LEARNING OUTCOME AND OBJECTIVES: Upon completion of this course, you will have increased your ability to incorporate ethical principles and behaviors into the practice of case management. Specific learning objectives include:

- Define ethics.
- Differentiate between ethical theories based on their purposes.
- Summarize the fundamental ethical principles generally associated with the practice of healthcare as a whole.
- Distinguish between how ethics and values operate in the healthcare setting.
- Discuss the Code of Professional Conduct for Case Managers.
- Describe the types of law in the United States.
- Identify how civil and criminal law apply to the practice of case management.
- Discuss legal and ethical factors relating to end-of-life care.

Why are ethics so important to consider, both in the practice of healthcare in general and case management in particular? Case managers, through their actions or inactions, can either help or hinder their clients in achieving their health and wellness objectives. They must therefore accept responsibility for their behavior, applying a clear understanding of ethical principles and the Code of Professional Conduct for Case Managers to make sound judgments in their professional practice (CCMC [Commission for Case Manager Certification], 2015). In addition to potential legal consequences, unethical behavior risks loss of trust among the public, both for individual case managers as well as for the profession as a whole.
WHAT ARE ETHICS?

Ethics are broadly defined as the division of philosophy that deals specifically with questions concerning the nature of values in regards to matters of human conduct. In considering ethical judgments and decisions, this branch of philosophy is primarily concerned with the ability to:

- Clarify the nature of such judgments in general
- Provide criteria for determining what is ethically right or wrong
- Investigate the grounds for holding these judgments to be correct

(Loyola University New Orleans, 2014)

Ethical Theories

Philosophers engaged with questions of ethics have generally sought to formulate and justify ethical theories. These theories are intended to explain the fundamental nature of that which is “good,” why it is “good,” and why the ethical principles most commonly used to evaluate human conduct follow (or do not follow) from these theories. Ethical theories may be presented for different purposes, as described by the examples below:

- **Descriptive ethics** seek to describe what people consider to be “good” or “right.” Such theories may be considered true or false depending on whether they do indeed describe correctly what people consider to be good or right. Example: asking a group of subjects whether they consider it right or wrong for a man to steal a drug to save his wife’s life, with the aim of describing the moral reasoning that lay behind their decisions (Kohlberg, 1971).

- **Normative (prescriptive) ethics** observe and describe what people consider to be right or wrong and then come to a conclusion about what is or is not right in that society. Such theories prescribe how people ought to act. Example: determining whether it is indeed right or wrong for a man to steal a drug to save his wife’s life according to society’s ethical standards.

- **Teleological ethical theory**, also called consequentialist theory, claims that it is the consequence, or end result, of an action that determines whether the action is right or wrong. Example: withholding bad news from a client because doing so will help the client in the long run.

- **Deontological ethical theory** argues that the motivation or intention for one’s action, as opposed to the consequences of the action, determines whether the action is right or wrong (Loyola University New Orleans, 2014). Example: not restraining a client against his or her will even if it may help the client in some way.
Ethical Principles and Healthcare

There are five fundamental ethical principles generally accepted and applied to the practice of healthcare as a whole.

- **Autonomy** refers to the ability of an individual to think, decide, and act upon one’s own initiative. It is the responsibility of the case manager to provide sufficient and accurate information to a client to allow the client to make informed decisions and to honor a client’s decisions regarding the services they receive even when a client’s decision may diverge from what the case manager would choose.

- **Beneficence** means working actively for the best interests of the client. This principle highlights the general concept of doing good for others and, in the context of a case manager-client relationship, entrusts a case manager with performing professional duties in a competent, caring manner that will benefit the client.

- **Nonmaleficence** means to do no harm to a client. This may mean carefully weighing potential benefits against potential negative results and/or side effects that may potentially result from providing case management services.

- **Justice** refers to a case manager’s ethical responsibility to, insofar as possible, provide equal and impartial treatment to all clients in similar situations, regardless of a client’s age, disability status, socioeconomic status, race, religion, gender identification, sexual orientation, or other background factors.

- **Fidelity** means keeping commitments and promises. It also refers to the trust that forms the bond of the case manager-client relationship, allowing genuine healing to take place. (University of Ottawa, 2014; CCMC, 2015)

ETHICS VERSUS VALUES

While the terms *ethics* and *values* are often used interchangeably, they are actually quite different in meaning. Ethics constitutes a broadly accepted collection of moral principles; values are much more individualized and relate to an individual’s personal set of standards regarding what is right, important, and valuable (Townsville Community Legal Services, 2014).

Ethical Dilemmas

An ethical dilemma arises when an individual becomes caught between two conflicting duties that mutually exclude one another but that would each be ethically viable if considered separately. In order to protect the best interests of the client and to minimize the risk of ethical and/or legal complaints, it is of utmost importance that case managers develop the skills and are aware of the resources available for the successful resolution of ethical dilemmas.

Resolution of ethical dilemmas in a professional setting requires a thoughtful and careful decision-making process and may include any or all of the following steps:
• Identifying ethical issues, including any conflicting values and duties. Relevant codes of ethics, standards, legal principles, agency policies, and one’s personal values must be considered.

• Identifying which individuals, groups, and/or organizations are likely to be affected by the ultimate decision. Who is involved and who has the right and/or the responsibility to make the decisions?

• Identifying possible courses of action, the participation involved in each, and possible benefits and risks of each option. Whom would each choice affect and how? What are the risks and potential benefits of each option?

• Consulting with colleagues and appropriate experts. Many healthcare institutions have formal ethics committees to assist in the resolution of ethical dilemmas, particularly in more complex cases such as those that involve delicate end-of-life issues. Ethics committees generally consist of members from a variety of clinical and non-clinical backgrounds, such as healthcare professionals, bioethicists, clergy, lawyers, and lay persons.

• Making and documenting the decision. A written record of the decision-making process is a crucial component in resolution of an ethical dilemma.

(National Association of Social Workers, Illinois Chapter, 2013)

CASE

Jennifer Cho is a nurse case manager at a small rural hospital. She is feeling tense because she knows she will face dilemmas around discharging patients from the full medical-surgical unit to make room for patients coming out of the emergency department and surgery. Her first client up for discharge is Mr. Jones, an 86-year-old patient who suffered a stroke five days ago and who no longer meets CMS inpatient guidelines for a medically justified hospital stay. The hospitalist has indicated that Mr. Jones is not likely to recover and is expected to live for less than six months.

Jennifer considers the options for the patient’s discharge: transfer him to a skilled nursing facility, send him home with his wife with hospice or home health services, or keep him in the hospital longer until his condition improves for a safer discharge. Jennifer wants to do what is best for the patient (beneficence) and to be sure that the conditions for Mr. Jones’s discharge will not cause him harm (nonmaleficence).

She enters the patient’s room to assess his condition and to talk to Mrs. Jones. Jennifer mentally reviews the patient’s history: he had a previous stroke 18 months ago and was discharged to a local rehab, where he did reasonably well and was soon able to return home. At that time, Mr. Jones could still, with minimal help, get himself out of bed, check his own blood sugars, and give himself insulin to manage his type 2 diabetes. He could swallow and eat independently and used a walker to get around. An in-home supportive services worker from the community came to the house and assisted him three days a week, and the couple received meal delivery once a day.
Now, however, it is apparent to Jennifer that Mr. Jones is medically and mentally very compromised. He can only swallow liquids that are thickened to honey consistency without choking, he is barely eating, and he has to be fed when he does eat. He is no longer ambulatory, and his wife is not capable of transferring him to a commode. Mentally, he goes in and out of lucidity, and he is not able to verbally express himself. Jennifer is not certain which discharge circumstances would be best for him, although she is clear that Mr. Jones is an appropriate candidate to receive hospice services.

Two hours later, Jennifer, a hospitalist, and Dwight, the social work liaison from the hospice agency, return to Mr. Jones’s room to talk with his wife. They start by acknowledging the difficulty of the situation and identify Mrs. Jones as the one who will make the final decision from among the possible options. Also in her eighties and with a chronic health condition, she says she understands that he is not likely to recover and so she would like to take her husband home to a familiar place. Jennifer explains to Mrs. Jones the much greater difficulties in caring for her husband now that he is bed-bound and unable to do anything for himself. Mrs. Jones seems distant but says she wants to try. She says they have a son living out of state who could probably come and help within a few days. She has no money for private caregivers, but she has neighbors who have offered to help.

Jennifer knows this is not the ideal discharge and is concerned about the inherent difficulties, but she wants to honor Mrs. Jones’s desire to try to provide care at home (autonomy). Dwight starts to work out the details of the discharge with the agency, and Jennifer enlists the aid of her case manager assistant to order the equipment Mr. Jones will need. Hospice states it can admit Mr. Jones that afternoon and will have another nurse case manager and home health aide visit to help Mrs. Jones take care of her husband’s basic needs. Dwight will visit the same day to enlist the help of neighbors and make contact with the Joneses’ son.

Jennifer is satisfied that she has made the best decisions to ensure the discharge is safe and charts what has transpired.

THE CODE OF PROFESSIONAL CONDUCT FOR CASE MANAGERS

Codes of ethics are formal statements that set forth standards of ethical behavior for members of a specific group. One of the hallmark characteristics of a profession is that its members subscribe to a code of ethics. Every member of a profession is expected to read, understand, and abide by the specific ethical standards of that profession.

