues in the Stewardship of Bed Spaces

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INTRODUCTION

The phrase "scarce medical resources" applies to personnel (for example, nurses), as well as healthcare funding, certain types of medical services (for example, organ transplantation), and even hospital bed space. While there are approximately 980,000 hospital beds in the United States,[1] hospitals can be at or near full capacity even in times lacking war, epidemic, or natural disaster. With the yearly total of hospital admissions rising[2] and hospital bed space capacity falling,[3] the dilemma of stable patients who refuse to be discharged must be addressed. While the national incidence of patients who refuse to be discharged is likely small, we have found that their effect on hospital medical staff and administration is large.

CASE REPORT

Both authors worked jointly on an ethics consultation request that was solicited by the Geriatrics Service of the Veterans Administration (VA) Greater Los Angeles Healthcare System (West Los Angeles VA Medical Center), with regard to a 79-year-old female patient who refused to be discharged from the hospital. She had been admitted to the hospital due to chronic, severe hip pain. The patient had been experiencing gradually increasing bilateral hip pain, to the point that it prevented her from ambulating and caused her to have to leave her own apartment and move in with her brother for assistance with activities of daily living. She was seen in our Rheumatology Clinic five days prior to admission and was given bilateral trochanteric bursae injections to relieve hip inflammation and pain. On the day of admission, she was seen in the Geriatrics Clinic, where she complained that she had received no relief from the injections and demanded that she be admitted to the hospital. There was some question about stress she was causing her caregiver as well. Even though the patient appeared clinically stable, she was admitted to the Geriatrics Unit to address her hip pain and to provide rehabilitation, aiming toward future placement in a suitable assisted-living facility.

The patient had a long history of psychiatric disease that included severe depression since the 1950s (requiring electroconvulsive therapy in 1996); mixed personality disorder with borderline, dependent, and passive-aggressive features; and memory problems. The patient was widowed and had three grown children from whom she was estranged; however, she had remained close to her brother. Her past medical history was

significant for lumbar degenerative disk disease with spinal stenosis, lumbar radiculopathy, gout, hypertension, osteoporosis, coronary artery disease, diverticulosis, colonic polyps, history of hysterectomy, and history of splenectomy.

During her hospital stay, the patient had extensive consultation with psychiatry for evaluation and treatment of depression. Her hip pain was evaluated with MRI (magnetic resonance imaging), demonstrating mild degenerative joint disease of the lumbar spine and hips. The patient refused treatment with NSAIDs (nonsteroidal anti-inflammatory drugs) because she had experienced gastritis when taking them in the past. Physicians tried to convince her to accept other medications, such as H2-blockers and/or proton-pump inhibitors, which would protect her stomach lining from NSAID-induced damage, but she refused to try them. She also refused to try tramadol, which had been recommended by the consulting rheumatologist. Extensive efforts were made by various individuals to convince her to try physical therapy, but she consistently refused this, saying she was in too much pain to participate. Psychiatry felt she possessed decision-making capacity to refuse these treatments. She got repeat injections into her trochanteric bursae, as well as neurontin, which provided some eventual relief. The patient also had a gouty flare in her left wrist during the hospitalization which was treated with colchicine effectively. Memory loss was noted at different times during the hospitalization, although her formal memory testing was normal. Vitamin B12 and TSH (thyrotropin) levels were checked, and both returned as normal. She was placed on vitamin E.

A date for discharge was set at hospital day #22, but the patient refused. A meeting was held with the patient and her brother, at which both refused any options for discharge and out-patient treatment. Both insisted on continued in-patient treatment until the painful condition was "completely gone," even though it was explained to them that this might take many weeks more. Specifically, she refused to go to her own home because of steps in the entry way, and her brother refused to have her return to his home because of his ill health. She also refused placement in a community nursing home or board and care facility because she did not want to share any of the cost.

Bioethics was consulted on hospital day #32 regarding the patient's refusal to accept treatment and to be discharged. She was lucid and possessed decision-making capacity regarding her own placement. We recommended that she be discharged from the hospital without further delay. On hospital day #44, after consultation with hospital officials, she was finally discharged to a community nursing home and, immediately upon arriving there, took a cab to her own home, where she remained.

