The Uncooperative Patient and the Least-Restrictive Protection Approach

Peter J. Martin, Esq.

Peter J. Martin, Esq.

It is a dilemma inherent in caregiving: what to do when a patient disagrees with what appears to be the obviously correct treatment decision? Inpatient facilities can suffer significant financial losses when a patient refuses care but cannot legally be transferred to another facility. One Massachusetts hospital faced this issue in a case decided by the Massachusetts Supreme Judicial Court on May 11, 2018, Guardianship of D.C., which offers helpful guidance on the scope of authority of both courts and guardians.

In January of 2016, the 79-year-old D.C. was admitted to the hospital with a hip fracture but refused to have corrective surgery or to take any medications. D.C. also presented with acute renal failure, pancreatitis and cardiac issues; she underwent a coronary bypass and a mechanical heart valve replacement. At the end of January 2016, the hospital petitioned the court for appointment of a guardian with specific authority to admit D.C. to a nursing facility. A temporary guardian was appointed in February and extended in March, but the guardianship lapsed in June. The hospital then went back into court in July with a new guardianship petition, stating that, in the SJC's words, "D.C. was an incapacitated person in need of guardianship based on her insistent refusal of medical care." A different judge held a trial at the hospital in September of 2016 and issued an opinion in November of 2016 that D.C. was not incapacitated. The judge wrote that D.C. was "demanding, difficult, obstreperous and plainly refused to assist or participate with various medical care personnel" but was not incapacitated, and therefore, a guardian could not be appointed for her. Nevertheless, the judge allowed the hospital's request that D.C. be transferred to a skilled nursing facility, finding that an acute setting was no longer required for her.

Presumably at this point, the hospital, armed with the judge's ruling about a SNF transfer, contacted appropriate facilities. One can only wonder what those facilities made of the judge's ruling, which fell short both of an appointment of a guardian with authority to consent to a transfer and of a direct order that such a transfer take place. Now, some 10 months after D.C. was admitted to the hospital, it moved for clarification of the judge's order.

The judge reiterated the finding that D.C. was not incapacitated. He also denied the hospital's requests that the judge appoint a guardian with authority limited to consenting to a SNF, or alternatively, that the judge issue an order regarding the hospital's authority to transfer D.C. to a SNF. Instead, the judge reported three questions to the Appeals Court. Before that appeal was heard, the hospital filed yet another petition for guardianship, and on Nov. 8, 2017, the judge found D.C. to be incapacitated and appointed a guardian with authority to admit D.C. to a nursing facility. One can presume that D.C. was then transferred to a suitable facility, some 21 months after being admitted to the hospital.

This sad saga left the hospital struggling to find recourse to get its patient the appropriate care in the right setting, with the patient being uncooperative but not legally incompetent. The three questions posed to the Appeals Court reflect three alternative forms of recourse. First, should a finding of incapacity be made, can a guardian without specific authority to do so admit the patient to a nursing facility? Second, can a limited guardian be appointed with authority to admit to a nursing facility if the patient is not deemed incapacitated? Third, can a probate court order a patient who is not incapacitated to be transferred to a nursing facility?

Th SJC answered all three questions in the negative. However, with respect to the first question, the court stated that once there is a judicial finding of incapacity and a further finding that transfer to a nursing facility is in the patient's best interest, then a guardian can admit the patient to the nursing facility, even if the patient objects. (The best interest finding can be omitted for short-term nursing facility admissions, but only if the incapacitated person does not object.) This answer clarifies what had apparently not been entirely clear under the new Massachusetts Uniform Probate Code (MUPC), which went into effect in 2009. The need for such clarification is suggested by the fact that the SJC took the initiative to consider the questions posed to the Appeals Court. The Court stated that there had been little opportunity to provide guidance on the new statute and a matter of "significant public importance." While the SJC did consider the particular questions posed, it is significant that it did not consider "the legal options available to an acute care hospital where a patient who is not incapacitated fails to leave upon discharge."

In addressing the three questions, the Court described the process of obtaining a general guardianship. That process includes consideration of the appropriateness of a limited guardianship in an effort to "encourage the development of maximum self-reliance and independence of the incapacitated person," in the words of the statute. In a Prefatory Note to the MUPC, this is called the "least-restrictive protection approach." Given this background, it is not at all surprising that the SJC would answer all three questions posed to the Appeals Court in the negative. In each case, the maximum feasible autonomy of the patient is furthered by requiring a best interest finding for an incapacitated person, and requiring in every case a finding of incapacity, prior to a nursing facility admission.

Inpatient facilities faced with situations such as D.C.'s might not, in appropriate cases, have to opt for the lengthy and frustrating guardianship process described above. There is still the option of discharging patients against medical advice, although that, too, can be troubling. In any event, caregivers need to remember that an "insistent refusal of medical care" does not mean that the patient is legally incapacitated. And, as much as caregivers want to provide care, even to the "demanding, difficult, obstreperous" and uncooperative patient, sometimes the legal system's insistence on the least-restrictive approach means caregivers have to let patients make bad decisions for themselves.

Peter J. Martin, Esquire, is a partner in the Worcester office of Bowditch & Dewey, LLP, his practice concentrating on health care and nonprofit law.