In order to assert the values and standards expected of members of the profession of case management, the Commission for Case Manager Certification (CCMC) publishes the Code of Professional Conduct for Case Managers with Standards, Rules, Procedures, and Penalties. The Code is regularly revised and updated, with the latest standards effective January 2015 (CCMC, 2015). Portions of this document are reproduced and discussed below.
Case managers may also belong to other professions that provide similar codes of ethics to guide those professions (for example, the American Nurses Association and the National Association of Social Workers). *(See also “Resources” at the end of this course.)*

**Principles and Rules Guiding Case Manager Conduct**

The Code of Professional Conduct for Case Managers is founded on eight principles:

**Principle 1:** Board-Certified Case Managers (CCMs) will place the public interest above their own at all times.

**Principle 2:** CCMs will respect the rights and inherent dignity of all of their clients.

**Principle 3:** CCMs will always maintain objectivity in their relationships with clients.

**Principle 4:** CCMs will act with integrity and fidelity with clients and others.

**Principle 5:** CCMs will maintain their competency at a level that ensures their clients will receive the highest quality of service.

**Principle 6:** CCMs will honor the integrity of the CCM designation and adhere to the requirements for its use.

**Principle 7:** CCMs will obey all laws and regulations.

**Principle 8:** CCMs will help maintain the integrity of the Code by responding to requests for public comments to review and revise the Code, thus helping ensure its consistency with current practice.

*(CCMC, 2015)*

The Code also lays out six rules that govern the professional conduct of case managers. Violation of any of these rules may result in disciplinary action by the CCMC, including the possible revocation of a CCM’s board certification.

**Rule 1:** A CCM will not intentionally falsify an application or other documents.

**Rule 2:** A CCM will not be convicted of a felony.

**Rule 3:** A CCM will not violate the code of ethics governing the profession upon which the individual’s eligibility for the CCM designation is based.

**Rule 4:** A CCM will not lose the primary professional credential upon which eligibility for the CCM designation is based.

**Rule 5:** A CCM will not violate or breach the Standards for Professional Conduct.

**Rule 6:** A CCM will not violate the rules and regulations governing the taking of the certification examination and maintenance of CCM Certification.

*(CCMC, 2015)*
Scope of Practice

Case management is a professional, collaborative, and interdisciplinary practice. Board certification indicates that the professional case manager possesses the education, skills, moral character, and experience required to render appropriate services based on sound principles of practice.

Board-certified case managers will practice only within the boundaries of their role or competence, based on their education, skills, and appropriate professional experience. They will not misrepresent their role or competence to clients. They will not represent the possession of the CCM credential to imply a depth of knowledge, skills, and professional capabilities greater than those demonstrated by achievement of certification.

UNDERLYING VALUES

- CCMs believe that case management is a means for improving health, wellness, and autonomy through advocacy, communication, education, identification of service resources, and service facilitation.
- CCMs recognize the dignity, worth and rights of all people.
- CCMs understand and commit to quality outcomes for clients, appropriate use of resources, and the empowerment of clients in a manner that is supportive and objective.
- CCMs embrace the underlying premise that when the individual(s) reaches the optimum level of wellness and functional capability, everyone benefits: the individual(s) served, their support systems, the healthcare delivery systems, and the various reimbursement systems.
- CCMs understand that case management is guided by the ethical principles of autonomy, beneficence, nonmaleficence, justice, and fidelity (see “Ethical Principles and Healthcare” above).

DEFINITION OF CASE MANAGEMENT

The practice of case management is a professional and collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet an individual’s health needs. It uses communication and available resources to promote health, quality, and cost-effective outcomes in support of the “triple aim” of improving the experience of care, improving the health of populations, and reducing per capita costs of healthcare.

ETHICAL ISSUES

Because case management exists in an environment that may look to it to solve or resolve various problems in the healthcare delivery and payor systems, case managers may often confront ethical dilemmas. Case managers must abide by the Code as well as by the professional
code of ethics for their specific professional discipline for guidance and support in the resolution of these conflicts.

**Standards for CCM Conduct**

The Code describes 25 standards for conduct, divided into five sections, as listed below.

**SECTION 1: THE CLIENT ADVOCATE**

CCMs will serve as advocates for their clients and perform a comprehensive assessment to identify the client’s needs; they will identify options and provide choices, when available and appropriate.

**SECTION 2: PROFESSIONAL RESPONSIBILITY**

S1. **Representation of Practice.** CCMs will practice only within the boundaries of their role or competence, based on their education, skills, and professional experience. They will not misrepresent their role or competence to clients.

S2. **Competence.** Case management competence is the professional responsibility of the CCM and is defined by educational preparation, ongoing professional development, and related work experience.

S3. **Representation of Qualifications.** CCMs will represent the possession of the CCM credential to imply the depth of knowledge, skills, and professional capabilities as intended and demonstrated by the achievement of board certification.

S4. **Legal and Benefit System Requirements.** CCMs will obey state and federal laws and the unique requirements of the various reimbursement systems by which clients are covered.

S5. **Use of CCM Designation.** The designation Certified Case Manager and the initials CCM may only be used by individuals currently certified by the Commission for Case Manager Certification. The credential is only to be used by the individual to whom it is granted and cannot be transferred to another individual or applied to an organization.

S6. **Conflict of Interest.** CCMs will fully disclose any conflict of interest to all affected parties and will not take unfair advantage of any professional relationship or exploit others for personal gain. If, after full disclosure, an objection is made by any affected party, the CCM will withdraw from further participation in the case.

S7. **Reporting Misconduct.** Anyone possessing knowledge not protected as confidential that a CCM may have committed a violation as to the provisions of this Code is required to promptly report such knowledge to CCMC.

S8. **Compliance with Proceedings.** CCMs will assist in the process of enforcing the Code by cooperating with inquiries, participating in proceedings, and complying with the directives of the Ethics & Professional Conduct Committee.
CASE

Darius Williams, RN, is a board-certified case manager with a home health agency. He has a very busy patient load. In addition to daily home visits to clients, he usually has two to three hours of charting and phone calls to physicians and clients at the end of the day. One of Darius’s specific responsibilities is to make sure that the plan of care ordered by each client’s physician is followed to the letter.

Darius has worked in home care for a number of years and is aware of the growing number of regulations guiding the profession. Some of the work he is asked to do, such as calling a doctor to report a “missed visit” with a patient, seems to do nothing more than add to his busy work. He is frustrated and angry that more and more demands on his time seem to take him away from caring for his clients.

Darius’s client Lloyd Jacobs was recently discharged from the hospital with heart failure and has an order for two MD visits every week for three weeks. During the second week, Mr. Jacobs refuses visits, stating that he is too busy and “feels just fine.” Darius talks to the patient and believes he is otherwise following medical advice and will recognize an exacerbation of heart failure early. Darius charts this in the client’s electronic file.

Back in his office toward the end of the day, Darius phones Mr. Jacob’s physician’s office to let them know about Mr. Jacobs’ missed visits. When he calls, Darius is put on hold and waits for over 10 minutes. Finally, he hangs up in frustration; he has too much work left to do that day to wait any longer on hold. He decides to chart that he called and left a message with supporting staff to let them know that Mr. Jacobs did not have a visit with the physician.

His action nags on Darius the following day; he is uncomfortable about falsifying records even though it was over something he considers trivial. He realizes this was a violation of the Code of Professional Conduct for Case Managers. He makes an appointment to talk to his supervisor and explains the situation. They agree that he will make another call to Mr. Jacobs’ doctor’s office today, according to agency policy. He will make a delayed entry in the client’s record indicating he was unable to contact the physician about the missed visits. There will be a warning placed in Darius’s personnel file.

Darius also describes to his supervisor about how hard it is to get in touch with physicians’ offices during the day and requests that she look into whether it would be feasible to use email or have one of the office support staff make such calls. She says she will look into it, since coming from a “culture of safety” perspective, she knows that if he has faced this situation, then other employees have probably done so as well and that it is likely a systemic problem.

Darius’s supervisor thanks him for rectifying his incorrect action and for speaking to her. He returns to his office and calls Mr. Jacobs’ physician. Today he gets through to the nurse, lets her know about Mr. Jacobs’ missed visits, and documents the call properly.
SECTION 3: CASE MANAGER / CLIENT RELATIONSHIPS

S9. Description of Services. CCMs will provide the necessary information to educate and empower clients to make informed decisions. At a minimum, CCMs will provide information to clients about case management services, including a description of services, benefits, risks, alternatives, and the right to refuse services. Where applicable, CCMs will also provide the client with information about the cost of case management services prior to initiation of such services.

S10. Relationships with Clients. CCMs will maintain objectivity in their professional relationships, will not impose their values on their clients, and will not enter into a relationship with a client (business, personal, or otherwise) that interferes with that objectivity.

S11. Termination of Services. Prior to the discontinuation of case management services, CCMs will document notification of discontinuation to all relevant parties consistent with applicable statutes and regulations.

SECTION 4: CONFIDENTIALITY, PRIVACY, SECURITY, AND RECORDKEEPING

S12. Legal Compliance. CCMs will be knowledgeable about and act in accordance with federal, state, and local laws and procedures related to the scope of their practice regarding client consent, confidentiality, and the release of information.

S13. Disclosure. CCMs will inform the client that information obtained through the relationship may be disclosed to third parties, as prescribed by law.