DISCUSSION

Ethical stewardship of resources requires that there be prudent exercises of evaluation, application, and withdrawal of medical resources.[4] In general, the bioethics literature has focused on stewardship from the standpoint of rare technologies (for example, organ transplantation) and costly technologies (for example, expensive medications, expensive medical devices). While hospital bed spaces are not rare in North America (and some other continents), bed space capacity can be considered as finite within each facility, and bed space occupancy can often be at or near 100 percent. Bed spaces can also be considered expensive, with daily, semiprivate, per diem charges in the acute care hospitals in the U.S. ranging from $700 to $1,000.[5]

We argue that stewardship of bed space precludes the premature discharge of patients; that is, the discharge of patients who are neither mentally nor physically stable, but also it precludes permitting patients to stay beyond their clinically appropriate discharge date (unless an appropriate discharge destination is unavailable). Two cases from legal literature exemplify this, namely, *Muse v. Charter Hospital*[6] and *Wickline v. California*.[7] In the first case, a teenager who had been hospitalized for 32 days (two days in excess of his insurance coverage) for treatment of depression and suicidal tendencies committed suicide two weeks after home discharge. The jury found that while the hospital had no written policy requiring doctors to discharge patients when funds expire, the hospital did have practices that encouraged doctors to do so. The jury awarded the patient's parents $7 million.

In *Wickline v. California,* a patient with Medi-Cal insurance (also known as California Medicaid, a federal and state tax-supported program for children and adults with low income and resources) was hospi-

talized for an obstruction of the terminal aorta in her leg. Medi-Cal authorized surgery and 14 days of hospitalization, but the doctor had requested 18 days. The patient was discharged on day 14, suffered complications, and eventually had to have her leg partially amputated. The court indicated that if it was in the patient's best interest to be hospitalized for 18 days, the doctor should have made some effort to keep her there. Further, the court indicated that Medi-Cal was not a party to the medical decision to discharge the patient, and thus could not be held liable for harm resulting from a negligently made medical decision. Both cases evidence that physicians retain ultimate responsibility for care, *even in the face of a lack of reimbursement.* Further support of this notion comes from the American Medical Association (AMA) which argues that physicians may not discontinue treatment of a patient, as long as further treatment is medically necessary, without giving the patient "reasonable assistance and sufficient opportunity" to make alternative arrangements for care.[8] Also, once having undertaken a case, a physician should not neglect the patient.[9]

In the case we presented, our patient was mentally and physically stable for discharge; however, she refused to leave the hospital. Her adamant refusal to vacate the hospital was frustrating for the medical staff as well as for hospital administration. The case consumed a considerable amount of personnel time and wasted medical resources, in that the care provided to this patient was done so in a setting that was not appropriate, based on her needs. This diverted resources from patients whose needs were a better match with our facilities. The Veterans Administration, as well as other healthcare systems, does recognize the fact that specialty geriatric in-patient programs may actually operate as a hybrid of acute and subacute care. That is to say, because of the complexity of caring for the elderly, a somewhat slower pace, as well as a multidisciplinary approach with some aspects of rehabilitative care, are justified to improve patients' quality of life, at the expense of prolonging length of stay.[10] Needless to say, even when these principles are accepted, stewardship of bed space and medical resources remains an important driving factor in the hospital environment.

In addition to our case, we identified two cases in the legal literature regarding stable patients who refused discharge. In the first case, *Jersey City Medical Center v. Lillian and Richard Halstead,*[11] the patient (Lillian Halstead) was hospitalized for five months for treatment of a "cardiovascular condition," after which time the hospital determined that the patient could be adequately cared for in a nursing home. Six more months elapsed, and the patient was still at the hospital, with neither the patient nor her son (durable power of attorney for healthcare) having done anything to effectuate a transition out of the hospital. The hospital petitioned the court and was granted an injunction requiring the patient's removal on the grounds that she was trespassing.

