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Review Article

Identifying and Addressing the Hidden Reasons Why Patients Refuse Discharge From the Hospital

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Background: *Consultation-liaison psychiatrists are often asked to evaluate patients who refuse discharge from a medical facility. Literature to guide clinicians on the management of these patients is very limited.* **Objective:** *This article seeks to explain this phenomenon through a case series, provide a differential diagnosis of patients who request to stay in the hospital, as well as provide clinicians with direction in the management of these difficult situations.* **Methods:** *We discuss a case series of 3 patients treated at a large academic medical center, who refused discharge, discuss potential differential diagnoses, and provide management recommendations to guide clinicians.* **Discussion:** *Providing care for a patient who refuses discharge can present several dilemmas for the treatment provider. Additionally, patients who refuse discharge may face emotional, physical, and financial costs secondary to continued unnecessary medical hospitalization. A variety of psychiatric conditions may contribute to a patient's desire to stay in the hospital.* **Conclusions:** *Patients who refuse medical discharge can present unique challenges for hospital-based medical providers as well as consultation psychiatrists who care for these patients. Careful consideration of diagnostic etiologies as well as coordination of care across the treatment team may be required to manage these unique and challenging cases.*

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INTRODUCTION

Consultation-liaison psychiatrists are frequently asked to evaluate patients who do not adhere to the medical recommendations of the primary treatment team. A common request is to assess a patient who desires to leave the hospital against medical advice. A psychiatrist can also be consulted to evaluate a patient who refuses discharge from the hospital when there is no medical indication for continued admission. As a guide for care and management, the published literature on the approach to patients who refuse to leave the hospital is considerably smaller when compared with that of patients who request to leave against medical advice. In this article, we present 3 patients who would not comply with discharge from the hospital and discuss a differential diagnosis for the sources of this behavior. Although there are many types of patients who refuse discharge, we selected 3 particularly challenging patients at our institution to represent this variety and provide a guide for an approach to management.

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CASE PRESENTATIONS

Case 1

Mr. A, a 45-year-old HIV-positive man with oxygen-dependent chronic obstructive pulmonary disease (COPD), bipolar disorder, and alcohol and cocaine use disorders, was admitted to the hospital with a COPD exacerbation. He averaged 1 to 2 hospitalizations per month for several years, each typically 1–2 weeks for COPD exacerbations, substance detoxification, or the treatment of common ailments such as pain, cough, and cold. Before his most recent admission, he had become homeless after being asked to leave his transitional housing because of continued substance use. Following treatment for his COPD exacerbation, he was medically cleared for discharge to the men's shelter by the primary team when he reported that he was suicidal, prompting a psychiatry consultation.

On interview, Mr. A reported that he had burned many bridges and stated he finds the hospital a "comforting place" where he knows "I will get good care." He asked the psychiatry consultant if he could be transferred to the psychiatric hospital "just for a week or so" because he felt that he could secure housing during that period. He stated that if the medical team discharged him to a shelter, he would immediately come back to the emergency department, because he refused to live on the streets any longer. After multidisciplinary discussions, given Mr. A's history of multiple readmissions and likelihood of another COPD exacerbation should he be discharged to the shelter, the team opted to keep him in the hospital for an additional 2 weeks, as social work, case management, and multiple nonprofit organizations assisted in finding him a more permanent housing solution with hopes to reverse the cycle of frequent chronic hospitalizations. Though the prolonged admission to a tertiary care medical center for nonmedical reasons was not an ideal use of hospital resources, the safety of continued monitoring and treatment of his COPD was weighed against the lack of adherence and likely substance abuse relapse should he be sent to the shelter, where he would have no place to store his medications and oxygen tank.

Case 2

Mr. B, a 20-year-old man with a history of migraines and a remote history of attention-deficit/hyperactivity disorder, was admitted to the hospital with a severe headache. He was treated with intravenous fluids, promethazine, prochlorperazine, magnesium, caffeine, and diphenhydramine, but symptom improvement did not occur until he was treated with gabapentin and methylprednisolone. Following improvement of his symptoms and a negative finding on medical workup (including lumbar puncture and neuroimaging studies), Mr. B was discharged home on hospital day 2 with a diagnosis of status migrainosus and with prescriptions for prochlorperazine, promethazine, and gabapentin. No follow-up was scheduled as Mr. B voiced his preference to arrange his own medical and mental health appointments. He requested a prescription for narcotic pain medications, which was declined.

After discharge, Mr. B never left the medical campus and almost immediately presented again to the emergency department with multiple complaints including migraine headache, seizure, and dystonic reaction (attributed to prochlorperazine intake by Mr. B). He was evaluated, medically cleared, and discharged from the emergency department 3 separate times, but he did not leave the medical campus. The psychiatry department was consulted again on his fourth emergency department presentation within 24 hours of his initial discharge. He was calm during the interview, without signs of confusion, agitation, or psychosis. He denied suicidal ideation and did not exhibit symptoms of an active mood, anxiety, or psychotic disorder.

A review of the state prescription database revealed that during the previous 12 months, Mr. B had filled 22 opioid prescriptions from 15 different providers at 11 different pharmacies. When this information was discussed with him, he remorsefully admitted that he had an addiction to opioid medications and that he continued to return to the emergency department to obtain them. He was invited to collaborate in formulating a workable outpatient plan of care that addressed his needs, and he was agreeable to treatment for substance dependence and supportive therapy for life stresses. He was discharged home without further incident.

Case 3

Mrs. C, a 29-year-old woman with history of an unspecified eating disorder, depression, pyoderma gangrenosum, and chronic lower extremity wounds for 2 years secondary to reported bilateral brown