S14. Client Protected Health Information. As required by law, CCMs will hold as confidential the client’s protected health information, including data used for training, research, publication, and/or marketing unless a lawful, written release regarding this use is obtained from the client/legal representative.

S15. Records. CCMs will maintain client records, whether written, taped, computerized, or stored in any other medium, in a manner designed to ensure confidentiality.

S16. Electronic Media. CCMs will be knowledgeable about, and comply with, the legal requirements for privacy, confidentiality, and security of the transmission and use of electronic health information. CCMs will be accurate, honest, and unbiased in reporting the results of their professional activities to appropriate third parties.

S17. Records: Maintenance/Storage and Disposal. CCMs will maintain the security of records necessary for rendering professional services to their clients and as required by applicable laws, regulations, or agency/institution procedures (including but not limited to secured or locked files, data encryption, etc.). Subsequent to file closure, records will be maintained for the number of years consistent with jurisdictional requirements or for a longer period during which maintenance of such records is necessary or helpful to provide reasonably anticipated future services to the client. After that time, records will be destroyed in a manner assuring preservation of confidentiality, such as by shredding or other appropriate means of destruction.
SECTION 5: PROFESSIONAL RELATIONSHIPS

S18. **Testimony.** CCMs, when providing testimony in a judicial or nonjudicial forum, will be impartial and limit testimony to their specific fields of expertise.

S19. **Dual Relationships.** Dual relationships can exist between the CCM and the client, payor, employer, friend, relative, research study, and/or other entities. All dual relationships and the nature of those relationships must be disclosed by describing the role and responsibilities of the CCM.

S20. **Unprofessional Behavior.** It is unprofessional behavior if the CCM:
   a. Commits a criminal act
   b. Engages in conduct involving dishonesty, fraud, deceit, or misrepresentation
   c. Engages in conduct involving discrimination against a client because of race, ethnicity, religion, age, gender, sexual orientation, national origin, marital status, or disability/handicap
   d. Fails to maintain appropriate professional boundaries with the client
   e. Engages in sexually intimate behavior with a client or accepts as a client an individual with whom the CCM has been sexually intimate
   f. Inappropriately discloses information about a client via social media or other means

S21. **Fees.** CCMs will advise the referral source/payor of their fee structure in advance of the rendering of any services and will also furnish, upon request, detailed, accurate time and expense records. No fee arrangements will be made that could compromise healthcare for the client.

S22. **Advertising.** CCMs who describe/advertise services will do so in a manner that accurately informs the public of the skills and expertise being offered. Descriptions/advertisements by a CCM will not contain false, inaccurate, misleading, out-of-context, or otherwise deceptive material or statements. If statements from former clients are used, the CCM will have a written, signed, and dated release from these former clients. All advertising will be factually accurate and will not contain exaggerated claims as to costs and/or results.

S23. **Solicitation.** CCMs will not reward, pay, or compensate any individual, company, or entity for directing or referring clients, other than as permitted by law and/or corporate policy.

S24. **Research: Legal Compliance.** CCMs will plan, design, conduct, and report research in a manner that reflects cultural sensitivity; is culturally appropriate; and is consistent with pertinent ethical principles, federal and state laws, host institution regulations, and scientific standards governing research with human participants.
S25. **Research: Subject Privacy.** CCMs who collect data, aid in research, report research results, or make original data available will protect the identity of the respective subjects unless appropriate authorizations from the subjects have been obtained as required by law.

**CASE**

Marisol Green is a case manager in an outpatient clinic. She has recently noticed that Alex, a disabled veteran on her current caseload, seems to be developing feelings for her that go beyond the usual client-case manager relationship. He frequently compliments her appearance and stops by her office even on days when they do not have an appointment. One morning, Marisol returns from lunch to find a bouquet of flowers on her desk. The card reads, “Thanks for helping me get back on my feet again. Will you have dinner with me on Friday? –Sincerely, Alex.”

While she is attracted to Alex and feels flattered by his attention, Marisol quickly realizes the potential ethical problem inherent in accepting a date with him. Marisol schedules a meeting with the clinic director to discuss the situation and to weigh her options.

In their meeting, Marisol and the director review the “Standards” section of the Code of Professional Conduct for Case Managers, noting that it is considered unprofessional behavior when a case manager “fails to maintain appropriate professional boundaries with the client.” Similarly, they note that it is unprofessional behavior to “engage in sexually intimate behavior with a client.”

Marisol and the director agree that the ethical action would be for her to explain to Alex that she cannot go on a date with him while he is still a client of hers.

**Complaints Regarding Code Violations**

The CCMC administers the Code with the intent to monitor the professional conduct of CCMs to promote ethical practices. The Commission receives and processes complaints from clients related to violations of the Code by board-certified case managers. The procedures and form for filing a complaint are described in the Code.

The Ethics and Professional Conduct Committee of the Commission, consisting of at least four members appointed by the chairperson, conducts hearings and takes timely action in response to complaints filed in this manner. The committee first determines whether the alleged conduct would violate the Code and, if so, whether to proceed. CCMs are notified in writing of complaints made against them and given a proscribed opportunity to respond.

Once the committee establishes there is reasonable basis to investigate a violation of the Code, a hearing may be conducted to determine whether the violation occurred and the appropriate disciplinary action. Both the CCM and the complainant may engage legal counsel, call witnesses,
and present evidence. Details concerning a hearing’s initiation, manner, location, costs, conduct, presentation of evidence, deliberations, decisions, and more are described in detail in the Code.

If it is determined that the Code has been violated, the committee may apply sanctions against the certified case manager. These may include a reprimand, probation, suspension, or revocation of certification. The Code provides for appeals to the committee’s decisions.

**CODE OF ETHICS FOR NURSES**

Many case managers are also licensed nurses. In addition to abiding by the laws established in their state’s Nurse Practice Act, every nurse case manager is expected to read, understand, and abide by the ethical standards of the nursing profession. The American Nurses Association publishes the *Code of Ethics for Nurses with Interpretive Statements* to guide nurses’ professional practice.

The following provisions of the code broadly describe the ethical obligations of nurses:

**Provision 1.** The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every individual.

**Provision 2.** The nurse’s primary commitment is to the patient, whether an individual, family, group, community, or population.

**Provision 3.** The nurse promotes, advocates for, and protects the rights, health, and safety of the patient.

**Provision 4.** The nurse has authority, accountability, and responsibility for nursing practice; makes decisions; and takes action consistent with the obligation to provide optimal care.

**Provision 5.** The nurse owes the same duties to self as to others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence, and continue personal and professional growth.

**Provision 6.** The nurse, through individual and collective effort, establishes, maintains, and improves the ethical environment of the work setting and conditions of employment that are conducive to safe, quality health care.

**Provision 7.** The nurse, in all roles and settings, advances the profession through research and scholarly inquiry, professional standards development, and the generation of both nursing and health policy.

**Provision 8.** The nurse collaborates with other health professionals and the public to protect human rights, promote health diplomacy, and reduce health disparities.

**Provision 9.** The profession of nursing, collectively through its professional organizations, must articulate nursing values, maintain the integrity of the profession, and integrate principles of social justice into nursing and health policy.

*Source: ANA, 2015.*
LEGAL CONCEPTS AND STATUTES

Case managers practice within a society governed by state and federal laws. For that reason, it is important that they understand the basis of law (jurisprudence) in the United States, its sources and types, and the relationship of law to ethics in the practice of case management.

Types of Law

Laws flow from ethical principles and are limited to specific situations and codified by detailed language. These rules of conduct are formulated by an authority with power to enforce them. As such, laws change with time and circumstances. There are two major divisions of law: civil and criminal.

The purpose of civil law is to make restitution for injury suffered by one or more individuals. Civil law is further divided into contract law and tort law.

- Contract law is concerned with legally binding agreements between two or more parties.
- Tort law is concerned with civil wrongs other than contracts, such as assault, battery, and professional negligence.

The purpose of criminal law is to protect society from actions that directly threaten the order of society. Because some crimes are more serious than others and children are considered less responsible for their acts than adults, there are three categories of criminal offenses:

- Misdemeanor
- Felony
- Juvenile

Criminal law is concerned with harm against society—that is, with action that directly threatens the orderly existence of society. Criminal acts, while causing harm to individuals, are offenses against the state. Thus, in criminal cases the government attorney acts as the prosecutor on behalf of the people. When a guilty verdict is returned, the victim usually does not receive redress (compensation) even though the person who commits the crime is punished in some way, such as being sentenced to jail, fined, or placed on probation. To receive compensation, the victim must bring a civil suit against the accused perpetrator (Hamilton, 1996).

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Proof: By a preponderance of the evidence; adjudicated by a judge or jury; a jury decision need not be unanimous

**Criminal Law**

**Function:** To protect society from actions that directly threaten its orderly existence. Criminal acts, while aimed at individuals, are offenses against the state; thus perpetrators are punished by the state (imprisoned, fined, performance of hours of work); victims usually are not compensated but may initiate civil action against perpetrators to recover monetary damages for injury or loss.

**Categories:**
- Misdemeanor: Lesser offenses (e.g., violations of professional practice acts [nursing, social work, physical therapy, speech therapy, etc.], vehicle code)
- Felony: Most serious offenses (e.g., murder, rape, burglary, grand theft)
- Juvenile: Crimes committed by minors (age varies with states and crimes)

Proof: Beyond a reasonable doubt; jury decision must be unanimous

Source: Adapted from Hamilton, 1996.

