



When Ethical Dilemmas Arise

In cases where the highest standards of care directly conflict with the wishes of a patient, facilities must be prepared to find the best possible solution.

FOR CAREGIVERS, THERE IS SOMETIMES no right answer. Take the case of Jane, a 63-year-old skilled nursing facility patient with no known family who has been diagnosed with schizophrenia. She is refusing to eat, although she agrees to continue taking her medications.

A group comprised of Jane's physician, the facility's medical director, and the care plan team considers several approaches to the case. Jane is assessed for depression, and a change in her schizophrenia medications is suggested. She is tantalized with her favorite foods. She is offered the possibility of moving into an assisted living facility and given opportunities to accept meaningful work. She gets extra attention from volunteers and staff. When that doesn't work, she is afforded less attention. She is encouraged to attend activities. The attending physician orders a full psychiatric consult.

Finally, the ethics committee is convened.

The Need For Action

Through it all, Jane doesn't budge from her position. She has functioned well in the facility over the past 11 years, and she has a circle of friends. Now, however, with no food for five days, she is losing weight and staying in her room more. Something has to happen.

"Jane" has made it clear to staff that she believes that her "quality of life" does not justify living any longer. She is ready to die, she says. The nursing facility staff are horrified at the thought. She is not terminally ill, and

her major problem—her mental illness—has been well controlled by medications. Jane's situation raises a number of ethical questions that now must be addressed.

- Is Jane's autonomy more impor-

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tant than the facility's obligation to provide necessary care?

- Is forcing her to eat a violation of her right to determine her own outcome?
- Is her behavior putting others at risk?
- Is she competent to make such a life-and-death decision?
- Should the facility have her hospitalized and hand off the problem to someone else?
- Should the caregiving team wait until she collapses and provide a feeding tube, in the hope that her condition can be reversed?
- Can she be left to die?

Home care providers are not exempt from such dilemmas. Among common ethical decisions is whether a client can safely remain in the home. In one case, "Jack," a 97-year-old paraplegic, wanted to return to his home, where he

would have to live alone. Although cognitively intact, he had virtually no family support for physical needs.

Nursing facility staff thought that the risk was too great to permit discharge; case managers disagreed, deciding that his right to determine his fate was more important than any negative results that stemmed from that decision.

Facing A Deadlock

Writing in his book, "Classical Cases in Medical Ethics," ethicist Gregory Pence summarizes such issues: "In moral discourse, we usually seek answers to the question, 'What is right?' Sometimes, however, we must admit that with regard to a certain issue we are hopelessly deadlocked." In short, there is no best solution, only the least bad solution.

The four ethical principles of health care, as derived from work by Tom Beauchamp and James Childress in "Principles of Biomedical Ethics" are autonomy (self-determination), beneficence (doing good), nonmaleficence (do no harm), and justice (treating like cases equally and unlike cases unequally). These principles are guidelines for persons seeking solutions in nearly every ethical dilemma, but they sometimes create additional questions because the values inherent in each principle often conflict.

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For example, Jane's own decision to discontinue eating (autonomy) may not override the professional caregiver's responsibility to ensure that she suffers no harm (nonmaleficence).

From Content To Process

When the four principles collide, author Pence recommends a "shift from content to process," that is, "rather than thinking of a solution as a specific answer, we can seek a process that will result in the fairest solution."

To help health care providers and ethics committees work through an ethical crisis such as that presented by Jane, it is helpful to have adopted a tool or checklist known as a heuristic device to help decision makers work toward that "fairest solution."

Many hospitals and health systems have such devices in place, partly due to accreditation requirements concern-

ing organizational ethics, but few nursing facilities are as well prepared to face such challenges.

Pearl Moore, RN, offered a short, memorable heuristic decision-making device in *ONS News*, a publication of the Oncology Nursing Society.

With its acronym, "CLICK," the following questions are an effective tool for employee training:

- *Consequence.* What are the consequences if I do this? Who will benefit? Who will suffer?
- *Legal.* Is it legal?
- *Image.* Would I like to see this on the front page of the newspaper? Would I feel good telling this to my friends and family?
- *Culture.* Does this decision support or damage the organization's culture and values?
- *Know.* Does doing this cause a

knot in my stomach? (Do I somehow know it's wrong?)

Other Analytical Approaches

Dunfee, Smith, and Ross, in a scholarly work called "Social Contracts and Marketing Ethics," offer a list of questions (based on research of Laczniak and Murphy) that reflect types of value tests that are as applicable to the ethical clinical decision-making process as they are to marketing decisions.

