CENTER FOR PRACTICAL BIOETHICS
GUIDANCE AT THE CROSSROADS OF DECISION

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The Ethics Dispatch

"The object of philosophy is the logical clarification of thoughts. Philosophy is not a theory but an activity."

- Ludwig Wittgenstein

Hot Topic

Hospital Discharge Dilemmas: Balancing Beneficence and Systemic Failures

Hospital discharge planning is a critical aspect of patient care that often presents complex ethical dilemmas. While the majority of discharges go smoothly, some discharges are more challenging. As Annie B. Friedrich states, "[p]atients may not want to leave the hospital, or they may insist on an unsafe discharge plan. In other cases, there may simply be no good place for the patient to go. These complex hospital discharge situations often involve ethical, legal, financial, and practical considerations," (Friedrich, 2020)."

These situations frequently involve conflicts between patient autonomy and the hospital's obligation to act in the patient's best interest. These conflicts raise ethical questions about how best to navigate the competing demands of *beneficence* (doing good for the patient) and *justice* (fair distribution of healthcare resources). In these cases, the principles of beneficence and justice are often at odds, leading to difficult decisions for hospitals and providers.

Demands of Beneficence

The principle of beneficence calls on healthcare providers to act in the best interests of patients by promoting their well-being and ensuring that they receive care that improves their health and quality of life. However, difficult discharges often highlight the limitations of the healthcare system and the systemic pressures that affect patient care. Patients may resist leaving the hospital for a variety of reasons, ranging from fear of deteriorating health outside the controlled hospital environment to concerns about the adequacy of post-discharge care. For example, some patients, particularly those with complex medical needs or chronic conditions, may feel that home care will not be sufficient to meet their needs, leading to a refusal to leave the hospital even when they no longer require acute care. In such cases, the healthcare provider must carefully weigh the benefits and risks of allowing the patient to remain in the hospital versus arranging for appropriate post-discharge care.

A prime example of this issue comes from an article by Stacey Kusterbeck published in Relias Media, which analyzes narratives of patients who refuse discharge, even when their medical conditions no longer require hospitalization. Some patients are driven by fear — fear of medical decline or the inability to get the care they need outside the hospital. This can be

especially true for rural patients who may be hours away from the hospital, raising concerns that any emergency medical event at home could result in severe harm. Despite comprehensive patient education and the provision of home care resources, these patients may still resist discharge, which complicates the discharge planning process (Kusterbeck, 2017). From the perspective of beneficence, providers must ensure that these patients receive the right support and resources to transition safely from the hospital.

Questions of Justice

However, while the principle of beneficence demands that hospitals act in the best interests of patients, the systemic realities of the healthcare system often complicate this process. Hospitals frequently face significant challenges in arranging suitable post-discharge care. Many patients, particularly those with complex or chronic conditions, require rehabilitation or nursing home care after hospitalization. Unfortunately, due to underfunding, limited options, and long waiting lists for skilled nursing facilities, patients are sometimes left with no viable discharge options. When patients who no longer require intensive care are unable to be placed in appropriate post-discharge settings, hospitals face a moral and logistical dilemma. The patient may remain in the hospital, occupying a bed that could be used by someone else, while other patients in need of care are unable to be admitted. This creates an ethical dilemma not just for the patient involved but for the hospital as a whole, raising questions of fairness and the equitable distribution of healthcare resources.

Reflecting this tension between beneficence and justice, John D. Banja, PhD, a medical ethicist at the Center for Ethics at Emory University in Atlanta, observes that hospitals may feel “stuck” with patients who refuse discharge due to the financial burdens of caring for them when no appropriate placement is available. Some patients, particularly those with complex needs, may resist moving to nursing homes, fearing poor care or inadequate facilities. The lack of coordination between hospitals, nursing homes, and home healthcare providers further complicates discharge planning. Banja argues that hospitals often have no choice but to bear the financial burden of keeping these patients in the hospital or risk lawsuits from families who object to the discharge plan (Kusterbeck, 2017). This situation creates a vicious cycle where hospitals are financially strained, and patients may not receive the appropriate level of care, all of which undermines the principle of beneficence.

One of the significant barriers to effective discharge planning is the breakdown in communication. In many cases, miscommunication about the discharge process leads to patient resistance, as they may feel unprepared for the transition and unsure of what will happen next. A lack of clear instructions, coupled with the absence of caregivers or family members during critical conversations, can create unnecessary distress and delay the discharge process. Patient resistance stems not from an inherent refusal to leave the hospital but from genuine concerns that have not been adequately addressed or communicated (Kusterbeck, 2017). In these situations, beneficence requires healthcare providers to ensure that patients and families are fully informed and that their concerns are addressed by the healthcare providers in a timely and respectful manner.

Systemic Reform

Ultimately, these difficult discharge scenarios reveal deeper systemic issues within the healthcare system that go beyond the actions of individual hospitals or healthcare providers. The lack of adequate post-acute care facilities, the financial burdens faced by hospitals, and the logistical challenges of coordinating discharge plans point to a broader structural failure in healthcare. It is not the hospitals themselves but the healthcare infrastructure that fails to provide sufficient resources to ensure that patients are able to transition safely and appropriately from the hospital to the next stage of care.