**Federal Statutory Issues in Case Management Practice**

Though healthcare regulation has historically been managed by individual states, the federal government has become increasingly involved in recent years. Of particular relevance to the practice of case management are several specific acts of Congress, including:

- Americans with Disabilities Act of 1990 (and Amendments of 2008)
- Health Insurance Portability and Accountability Act of 1996
  
  *(See also “Resources” at the end of this course.)*

**AMERICANS WITH DISABILITIES ACT (ADA)**

The Americans with Disabilities Act (ADA, 2014) of 1990 is a broad-reaching civil rights statute. Amended in 2008 to broaden protections for workers with disabilities, it protects the rights of people with a variety of ailments, including persons infected with human immunodeficiency virus (HIV) and those with respiratory and musculoskeletal disorders. Its provisions include measures of particular interest and relevance to case managers, such as access to public buildings, equal legal protection of persons living with disabilities, and nondiscrimination in employment situations.

**HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)**

The Health Insurance Portability and Accountability Act of 1996 limits the extent to which health insurance plans may exclude care for pre-existing conditions and creates special programs to control fraud and abuse within the healthcare system. The most well-known provision of the act is its standards regarding the electronic exchange of sensitive, private health information. Known as privacy standards, these rules 1) require the consent of clients to use and disclose...
protected health information, 2) grant clients the right to inspect and copy their medical records, and 3) give clients the right to amend or correct errors. Privacy standards require all hospitals and healthcare agencies to have specific policies and procedures in place to ensure compliance with the rules.

**State Practice Acts**

Case management is not typically regulated under state practice acts governing certain professions. However, many case managers are also licensed professionals—such as nurses, social workers, physical therapists, speech therapists—and therefore practice under state jurisdiction. Licensure in those professions is required by any professional wishing to practice in the United States. Licenses must be renewed on a regular basis (which varies by state), and most states require the completion of some level of continuing education in order for a licensee to qualify for license renewal.

States each adopt their own practice act governing nursing, social work, and similar professions. Those professionals must practice within the scope defined by individual states’ practice acts, which generally include rules and requirements for educational institutions and practitioners regarding:

- Scope of practice
- Licensure
- Competency
- Disciplinary sanctions
- Supervision of assistants and aides

Each state practice act may have language that differs from other states in regard to evaluations/reevaluation, delegation and supervision of unlicensed personnel, specific areas of practice restriction, or issues of direct access.

The goal of professional practice acts and their administrative boards is to protect the public by setting standards for the practice of those professions. It is the responsibility of practitioners to know and abide by the provisions of these acts and abide by the rules and regulations of the state(s) in which they are licensed.

**COMPLAINTS AND VIOLATIONS**

It is a criminal offense to violate provisions of a state’s professional practice acts. When individuals or agencies believe a professional such as a nurse or social worker has violated a provision of their state’s relevant practice act, they may complain to the pertinent administrative board of the state. This board will investigate the allegations, and if sufficient evidence is found to support the complaint, state attorneys may file a complaint against the licensee.
Because a state license cannot be taken away without due process, licensees have the right to a public hearing before the board, to be represented by an attorney, and to present witnesses on their own behalf. Following such a hearing, the board may: 1) take no action, 2) reprimand the licensee, 3) suspend or revoke the individual’s license, or 4) place the licensee on probation.

Although practice acts do vary from state to state, they contain similar grounds for complaints, such as:

- Obtaining a license by fraud
- Practicing in a grossly incompetent or negligent manner
- Diverting controlled substances for personal use
- Being convicted of a felony

It is the responsibility of license holders to know, understand, and obey the rules and regulations of the state in which they are licensed to practice. (See “Resources” at the end of this course.)

CASE

Jing Wu is a social worker case manager who works in a skilled nursing facility. Though she excels in her professional and clinical responsibilities, she has lately been struggling with some personal issues, including a health crisis with her elderly father and a recent acrimonious divorce. She also just found out that her teenaged son dropped out of high school.

With all the recent upheaval in her personal life, Jing accidentally misplaced the letter from the state board of social work that contained the forms for her upcoming licensure renewal deadline. Three weeks after the renewal deadline had passed, the director of the facility where Jing works requested updated copies of state licenses for all licensed employees. Jing realized that she had forgotten to renew her social work license, which was now expired. To make matters worse, Jing also realized that she had not completed sufficient continuing education to be eligible for license renewal. Jing was extremely upset and embarrassed and became tearful in her manager’s office as she described the recent stressors in her life that had contributed to her forgetting to complete her license renewal requirements.

Jing’s manager, Dorothy, was a very supportive and knew Jing to be a loyal employee and highly competent case manager who had simply made a mistake. Dorothy gently explained to Jing that she would have to cease practicing immediately and that having a lapsed license puts both her and the facility at risk. She should begin the process of reinstating her license in accordance with the social work practice act of their state, including payment of applicable penalties and completion of requisite paperwork. In addition, they will need to call the state board in order to explain the situation and to determine if she or the facility are liable for any disciplinary action due to her having inadvertently practiced for three weeks with a lapsed license.

They also discussed Jing’s other recent personal stressors, and Dorothy suggested that Jing use some of her accrued paid time off both to address her personal issues and to complete the continuing education that she needs to reinstate her license.
CIVIL LAW AND CASE MANAGEMENT

Civil law is concerned with harm against individuals, including breaches of contracts and torts. A civil action is considered a wrong between individuals. Its purpose is to make right the wrongs and injuries suffered by individuals, usually by assigning monetary compensation. It is important to be aware that an action can potentially be both criminal and civil in nature (Stanford & Connor, 2012).

A contract is a legally binding agreement between two or more parties. Breaking such an agreement—such as a written employment agreement between a healthcare agency and a case manager—is called a breach of contract. Both parties to a contract must do exactly what they agreed to do or they risk legal action being taken against them. For that reason, it is vital that each party clearly understands all the terms of a contractual agreement before signing it (Hamilton, 1996).

A tort is a wrong against an individual. Torts may be classified as either intentional or unintentional.

- Intentional torts include assault and battery, false imprisonment, defamation of character, invasion of privacy, fraud, and embezzlement.

- Unintentional torts are commonly referred to as negligence. In order to be successfully claimed, negligence must consist of four elements: duty, breach of duty, causation, and damages.
  (Stanford & Connor, 2012)

Intentional Torts

ASSAULT AND BATTERY

Assault is doing or saying anything that makes people fear they will be touched without their consent. The key element of assault is fear of being touched, for example, threatening to force a resistant client to get out of bed against his or her will.

Battery is touching a person without consent, whether or not the person is harmed. For battery to occur, unapproved touching must take place. The key element of battery is lack of consent. Therefore, if a man bares his arm for an injection, he cannot later charge battery, saying he did not give consent. If, however, he agreed to the injection because of a threat, the touching would be deemed battery, even if he benefited from the injection and it was properly prescribed.

Except in rare circumstances, clients have the right to refuse treatment. Other examples of assault and battery are:

- Forcing a client to submit to treatments for which he or she has not consented orally, in writing, or by implication
• Moving a protesting client from one place to another
• Forcing a client to get out of bed to walk
• In some states, performing blood alcohol tests or other tests without consent
  (Hamilton, 1996)

FALSE IMPRISONMENT

False imprisonment is confining people against their will by physical or verbal means. Some examples of false imprisonment are:

• Restraining a client for non–medically approved reasons
• Restraining a mentally ill client who is not a danger to self or others
• Detaining an unwilling client in the hospital if the client insists on leaving
• Detaining a person who is medically ready for discharge for an unreasonable period of time
  (Hamilton, 1996)

DEFAMATION OF CHARACTER

Defamation of character is communication that is untrue and injures the good name or reputation of another or in any way brings that person into disrepute. This includes clients as well as other healthcare professionals. When the communication is oral, it is called slander; when it is written, it is called libel. Prudent healthcare professionals: 1) record only objective data about clients, such as data related to treatment plans and 2) follow agency policies and approved channels when the conduct of a colleague endangers client safety (Hamilton, 1996; Stanford & Connor, 2012).

INVASION OF PRIVACY

Invasion of privacy includes intruding into aspects of a patient’s life without medical cause. Invasion of privacy is a legal issue separate from violations of HIPAA’s privacy rule due to the fact that invasion of privacy goes beyond protected health information.

CASE

Agnes Aquino, a case manager at the local hospital, was chatting with her neighbor, Sonja, an occupational therapist who works in home health, while they did yard work together. When they were finished digging up a flowerbed, Sonja shook out her wrists and said, “Wow, I feel like I just gave myself carpal tunnel syndrome from all that digging!”

“That reminds me,” Agnes said. “You’ll never guess who I saw at the hospital today—remember Manny, who used to date your sister? Well, he was just referred to our outpatient clinic for treatment of carpal tunnel symptoms! I always thought he was pretty tough, but it
turns out that he’s a real wimp when it comes to pain. Makes you wonder if he’s all that good a mechanic, really.”

Suddenly, Agnes realized she had violated the standards of the Code of Professional Conduct for Case Managers as well as the federal Health Insurance Portability and Accountability Act (HIPAA) by disclosing confidential client information without authorization. Not only had Agnes violated the Code and the law by disclosing confidential information, if the matter were to become known to her client, a legal suit of slander could be realistically be brought against her. She acknowledged her inappropriate behavior to Sonja and apologized, resolving not to act in such a manner in the future.