- Does the contemplated action violate the law? (Legal Test)
- Is this action contrary to widely accepted moral obligations? (Duties Test)
- Does the proposed action violate any other special obligations? (Special Obligations Test)
- Is the intent of the contemplated action harmful? (Motives Test)
- Is it likely that any major damages

Chain-Owned SNFs Must Tailor To Local Needs

Standard marketing and strategic planning practices may adversely affect patient care throughout a nursing facility chain, but only if too much emphasis is placed on such administrative standards to the detriment of clinical and facility standards, according to a recent study from the University of Michigan, School of Public Health.

The researchers stress that "chain ownership is not necessarily bad for the quality of health care," but point out that shifting away from community values and local needs, in addition to over-emphasizing administrative rather than clinical outcomes, could be problematic.

Optimizing patient care, the study's authors assert, would require nursing facility chains to balance administrative efficiency with the local needs of the individual chain-owned facilities. "Standardization is a way to think

about changing service delivery across many areas, including administrative and clinical processes and even within facility layout," said Jane Banaszak-Holl, corresponding author on the study. "Chains that over-emphasize administrative processes don't take advantage of how much their staff can learn—and ultimately improve patient care—from the shared knowledge of developing protocols for handling resident needs."

A good corporate chain, Banaszak-Holl suggests, can implement a set of practices that still attends to local needs and resident outcomes while introducing greater economies of scale and better business practices.

According to the study's authors, an example of standardizing administrative processes would be to share common marketing materials, while facility standardization would entail use of the

same facility layout.

In addition, an example of standardization of a clinical process was defined by the authors as the implementation of guidelines for the treatment of resident pressure ulcers throughout the chain.

The study examines the effects of corporate standards and training in three areas: administrative processes, clinical processes, and facility design.

The researchers also considered the total number of health deficiencies given to the facilities on state inspections, as well as the percentage of residents with pressure ulcers.

"Consumers need ways to identify what is a good or bad nursing home when making choices about where to place a loved one," said Banaszak-Holl.

—Meg LaPorte

to people or organizations will result from the contemplated action? (Consequences Test)

■ Is there a satisfactory alternative action that produces equal or greater benefits to the parties affected than the proposed action? (Utilitarian Test)

■ Does the contemplated action infringe upon property rights, privacy rights, or the inalienable rights of the patient? (Rights Test)

■ Does the proposed action leave another person or group less well off? Is this person or group already a member of a relatively underprivileged class? (Justice Test)

These authors contend that a negative response to any of the above questions demands further review. An ethics consultant may bring fresh perspective to such issues, when a committee cannot reach consensus.

One example of an organization in

which institutionalization of an ethics procedure is in place is Providence Health System, a Catholic hospital system in Seattle. Employees are offered via the public Web site clearly written guidance in the ethical decision-making process, the Four R's of Ethics:

1.) *Recognize*. Learn to recognize a value conflict for what it is.

2.) *Respond*. Once a value conflict is recognized, respond—don't ignore it. Either resolve it or refer it.

3.) *Resolve*. If possible, resolve the value conflict using an ethical decision-making process.

4.) *Refer*. If we can't resolve it or if we need help, refer it in a timely way to the appropriate person.

The information makes abundantly clear that the employee is "not alone," and that help in decision making is available.

System ethicist Jan Heller also pro-

vides a heuristic device for those called upon to make decisions: Identify the appropriate decision makers. These decision makers should agree on what the conflict is. Get more information if needed. Note as many ways as possible to respond to the conflict, and consider how people and organizations are affected under each option. Make the decision by selecting the best option. Consider the facility's mission, core values, personal and professional values, the circumstances surrounding the values conflict, and the effects of the decision on the people and organizations identified.

An Ethicist's View

Michele Mathes, an attorney and director of education and training with the nonprofit organization, Center for Advocacy for the Rights and Interests of the Elderly (CARIE) in Philadelphia, has tackled the complexities of resolving ethical dilemmas in long term care. CARIE's ethics training program for long term care providers and staff makes a compelling case for a different approach to decision making based on the differences between ethical dilemmas in acute and long term care settings. The client-caregiver relationship, the mental status of the client, the common absence of advance directives, and the more dependent situation in which the client finds himself or herself require health care providers to delve more deeply into the person's background as they try to reach the best decision when there are hard choices.

There are seldom easy answers to ethical dilemmas in health care, especially in the clinical care environment. Health care organizations that educate their staff members; offer supportive services; provide clear legal guidance for understanding of relevant laws; clearly promote their missions and values; and offer understandable, accessible, heuristic devices will, over time, improve the ethical decision-making process. ■