To truly embody the principle of beneficence, healthcare systems must

address these structural issues, ensuring that patients have access to a full spectrum of post-discharge care options. Only by doing so can we ensure that patients receive the care they need, that hospital resources are used equitably, and that healthcare providers are able to act in the best interest of all patients. Without systemic reform, hospitals will continue to face difficult ethical decisions where the principle of ideal beneficence remains a daily challenge.

Sources:

Patients Who Refuse Discharge Are ‘Disaster in the… | Relias Media

Addressing complex hospital discharge by cultivating the virtues of acknowledged dependence - PubMed

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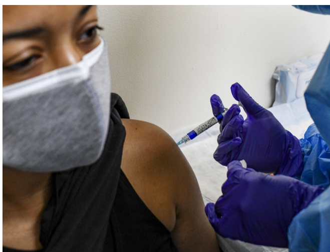
Bioethics in the News



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The Ethics of Prenatal Genetic Testing

Case Study: Challenging Hospital Discharge Plans

Mr. Rand Cannot Be Discharged Back to His Long-Term Care Facility

Mr. Rand is a 78-year-old gentleman who was admitted to the hospital after being found unresponsive in his room at his long-term care facility. He has a long history of cardiac and respiratory issues, which he has been managing well, but recently his condition has worsened. Although he lives in a care facility, Mr. Rand has been able to maintain a high level of independence and takes great pride in it.

Upon admission, it was determined that Mr. Rand had experienced respiratory failure and would require prolonged mechanical ventilation. During his hospitalization, it was also discovered that his renal function had deteriorated, necessitating the start of dialysis. Unfortunately, the long-term care facility where Mr. Rand has resided for the past few years informed the hospital that they are unable to care for him in his current condition, given his need for dialysis and continued ventilator support.

The hospital has reached out to multiple facilities across the country, but none have been able or willing to accept him. Because he is ventilator-dependent, Mr. Rand needs to remain in the ICU. However, aside from his need for mechanical ventilation and dialysis, there is no other medical reason to keep him in the hospital at this time.

Mr. Rand expresses a strong desire to return to his long-term care facility, which he considers his home. However, he also recognizes the reality of his medical situation and is open to exploring other options as long as they support his goal of recovery. He hopes to stay close to home but is also focused on his long-term health and recovery. He has now been hospitalized for over two months, and there is no clear timeline for his discharge.

Given these circumstances, the medical team has sought guidance from the ethics committee to determine if continuing Mr. Rand's hospitalization is appropriate or if it has become futile.

Ethical Musings

Hospitals and Their Evolving Purpose

What is the purpose of the hospital? Who is the hospital intended to serve? These may seem like straight-forward questions, but the answers are ever changing.

From Care to Scientific Advancement

Today, patients -- anyone and all -- are admitted to a hospital with the hope of achieving a cure and are then discharged when either that cure is achieved or is determined to not be achievable. But that was not always how things were.

Hospitals in the early 20th century operated on a different model and approach. Treatment and care were typically delivered by a doctor who traveled to patients' homes. Medicine was much more limited than it is today, with the key concept being care. Hospitals were for those who did not have a home, or family, or support.

As the century progressed, the model of the hospital shifted from its roots as a place that would care for those who did not have anyone else to a location of where advanced science could help and cure patients.

"One of the defining characteristics of hospitals during this period was the way the power of science increasingly affected hospital decisions. By 1925, the American hospital had become an institution whose goals were recovery and cure to be achieved by the efforts of professional personnel and increasing medical technology" (Penn Nursing, History of Hospitals).

From Science to Continuum of Care

Now, change is happening again, with hospitals becoming just one stop on a much larger continuum of care. The role of the hospital has been separated

and distributed across many different locations, from stand-alone emergency departments to urgent care locations, PCP offices, skilled nursing facilities, rehab, to end-of-life locations such as hospices.

What was the “hospital” has become is many different locations. Society is having difficulty adapting because our mindset, laws and policies still recognize the hospital as what it used to be, not what it currently is. Hospitals cannot deny someone in need, but out-patient locations and step-down facilities are not bound by such rules. Discharge, in such an environment, can present challenges.

Location of Last Resort

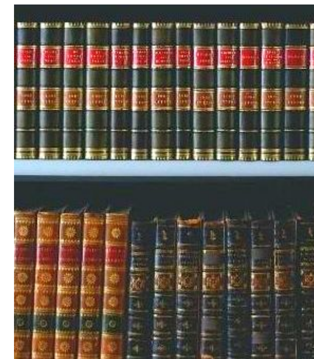
Added to that, advancements in medicine are creating more complicated patients. A hundred years ago, society did not have the issue of finding locations for patients who are ventilator dependent while requiring dialysis. Now, these patients are a common occurrence, but it is increasingly difficult to find appropriate locations for them outside of the hospital. The goal of the hospital is to discharge these patients to a more appropriate location, but when that location does not exist, the hospital becomes the location of last resort for so many patients.

Hospitals were founded on the principles of charity, humanity, and care for those who have nowhere else to go. Capitalism changed this aspect of hospitals but as medicine continues to advance and become more complicated, this role is returning to the hospital whether it likes it or not. Hospitals are becoming locations for people who do not have a support system, or economic standing to avoid them.

Sources:

https://www.nursing.upenn.edu/nhhc/nurses-institutions-caring/history-of-hospitals/

Ethics Committee Consortium Resources



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