The following day Agnes made an appointment and reported her HIPAA violation to her supervisor. Her supervisor then called the privacy officer at the hospital and submitted a detailed report on the disclosure. The privacy officer, according to protocol, next reported the incident to the state and wrote a letter to Manny letting him know his privacy had been breached.

Because Agnes was a valued hospital employee and had no previous infractions of this or any other type, and because the violation was one of carelessness, her consequence was limited to one-on-one counseling with her supervisor and a written warning placed in her personnel file. In addition, the supervisor set up a mandatory in-service seminar for everyone in the case management department to reinforce the seriousness of breaching a patient’s privacy.

For his part, Manny decided not to pursue any further action even though he was aware he could have filed a complaint with the state or federal government or with the hospital. In addition, he opted not to file a civil lawsuit even though his privacy had been breached and his reputation had been damaged.

FRAUD

Fraud includes deceitful practices in healthcare and can include the following:

- False promises
- Upcoding (such as billing group treatment sessions as individual therapy)
- Insurance fraud

EMBEZZLEMENT

Embezzlement is the conversion of property that one does not own for his or her own use, such as when an employee appropriates funds from a company bank account (Stanford & Connor, 2012).
Unintentional Torts: Negligence

It is the legal responsibility of all case management professionals to uphold a certain standard of care. This standard is generally measured against an established norm of what other similarly trained professionals would do if presented with a comparable situation.

ELEMENTS OF NEGILIGENT CARE

In the case of negligent care, four components must be present in order to establish a successful unintentional tort claim.

1. **Duty** is established when a case manager agrees to treat a patient.

2. **Breach of duty** occurs when a case manager fails to act in a manner consistent with what another member of the profession would prudently do in a similar situation.
   - Misfeasance occurs when a mistake is made (such as administering a treatment to the wrong patient).
   - Nonfeasance occurs when a case manager fails to act (such as not assisting a client who displays suicidal intent).
   - Malfeasance occurs when the negligence action involves questionable intent (such as physically pulling a resistant client from bed and causing bruises on the patient’s wrist).

3. **Causation** requires that an injury of ill-effect to the client must be proven to have been a direct result of the action (or lack of action) taken by the case manager.

4. **Damages** refers to the actual injuries inflicted by the accused for which compensation is owed.
   (Stanford & Connor, 2012)

**CASE**

Samantha Henry, an RN case manager, works for a home health agency. One weekend a month, she is required to take call for the agency and to admit new patients. This Saturday, her first patient will be Ms. Rose, who had just been discharged home from the hospital following open-heart surgery, complicated by a pulmonary embolism.

Reading the patient’s chart, Samantha learns that Ms. Rose requires close monitoring for her two blood-thinning drugs and that her hospital discharge plan calls for a blood draw in the hospital ED that weekend, after which the hospital pharmacy will receive the lab results and contact the patient with instructions on her medication.

When Samantha calls Ms. Rose Friday night to set up a Saturday home visit, the patient says she is very tired after leaving the hospital and asks whether Samantha can draw the blood when
she comes to the house in order to save her a trip back to the hospital. Samantha, thinking the patient’s request for a home blood draw is reasonable and noting the physician’s order for the lab draw, agrees to draw the blood at Mr. Rose’s house during the course of her home health admission.

The next morning, Samantha draws the blood without incident and drops the specimen off at the hospital lab. She asks the lab technician to call the pharmacy with the lab results, stating that the pharmacy will then let the patient know how much blood-thinning medicine to take. Samantha trusts the lab and pharmacy tech to follow through.

When Samantha arrives at Ms. Rose’s on Sunday morning to visit the patient and draw the Sunday lab, the patient says she has not heard from the lab and just assumed she wasn’t supposed to take her medication the day before. When Samantha phones the pharmacy, they tell her they never received any results from the lab. Instead, it turns out that the lab tech left a voicemail message for Ms. Rose’s doctor.

Samantha then learns that the lab results indicated Ms. Rose should have resumed the blood thinner the previous day. In the meantime, the patient has begun to have shortness of breath, and Samantha calls 911 so that Ms. Rose can be reevaluated in the emergency department. Samantha realized that her actions in doing the home blood draw could result in a claim of negligence against her. This situation involves a possible breach of duty in which Samantha has mistakenly drawn the patient’s blood at home contradicting the physician’s order for a hospital blood draw. The patient may now be suffering an ill-effect and could sustain actual injuries due to not having taken her medication, which could be shown to be a direct result of Samantha’s action.

**PRINCIPLES AFFECTING MALPRACTICE ACTIONS**

Professional negligence (malpractice) is the improper discharge of professional duties or failure to meet standards of care, resulting in harm to another person. Four important principles affect malpractice actions: individual responsibility, *respondeat superior*, *res ipso loquitor*, and standard of care.

- **Individual responsibility** affirms the principle that every person is responsible for his or her own actions. Even when several other people are involved in a situation, it is difficult for any one person to remain free of all responsibility and shift all responsibility to others.

- **Doctrine of *respondeat superior*** (“let the master speak”) holds employers indirectly and vicariously liable for the negligence of their employees who are acting within the scope of their employment at the time a negligent act occurs. This doctrine allows an injured party to sue both the employee and employer, to sue only the employee, or to sue only the employer for alleged injuries. Although each person is responsible for her or his own acts, professionals with oversight duties are held responsible for the actions of those they supervise. For example, a case manager may be held accountable for other case managers that he or she supervises.
• **Doctrine of res ipso loquitor** ("the thing speaks for itself") is a rule of evidence designed to equalize the positions of plaintiffs and defendants in the situation when plaintiffs (those injured) may be at a disadvantage. The rule allows a plaintiff to prove negligence by circumstantial evidence when the defendant has the primary, and sometimes only, knowledge of what happened to cause an injury.

Generally speaking, plaintiffs must prove every element of a case against defendants. Until they do, the court presumes that the defendants did meet the applicable standard of care. However, when the court applies the *res ipso loquitor* rule, defendants must prove that they were not negligent. Plaintiffs can ask the court to invoke the *res ipso loquitor* rule if three elements are present:

1. The act that caused the injury was in the exclusive control of the defendant.
2. The injury would not have happened in the absence of negligence by the defendant.
3. No negligence on the part of the plaintiff contributed to the injury.  
   (Fremgen, 2011)

• **Standard of care** refers to the level of care provided to a client that would be reasonably expected to be provided by another individual in a comparable situation.

### Preventing Malpractice Claims

Because today’s healthcare consumers are more likely to take an active role in their care, more likely to question the quality of healthcare services, and more apt to take legal action against providers, case managers must take precautions to minimize the risk of malpractice claims being brought against them. Below are some suggested actions that may help prevent malpractice claims. *(This information is in no way intended to be a substitute for professional legal advice.)*

• **Delegate duties cautiously.** Case managers are responsible for their subordinates. When assigning a task, ensure the task is not beyond the ability or scope of practice of the subordinate because, if an error occurs, the supervising case manager is responsible.

• **Develop self-awareness.** Case managers must recognize their own strengths and weaknesses and use continuing education to expand their knowledge and skill set. They should not be afraid to admit lack of knowledge in some clinical areas and should not take on clients whose needs lie outside of their skill set or scope of practice.

• **Follow agency policies and procedures.** These documents are designed to prevent errors, injuries, and accidents. If an error occurs and legal action results, the court will want to know if the case manager followed established policies and procedures.

• **Document actions accurately.** Legally, if an action is not documented, it did not happen. Notes should be written accurately, objectively, and without subjective judgments that could be construed as libelous.
• **Write detailed incident reports.** Case managers must document in detail all errors, injuries, and accidents. Because long periods of time may elapse between an incident and court action, an incident report may be the only detailed account of what happened.

• **Recognize suit-prone clients and intervene appropriately.** When people feel frightened and powerless, they may become critical and demanding. By reacting defensively or avoiding such clients, a case manager may inadvertently confirm clients’ fears and/or foster their anger. When case managers listen actively, discuss service plans openly, and involve clients in decision-making, they help to foster trust and respect.

• **Prevent accidents.** Be alert for hazards that cause injury. Spilled water, broken equipment, protruding apparati, exposed electrical wires, and cluttered hallways are accidents waiting to happen. When they do, people are more likely to suffer injuries, and healthcare professionals may be held responsible.

• **Become informed consumers of professional liability insurance.** The possibility of being sued is real. Lawsuits are costly and the price of defending oneself may be immense. Given these realities, case managers should become informed consumers of professional liability insurance (see below).

  (Hamilton, 1996)

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**PROFESSIONAL LIABILITY INSURANCE**

Professional liability insurance shifts the cost of a suit and its settlement from a person to an insurance company. Such insurance covers acts committed by an individual when he or she is functioning in a professional capacity.

Employer policies cover healthcare professionals only while they are on the job working for that employer within the scope of the employer’s job description. Individual policies give named holders more power to control decisions than if they are insured only under the policy of the employer. Case managers in independent practice need to know whether an insurance policy covers them as independent practitioners or whether they are only covered when they are employed by a healthcare agency.

Many policies exclude coverage of criminal acts, such as intentional torts (assault, battery, false imprisonment, etc.) and disciplinary actions brought by licensing boards against licensed professionals.