In the second case, *Wyckoff Heights Medical Center v. Luis Rodriguez*,[12] a diabetic, quadriplegic (Luis Rodriguez) was deemed stable following 10 days of hospitalization. A discharge plan was created that denoted transfer to a nursing home because the patient was not eligible for home nursing care, due to his past history of physical abuse of nurses. In fact, only one nursing home agreed to accept the patient for transfer; however, the patient refused transfer, indicating he did not approve of the facility. The hospital petitioned the court and was granted an injunction ordering the patient to leave the hospital on the grounds that his continued presence was an "abuse." Further, the court indicated that the fact that the patient did not approve of the nursing home was "immaterial."

The University of California, Los Angeles (UCLA) Medical Center has reported five cases of "involuntary discharge."[13] In their experience of dealing with difficult patients, they have created a Patient Care Management Issues (PCMI) team who deals with 19 categories of patients, including those who disobey hospital rules (for example, smoking on the ward) and those who refuse discharge. All hospital staff receives training on how the PCMI team can help them deal with difficult patients. As with most institutions, involuntary discharge is seen as a last resort and is preceded by a warning letter to the patient. UCLA reports no adverse (litigious) consequences of these forced discharges.

Hospitals have a moral duty to reserve bed spaces for persons who actually need medical care in a hospital setting. Failure to appropriately discharge patients causes the potential for serious prejudice to patients who actually require hospital care. That said, hospitals have a duty to the public to remove patients who no longer need treatment. Table 1 presents guidelines for discharge planning. Some hospitals have even

incorporated bed space stewardship into their corporate Code of Ethics.[14] If surrogate decision makers are confounding the discharge process and their decision-making capacity is suspect, it is appropriate to consider appointment of a new decision maker so as to effectuate a discharge plan. Guidance for this process is discussed elsewhere.[15]

We acknowledge that removing patients who refuse to be discharged can be potentially problematic for hospitals, from the standpoint of media relations. Patients who are "unhappy" for a variety of reasons sometimes use the media (for example, newspapers, television) to intimidate hospitals into catering to their demands. Additionally, court orders and litigation do have a "yuck factor." Thus, in an effort to avoid "bad press," hospitals often succumb to these patients' demands, or they transfer them to other facilities that can meet their "needs." No hospital wants to be viewed as kicking a 79-year-old female patient "to the curb," yet, for the reasons discussed, in these situations, there should be a balance between hospitals as "medical Marriotts" and as treatment centers. We agree with the American College of Emergency Physicians' stewardship perspective, that ". . . physicians must keep the patient's interest as a primary concern while recognizing that inappropriate, marginally beneficial and futile care is not morally required."[16]

In the case of patients who are unruly or noncompliant, yet are in need of medical care, there is effectively no treatment alliance between the medical team and the patient, thus attempts to optimally treat the patient are confounded.[17] In these situations, the best option often is to transfer such patients to other hospitals where a treatment alliance can be established, since the creation of a treatment alliance can be a first step toward ethical stewardship of medical resources.

Table 1
Discharge Planning Guidance

1. The patient *must* be stable for discharge.
2. The decision for discharge *must* be based on medical, not financial considerations.
3. Encourage the patient (or surrogate) to participate in discharge planning.
4. Give the patient (or surrogate) written notice of the intent to discharge.
5. Allow for an appeal of the discharge determination.
6. Involve Social Work, Pastoral Care, Legal Counsel, Ombudsman, and the Ethics Committee/hospital ethicist as necessary.

CONCLUSION

Hospitals have a duty not to permit their facilities to be diverted to uses for which they are not intended (for example, hotels, nursing homes). Likewise, physicians and hospitals should not be held captive by patients. Whether the need is to discharge hospital patients or to move them to lower intensity of care settings within the hospital, medical staff must not allow patients to abuse the system that takes care of them, as this diverts material and human resources from patients who need it most. While evicting patients from the hospital may be emotionally taxing for staff and administrators, failure to do so results in poor stewardship of resources and is a disservice to the community the hospital serves.

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NOTES

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