A liability insurance policy is a legal contract between an insurance company and a policyholder. False information on the application may void the policy.
LEGAL AND ETHICAL FACTORS IN END-OF-LIFE CARE

Various legal and ethical issues may arise for case managers who are serving patients nearing the end of life. These patients, and others facing chronic or debilitating conditions, often wish to address questions regarding healthcare and/or end-of-life decisions. Thus, case managers should be aware of the legal and ethical aspects related to these issues, among others:

- Advance directives
- Right to die
- Organ donation

Advance Directives

Advance medical directives are documents containing patients’ oral and written expressions of their preferences about future medical care if they should become unable to speak for themselves. Federal law (the Patient Self-Determination Act) requires hospitals to inform patients that they have the right to complete an advance directive.

Less than one third of Americans have advance directives (i.e., a living will and a healthcare power of attorney). Older patients are more likely to have such directives, with 41.2% self-reporting them in a recent study (Waite et al., 2013).

When a surrogate is making end-of-life decisions for a patient, the surrogate will be expressing the wishes of the patient that they have previously discussed. Particularly in the case of chronic illness where a slow physical or mental decline takes place, advance directives provide the opportunity to ensure that a person’s own preferences will be followed. Copies of the advance directive may be given to family, care providers, one’s hospital, an attorney, or others. The plan should be reviewed periodically to provide for necessary updates (CDC, 2014).

Healthcare professionals have an obligation to work with patients and their families to reach decisions that balance autonomy and beneficence.

PATIENT SELF-DETERMINATION ACT

The responsibility held by case managers to ensure and respect a client’s right to autonomy is also legally enforced by the federal Patient Self-Determination Act (PSDA) of 1991. The PSDA mandates that any Medicare- and/or Medicaid-certified healthcare institution must actively work to educate adult patients and the community as a whole about the rights of a patient to accept or refuse healthcare interventions. The PSDA obligates healthcare providers to ensure that patients are informed of their legal rights, under individual state law, to make decisions about their own healthcare, as well as to create an advance directive for themselves.

This law mandates that patients admitted to healthcare facilities be asked whether they have an advance directive in place; that healthcare facilities maintain policies and procedures regarding
advance directives; and that this information be provided to patients when they are admitted. (The PSDA defines an advance directive as a “written instrument, such as a living will or durable power of attorney for healthcare, recognized under state law, relating to the provision of such care when the individual is incapacitated.”) Advance directive laws were put into place in response to several highly visible legal cases in order to protect the right of a patient to predetermine whether or not to receive life-sustaining healthcare interventions.


LIVING WILL AND MEDICAL POWER OF ATTORNEY

In most states, an advance directive can be either a living will or a medical power of attorney, also called a durable power of attorney for healthcare, a healthcare proxy, or declaration or appointment of a healthcare agent. Advance directives are regulated by state law and therefore differ from state to state.

A living will is a document one can write while alive to dictate preferences for healthcare decisions. A medical or durable power of attorney names one or more people who may make decisions for the person who is unable to make their wishes known (CDC, 2014). A healthcare proxy is the person who is named as the decision maker and may have his or her name listed in the advance directive form.

According to the President’s Council on Bioethics (2005), “advance instruction directives (or living wills), though valuable to some degree and in some circumstances, are a limited and flawed instrument for addressing most of the decisions caregivers must make for those entrusted to their care.” Rather than try to anticipate every aspect of future circumstances, the Council found that,

Advance proxy directives are much more valuable and should be encouraged. . . . Naming of proxy decision makers provides clear identification of who shoulders the responsibility to act for the patient and makes it clear to physicians and others with whom they must deal. Such knowledge makes it much more likely that there will be the desirable discussions between family and professional caregivers at all important junctures of treatment and care.

PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

Several states have adopted an advance directive form developed in Oregon and known as POLST, which stands for Physician Orders for Life-Sustaining Treatment (POLST, 2016). This simple form, to be completed and signed by both patient and a physician or nurse practitioner, specifies the patient’s preferences concerning measures such as antibiotics, artificial nutrition (including tube feeding) and hydration, cardiopulmonary resuscitation (CPR), comfort measures, and mechanical ventilation/respiration.
The form is printed on brightly colored paper and stays with the patient during transfers from one care setting to another. Patients at home keep the POLST form on the refrigerator, where emergency responders can find it. Long-term care facilities retain POLST forms in residents’ charts. (See “Resources” at the end of this course for information about POLST programs in each state.)

DO-NOT-ATTEMPT-RESUSCITATION (DNAR) ORDERS

Do-not-attempt-resuscitation orders (formerly known as do-not-resuscitate orders) have been renamed to emphasize the minimal likelihood of successful CPR. Additionally, a specific order to refrain from intubation is referred to as “do not intubate” (DNI).

Patients and families need to understand not only the unlikely success of resuscitation but also the risks involved, which include fractured ribs, damaged internal organs, and neurologic impairment. Although the patient (or family) must ultimately decide about whether to attempt CPR, healthcare professionals need to explain that withholding CPR does not equate with letting someone die. Rather, a DNAR order should be considered an “allow natural death” (AND) order (Curesearch, 2016).

The primary care provider should discuss the possibility of a DNAR order as soon as it is reasonable. A delay in putting a DNAR order in place may result in treatment unwanted by the patient and distress for the healthcare team. The DNAR order should be readily available in the event of an emergency to ensure that the patient’s wishes will be honored. It should be posted prominently, either on the head or foot of the bed, or if the patient is at home, on the refrigerator. The specifics of the order should also be carefully documented in the patient’s chart (University of Illinois at Chicago, 2013).

MECHANICAL VENTILATION (MV)

Decisions about mechanical ventilation can be spelled out in the patient’s advance directive. Some patients choose to forgo MV, believing that it merely prolongs the dying process. Others choose to have MV when they can no longer breathe on their own. Choosing MV may reflect the erroneous belief that this life-sustaining treatment can improve the patient’s prognosis.

Depending on the physician, choosing MV may affect the physician’s certification of the patient as terminal and, therefore, the patient’s eligibility for hospice benefits. Use of MV requires that the patient lie in bed or sit in a chair with restricted movement. If an endotracheal tube is used, the patient will not be able to speak or swallow. Mechanical ventilation also increases the risk of pneumonia because it prevents patients from coughing effectively and allows fluid to build up in the lungs.

Once MV is started, the decision to withdraw it may present a legal and ethical controversy for the physician and the family. In some cases, withdrawal of this life support may require a court order.
ARTIFICIAL NUTRITION AND HYDRATION (ANH)

Patients who receive hospice care have food and drink as they wish or need. Some individuals make their own choice (often as part of an advance directive) to stop or limit eating or drinking at a certain point in their dying process. When oral nutrition is no longer safe for a patient, ANH using enteral feeding tubes is sometimes used to deliver nutrition (Arenella, 2014).

Decisions about whether to have ANH involve weighing the potential benefit and the burden to the patient. Clinicians need to help families understand that forgoing ANH is not “killing” or “starving” the patient. The most recent American Nurses Association (ANA) position statement shows there is consensus in the nursing profession regarding ANH. The ANA supports a patient’s (or surrogate’s) right to weigh the risks and benefits of ANH after a full discussion by the healthcare team (ANA, 2011). The ANA position statement supports the ANA beliefs about autonomy, relief of suffering, and patients receiving expert care at the end of life.

Little evidence supports the use or disuse of hydration as a comfort measure in end of life. The reason for this lack of evidence is that it is not ethically possible to conduct a controlled, randomized clinical trial in which one group of patients near the end of life receives hydration and a second group has hydration withheld (AAHPM, 2013).

Although ANH may extend the patient’s life a few days or weeks, there is considerable physical and emotional trauma in inserting a nasogastric tube or undergoing surgery to place a gastrostomy (feeding) tube. There is also the increased risk of infection, increased risk of aspiration, erosion of nasal tissue, and increased diarrhea, all of which would prolong suffering.

Application of restraints to keep the patient from pulling out the tube can cause the patient to struggle. Nasogastric tube feedings can lead to such complications as pain, aspiration pneumonia, epistaxis, pharyngitis, esophagitis, airway obstruction, and metabolic derangements. Many health professionals feel that hospice care with cessation of feeding and fluids is a more humane alternative to ANH (AAHPM, 2013).

There is widespread use of feeding tubes at the end of life, particularly in patients with Alzheimer’s disease or other cognitive impairment, even though there is not sufficient evidence to prove enteral tube feeding is beneficial in patients with advanced dementia.

Research suggests that people who choose not to have ANH do not suffer due to hunger or thirst. Furthermore, without ANH, patients are less likely to experience bloating or to develop pleural effusions (fluid around the lungs), which can cause shortness of breath, or fluid in the throat, which requires suctioning. Studies also indicate that forgoing artificial hydration increases the body’s production of endorphins (natural pain-relieving hormones), making the patient more comfortable and less likely to experience pain. The only side effect of dehydration at the end of life is dry mouth, which can be relieved by good mouth care, ice chips, or moistened sponge swabs (Arenella, 2014).
CASE

Kathy, a hospice nurse case manager, was questioned by the family of an elderly patient on home hospice care. When the discussion turned to a decision about continuing artificial nutrition and hydration (ANH) for their loved one, a few of the family members expressed concern that withholding nourishment and liquids would cause unnecessary suffering by “starving her to death.” Kathy was able to explain that studies showed no benefit in giving tube feedings or intravenous (IV) therapy to dying patients, and in fact could possibly cause complications resulting in discomfort or pain. Kathy assured the family that should they decide to discontinue artificial nutrition and hydration, she and the hospice staff would continue to keep the patient comfortable. They would give her pain medication and anti-anxiety medication when needed, and wet her mouth with ice chips and moistening swabs to keep it from feeling dry.

The Right to Die

The right-to-die movement in America is gaining public support, indicating widespread dissatisfaction with the quality of end-of-life care. The right-to-die concept includes assisted suicide (also called physician aid in dying [PAD]) and voluntary active euthanasia. In assisted suicide, the healthcare practitioner, usually a physician, provides the means to end life, such as a prescription for a lethal amount of drugs or the drugs themselves, or other measures, by a person who has knowledge of the patient’s intention.

According to the American Nurses Association (2015) Code of Ethics, Provision 1.4, however, nurses “may not act with the sole intent of ending a patient's life” even though such action may be motivated by compassion, respect for patient autonomy, and quality of life considerations.

Both nurses and physicians are confronted with requests for assistance in dying. However, this practice is legal in only five states. In 1994, Oregon became the first state to pass right-to-die laws. Montana and Washington soon followed (Hendry et al., 2013). In 2013, the Vermont legislature passed a right-to-die law in a close 75–65 vote. The guidelines for practice are very stringent. In 2015, California became the fifth state to pass a law allowing terminally ill patients the right to end their own lives by using a lethal dose of medications ordered by a physician and self-administered. Two physicians must attest to the patient’s being terminal within six months and mentally capable of making the decision (California Legislative Information, 2016). In addition, the patient must be physically able to ingest the lethal dose of medication themselves without help from another person.

Healthcare practitioners acknowledge that there is an “underground” practice of assisted suicide in the United States. Some maintain that the principle of double effect is used to justify what is really assisted suicide. The principle of double effect states that the potential to hasten imminent death is acceptable if it is the unintended consequence of the primary intention to provide comfort and relieve suffering. For example, a terminal patient with severe difficulty breathing may be given large doses of narcotic to relieve suffering. As the breathing is eased by the narcotic, there may be a second effect that stops breathing altogether.
Organ and Tissue Donation

Case managers may be called upon to discuss the issue of organ and tissue donation with family members and patients. It is therefore helpful to understand the basics about the donation process and related ethical and legal issues.

In 1984, Congress passed the National Organ Transplant Act (NOTA) and established the Organ Procurement and Transplant Network (OPTN) to guarantee the fair distribution of donated organs. Today there are 58 state organ procurement organizations (OPOs) that arrange for the recovery of all organs and tissues that become available for transplant. These organizations are members of the OPTN, federally designated, nonprofit, and state-licensed.

ORGAN DONATION PROCESS

The organ donation process begins when individuals make the decision to register as an organ donor. This often involves signing up directly with the state OPO or when applying for or renewing a driver’s license or state ID. Once a decision has been made to become a donor, family members should be informed so that they can cooperate with the facility staff regarding the donor’s wishes.

When all possible efforts at saving a potential donor’s life have failed, for example, following a fatal accident or terminal illness, testing begins to determine whether brain death has occurred. In most circumstances, a neurologist, neurosurgeon, or intensive care specialist establishes the irreversibility of coma in such cases. A neurological assessment must show that the patient lacks all evidence of responsiveness.

When brain death has been confirmed, the hospital notify the local OPO. If the patient is a potential donor, an OPO representative immediately goes to the hospital and searches the state’s donor registry for legal consent. If the patient is not registered and there is no other legal consent, consent from the family will be required. When this is obtained, medical evaluation continues.

Following medical evaluation to establish suitability and once all contraindications have been ruled out, a potential donor may be accepted. The OPTN is then contacted by the OPO in order to begin a search for matching recipients. When a list of possible matching recipients is obtained, the donation is offered to the first patient on the list.

During the above process, the donor is maintained on artificial support. The condition of every organ is monitored by hospital medical and nursing staff along with the OPO coordinator, who also arranges arrival and departure times of both surgical teams. When the surgical team arrives, the donor is taken to the OR, and under sterile technique, organs and tissues are recovered and all incisions closed. The tissue and organs are then transported rapidly by commercial or contracted airplanes, helicopters, and/or ambulances to the hospital where the transplant recipient is waiting and may be prepped and ready in the OR (USDHHS, 2016a).
LEGAL DECISION-MAKING AUTHORITY

An important barrier to donation involves the ultimate responsibility for making the decision to donate. In the United States, the system of deceased-donor organ donation is based on “explicit consent.” That means an individual is assumed not to be a donor unless he or she has indicated his or her wishes by registering to donate (i.e., “opt in”). Some countries have a system whereby all individuals are assumed to be donors unless they have “opted out,” however, studies have found that donor shortages remain under this system as well (Shepherd et al., 2014).

The Uniform Anatomical Gift Act (UAGA) of 2006 provides the legal framework for determining consent for organ donation. As of 2014, 47 states have enacted some form of this act, which specifically prevents any family member or otherwise responsible party from revoking an individual’s first-person consent.

Despite the laws supporting the wishes of the deceased, however, it is common practice for family members to be given the power to override these wishes. Factors that may influence physicians or OPOs to allow a family’s wishes to override the individual’s consent may include discord produced by family refusal and potential generation of conflict between the family and physician. Concerns about potential lawsuits and the controversy and adverse publicity that may result are considered potentially damaging to the efforts to increase organ donations.

Organ transplant agencies also have the right to decline the organs if they believe that the negative impact of accepting an organ under controversial circumstances would outweigh the value of the organ itself (USDHHS, 2016b; Chon et al., 2014).

ETHICAL CONFLICTS AS BARRIERS TO DONATION

While there is little research or consensus, limited studies indicate certain ethical concerns and conflicts among both physicians and nurses that interfere with the organ donation process. Such concerns and conflicts include the following:

• Lack of knowledge about the organ donation process, causing a negative impact on attitudes that can lead to failure to identify potential donors

• Difficulty accepting brain death as death (i.e., belief that as long as a patient’s heart is beating, the patient is still alive and should continue to receive care)

• Difficulty removing a ventilator for a donation after cardiac death when there is still minimal brain activity (i.e., belief in the possibility that the person may recover)

• Difficulties among the multidisciplinary team during the organ donation process related to:
  o Lack of commitment on behalf of healthcare professionals to the process
  o Lack of knowledge regarding how to carry out brain death protocol and doubt about when to begin the process
ETHICS AND INVOLUNTARY COMMITMENT FOR PATIENTS AT HIGH RISK FOR SUICIDE

Case managers may encounter patients who are at risk for suicide, and admission to a psychiatric hospital or unit generally is necessary for those at high risk for suicide in order to keep them safe. The greatest majority of such admissions are voluntary, which means the person freely agrees to be admitted for treatment. Anytime someone attempts suicide and refuses treatment, however, the person most likely will be involuntarily committed for treatment.

WHAT IS INVOLUNTARY COMMITMENT?

Involuntary commitment means placing a person in a psychiatric hospital or unit without their consent. The laws governing involuntary hospitalization vary from state to state, but in general, they confine involuntary commitment to persons who are mentally ill and/or under the influence of drugs or alcohol and are deemed to be in imminent danger of harming themselves or others. In the United States, the maximum initial time for involuntary commitment is usually 3 to 5 days. If the person is not discharged on or before the 3- to 5-day limit because more treatment is necessary, a court order may be sought to extend the involuntary commitment.

Source: Caruso, n.d..

The question of whether or not involuntary hospitalization is ethically justified remains open for consideration. The ethical principles of autonomy, beneficence, nonmaleficence, and justice all come into play when a decision is being made regarding the disposition of a patient considering suicide, but they provide nominal protection to the suicidal patient.

The ethical principle of autonomy calls for respect, dignity, and choice, and therefore a person should not be coerced or manipulated into treatment if he/she is capable of autonomous decision-making. Taking away a person’s freedom when no crime has been committed is a very serious enterprise. Cases involving a suicidal patient are the classic example of what is considered justified involuntary hospitalization. However, there is ambivalence concerning this, and it is argued by some that the risk of suicide by itself may not be sufficient justification.

Studies have shown that concerns relating to beneficence and protecting a patient from self-harm are more important to clinicians than a patient’s ability to make an autonomous decision. Hospital emergency departments in the United States take this approach and protect the right of health even though doing so infringes on the person’s autonomy (ANA, 2015; White, 2013).
Differing Perspectives

Approaching the question of what should be done about a patient who has expressed verbally or by action the wish to die, there are several different perspectives. Three such points of view are the libertarian, the communitarian, and the egalitarian-liberal perspectives.

LIBERTARIAN PERSPECTIVE

Autonomy is the crucial concern of this perspective. From this vantage point, involuntary hospitalization:

- Takes away the person’s freedom
- Restricts what the person can do with his/her body
- Prevents the person from protecting property (job, home)
- Is a means to manage people who do not adhere to social norms
- Coerces and manipulates patients into treatment
- Raises financial issues that may affect the patient and/or infringe on the property rights of other citizens (e.g., use of tax dollars)
- Does not recognize that suicide is sometimes a rational choice based on competent thought and decision-making skills

COMMUNITARIAN PERSPECTIVE

This approach disregards the person’s autonomy and exclusively considers the community values of the clinician making the decision. It views suicide as morally wrong and offensive to the dominant group, and intervention must take place to prevent it. The belief that suicide is bad and morally wrong is a common perspective in the United States.

EGALITARIAN LIBERAL PERSPECTIVE

This approach states that the government’s role is to protect individual rights. But, if additional rights, such as the right to health, are not protected, then the rights of liberty and autonomy may not be possible. Involuntary hospitalization protects the person from a decision-impairing disease or disorder that puts the patient at risk for self-injury or death, and treatment of said disease or disorder gives the patient the right of health. Without health, it is said, other rights may not be possible. But how can a mental health professional know in advance that forcible treatment is justified, especially since there are no objective tests to verify whether or not a decision-impairing disease or disorder may or may not exist?
Possible Outcomes of Involuntary Hospitalization

Hospitalization is a predictable outcome of expressing suicidal ideation and feelings and is often felt by the patient to be an undesired consequence of doing so. It is believed by some that legal holds can “train” a person to avoid expressing suicidal feelings unless they wish to be placed in a costly inpatient unit and experience the shame and stigma that is often the aftermath. On the other side of the argument, however, it can demonstrate to patients that their expressed wish or attempt to die is being taken seriously.

Legal holds and hospitalization may make society and providers feel better, but there are some possible consequences to be considered:

- The dual role of counselor/clinician as a trusted sounding board and as an agent for the state can impair future interactions with the patient and the patient’s future contacts with other healthcare professionals.
- When a clinician asks for a commitment warrant, confidentiality is, essentially, broken.
- These actions involve choosing between the rights of the many and the rights of one, the patient.
- Civil action is a viable option for those who believe they were falsely committed, and lawsuits are not uncommon.

(White, 2013; Sullum, 2012; Sjöstrand et al., 2015)

CONCLUSION

As case managers assume an increasingly important role in the healthcare environment, it is of vital importance that they adhere strictly to existing laws and ethical principles. Case managers are responsible for maintaining the highest standards of professional conduct. These standards arise from ethical principles, fundamental concepts by which people gauge the rightness or wrongness of behavior, and laws, which flow from ethical principles and are limited to specific situations, codified by detailed language and formulated by an authority with power to enforce them.

Ethical standards of behavior for certified case managers have been developed by the Commission for Case Manager Certification. Likewise, professional practice acts in individual states outline laws governing licensed professionals such as nurses and social workers. Continuing competence in both ethics and jurisprudence is vital for all practicing case management professionals, regardless of experience level or practice setting.
RESOURCES

Americans with Disabilities Act
http://www.ada.gov/2010_regs.htm

Code of Ethics (National Association of Social Workers)
https://www.socialworkers.org/pubs/code/default.asp

Code of Ethics for Nurses (American Nurses Association)
http://www.nursingworld.org/codeofethics

Code of Professional Conduct for Case Managers (Commission for Case Manager Certification)

Core ethics documents (American Physical Therapy Association)
http://www.apta.org/Ethics/Core/

Ethics Advisory Council (National Hospice and Palliative Care Organization)
http://www.nhpco.org/committees/ethics-advisory-council

Find your nurse practice act (National Council of State Boards of Nursing)
https://www.ncsbn.org/npa.htm

HIPAA general information
http://www.cms.hhs.gov/hipaaGenInfo

National POLST Paradigm: Programs in Your State
http://polst.org

Social work regulatory boards and colleges (Association of Social Work Boards)
https://www.datapathdesign.com/ASWB/LR/Prod/cgi-bin/LawBoardWebsiteDSWBDDL.dll/NewLAWBoards

State codes of ethics (American Speech-Language-Hearing Association)
http://www.asha.org/Advocacy/state/State-Codes-of-Ethics/

REFERENCES


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TEST

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1. Broadly defined, ethics is concerned with:
   a. Questioning the nature of values as they apply to human conduct.
   b. Protecting society from actions that directly threaten its order.
   c. Punishing members of society for actions that are wrong.
   d. Organizing people to rise up and change society.

2. A case manager considers a decision to be right because his or her motivation is good whether or not there will be negative consequences. This is an example of which type of ethical theory?
   a. Deontological
   b. Consequential
   c. Teleological
   d. Moral

3. When a case manager refuses to serve a client based on the client’s sexual orientation, the case manager is violating which ethical principle?
   a. Nonmaleficence
   b. Justice
   c. Autonomy
   d. Beneficence

4. Which is not a typical step in the process of resolving ethical dilemmas in a professional setting?
   a. Identifying any conflicting values and duties
   b. Making a decision without regard for who will be affected by the decision
   c. Consulting with colleagues and appropriate experts
   d. Keeping a written record of the decision-making process

5. The purpose of a code of ethics is to:
   a. Describe the scope of practice of a profession.
   b. Describe standards of behavior of a profession.
   c. Establish laws for the practice of a profession.
   d. Serve as a substitute for a state practice act.
6. Which is **not** one of the principles of the Code of Professional Conduct for Case Managers? Certified case managers will:
   a. Obey all laws and regulations.
   b. Place the public interest above their own at all times.
   c. Renew their certification every two years.
   d. Always maintain objectivity in their relationships with clients.

7. According to the Code of Professional Conduct for Case Managers, a certified case manager:
   a. May be convicted of a felony if it is unrelated to the practice of case management.
   b. May discriminate for religious reasons on the basis of a client’s sexual orientation.
   c. Is required to shred all client records within one year of terminating services to that client.
   d. Is required to report violations of the Code by other case managers.

8. A nurse case manager violates a regulation of the nurse practice act in her state. Her offense is categorized as a:
   a. Criminal misdemeanor.
   b. Criminal felony.
   c. Civil tort violation.
   d. Civil contract violation.

9. A federal law specifically dealing with the rights of patients in regard to private and/or sensitive healthcare information is the:

10. The goal of state practice acts is to:
    a. Create an administrative body to define a profession.
    b. Describe the scope of practice of a profession.
    c. State the competency requirements of a profession.
    d. Protect the public by setting standards of education and practice.
11. Restraining a mentally ill client against his will and who is not a danger to self or others is an example of:
   a. Invasion of privacy.
   b. Fraud.
   c. Defamation of character.
   d. False imprisonment.

12. A case manager acts in a manner that is not consistent with the standards of care for a case management professional, and those actions result in an injury to the client. This is an example of:
   a. An intentional tort.
   b. Negligence.
   c. A criminal offense.
   d. The doctrine of respondeat superior.

13. When working with a client who seems likely to seek legal action, a case manager’s action is to:
   a. Listen actively and attentively to the client and document treatment diligently.
   b. Respond defensively whenever the client mentions lawsuits or expresses displeasure.
   c. Delegate treatment whenever possible to a subordinate.
   d. Advise the client that a negative attitude will likely have an adverse effect on his or her outcome.

14. Upon a patient’s admission, Medicare- and/or Medicaid-certified healthcare facilities comply with the Patient Self-Determination Act by:
   a. Informing the patient about the expected cost of his or her treatment.
   b. Asking the patient if he or she has an advance directive in place.
   c. Educating the patient about the risk of contracting healthcare-associated infections.
   d. Determining the patient’s other sources of health insurance coverage.

15. Although advance directives are useful in making decisions about end-of-life care, some experts recommend:
   a. Leaving end-of-life decisions to other adult family members.
   b. Appointing a healthcare proxy who will decide for the patient should he or she no longer be able to make sound decisions.
   c. Allowing the patient’s primary care physician to decide what is best for the patient.
   d. Waiting until the diagnosis of a serious illness to make difficult ethical decisions about patient care.
16. Do-not-attempt-resuscitation (DNAR) orders are written:
   a. By a physician or nurse when the patient’s family fails to do so.
   b. And recorded only in the patient’s chart in order to protect patient privacy.
   c. And posted prominently for easy access in the event of an emergency.
   d. For all patients in order to permit a natural death.

17. By forgoing artificial nutrition and hydration at the end of life, the patient:
   a. Experiences considerable physical and emotional trauma.
   b. Suffers more due to increased hunger and thirst.
   c. Develops pleural effusions.
   d. Increases his or her body’s production of endorphins.

18. Physician aid in dying (PAD) is legal:
   a. In all 50 states and the District of Columbia.
   b. In Canada, but not in the United States.
   c. Only in a few states.
   d. Only with the permission of the dying patient’s family.

19. Which is a true statement regarding organ donation in the United States?
   a. In most states, individuals are assumed to be organ donors unless they have “opted out” when applying for a driver’s license.
   b. The Uniform Anatomical Gift Act allows family members to revoke a deceased individual’s first-person consent to be an organ donor.
   c. Potential lawsuits from family members is no longer a concern affecting organ donation efforts.
   d. Both brain death and a lack of responsiveness are established before an individual is considered for organ donation.

20. Which statement describes the egalitarian liberal ethical perspective regarding involuntary hospitalization of a suicidal individual?
   a. Involuntary hospitalization protects the individual from self-injury or death and gives the individual the right of health.
   b. Involuntary hospitalization demonstrates to the individual that his or her expressed wish to die by suicide is being taken seriously.
   c. Involuntary hospitalization does not recognize that suicide is sometimes a rational choice based on competent decision-making skills.
   d. Involuntary hospitalization prevents the individual from committing an act that society considers morally wrong and offensive.